Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Client: Holly Academy

Healthy *Blue* Living℠ HMO $1000

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Healthy Blue Living subscribers must complete program requirements within the first 90 days of enrollment or re-enrollment. To qualify for or maintain enhanced benefits, the subscriber needs to complete a health assessment and qualification form during the first 90 days and follow their primary care physician's recommendations for a healthy lifestyle. If a tobacco user, must enroll in the BCN-sponsored tobacco cessation program within 120 days of the start of the plan year. If BMI is greater than or equal to 30, must select and begin participating in a weight management program within 120 days of the start of the plan year.

	Enhanced Benefits	**Standard Benefits**
	CLSSLG, D1000, WDRPOV, CI20%, 2KECM, 6600PM, CO25, 35RP, ER150, UR35, IMG150, DSR20%, OMRR, VACR50	**CLSSLG, D3000, WDRPOV, CI30%, 3KECM, 6600PM, CO30, 40RP, ER150, UR50, IMG150, DSR30%, OMRR**, VACR50
Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums **Note:** The **Deductible** will apply to certain services as defined below.		
Deductible **Note:** Coinsurance and select fixed dollar copays apply once the deductible has been met.	$1,000 per individual/$2,000 per family per calendar year	$3,000 per individual/$6,000 per family per calendar year
Fixed dollar copays	$25 for office visits, $25 for medical online visits, $35 for specialist visits, $35 for urgent care visits, $150 for emergency room visits, $150 for high tech imaging and $5 for allergy injections	$30 for office visits, $30 for medical online visits, $40 for specialist visits, $50 for urgent care visits, $150 for emergency room visits, $150 for high tech imaging and $5 for allergy injections
Coinsurance	20% and 50% for select services as noted below	30% and 50% for select services as noted below
Annual Coinsurance Maximum – The following services DO NOT apply to the Annual Coinsurance Maximum if they are included in your coverage: • Deductible amounts • Services with a flat dollar copay • Infertility services • Male Mastectomy • Reduction Mammoplasty • Male Sterilization • Elective Abortion • TMJ • Orthognathic Surgery • Weight Reduction procedures • Durable Medical Equipment • Prescription Drugs • Prosthetics and Orthotics • Diabetic Supplies	$2,000 per member/$4,000 per family per calendar year	$3,000 per member/$6,000 per family per calendar year
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	$6,600 per member/$13,200 per family per calendar year	$6,600 per member/$13,200 per family per calendar year

	Enhanced Benefits **CLSSLG, D1000, WDRPOV, CI20%, 2KECM, 6600PM, CO25, 35RP, ER150, UR35, IMG150, DSR20%, OMRR,** VACR50	Standard Benefits **CLSSLG, D3000, WDRPOV, CI30%, 3KECM, 6600PM, CO30, 40RP, ER150, UR50, IMG150, DSR30%, OMRR,** VACR50
Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage		
Health Maintenance Exam	Covered – 100%	Covered – 100%
Annual Gynecological Exam	Covered – 100%	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%	Covered – 100%
Well-Baby and Child Care	Covered – 100%	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%	Covered – 100%
Routine Colonoscopy	Covered – 100%	Covered – 100%
Mammography Screening	Covered – 100%	Covered – 100%
Voluntary Female Sterilization	Covered – 100%	Covered – 100%
Breast Pumps	Covered – 100%	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%	Covered – 100%
Physician Office Services		
PCP Office Visits	Covered – $25 copay	Covered – $30 copay
Online Visits	Covered – $25 copay	Covered – $30 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – $35 copay	Covered – $40 copay
Emergency Medical Care		
Hospital Emergency Room – copay waived if admitted	Covered – $150 copay after deductible	Covered – $150 copay after deductible
Urgent Care Center	Covered – $35 copay	Covered – $50 copay
Ambulance Services – medically necessary	Covered – 80% after deductible	Covered – 70% after deductible
Diagnostic Services		
Laboratory and Pathology Tests	Covered – 100%	Covered – 100%
Diagnostic Tests and X-rays	Covered – 80% after deductible	Covered – 70% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered – $150 copay after deductible	Covered – $150 copay after deductible
Radiation Therapy	Covered – 80% after deductible	Covered – 70% after deductible

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Maternity Services Provided by a Physician		
Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – $25 copay	Covered – $30 copay
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges	Covered – 100% after deductible for professional services; see Hospital Care for facility charges
Hospital Care		
General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible; unlimited days	Covered – 70% after deductible; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 80% after deductible	Covered – 70% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care	Covered – 80% after deductible up to 45 days per calendar year	Covered – 70% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible when authorized	Covered – 100% after deductible when authorized
Home Health Care	Covered – $35 copay after deductible	Covered – $40 copay after deductible
Surgical Services		
Surgery – includes all related surgical services and anesthesia.	Covered – 80% after deductible	Covered – 70% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50% after deductible	Covered – 50% after deductible
Elective Abortion (One procedure per two year period of membership)	Covered - 50% after deductible	Covered - 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered – 80% after deductible	Covered – 70% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible	Covered – 50% after deductible

