CHARTER SCHOOLS USA

Employee Benefits *Handbook*

Plan year January 1, 2017 through to December 31, 2017

Dear CSUSA Team:

As we continue on our journey toward greatness with PURPOSE, PASSION and INTEGRITY, I want to make you aware of our commitment to GRIT when it comes to your benefits program. Our team has rolled up its sleeves and worked hard to provide not only a competitive, comprehensive benefits package for you, but one that is easy to access and provides the best overall coverage based on your needs. We know that in the ever-changing healthcare and insurance industry, we must take responsibility for our own health and wellness. Our PURPOSE is to provide you with the information you need to make the best decisions and keep premiums as low as possible. I am excited to highlight a few of the changes we have made for this year.

We know that you have established a meaningful relationship with your Primary Care Physician. Your physician knows you better than anyone and can help you set healthy benchmarks and provide confidential advice on improving your health. Your annual wellness care visits will continue to earn you insurance premium discounts, in addition to improving your overall health.

Learning and understanding your benefits can be time consuming and overwhelming. To help with your decisions, you have access to **alex**, your virtual benefits counselor. Alex is an online interactive tool that explains every option you have in an easily understood format using every day terms and leading you to a customized description of your benefits. You can review Alex as needed at your own pace whenever you have a question.

We have also worked with our carriers to design a third lower cost medical plan called Consumer Driven Plan (CDP) with co- pays for office visits and prescriptions. I encourage you to carefully review and consider the CDP and to ask questions until you feel you are completely informed.

Our carriers have numerous resources available to you that can help you find the best healthcare options while allowing you to manage costs. I hope the tools and resources available to you this year will help you make informed benefits decisions for you and your family. Thank you for your continued PASSION and being an important part of the CSUSA family.

Sincerely,

Jonathan K. Hage
President & CEO

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Welcome to Charter Schools USA Benefits Handbook

Important Notice to Employees

This Benefits Guide provides a general description of the various benefits available to you through the CSUSA Employee Benefits Program. The details of these plans and policies are contained in the official plan and policy documents. This guide is meant only to cover the major points of each plan or policy. It does not contain all of the facts regarding coverage, limitations, or exclusions that are contained in the policy documents. In the event of a conflict between the information in this guide and the formal policy documents, the formal documents will govern the actual benefits provided.

The rates and payroll deductions provided in this illustration are meant for illustrative purposes only and may not reflect final underwriting adjustments. Please refer back to your employer for confirmation of your premium responsibilities.

Child Dependent Limitations:

Dependent child: Birth to age 30

Eligible Employees:

To be eligible for benefits, you must be working at least 30 hours per week. For specific details please refer to your plan documents. New full time employees' benefits for all lines of coverag will begin on the 1st of the month following 60 days of full time employment. New full time employees' benefits for all lines of coverage in the state of Indiana will begin the 1st of the month following the date of hire of full time employment.

Eligible Dependents for all plans:

- Legal spouse
- Qualified Domestic Partner (same & opposite sex)
- Natural child
- Stepchild
- Legally adopted child
- Foster Child
- Child placed in your home for purpose of adoption
- Child for whom legal guardianship has been awarded to the Participant or the Participant's spouse/Domestic Partner
- Child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order

Qualifying Event

Unless you have a Qualifying Event, coverage elections made at Open Enrollment cannot be changed until the next annual Open Enrollment period. A Qualifying Event allows you to make a change to your benefit elections within 30 days of the event.

Examples of Qualifying Events include:

- Marriage / Divorce
- Birth, or adoption
- Death of your spouse or covered child
- Change in work status that affects your benefits
- Receiving Qualified Medical Child Support Order

If you do not notify Human Resources within 30 days of a family status change, you will have to wait until the next annual open enrollment period to make benefit changes unless you have another family status change.

Family Member Documentation

Members of your family may be eligible for plans in the CSUSA Welfare Benefit Plan, including, but not limited to, Medical, Dental, Vision and Life insurance benefits. You are required to submit valid proof of eligibility documentation as required when you enroll your family members and/or at any time additional documentation or verification is requested for enrollment.

CSUSA and its third party administrators may audit benefits eligibility at any time. Falsifying claims, eligibility (including failure to provide required notification of a life event, such as a divorce) or other such documents may result in employees or their families receiving benefits for which you are not entitled. Such conduct is unacceptable and, may constitute theft, and could result in denial of claims, loss of coverage and disciplinary action up to and including termination of employment.

Once you have made your elections and add your dependent(s) to coverage, your dependent(s) coverage will be pending until he/she has been verified. You will receive a letter from the Department of Verification Services (DVS) requesting documentation on your dependents(s). All dependent information should be sent by one of the following means:

Fax: **866-400-1686**

Mail: **Charter Schools USA ADP_DVS**
PO BOX 2338
Alpharetta GA 30023-2338

You are required to submit these documents within 30 days of being contacted. The process takes an estimated time of 7 days once the required information is received. If you fail to provide the documents, your family members will not be enrolled and you will have to wait until the Annual Enrollment Period for the 2017 Plan Year.

FAMILY MEMBER	DESCRIPTION	REQUIRED DOCUMENTATION
Spouse	Your lawful Spouse (if not legally separated from you, the employee) who qualifies as a Spouse for purposes of the Internal Revenue Service Code of 1986 (as in effect on January 1, 2004)	Copy of Marriage Certificate issued by a governmental agency (Certified translated copy if in a foreign language).
Natural Child	Your children (natural, stepchild, and/or legally adopted), up to age 26 or 30 if they are unmarried, have no dependents of their own and are dependent upon you for financial support.	Copy of Birth Certificate issued by a governmental agency; Hospital Birth Record (for new born); other legal document establishing parentage. (Employee must be listed on the birth certificate, hospital birth record or other legal document).
Stepchild		Copy of Birth Certificate issued by a governmental agency or other legal document establishing parentage. (Employee's spouse must be listed on birth certificate or other legal document).
Legally Adopted Child (or Child Placed for Adoption)		Copy of Adoption (or Adoption Placement) Orders proving legal obligation and issued by a court or other legal authority.
Child for Whom you have a Legal Obligation	Child for whom you (or, alternatively, you and your Spouse) have been appointed by a court of competent jurisdiction as the person(s) having custody of the child and the sole legal right and obligation to provide support and medical care for the child, but only if the child resides in your household on a permanent basis, and the child's parents are deceased, or the parental rights of the child's parents are permanently terminated, or the Plan Administrator determines, in its sole discretion, that the child's parents are totally disabled and financially unable to provide any support or care for the child.	Copy of Birth Certificate issued by a governmental agency; Court Documentation providing your custody and the sole legal right and obligation to provide support and medical care for the child; proof the child lives in your household on a permanent basis; proof the child's parents are deceased or have had their parental rights permanently terminated (or proof the child's parents are totally disabled and financially unable to provide any support or care for the child).

How to Enroll

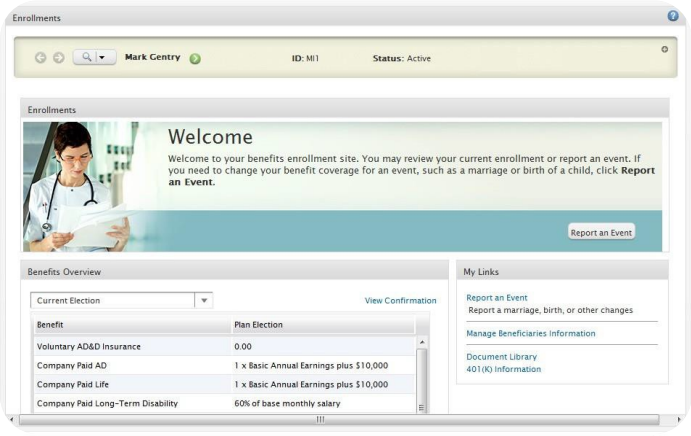
Picking the right benefit plans can be a challenge. Which medical plan is best for me? How much should I save in my flexible saving accounts? Should I get extra life insurance? Does a health savings account make sense for me? The decisions are important, and a lot goes into making the right choice. To make the process easier for you, CSUSA has brought in an easy to use online tool called **alex**! All you have to do is log on and respond to his questions, **alex** will prompt you for some basic information about you and your family, ask a few questions about how your personal situation (everything you say remains confidential) and **alex** will help you figure out what to choose based on your responses.

Talking with **alex** feels like having a conversation with a real person, and because **alex** uses simpler language and avoids insurance jargon, its explanations and recommendations are easy to understand. Also, because **alex** is available from any computer with an internet connection you can use it with your family as you consider your options. And if you have any questions about how anything works, **alex** can walk you through them.

Start a conversation with **alex** today. Visit myalex.com/csusa/2016

alex does not create, receive, maintain, transmit, collect or store any identifiable end-user information.

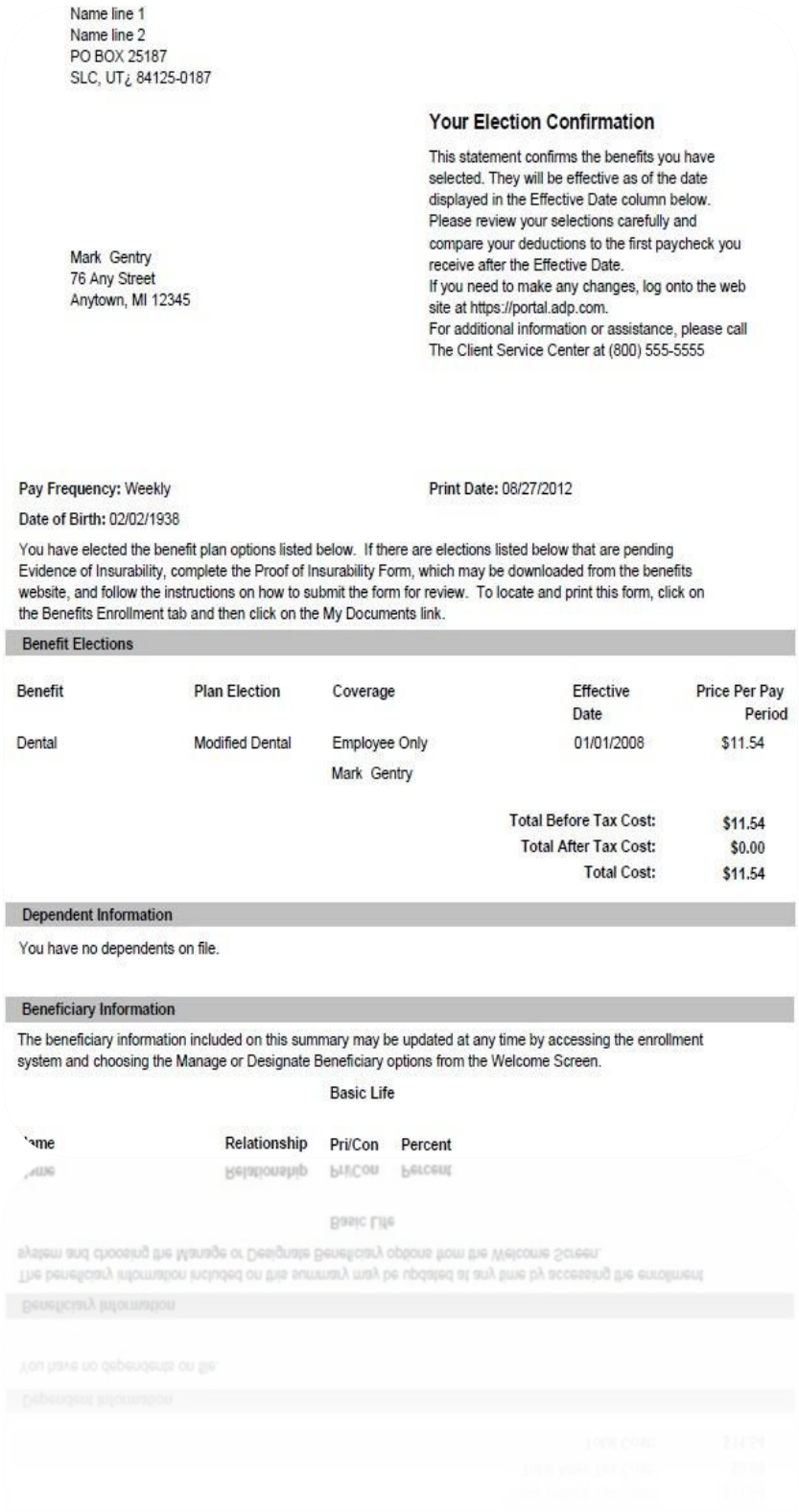
Log on to: https://portal.adp.com/public/index.htm to access the Health and Welfare site. Your username and password are the same as when you login to view your paystubs and make changes to your personal information. The employee dashboard opens. For example, during annual enrollment, and you will see the following:



Review Your Benefits

You can review your benefit elections any time throughout the year. Complete the following to review benefits:

- ✓ Access the benefits system
- ✓ Select the event for which you want to view election from the drop-down menu
- ✓ Click the View confirmation link to view and print the confirmation, which will display in PDF format.
- ✓ Print out a copy of the election confirmation and provide it to your School Operations Administrator.



Name line 1
Name line 2
PO BOX 25187
SLC, UT¿ 84125-0187

Your Election Confirmation

This statement confirms the benefits you have selected. They will be effective as of the date displayed in the Effective Date column below.
Please review your selections carefully and compare your deductions to the first paycheck you receive after the Effective Date.
If you need to make any changes, log onto the web site at https://portal.adp.com.
For additional information or assistance, please call The Client Service Center at (800) 555-5555

Mark Gentry
76 Any Street
Anytown, MI 12345

Pay Frequency: Weekly **Print Date:** 08/27/2012

Date of Birth: 02/02/1938

You have elected the benefit plan options listed below. If there are elections listed below that are pending Evidence of Insurability, complete the Proof of Insurability Form, which may be downloaded from the benefits website, and follow the instructions on how to submit the form for review. To locate and print this form, click on the Benefits Enrollment tab and then click on the My Documents link.

Benefit Elections

Benefit	Plan Election	Coverage	Effective Date	Price Per Pay Period
Dental	Modified Dental	Employee Only Mark Gentry	01/01/2008	$11.54

Total Before Tax Cost:	$11.54
Total After Tax Cost:	$0.00
Total Cost:	$11.54

Dependent Information

You have no dependents on file.

Beneficiary Information

The beneficiary information included on this summary may be updated at any time by accessing the enrollment system and choosing the Manage or Designate Beneficiary options from the Welcome Screen.

Basic Life

`ame	Relationship	Pri/Con	Percent

CSUSA Retirement Plan

Who is eligible to participate in the 401(K)?

- ✓ Full time employee
- ✓ You must complete 60 days of service
- ✓ At least 21 years of age

How much can I contribute?

- ✓ $18,000 for the year 2016
- ✓ Employees age 50 or older can qualify for additional before-tax "catch up" contributions. The maximum amount is $6,000
- ✓ CSUSA matches 25% up to the first 6%

Contributions:

- ✓ Employees currently in the plan can make changes to their contribution at any point and the changes will be reflected on the following pay period.

Entry Date(s):

- ✓ January 1st
- ✓ April 1st
- ✓ July 1st
- ✓ October 1st

Vesting

The Company's contributions are vested as follows:

- ✓ Upon completion of 1 year: 25%
- ✓ Upon completion of 2 years: 50%
- ✓ Upon completion of 3 years: 75%
- ✓ Upon completion of 4 years: 100%

TRANSAMERICA
Retirement Solutions

Navigating Through your CSUSA Retirement Plan

alex explains your retirement savings plan and helps you decide how much to contribute.

The link below is to the **alex** tool which can help you walk through the retirement plan offered by CSUSA.

https://www.myalex.com/csusa/retirement

Please note: that **alex** is not the enrollment site, once you have decided which benefits you wish to enroll in, you will log into the ADP Employee Self Service portal and make your benefits elections.

To enroll please go online to www.TA-Retirement.com or call 1-800-401-8726. More information can be found in the ADP portal as well.

Medical Insurance
Cigna

Cigna - In Network Benefits			
Deductible	Choice Fund Open Access Plus H S A	Open Access Plus IN	CDP
Individual	$2,000	$1,750	$5,000
Family	$4,000	$3,500	$10,000
Coinsurance	20%	30%	30%
Calendar Year Out of Pocket			
Individual	$6,450	$6,600	$6,600
Family	$12,900	$13,200	$13,200
Physician Office Visits	No referrals needed	No referrals needed	No referrals needed
Primary Care Physician	Deductible then Coinsurance	$45	$25
Specialist	Deductible then Coinsurance	$65	$65
Preventive Care			
Routine Adult Physical Exam	Covered at 100%	Covered at 100%	Covered at 100%
Well Woman Exam	Covered at 100%	Covered at 100%	Covered at 100%
Routine Mammograms	Covered at 100%	Covered at 100%	Covered at 100%
Children's Wellness Visits	Covered at 100%	Covered at 100%	Covered at 100%
Diagnostic/Lab			
Blood Work	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Diagnostic Lab & X-rays - Independent Diagnostic Facility	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Advanced Imaging (MRI/PET/CT Scans/Nuclear Medicine)	Deductible then Coinsurance	$300 per type of scan/day Deductible then Coinsurance	$300 + Deductible + 30% Coinsurance
Hospitalization/ Outpatient Services			
Inpatient Hospitalization (Facility)	Deductible then Coinsurance	$500/day + Ded + 30% Coinsurance	$500 + Ded + 30% Coinsurance
Outpatient Surgery (Facility)	Deductible then Coinsurance	$300/day + Ded + 30% Coinsurance	$300 + Ded + 30% Coinsurance
Emergency Room	Deductible then Coinsurance	$300	$300 + Ded + 30% Coinsurance
Urgent Care	Deductible then Coinsurance	$150	$150
Pharmacy (Rx)			
Retail	Deductible then $15 / $45 / $80	$20 / $50 / $85	$10 / $60 / $95 / 50% to $250
Mail Order	Deductible then $38 / $113 / $200	$50 / $125 / $213	$25 / $150 / $238 / 50%
Cigna - Out of Network Benefits			
Deductible: Individual / Family	$5,000 / $10,000	n/a	n/a
Out of Pocket Maximum: Individual / Family	$20,000 / $40,000	n/a	n/a
Coinsurance	50%	n/a	n/a
Semi-monthly payroll deductions			
Employee Only	$37.68	$89.51	$31.00
Employee + Spouse	$102.24	$269.55	$84.00
Employee + Child(ren)	$94.17	$245.54	$76.00
Employee + Family	$138.55	$377.57	$121.00

Cigna Choice Fund
Open Access Plus HSA

What is an HSA?

- A pre tax-advantaged savings account, owned by you
- It is portable, never forfeited and rolls over year after year.
- Funds you contribute are tax-free and can be used to pay for qualified medical, dental, vision and pharmacy expenses.
- You determine the amount you would like to contribute per paycheck.
- Debit cards are issued to all participants to pay for eligible expenses

How does it work?

- Use Cigna Choice Fund/HSA Bank MasterCard OR the HSA check book OR Online bill pay to pay for qualified expenses
- In most cases your in-network doctor will not collect any money from you at the time of your visit. Instead, your doctor will send the claim directly to Cigna. Cigna will process the claim and determine payment for eligible services.
- For a list of eligible expenses visit irs.gov or Cigna.com/expenses

What are the annual IRS contribution limits?

- Contributions made by all parties to an HSA cannot exceed the annual HSA limit set by the Internal Revenue Service (IRS).

Coverage Tier	2016 Annual Contribution Limits	2017 Annual Contribution Limits
Individual	$3,350	$3,400
Family (Individual plus dependent)	$6,750	$6,750
Catch Up (age 55 or older)	$1,000	$1,000

HEALTH CARE ANSWERS WHEN YOU NEED THEM

Cigna Group Insurance Value-Add Services

Available at no cost to you as part of your Cigna benefits!

Welcome to a value-add service designed to help you, and your family, navigate the health care landscape - one turn at a time. Let us help you – your spouse, dependents, parents and parents-in-law – get the answers you need, when you need them.

Don't know where to turn? We point the way.

- Find the right health care professionals based on your needs
- Schedule appointments; arrange for medical tests or special treatments
- Answer questions about diagnoses, test results, treatments and medications

Want to maximize your benefit dollars?
We can help you save.

- Get the estimated fees for services in your area
- Find options for non-covered and alternative health services
- Receive information about generic drug options
- Address questions and concerns related to your medical bills

Need eldercare or special needs services?
We're there for you.

- Find in-home care, adult day care, group homes, assisted living and long-term care
- Clarify or get help applying for Medicare, Medicare Supplement plans and Medicaid
- Coordinate care among multiple providers
- Arrange transportation to appointments

cut and fold

CIGNA GROUP INSURANCE

Health Advocacy Services

Access to help when you need it for all your health care, insurance or medical bill needs – for you and your family, including parents and parents-in-law.

24/7 support **866.799.2725**

Cigna

Health advocacy services are NOT health insurance or medical services, and this program does not provide either for health care services or for the reimbursement for financial losses of health care services. Health advocacy services are provided under a contract with Health Advocate, Inc. subject to all of the terms of that contract. Presented here are highlights of the program. Full terms, conditions and exclusions are contained in the Health Advocate service agreement. "Health Advocate" and "Medical Bill Saver" are trademarks of Health Advocate, Inc. used under license.

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Help is only a call away.
Call 866.799.2725

Together, all the way.℠

Cigna

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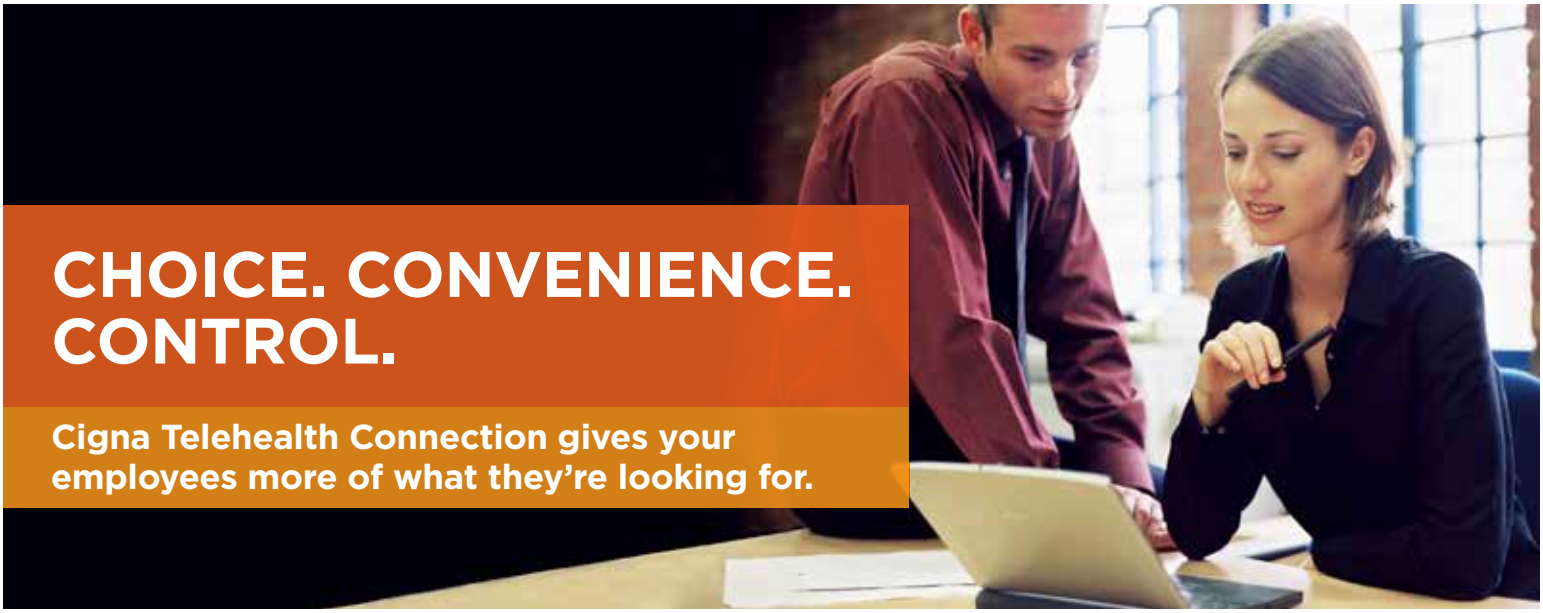

CHOICE. CONVENIENCE. CONTROL.

Cigna Telehealth Connection gives your employees more of what they're looking for.

Good news. Now, most Cigna medical plans provide covered employees with access to two telehealth services – American Well (AmWell) and MDLIVE. We call it Cigna Telehealth Connection, telehealth services designed to offer employees greater control when they need to see a doctor.

With Cigna Telehealth Connection, employees can get the care they need – including most prescriptions – for a wide range of minor conditions. They can connect with a board-certified doctor when, where and how it works best for them – via video or phone – without having to leave home or work.

Choose when: Day or night, weekdays, weekends and holidays.

Choose where: Home, work or on the go.

Choose how: Phone or video chat.

Choose who: AmWell or MDLIVE doctors.

AmWell and MDLIVE televisits can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. Costs are the same or less than a visit with a primary care provider. Giving employees an easy-to-use and cost effective alternative to care can help reduce costs and non-urgent ER visits.

We encourage you to have your employees register for one or both services, so they're ready when and if they need care.

Visit the websites*

- **AmWellforCigna.com**
- **MDLIVEforCigna.com**

Or Call*

- **AmWell at 855-667-9722**
- **MDLIVE at 888-726-3171**

Tell your employees about Cigna Telehealth Connection, so they'll be ready whenever they need these services.

AmWell and MDLIVE are only available for medical visits. For covered services related to mental health and substance abuse, employees have access to the **Cigna Behavioral Health** network of providers.

- Go to **Cignabehavioral.com** to search for a video telehealth specialist
- Call to make an appointment with your selected provider

Telehealth visits with Cigna Behavioral Health network providers cost the same as an in-office visit. See your plan materials for costs and coverage details.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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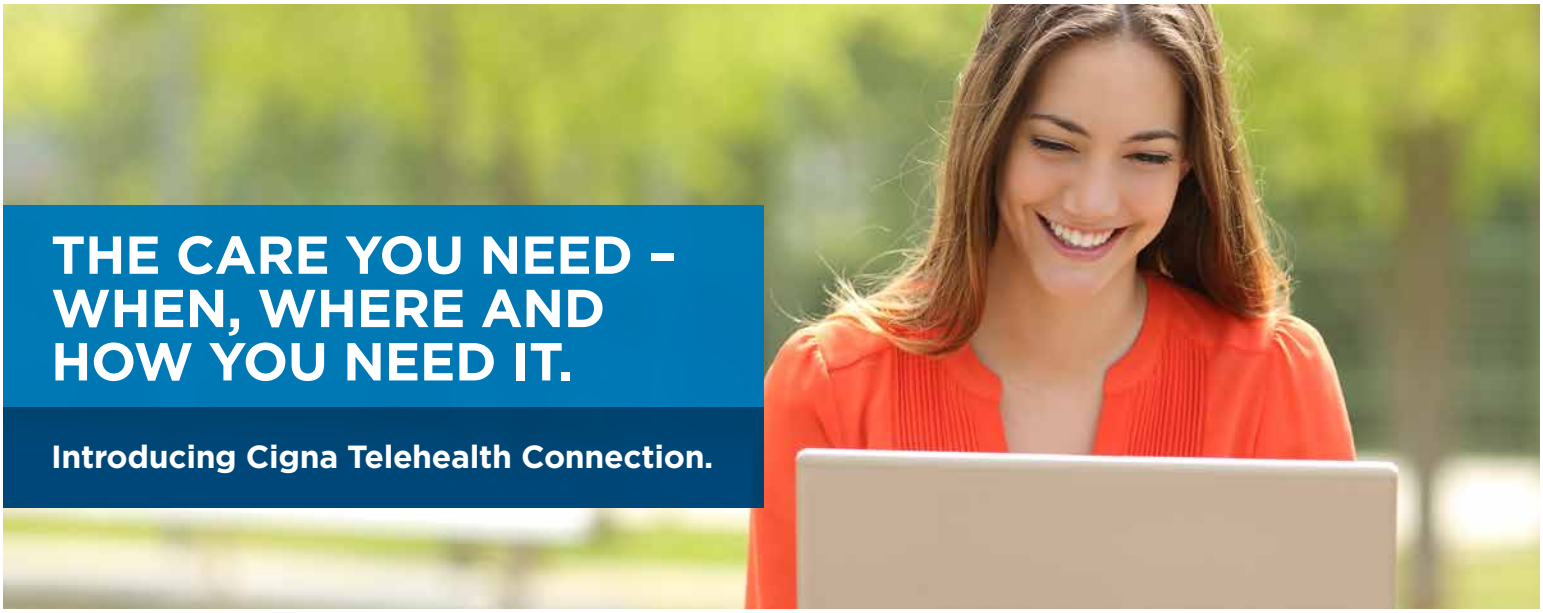

THE CARE YOU NEED – WHEN, WHERE AND HOW YOU NEED IT.

Introducing Cigna Telehealth Connection.

Choice is good. More choice is even better.

Now Cigna provides access to **two** telehealth services as part of your medical plan – **AmWell** and **MDLIVE**.

Cigna Telehealth Connection lets you get the care you need – including most prescriptions – for a wide range of minor conditions. Now you can connect with a board-certified doctor via secure video chat or phone, without leaving your home or office. When, where and how it works best for you!

Choose when: Day or night, weekdays, weekends and holidays.

Choose where: Home, work or on the go.

Choose how: Phone or video chat.

Choose who: AmWell or MDLIVE doctors.

Say it's the middle of the night and your child is sick. Or you're at work and not feeling well. If you pre-register on both AmWell and MDLIVE, you can speak with a doctor for help with:

- sore throat
- headache
- stomachache
- fever
- cold and flu
- allergies
- rash
- acne
- UTIs and more

The cost savings are clear.

Televisits with AmWell and MDLIVE can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. And the cost of a phone or online visit is the same or less than with your primary care provider. Remember, your telehealth services are only available for minor, non-life threatening conditions. In an emergency, dial 911 or go to the nearest hospital.

AmWell and MDLIVE are only available for medical visits. For covered services related to mental health and substance abuse, you have access to the **Cigna Behavioral Health** network of providers.

- Go to **Cignabehavioral.com** to search for a video telehealth specialist
- Call to make an appointment with your selected provider

Telehealth visits with Cigna Behavioral Health network providers cost the same as an in-office visit.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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Choose with confidence.

AmWell and MDLIVE are both quality national telehealth providers, so you can choose your care confidently. When you can't get to your doctor, Cigna Telehealth Connection is here for you.

Register for one or both today so you'll be ready to use a telehealth service when and where you need it.

AmWellforCigna.com*
855-667-9722

MDLIVEforCigna.com*
888-726-3171

Signing up is easy!

Set up and create an account with one or both AmWell and MDLIVE

Complete a medical history using their "virtual clipboard"

Download vendor apps to your smartphone/mobile device**

Cigna®

*Availability may vary by location and plan type and is subject to change. See vendor sites for details.

**The downloading and use of any mobile app is subject to the terms and conditions of the mobile app and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

AmWell and MDLIVE are independent companies/entities and are not affiliated with Cigna. The services, websites and mobile apps are provided exclusively by AmWell and MDLIVE and not by Cigna. Providers are solely responsible for any treatment provided. Not all providers have video chat capabilities. Video chat is not available in all areas. AmWell/MDLIVE services are separate from your health plan's provider network. Telehealth services may not be available to all plan types. A Primary Care Provider referral is not required for AmWell/MDLIVE services.

In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

Tips for Saving Money on your Medical Plan

- ✓ Schedule your wellness exams (well women, annual physical, etc.). Your cost = $0
- ✓ Schedule your preventive screenings (mammogram, colonoscopy, prostate (PSA), etc.). Your cost = $0
- ✓ Save money by visiting your Primary Care Physician before a specialist.
- ✓ Save money by using an Urgent Care facility instead of an Emergency Room.
- ✓ Save money by utilizing a free-standing Imaging Center for X-rays and complex imaging instead of a hospital
- ✓ Save money by utilizing an Ambulatory Surgical Center for outpatient surgery instead of a hospital.
- ✓ Utilize the generic RX programs at Wal-Mart, Target, Publix, & Kmart.

NOTE: if you utilize these Rx programs, do not provide the Pharmacist with your Cigna ID card. You do not need medical insurance to utilize these programs.

Wal-Mart & Target - pay $4 per script for a 30-day supply and $10 per script for a 90-day supply.

In Florida Publix offers some antibiotics for $0 (Amoxicillin, Ampicillin, Cephalexin, Ciprofloxacin and Penicillin) as well as FREE Metformin, FREE Lisinopril, & FREE Amlodipine.

Kmart - pay $5 per script for a 30-day supply and $10-$15 per script for a 90-day supply.

- ✓Save money by taking a Generic drug instead of a Brand Name drug.
- ✓Ask your doctor for samples when trying a new drug or even for existing prescriptions.
- ✓Look for coupons and special offers on your prescription manufacturer's website.
- ✓CVS Minute Clinics are staffed by Nurse Practitioners & Physician Assistants.

Visit the Minute Clinic and pay your PCP copay. Services include: treatment for illnesses and injuries, vaccinations, physicals, wellness screenings, diagnosis and treatment of strep throat, pink eye, ear, nose and throat infections, flu, and poison ivy. Education provided for those with diabetes, high cholesterol, and high blood pressure as well as smoking cessation services.

Walgreen Take Care Clinics are staffed by Nurse Practitioners.

Visit the Take Care Clinic and pay your PCP copay. Services include: back to school physicals, and blood pressure, cholesterol, diabetes and health screenings. Monitoring and managing of ongoing health conditions like thyroid disorders, osteoporosis, chronic bronchitis, asthma, acid reflux and cardiovascular conditions.

KNOW YOUR OPTIONS

-Time saving and cost effective methods for getting the right kind of immediate medical care when your doctor is not available.

Convenience Care Clinics

In situations where you may not be able to get in to see your primary care doctor and your condition is not urgent or an emergency, you may want to consider a Convenience Care Clinic. Convenience Care Clinics are conveniently located in malls or some retail stores, such as CVS Caremark, Walgreens, Walmart and Target, and offer services without the need to schedule an appointment. These services are often provided at a lower out of pocket cost than at urgent care clinics and emergency room visits. Services at these types of clinics are usually available to patients 18 months of age or older.

Urgent Care Centers

In situations where you need medical care fast, but a trip to the emergency room is not necessarily required, you may want to consider an Urgent Care Center. At urgent care centers you can be treated for many minor medical issues, usually at a lower cost, and on quicker turn around than an emergency room.

Emergency Rooms

In situations where you think that you or a covered dependent may be experiencing a true medical emergency you should go to the nearest Emergency Room or call 911.

Where should I go?

Minor Health Issues	Moderate Health Issues	Life Threatening Emergencies
• Common infections (Sore or strep throat, urinary tract and bladder infections, earaches and ear infections, pink eye • Minor fevers • Cough, colds, and flu • Nasal congestion • Allergy symptoms • Skin issues(rashes, ringworm, and chicken pox) • Head lice • Insect bites • Minor burns, cuts, and scrapes • Sprains and strains	• Migraines • Severe back pain • Vomiting and diarrhea • Minor broken bones • Fevers • Asthma attacks • Severe cough • Eye irritations • Animal bites • Wounds requiring stitches	• Loss of consciousness • Chest pain • Severe trouble breathing • Sudden loss of vision, numbness or difficulty speaking • Severe abdominal pain • Coughing or vomiting blood • Severe bleeding • Severe burns • Head trauma • Major broken bones • Seizures/ convulsions
Convenience Care Clinics		
Urgent Care Centers		Emergency Rooms

*The information provided in this material should not be viewed as medical advice from Charter Schools USA or Insurance Office of America. If you have questions concerning your medical conditions, drugs, treatment plans or symptoms consult your healthcare provider.

Wellness

CSUSA offers an enhanced wellness plan through Cigna that pays you to take steps towards a healthier life.

Steps to take:

Complete 2 part wellness screening, within 60 days of initial benefits eligibility

- ✓ Biometric testing
- ✓ Complete the Health Risk Assessment (HRA) through www.mycigna.com

Both steps must be completed to receive incentive

For spouse participation visit https://portal.adp.com

- ✓ Employee only can receive up to $25 total off of medical premium.
- ✓ Employee/Spouse can receive up to $50 total off of medical premium.
- ✓ The Wellness discount is for the medical premium only.

MotivateMe...Take Action...Save $$$

Eligible medical plan participants will receive semi-monthly premium credits for completing the following the steps below. To view your incentives and progress register at myCigna.com or Download the app from:

Step 1 - $10 Credit

- ✓ Get your Biometric Screening
- ✓ Complete your Health Risk Assessment (HRA)

Step 2 - $15 Credit

- ✓ Complete (3) three of the following goals:

- ☑ Adult physical
- ☑ Achieve BP of <= 139 / <=89
- ☑ Routine Mammogram
- ☑ Colon Cancer screening
- ☑ Cervical Cancer Screening
- ☑ Annual OB/GYN exam
- ☑ Achieve LDL of <= 145mg/dl
- ☑ Achieve BMI < 30

Upon completion of the above activities, participants will earn a premium credit for the remainder of the plan year.

Dental Insurance
Cigna PPO

Summary of Benefits	IN-Network	Non-Network
Calendar Year Deductible	Individual $50 / Family $150	
Calendar Year Maximum	$1,500	
Orthodontia Lifetime Maximum	$1,000	
Preventive Services		
Oral Exams Prophylaxis: Routine Cleanings Fluoride Application/ Sealants Space Maintainers Bitewing X-rays, Full Mouth X-rays	0%	0%
Basic Services		
Fillings Periodontal Scaling and Root Planning Oral Surgery- Simple Extractions Oral Surgery- all except simple extractions Extractions (routine and surgical) Anesthetics Surgical; Extractions of Impacted Teeth	20%	50%
Major Services		
Crowns Dentures Bridges Inlays/Onlays Prosthesis to over Implant Denture Adjustments and Repairs	50%	50%
Orthodontia Services (children to age 19)		
Diagnostics and Treatments	50%	50%
Semi-Monthly Payroll Deductions		
Employee Only		$8.12
Employee + Spouse		$22.95
Employee + Child(ren)		$28.89
Employee + Family		$43.72

Dental Insurance
Cigna HMO

Schedule Lists Of Benefits	
Procedure	**Patient Charge**
Office visit fee (Per patient, per office visit in addition to any other applicable patient charges)	$5.00
Office visit – After regularly scheduled hours	$40
Comprehensive periodontal evaluation – New or established patient	$0
X-rays	$0
Oral cancer screening using a special light source	$50
Prophylaxis (Cleaning) – (Limit 2 per calendar year)	$0
Sealant – Per tooth	$12
Preventive resin restoration in a moderate to high caries risk patient – Permanent tooth	$12
Space Maintainer	$35 - $45
Amalgam	$0
Resin based composite	$0 - $105
Inlay, Onlay, Crown	$240 - $285
Endodontics (Root canal treatment, excluding final restorations)	$12 - $340
Periodontal scaling and root planning	$40 - $50
Periodontal maintenance	$40
Dentures	$165 - $245
Repair resin denture base	$40
Replace broken teeth – Per tooth	$40
Implants	$525 - $760
Local Anesthesia	$0
General anesthesia – First 30 minutes	$160
General anesthesia – Each additional 15 minutes	$75
Surgical removal of erupted tooth – Removal of bone and/or section of tooth	$40
Removal of impacted tooth	$65 - $135
Surgical access of an un-erupted tooth (Excluding wisdom teeth)	$110
Pre-orthodontic treatment visit	$125
Children – Up to 19th birthday: 24-month treatment fee	$1,608
Adults: 24-month treatment fee	$2,592
Orthodontic retention – Removal of appliances, construction and placement of retainer(s)	$295

This list is just a summary of the commonly used dental treatments. A complete list of services and charges will be provided to you after you enroll.

Semi-Monthly Payroll Deductions	
Employee Only	$0.00
Employee + Spouse	$4.56
Employee + Child(ren)	$6.85
Employee + Family	$13.20

Vision Insurance
Cigna Standard PPO

Benefit	In-Network	Out-of Network	Frequency
Comprehensive Eye Exam	$10	n/a	12 months
Exam Allowance	Covered after copay	Up to $45	
Materials Copay	$20	n/a	
Frames	Up to $130	Up to $71	
Standard eyeglass lenses			
Single Vision	Covered 100% after copay	Reimbursed up to $32	12 months
Bifocal		Reimbursed up to $55	
Trifocal		Reimbursed up to $65	
Lenticular		Reimbursed up to $80	
Contact Lenses (in lieu of eyeglasses)			
Elective Contact Lens	Up to $130	Reimbursed up to $105	12 months
Therapeutic	Covered 100%	Reimbursed up to $210	
Semi-Monthly Payroll Deductions			
		Employee Only	$2.53
		Employee + Spouse	$6.01
		Employee + Child(ren)	$5.71
		Employee + Family	$7.80

Basic Life Insurance
Cigna

Paid 100% by CSUSA

As a full time benefit eligible employee of CSUSA you receive a basic life benefit of one times your annual earnings up to a maximum of $150,000. In the event you pass away due to an accident your benefit doubles. Take this time to update your Beneficiary form because claims are adjudicated based on your most recent Beneficiary form and not your current marital or relationship status.

Benefit Summary	
Life Benefit Amount	1 X Annual Earnings, subject to a maximum of $150,000
Eligibility	Active, full-time employees working a minimum of 30 hours per week.
Benefits Reduction Schedule	67% at age 70, and 45% at age 75
Additional Characteristics	Conversion, Seatbelt / Airbag Benefit
Accidental Death & Dismemberment(AD&D) Benefit Amount and Maximum	1 time annual compensation rounded to $1,000 subject to a minimum of $10,000 not to exceed $150,000

Voluntary Life and AD&D Insurance
Cigna

Voluntary Life and AD&D Benefit Summary		
Employee	Benefit Amount	Units of $10,000
	Guaranteed Coverage Amount	The lesser of 5 times annual compensation or $150,000
	Maximum	The lesser of 5 times annual compensation or $500,000
	Benefit Reduction Schedule	Benefits will reduce to 67% at age 70, 45% at age 75
	Accidental Death & Dismemberment (AD&D) Benefit Amount	Units of $10,000 The lesser of 5 times annual compensation rounded to the next highest $1,000 to a maximum of $500,000
Voluntary Term Life		
Spouse (Up to age 70)	Spouse is eligible provided that you apply for and are approved for coverage for yourself	
	Benefit Amount	Units of $10,000
	Guaranteed Coverage Amount	$50,000
	Maximum	The lesser of $250,000 or 100% of the Employee's Voluntary Life Insurance Amount
Voluntary Term Life		
Dependent Children	6 months to age 26, as long as you apply for and are approved for coverage for yourself. Premium includes all eligible children.	
	Maximum Per Child	$10,000
	Benefit Amount from Birth to 6 Months	$500
Rate Summary	Monthly per $1,000 of coverage	
Child Life Rate per $1,000	$0.100	Vol Life & AD&D Combined For The Employees Only
Spouse Life Rate per $1,000	Age Banded	
Under 25	0.030	0.050
25-29	0.060	0.080
30-34	0.060	0.080
35-39	0.090	0.110
40-44	0.130	0.150
45-49	0.200	0.220
50-54	0.310	0.330
55-59	0.610	0.630
60-64	0.770	0.790
65-69	1.310	1.330
70-74	2.520	2.540
75+	4.800	4.820
Voluntary Life Features	Accelerated Death Benefit – Terminal Illness, Continuation for Disability for Employees Age 60 or over, Extended Death Benefit, Waiver of Premium, Rehabilitation During a Period of Disability	

Short-term Disability

Benefit Summary	
Eligibility	Active, full-time Employees of the Employer working a minimum of 30 hours per week
Core Weekly Benefit Employer Paid	Benefit Amount Maximum Up to 60% of your weekly covered earnings $250 per week
Buy-Up Weekly Benefit Employee Paid	Benefit Amount Maximum Up to 60% of your weekly covered earnings$1,500 per week
Elimination Period	You must be continuously disabled for the later of any accumulated sick leave or 14 days from accident and 14 days from sickness.
Benefit Duration	Once you qualify for benefits under this plan, you continue to receive them until the end of the 11 week benefit period, or until you no longer qualify for benefits, whichever occurs first.
Cost	The cost of the core benefit is paid for by your employer.
Core and Buy-Up Benefit Explanation	These plans offer two levels of coverage. (1) an employer-paid core benefit, and (2) an employee-paid optional level, which allows you to change the maximum weekly benefit.
Definition of Disability	Own Occupation Disability means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation and/or you are unable to earn 80% or more of your covered earnings from working in your regular occupation. We will require proof of earnings and continued disability.
Covered Earnings	Covered earnings means your wages or salary, not including bonuses, commissions, overtime and other extra compensation.

Long term Disability

Benefit Summary		
Eligibility	Active, full-time Employees of the Employer regularly working a minimum of 30 hours per week.	
Monthly Benefit	Benefit Amount	Up to 60% of your monthly covered earnings
	Maximum	$5,000 per month
	Minimum	Greater of $100 or 10% gross monthly benefit.
Elimination Period	You must be continuously disabled for 90 days, before benefits may be payable.	
Cost	The cost of this insurance program is paid for by you.	
Definition of Disability	Disability means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation and you are unable to earn 80% or more of your indexed earnings from working in your regular occupation. After benefits have been payable for 24 months, you are considered disabled if solely due to your injury or sickness, you are unable to perform the material duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience, and you are unable to earn 80% or more of your indexed earnings. We will require proof of earnings and continued disability.	
Covered Earnings	Covered earnings means your wages or salary, not including bonuses, commissions, overtime and other extra compensation.	
Earnings While Disabled	During the first 24 months that benefits are payable, benefits will be reduced if benefits plus income from employment exceeds 100% of pre-disability covered earnings. After that, benefits will be reduced by 50% of earnings from employment.	
Pre-existing Conditions	Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures,) or for which a reasonable person would have consulted a physician during the 6 months just prior to the most recent effective date of insurance. Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance.	
Cost	The cost of this insurance program is paid for by you.	

The costs per $100 of monthly covered earnings are shown below.

Age	Monthly per $100 Covered Payroll
<20	$0.154
20-24	$0.154
25-29	$0.154
30-34	$0.181
35-39	$0.235
40-44	$0.325
45-49	$0.560
50-54	$0.830
55-59	$1.047
60-64	$1.201
65 and Up	$1.165

Employee Assistance Program

The Employee Assistance Program (EAP) offers support, guidance and resources that can help you resolve personal issues and meet life's challenges. CSUSA provides this service at no cost to you.

The EAP can help you with all of the following:

- ✓ Child care and Elder care
- ✓ Alcohol and drug abuse
- ✓ Life Improvement
- ✓ Difficult Relationships
- ✓ Stress and anxiety with work or family
- ✓ Depression
- ✓ Personal Achievement
- ✓ Emotional Well being
- ✓ Financial and legal concerns
- ✓ Grief and loss
- ✓ Identity theft and fraud resolution

The Program is available 24 hours a day, every day, to you and members of your household. You'll receive up to three face-to-face counseling sessions per issue.

Employer ID: Charter Schools USA

Call 877-622-4327 or visit
www.cignabehavioral.com

Important information about your company's benefits from Unum

As a benefit-eligible employee of CSUSA, you may participate in these employee benefits.

What's being offered

Accident Insurance

With the high cost of medical care today, a trip down the stairs can hurt your bank account as much as your body. Accident insurance can pay you money based on the injury and the treatment you receive, whether it's a simple sprain or something more serious, like an injury from a car accident. Your plan can pay you a benefit for an emergency room treatment, stitches, crutches, injury-related surgery and a list of other accident-related expenses. The money is paid directly to you and you decide how to spend it. You can also purchase coverage for your spouse and dependent children.

Specified Critical Illness Insurance

What's a critical illness? Some common examples are heart attack and stroke. Some policies can also include coverage for cancer. But this coverage also includes serious conditions like permanent paralysis — the kind of injury that can happen to a healthy person in a car or skiing accident, for example. The medical treatment for these conditions can be very expensive. Critical illness insurance can help by paying a lump sum payment directly to you at the first diagnosis of a covered condition. You decide how to spend it. You can also purchase coverage for your spouse and dependent children.

Whole Life Insurance

Whole life insurance can pay money to your loved ones when you die, but it offers additional value as well. This plan features a "living" benefit. If you are diagnosed with a terminal illness with life expectancy of one year or less, you can request that some or all of the death benefit be paid to you while you are living. Whole life insurance premiums won't increase with age and your policy can build cash value over time. You can use this cash value later in life to buy a smaller, "paid-up" policy with no more premiums due.

How to enroll

1. Review your benefit booklet and/or ADP Portal regarding your benefit options, policy provisions and exclusions and limitations.
2. Select the benefit choices that are right for you and your family (if applicable). If you have any questions, be prepared to ask them when you contact the enrollment line.
3. Call the enrollment line at 866-643-9446. It's available 8 a.m. to 8 p.m. EST.
   Depending on your benefit selections and any questions you may have, the telephone enrollment process should take about 10-20 minutes. When your call is complete, the benefit representative will provide you with a customer number – which will act as your receipt and confirmation of the call.

The Unum benefits representative who meets with you or takes your call is trained to answer your questions and help you determine what benefits are best for you and your family. The representative is licensed in your state and is not paid commissions based on whether you purchase coverage.

Voluntary Supplemental Products
Unum

ACCIDENT INSURANCE

You work hard for your paycheck. But it can be hard to budget for life's unexpected emergencies. That's why Charter Schools USA, Inc. is giving you the option to purchase ACCIDENT Insurance from Unum. It can help protect your finances from the uncertainty of the future and give you a little peace of mind.

Who's at risk? Every 10 minutes more than 700 Americans suffer an injury severe enough to seek medical help. (1) More than twice as many injuries requiring medical attention happen off the job rather than at work (2).

Accident insurance*

With the high cost of medical care today, a trip down the stairs can hurt your bank account as much as your body. Unum's coverage provides a lump-sum benefit based on the type of injury (or covered incident) you sustain or the type of treatment you need, whether it's a simple sprain or something more serious, like an injury from a car accident. Your plan can pay you a benefit for an emergency room treatment, stitches, crutches, injury-related surgery and a list of other accident-related expenses. The money is paid directly to you and you decide how to spend it. You can also purchase coverage for your spouse and dependent children.

An illustrative example of how accident coverage can help you with your expenses*

40-year-old claimant

Accident: Fall at home

Injury: Broken toe and ACL tear (knee ligament injury)

Out-of-pocket expenses incurred:

$100 emergency room co-pay
$250 deductible
$750 co-insurance for surgery ($3,750 x 20%)
$150 co-pay for 10 physical therapy visits

Total out-of-pocket expenses: $1,250

Benefits paid:

$150 emergency room visit
$100 appliance (knee brace)
$100 fractured toe
$400 surgical ligament tear repair
$ 50 follow-up appointment
$150 for six physical therapy sessions

Total benefit paid under policy: $950

*Costs of treatment and benefit amounts may vary.

Choose the coverage that's right for you. Your Accident Insurance plan can provide benefits for covered accidents that occur on and off the job. Accident insurance is offered to all eligible employees ages 17 to 80 who are actively at work.

Available Family Coverage:
Spouse: Ages 17 to 80, if actively at work or not disabled.

Child coverage: Available for dependent children age 14 days until their 26th birthday, regardless of marital or student status.

If a family plan is purchased, dependent children are covered until their 26th birthday.

If a child-only plan is purchased, dependent children are covered until their 24th birthday.

Employees must be US citizens or legally authorized to work in the US to receive coverage. Spouses and dependents must reside in the US to receive coverage.

1,2 National Safety Council, Injury Facts (2014).

LIMITED BENEFIT POLICY.
Individual products are underwritten by: Provident Life and Accident Insurance Company, Chattanooga, Tennessee. This base policy provides Accident insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Forms L-21762 and FUL-21762 and contact your Unum representative.

Voluntary Supplemental Products
Unum

What's the risk? Every 34 seconds someone in America will have a coronary event. [1]
The risk of developing cancer during a lifetime is nearly 1 in 2 for men and 1 in 3 for women. [2]

Critical illness insurance*

Critical illness insurance pays you a lump-sum benefit at the first diagnosis of a covered illness.* It can be used however you choose for the expenses health insurance doesn't cover. You decide how to spend it. You can also purchase coverage for your spouse and dependent children. Illness covered by the base plan include: Heart attack, Stroke, Major organ transplant, Permanent paralysis, End-stage renal (Kidney) failure, Coronary artery bypass surgery (pays 25% of lump-sum benefit).

Optional Cancer Rider - Illnesses covered by the cancer rider include: Cancer, Carcinoma in situ[3]. 100% of the benefit amount is paid for a cancer diagnosis and 25% for carcinoma in situ.

Your employer has also included the Health Screening Benefit Rider. This benefit pays $50 per calendar year per insured individual if a covered health-screening test is performed, including blood tests, chest x-rays, stress tests, mammograms and colonoscopies. Eligibility begins 30 days after the coverage effective date. A full list of more than 20 covered tests will be provided in your policy.

Policy Provisions
Reduction of benefits: The benefit amount for the employee and spouse reduces by 50% on the first policy anniversary after the insured individual's 70th birthday, or five years after the policy effective date, whichever is later. Premiums for the policy will not be reduced. If partial benefits for coronary artery bypass surgery or carcinoma in situ have been paid prior to the reduction of benefits, then the new benefit amount will be calculated by applying the 50 % to the benefit amount reduced by the prior payout.
Cancer and carcinoma in situ waiting period: No benefits will be paid for cancer or carcinoma in situ if the date of diagnosis occurs during the first 30 days from the coverage effective date.

Available Coverage:
Eligible employees ages 16 to 69 (64 in California) who are actively at work. Choose the benefit amount that's right for you – from $5,000 to $50,000 in $1,000 increments.[4]
Spouse Rider: Ages 16 to 64 with purchase of employee policy. From $5,000 to $30,000[5] in $1,000 increments.
Child Rider: Available for dependent children, newborn until their 26th birthday, regardless of martial or student status, with purchase of an employee policy. From $2,500 or $5,000 – one rider covers all children.

1 American Heart Association, "Heart Disease and Stroke Statistics – 2013 Update: A report from the American Heart Association, " Circulation (Jan. 1/8, 2013).

2 American Cancer Society, Cancer Facts & Figures 2013 (2013).

3 Cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues

4 In WA, the minimum base policy is $25,000. In FL, employee coverage is available from $8,000 up to $49,000 in $1,600 increments.

5 Employees and spouses may be covered under a policy or the spouse rider, but not both. TX spouse rider maximum is $25,000. In FL, spouse coverage is available from $8,000 up to $28,800 in $1,600 increments.
This material is intended to be a brief description of the policy. The policy definitions, exclusions and limitations will be used to determine actual benefit decisions. After a policy is issued you will have a 30-day period during which the policy can be cancelled at no cost to you. Produce availability and provisions may vary by state. See the actual policy or your Unum representative for specific provisions and details of availability.

* LIMITED BENEFIT POLICY.

Individual products are underwritten by: Provident Life and Accident Insurance Company, Chattanooga, Tennessee

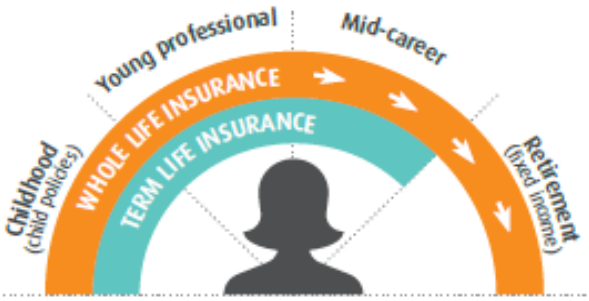
unum
Better benefits at work.

Whole Life Insurance

Get lifetime coverage and useful cash benefits, too.

Whole Life Insurance provides much more than a death benefit — it also offers valuable "living benefits" that you can use during times of need. And you can keep your Whole Life coverage after you retire, making it an essential complement to Term Life.

Whole Life provides a lifetime of coverage.



Whole Life: Benefits for a lifetime

What is Whole Life?

- Whole Life offers "living benefits" you can use when you need them, as well as a death benefit.

What features are available?

- Cash value. This policy accumulates cash value.* You can borrow funds from this value as needed.
- Living benefit option rider. If you are diagnosed with a terminal illness, you can request up to 100% of your policy's benefit amount and use it for any purpose.**
- Long term care benefits.† Your policy may include a long term care rider — see your plan administrator.

How does it work?

- Your premiums are level for life. Premiums will be conveniently deducted from your paycheck.
- Your death benefit is level, too. The benefit does not decrease with age.
- You own the policy.†† You can keep the policy if you leave or retire. You'll pay the same premium.

Three reasons to buy Whole Life at work — now!

1. Whole Life rates. The rates available through your employer are typically more affordable than those available elsewhere.
2. Age-based premiums. Premiums are based on your age when you purchase, and don't increase as you get older. So the earlier you buy, the lower your premium will be for the life of your policy.
3. Guaranteed issue. Generally available during the initial enrollment at your workplace. When it's offered to you, you can purchase coverage up to a set amount, without medical exams or health questions. If you don't purchase the maximum amount, you have the option to increase it up to that level during future enrollments — no questions asked!‡

Premium payment options

You may have two options for paying premiums:

- "Lifetime premium." Coverage continues as long as you pay your premiums.
- "Paid-up at 70." Available when purchased between the ages 15 and 50. Adjusts the premium so that the policy is fully paid up when you turn 70.

Sample rates based on $25,000 benefit amount

	Lifetime premium		Paid-up at 70	
Issue age	Weekly premium	Guaranteed cash value at 65	Weekly premium	Guaranteed cash value at 65
25	$ 4.19	$9,840	$ 4.91	$10,996
35	$ 6.44	$8,851	$ 7.76	$10,567
45	$10.79	$7,140	$13.92	$ 9,716

Sample non-tobacco user rates. Premium rates vary by age, coverage amount and tobacco use. For illustration purposes only.

How to apply To learn more, watch for information from your employer.

Customer Service: 800- 635-5597

Get the coverage you need.

Coverage options available

Who can have it?	What's the benefit amount?	How long can they keep it?
Individual employee coverage Ages 15–80	Minimum policy amount of $2,000. Actual benefit amount based on coverage amount chosen and age at issue.##	You can keep it as long as you want it. If you leave your employer, you would be billed directly at home.
Individual spouse coverage Ages 15–80	Minimum policy amount of $2,000. Actual benefit amount based on coverage amount chosen and age at issue.##	If you leave your employer, you can keep your spouse's policy and be billed directly at home.
Spouse Term Life Benefit Spouses age 15–50. The employee must purchase coverage to add this spouse Term Life benefit. This benefit is not available if you purchase individual coverage for your spouse.	$5,000 to $25,000 — coverage cannot exceed the employee base coverage amount.	Coverage lasts for 20 years.
Individual child coverage No employee or spouse purchase needed. Available to eligible children, stepchildren, legally adopted children and grandchildren (14 days until their 26th birthday) of the primary insured adult.	Up to $50,000 — benefit amounts are based on issue age and premium selected.	Your children can keep it, even if you leave your employer. You would be billed directly at home.
Child Term Life Benefit With purchase of employee or spouse policy, available to eligible children, legally adopted children and stepchildren (14 days until their 25th birthday) of the primary insured adult.	$1,000 to $10,000 — one rider covers all children.	Coverage ends when your policy ends or when children turn 25. At that time, children are guaranteed the right to buy an individual Whole Life policy at 5 times the amount of their rider.

Additional protection options you may have

Additional 50% Term Life coverage

This option may be available for purchase. This is an affordable way to increase your coverage by 50% of your base policy amount. The option lasts for 20 years.
For example, if you purchase a $25,000 Whole Life policy, you can get an additional $12,500 (or 50%) of term life coverage for 20 years.

Purchase $25,000 base coverage + **Additional $12,500 (or 50%) of coverage for 20 years** = **$37,500 total coverage**

Accidental Death Benefit

Depending on your plan, this benefit may be available at initial enrollment to employees and spouses ages 15 to 65. It can pay an additional death benefit equal to the base policy amount ($150,000 maximum) if the policyholder dies before age 70 as the result of a covered accident.

Purchase $25,000 base coverage + **Accidental Death benefit which adds another $25,000** = **$50,000 total coverage**

* The policy accumulates cash value based on a non-forfeiture interest rate of 4.5% and the 2001 CSO mortality table. The cash value is guaranteed and will be equal to the values shown in the policy. Cash value will be reduced by any outstanding loans against the policy.

** You can request an advance, up to 100% of your benefit amount up to $150,000 maximum if you are terminally ill and are expected to live 12 months or less (24 months or less in IL, MA, and WA).

† Your policy may include a long term care rider which allows you to use the death benefit to pay for long term care. You must have received long term care for 90 days. Subject to rider conditions.

†† Coverage becomes effective the first day of the month your payment is deducted from your paycheck. If you leave your job, Unum will bill you directly.

If you increase your coverage later, you receive an additional policy for the increased amount. The premiums will be based on your age at the time you increase the coverage.

Must meet minimum policy amount and minimum premium amount.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must reside in the U.S. to receive coverage.

Exclusion: Life insurance benefits will not be paid for deaths caused by suicide. If within 24 months (12 months in Colorado, Missouri and North Dakota) from the policy effective date, the insured commits suicide, whether sane or insane, Unum will not pay the death benefit. The amount payable by us in place of all other benefits, shall be the sum of premiums paid, without interest, less the sum of any debt and the cost of any riders.

Termination of coverage: The policy will terminate on the earliest of the following: 1. written request by you to terminate the policy; 2. the insured dies; 3. the policy matures; or 4. the loan value exceeds the guaranteed cash value of this policy.

Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

Underwritten by: Provident Life and Accident Insurance Company, Chattanooga, Tennessee In NY, underwritten by: First Unum Life Insurance Company, New York, New York

This information is not intended to be a complete description of the insurance coverage available. The policy has exclusions and limitations which may affect any benefits payable For complete details of coverage please refer to policy form L-21848 and FUL-21848-NY or contact your Unum representative.

Unum complies with all state civil union and domestic partner laws when applicable.

unum.com

The advice you need, anytime, anywhere.

CHARTER SCHOOLS USA

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** Save $5.00 When Bundling Both Plans*

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FOR MORE INFORMATION, PLEASE CONTACT:

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Worry Less. Live More.

Flexible Spending Account (FSA)

Flexible Spending Accounts (FSAs) have become a popular vehicle for reducing rising health care costs. By contributing pre-tax dollars into an FSA, you can save an average of 20% on eligible expenses every year.

You may anticipate in the following Flexible Spending Accounts: Health Care Flexible Spending Account Employees use pre-tax dollars to pay for insurance deductibles, co-payments, glasses and contact lenses, orthodontia, over-the-counter medications, and hundreds of other health care-related expenses not covered by their insurance plans. The maximum contribution amount for period 01/01/2017 through 12/31/2017 is $2,600.

Please note: Under the ACA/ healthcare reform effective January 1, 2011, claims for over-the-counter medicine or drug expenses (other than insulin) cannot be reimbursed without a prescription. This rule does not apply to items for medical care that are not medicines or drugs.

For a complete list of Eligible Expenses reimbursable with an FSA account, as well as a complete list of Ineligible Expenses, please visit the following IRS link:

www.irs.gov/publications/p502/ar02.html#en_US_publink1000178947

Dependent Care Flexible Spending Account Employees use pre-tax dollars to be reimbursed for work-related day care expenses for their children or dependent adults. The maximum contribution amount for period 01/01/2017 through 12/31/2017 is $5,000 if you are married and filing a joint return or if you are a single parent. If you are married but filing separately, the annual maximum contribution is $2,500.

The following table offers an example of the savings experienced by participating in an FSA:

	FSA Participant	FSA Non Participant
Annual Gross Income	$31,000	$31,000
FSA Deposit for Reoccurring	-$2,500	-$0.00
Taxable Gross Income	$28,500	$31,000
Federal & Social Security Tax	-$6,455.25	-$7,021.50
Annual Net Income	$22,044.75	$23,978.50
Cost of recurring Expenses	-$0.00	-$2,500.00
Spendable Income	$22,044.75	$21,478.50

Health Savings Account (HSA)

It's no secret that health care costs are getting less affordable, and the cost to provide health care coverage continues to escalate. Like many companies, we need to control these costs to stay competitive. At the same time, we want to be sure that our health benefits do what they are intended to do, which is to help you and your family achieve and maintain your health potential.

Fortunately, good health can actually cost less. Over the long-term, if our health benefits program can help you maintain or improve your health, we all win. That's why we are excited to offer a plan option that includes a Health Savings Account (HSA) plan, Choice Fund Open Access HSA. When you enroll in this plan, you may open an HSA account that accumulates funds to cover your health care expenses.

HSAs offer you the following advantages:

- ✓ Tax Savings. You contribute pre-tax dollars to the HSA. Interest accumulates tax-free and funds are tax-free to withdraw for medical expenses.
- ✓ Reduce your out-of-pocket costs. You can use the money in your HSA to pay for eligible medical expenses and prescriptions. The HSA funds you use can help you satisfy your plan's annual deductible.
- ✓ Invest the funds and take them with you. Unused account dollars are yours to keep even if you retire or leave the company. Additionally, you can invest your HSA funds, so your available health care dollars can grow over time.
- ✓ The benefits of preventive care, without the cost. Receive 100 percent coverage for nationally recommended preventive care, with no deduction from your HSA or out-of-pocket costs for you when you see an in-network provider.
- ✓ The opportunity for long-term savings. Save unused HSA funds from year to year – money you can use to reduce future out-of-pocket health expenses. You can even save HSA dollars to use after you retire.

Maximum allowable HSA contributions are federally defined each year. For **2017** the maximum contributions are $3,450 for Individual and $6,750 with dependents. Individuals over 55 may take a $1,000 catch up contribution.

CSUSA will pay the monthly administrative fees while you are an active employee. You will be responsible to pay any other associated fees.

Qualified Medical Expenses

The Internal Revenue Service defines qualified medical care expenses as amounts paid for the diagnosis, cure or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.

Under a rule that went into effect January 1, 2011, claims for over-the-counter medicine or drug expenses (other than insulin) cannot be reimbursed without a prescription. This rule does not apply to items for medical care that are not medicines or drugs.

Unfortunately, we cannot provide a definitive list of "qualified medical expenses", however the following list includes common qualified medical expenses. This list is subject to change in accordance with IRS regulations. To see a full list of current qualified medical expenses please visit: http://www.irs.gov/pub/irs-pdf/p502.pdf.

- Abortion
- Acupuncture
- Alcoholism treatment
- Ambulance
- Annual physical examination
- Artificial limb
- Artificial teeth
- Bandages
- Birth control pills
- Body scan
- Braille books and magazines
- Breast pumps and supplies
- Breast reconstruction surgery
- Capital expenses (improvements or special equipment installed to a home, if meant to accommodate a disabled condition)
- Car modifications or special equipment Installed for a person with a disability
- Chiropractor
- Christian Science practitioner
- Contact lenses
- Crutches
- Dental treatment
- Diagnostic devices
- Disabled dependent care expenses
- Drug addiction treatment
- Eye exam
- Eye glasses
- Eye surgery
- Fertility enhancement (in vitro fertilization or surgery)
- Guide dog or other service animal
- Health institute fees (if prescribed)
- Intellectually or developmentally disabled care, treatment or special home
- Laboratory fees
- Lactation expenses
- Lead-based paint removal (if a child in the home has lead poisoning)
- Learning disability care or treatment
- Legal fees associated with medical treatment
- Lifetime care, advance payments or "founder's fee"
- Lodging at a hospital or similar institution
- Long-term care
- Medical conference expenses, if the conference concerns a chronic illness of yourself, your spouse or your dependent
- Medical information plan
- Medications, if prescribed
- Nursing home fees
- Nursing services
- Operations
- Osteopath
- Oxygen
- Physical examination
- Pregnancy test kit
- Prosthesis
- Psychiatric care
- Psychologist
- Special education
- Sterilization
- Stop-smoking programs
- Therapy received as medical treatment
- Transplants
- Transportation for medical care
- Tuition for special education
- Vasectomy
- Vision correction surgery
- Weight-loss program if it is a treatment for a specific disease
- Wheelchair
- Wig
- X-ray

Ineligible Medical Expenses

The following list includes examples of products and services that are **NOT** eligible for reimbursement according to the IRS. Please note **that this list is not all-inclusive**, and is subject to change.

- Babysitting, childcare and nursing services for a normal, healthy baby
- Controlled substances or illegal drugs
- Cosmetic surgery
- Dancing lessons
- Diapers or diaper service
- Electrolysis or hair removal
- Funeral expenses
- Future medical care (except advance payments for lifetime care, or long-term care)
- Hair transplant
- Health coverage tax credit
- Household help
- Illegal operations or treatments
- Insurance premiums (with a few exceptions)
- Maternity clothes
- Medication from other countries
- Nonprescription drugs and medicine, except insulin (over-the-counter medicine is eligible for reimbursement with a prescription)
- Nutritional supplements, unless recommended by a medical practitioner as treatment for a specific medical condition
- Personal use items (e.g., toothbrush, toothpaste, dental floss)
- Swimming lessons
- Teeth whitening
- Veterinary fees
- Weight-loss program (unless for a specific disease diagnosed by a physician)

Glossary of Commonly Used Terms

ANNUAL ENROLLMENT: Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

CARRIER: The insurance company.

CLAIM: The request for payment for benefits received in accordance with an insurance policy.

COPAY: A co-payment, or copay, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

IN NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers.

EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it is payment, denial, or pending) to a medical claim processed on your behalf.

EVIDENCE OF INSURABILITY (EOI): This is the medical information you must provide that requires review and approval by the insurance company BEFORE coverage becomes effective. This may include medical records and a physical exam.

HMO: Health Maintenance Organization, this type of medical plan is network exclusive. A participant must receive services from in-network providers except in a case of medical emergency.

MAIL ORDER PRESCRIPTIONS: Used for maintenance drugs, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma, this also includes birth control.

MAXIMUM OUT OF POCKET: The total amount a covered person must pay before his or her benefits are paid at 100%. Deductible, copayments, and coinsurance may apply towards the maximum out of pocket, depending on the plan.

OUT OF NETWORK: The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of-network, but will pay higher out- of-pocket costs.

PARTICIPATING PROVIDER: Individual physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

PCP (PRIMARY CARE PHYSICIAN): A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician.

PPO: Benefits paid for both in and out of a network of doctors. Member makes choice with knowledge that better benefits are available in network. Plans feature office visit copays, deductibles at a variety of levels and then coinsurance to a maxi- mum out of pocket expense. Usually includes copays for prescription drugs.

PREVENTIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

REFERRAL: A written recommendation by a physician that a member may receive care from a specialty physician or facility.

SPECIALIST: A participating physician who provides non-routine care, such as a dermatologist or orthopedist

Expanded Women's Preventative Health Benefits

The Affordable Care Act (ACA or Health Care Reform) requires some health plans to cover certain preventive health services for women at no cost to the member, when they are provided in-network.

The following preventive care services for women will generally be covered at no cost, when provided by an in-network doctor/facility:

- ✓ Anemia screening on a routine basis for pregnant women
- ✓ Breast cancer genetic test counseling (BRCA) for women at higher risk for breast cancer
- ✓ Breast cancer mammography screenings every one to two years for women over age 40
- ✓ Breast cancer chemoprevention counseling for women at higher risk
  Breast feeding comprehensive support and counseling from trained providers and access to breast feeding supplies, for pregnant and nursing women
- ✓ Cervical cancer screening for sexually active women
- ✓ Chlamydia infection screening for younger women and other women at higher risk
- ✓ Contraception for FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt religious employers
- ✓ Domestic and interpersonal violence screening and counseling for all women
- ✓ Folic acid supplements for women who may become pregnant
- ✓ Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- ✓ Gonorrhea screening for all women at higher risk
- ✓ Hepatitis B screening for pregnant women at their first prenatal visit
- ✓ HIV screening and counseling for sexually active women
- ✓ Human Papillomavirus (HPV) DNA test every three years for women with normal cytology results who are 30 or older
- ✓ Osteoporosis screening for women over age 60 depending on risk factors Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- ✓ Sexually transmitted infections counseling for sexually active women
- ✓ Syphilis screening for all pregnant women or other women at increased risk
- ✓ Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- ✓ Urinary tract or other infection screening for pregnant women
- ✓ Well-woman visits to get recommended services for women under age 65

Women's Health and Cancer

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- ✓ Reconstruction of the breast on which the mastectomy was performed;
- ✓ Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- ✓ Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan.

For more information, you can visit this U.S. Department of Health and Human Services website

http://www.dol.gov/ebsa/publications/whcra.html and the U.S. Department of Labor at: **https://www.dol.gov/ebsa/consumer_info_health.html**

Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth;

- ✓ following a normal vaginal delivery, to less than 48 hours, and
- ✓ following a cesarean section, to less than 96 hours.

Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards an attending health care provider may in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay. Further, a health insurer or health maintenance organization may not:

- ✓ Deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage;
- ✓ Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage;
- ✓ Provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage;
- ✓ Require a mother to give birth in a hospital; or
- ✓ Restrict benefits for any portion of a period within a hospital length of stay described in this notice.

These benefits are subject to the plan's regular deductible and copay. For further details, refer to your SPD. Keep this notice for your records and call Human Resources for more information.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from CSUSA, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Florida, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or visit **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, CSUSA's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in Florida, you may be eligible for assistance paying CSUSA health plan premiums. You should contact Florida Medicaid for further information on eligibility.

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

To see if any more States have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Pre-existing Conditions Exclusion Period
As a result of the Patient Protection & Affordable Care Act, pre-existing condition exclusions will not apply to dependent children under 19 years of age. A pre-existing medical condition is an illness or any related condition for which a member received services, supplies or medication in the 6 months prior to enrollment under this medical plan.

A pre-existing condition does not include:

- A pregnancy existing on the enrollment date
- Genetic information

Unless you have maintained continuous medical insurance coverage without a break of more than 63 days prior to your eligibility for this medical plan, benefit coverage for services, supplies and medication(s) received for a pre-existing condition(s) will be excluded (not covered) for the first 12 months of coverage.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-436-7442
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: http://www.medicaid.gov/medicaid-chip-program-information/by-state/florida.htmlPhone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.medicaid.gov/medicaid-chip-program-information/by-state/louisiana.html Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.ht m Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources 954-202-3500.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Charter Schools USA	
5. Employer address	**6. Employer phone number**
800 Corporate Dr	954-202-3500

7. City	8. State	9. ZIP code
Ft. Lauderdale	FL	33314

10. Who can we contact about employee health coverage at this job?	
Human Resources	
11. Phone number (if different from above)	**12. Email address**

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

- As your employer, we offer a health plan to:
  - ☑ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $31.00
b. How often? ☐ Weekly ☐ Every 2 weeks ☑ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Important Notice from CSUSA About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. **CSUSA has determined that the prescription drug coverage offered by the Cigna plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current CSUSA coverage will not be affected. You can keep the Cigna medical plan if you elect part D and this group plan will coordinate with Part D coverage; for those individuals who elect Part D coverage only and terminate the group plan, coverage under the entity's plan will end for the individual (and all covered dependents if the individual is the employee under the group plan, etc.). *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current CSUSA coverage, be aware that you and your dependents will not be able to get this coverage back until the next annual open enrollment period.

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: **January 1, 2017**
Name of Entity/Sender: **CSUSA**

Address: **800 Corporate Dr., Ft Lauderdale FL 33314**
Phone Number: **(954) 202-3500**

HIPPA Privacy Notice Reminder

Protecting the confidentiality of your personal medical information has always been an important priority. The Group Health Plans sponsored by CSUSA maintain policies to safeguard the privacy of your medical information and to comply with federal law (specifically, "HIPAA" and the privacy rules issued under HIPAA). We are required by federal law to protect the privacy of your individual health information (referred to in this reminder as "Protected Health Information"). We are also required to provide you with this reminder regarding our policies and procedures on your Protected Health Information. For more information about your privacy rights or to request a copy of the Health Plan's Notice of Privacy Practices please contact:

CSUSA, Inc.

Human Resources; (954) 202-3500

The Notice of Privacy Practices provides detailed information on how the Health Plan may use your information as well as what rights you have regarding that information. ***Note:*** *If you are covered by an insured health option under the Health Plan, you will also receive a separate reminder from your insurer or HMO.*

HIPPA Special Enrollment Rights

Loss of other Coverage

If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. You will be required to submit a signed statement that this other coverage as the reason for waiving enrollment originally. To be eligible for this special enrollment opportunity you must request enrollment **within 30 days** after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependents as a result of Marriage, Birth, Adoptions or Placement for Adoption

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment **within 30 days** after the marriage, birth, adoption or placement for adoption.

Important Contact Information

Benefit Plan	Phone Number	Website
Cigna Enrollment Info Line	800-401-4041	www.Mycigna.com
Cigna Medical	800-244-6224	www.Mycigna.com
Cigna Dental	800-244-6224	www.Mycigna.com
Cigna Vision	800-244-6224	www.Mycigna.com
mployee Assistance Program	877-622-4327	www.Cignabehavioral.com
Flexible Spending Accounts ADP FSA Solution Center	888-557-3156	www.spendingaccounts.info
Cigna Short Term Disability	800-362-4462	www.Mycigna.com
Cigna Long Term Disability	800-362-4462	www.Mycigna.com
Cigna Life Insurance	800-362-4462	www.Mycigna.com
MdLive	888-726-3171	www.MDLIVE.com
AmWell	855-667-9722	www.AmWell.com
UNUM: Voluntary Accident Insurance, Critical Illness, Whole Life Insurance	800-635-5579	
TransAmerica Retirement - 401K	800-401-8726	www.TA-Retirement.com

Notes

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