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Mental Health Care and Substance Use Disorder Treatment		
Inpatient Mental Health Care	Covered – 80% after deductible	Covered – 70% after deductible
Inpatient Substance Use Disorder	Covered – 80% after deductible	Covered – 70% after deductible
Outpatient Mental Health Care includes online visits **Note:** For diagnostic and therapeutic services, the medical benefit applies.	Covered – $25 copay	Covered – $30 copay
Outpatient Substance Use Disorder	Covered – $25 copay	Covered – $30 copay
Autism Spectrum Disorders, Diagnoses and Treatment		
Applied behavioral analyses (ABA) treatment through age 18	Covered – $25 copay	Covered – $30 copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18 Physical, speech and occupational therapy for autism spectrum disorder diagnosis is unlimited.	Covered – $35 copay after deductible	Covered – $40 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit	See your outpatient mental health benefit and medical office visit benefit
Other Services		
Allergy Testing and serum	Covered – 50% after deductible	Covered – 50% after deductible
Allergy office visits	Covered – 50% after deductible	Covered – 50% after deductible
Allergy Injections	Covered – $5 copay	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $35 copay; up to 30 visits per calendar year	Covered – $40 copay; up to 30 visits per calendar year
Outpatient Therapy/Rehabilitation – subject to meaningful improvement within 60 days	Covered – $35 copay after deductible; limited to 60 visits per calendar year for any combination of therapies	Covered – $40 copay after deductible; limited to 60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%	Covered – 50%
Diabetic Supplies	Covered – 80%	Covered – 70%

Blue Care Network of Michigan

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Benefits-at-a-Glance for Healthy Blue Living℠
Prescription Drug Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Prescription Drugs	Enhanced	Standard
Tier 1A – Value Generics	$4 Copayment	$6 Copayment
Tier 1B - Generics	$15 Copayment	$25 Copayment
Tier 2 – Preferred Brand Drugs	$40 Copayment	$50 Copayment
Tier 3 – Non-Preferred Drugs	$80 Copayment	$80 Copayment
Tier 4 – Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment $200)	
Tier 5 Non-Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment $300)	
Sexual Dysfunction Drugs	50% Coinsurance of the BCN Approved Amount	
Contraceptives **Note:** Your cost sharing may be waived for Tier 1B, Tier 2 or Tier 3 contraceptive drugs if there are no appropriate generic products or preferred drugs available.	• Tier 1A – Covered in Full • Tier 1B – $15 Copay • Tier 2 - $40 Copay • Tier 3 - $80 Copay	• Tier 1A – Covered in Full • Tier 1B - $25 Copay • Tier 2 - $50 Copay • Tier 3 - $80 Copay
Preventive Medications	• Tier 1A – Covered in Full • Tier 1B Generic – Covered in Full • Tier 2 Preferred Brand – Covered in Full • Tier 3 Non-Preferred Drugs – Covered in Full	• Tier 1A – Covered in Full • Tier 1B Generic – Covered in Full • Tier 2 – Preferred Brand – Covered in Full • Tier 3 – Non-Preferred Drugs – Covered in Full
31-90 day supply for Mail-Order Pharmacy	Three times applicable copay minus $10	
84-90 day supply for Retail Pharmacy	Three times applicable copay minus $10	
Out-of-Pocket Maximum	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits.	

Definitions

Brand Name Drug	Manufactured and marketed under a registered trade name and trademark. • Multi-source Brand Name Drug: a drug that is available from a brand name manufacturer and also has a generic version. • Single Source Brand Name Drug: the drug can only be produced by the company holding the patent; no generics are available.
Generic Drugs	Prescription drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Non-Preferred Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
Non-Preferred Specialty Drugs	Specialty drugs that may not have a proven record for safety or their clinical value may not be as high as the Specialty Drugs.
Out-of-Pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.
Preferred Brand Drugs	Prescription drugs that are Single Source Brand drugs that have a proven record for safety and effectiveness.
Preferred Specialty Drugs	Generic or Single Source Brand Specialty drugs that have a proven record for safety and effectiveness and offer the best value to our members.
Value Generic Drugs	Prescription drugs that have a proven clinical value essential for treatment of chronic conditions.

Enhanced: P415CL, 90D3X; Standard: P625CL, 90D3X

Delta Dental of Michigan
Dental Benefit Highlights for
Holly Academy
Plan MC100

Delta Dental PPO (Point-of-Service) *Coverage effective September 1, 2021*	PPO Dentist	Premier Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Sealants - to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services - fillings and crown repair	90%	80%	80%
Endodontic Services - root canals	90%	80%	80%
Periodontic Services - to treat gum disease	90%	80%	80%
Oral Surgery Services - extractions and dental surgery	90%	80%	80%
Other Basic Services - misc. services	90%	80%	80%
Relines and Repairs - to bridges, dentures, and implants	90%	80%	80%
Major Services			
Major Restorative Services - crowns	60%	50%	50%
Prosthodontic Services - bridges, implants, and dentures	60%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	Up to age 19	Up to age 19	Up to age 19

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

Maximum Payment – $1,000 per person total per benefit year on all services except orthodontics. $1,000 per person total per lifetime on orthodontic services.

Deductible – $50 deductible per person total per benefit year limited to a maximum deductible of $150 per family per benefit year. The deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services.

Note - *This document is only intended to provide a brief description of your benefits. Please refer to your Certificate and summary for a complete description of benefits, exclusions, and limitations.*

Welcome to Michigan's largest dental benefits family!

As a member of Delta Dental of Michigan, you have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier.

- It's easy to find a dentist! Four out of five dentists nationwide participate in our network.
- You have superior access to care and fee savings because of our agreements with participating dentists.
- Our dentists cannot balance bill you, which means more money in your pocket!
- No troublesome paperwork! Network dentists will fill out and file your claims.
- Pay only your copayments and/or deductibles when you receive care from network dentists -- there are no hidden fees.
- You can still visit nonparticipating dentists, but you may be billed the full amount at the time of service and then have to wait to be reimbursed.

Quality Dental Program

With our quick and accurate claims processing, *we pay more than 90% of claims in 10 days or less.* Delta Dental also offers world-class customer service from our award winning call center.

Online Access

Our online Consumer Toolkit lets you access your dental plan securely over the Internet. You can find a dentist, check benefits, select paperless notices, review claims and amounts used toward maximums, print ID cards, and more -- all at your own convenience.

A Healthy Smile

Keep your smile healthy with dental benefits from Delta Dental. Your smile is a good indicator of your health. Did you know that your dentist can detect up to 120 different diseases, including diabetes and heart disease? Early detection is one of the best ways to prevent further complications.

Questions?

If you have questions, please call our Customer Service team at (800) 524-0149 or look online at www.DeltaDentalMI.com.

Holly Academy

SUMMARY OF BENEFITS

Additional discounts

40%OFF

Complete pair of prescription eyeglasses

20%OFF

Non-prescription sunglasses

These discounts are not insured benefits and are for in-network providers only. For vision plans with qualified materials benefit only. Not applicable for exam only vision plans.

Take a sneak peek before enrolling

- You're on the Insight Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1.866.804.0982
- For LASIK providers, call 1.800.988.4221

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$20 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	$40	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Any available frame at provider location	$0 copay; 20% off balance over $150 allowance	Up to $105
STANDARD PLASTIC LENSES		
Single Vision	$20 copay	Up to $30
Bifocal	$20 copay	Up to $50
Trifocal	$20 copay	Up to $70
Lenticular	$20 copay	Up to $70
Progressive - Standard	$75 copay	Up to $50
Progressive - Premium Tier 1	$105 copay	Up to $50
Progressive - Premium Tier 2	$115 copay	Up to $50
Progressive - Premium Tier 3	$130 copay	Up to $50
Progressive - Premium Tier 4	$195 copay	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45 copay	Up to $5
Anti Reflective Coating - Premium Tier 1	$57 copay	Up to $5
Anti Reflective Coating - Premium Tier 2	$68 copay	Up to $5
Anti Reflective Coating - Premium Tier 3	$85 copay	Up to $5
Photochromic - Non-Glass	$75	Not covered
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	Up to $105
Contacts - Disposable	$0 copay; plus balance over $150 allowance	Up to $105
Contacts - Medically Necessary	$0 copay; Paid-In-Full	Up to $210
OTHER		
Hearing Care from Amplifon NetworkCare	Discounts on hearing exam and aids; call 1.844.526.5432	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCIES *(Plan allows member to receive either contacts and frame, or frames and lens services)*

Exam	Once every plan year
Frame	Once every other plan year
Lenses	Once every plan year
Contacts	Once every plan year

QL-0000004136

Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Better benefits at work.

Summary of Benefits:

Group Life/Accidental Death & Dismemberment / Policy # 539522

Group Name: Holly Academy

Contributions: Non-Contributory

Class: All Employees except aides, substitute teachers & secretarial staff working at least 40 hours per week.

Coverage Information

Employee Life Benefit	1x annual earnings to a maximum of $130,000
Employee AD&D Benefit	100% of the Life Benefit Amount
Age Reduction Schedule	Life Benefit Reduces to: • 65% of original amount at age 70; • 50% of original amount at age 75

Plan Information

Guarantee Issue	$130,000
Accelerated Benefit	100% of the Life Benefit Amount to a maximum of $250,000
Can I take the insurance with me if I leave the company?	Yes, this policy is **Portable.**
General Limitations and Exclusions	Life benefits will not be paid when death is caused by, contributed to by, or results from suicide occurring within 24 months after the employee's initial effective date of insurance; and occurring within 24 months after the date any increase or additional insurance becomes effective for the employee (applies to contributory amounts and medically underwritten amounts). You are not eligible to apply for **portable** coverage for yourself if you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy.