July 19, 2011

Dear Member of Team Mosaica—

Our health insurance plan will be changing effective September 1, 2011. The last year has seen significant inflation in health care costs and we have worked our hardest to minimize the impact on members of Team Mosaica.

Here are the key elements to the medical insurance plan for the new school year.

- Our medical provider will continue to be **Blue Cross Blue Shield of Michigan**, which will continue to sub-contract with health care providers and other insurance companies throughout the country and, indeed, the world in order to maintain complete coverage for all employees. **That means that continuing employees will in all likelihood not need to change primary care physicians or providers.**

- **Our new plan is named "Simply Blue PPO – Plan 250"** and the differences between it and the current "Community Blue PPO – Plan 10" are highlighted in yellow on the attached three-page Comparison of Benefits.

- For full-time employees, we will continue to pay the **full premium for individual coverage**, with no employee contribution required. Coverage will be available for a family contract for $864 per month and for a two-person contract for $605 per month. This premium can be paid on a pre-tax basis through payroll deduction. Also, employees who can demonstrate medical coverage through a spouse's plan or other plan will be entitled to a $140 monthly "cash in lieu" payment as in the past.

- The new plan will have **some lower costs, some higher costs and many that remain the same** when you use medical services, including:
    - **Copays for Doctor Office visits and Urgent Care visits are reduced from $25 per visit to $20 per visit.**
    - **Copays for Emergency Room visits are increased from $100 to $150.**
    - The annual in-network **deductible** of $250 ($500 for families) on hospital and diagnostic care **remains the same.**
    - The annual in-network **co-insurance requirement increases from 10% to 20%;** however, **the maximum co-insurance of $500 ($1,000 for families) remains the same.** The co-insurance requirement means that if you go to the hospital, you will be responsible for 20% of hospital charges, up to the same maximum of $500 (or $1,000 for families) as in the current year.

- The old Community Blue PPO Plan covered preventive services at 100% (no deductible), but limits payments for preventive services to a maximum of $1,000 per member per calendar year. **The new Simply Blue PPO Plan does NOT limit preventive services to the $1,000 maximum, and it will continue to cover preventive services at 100% (no deductible). Also, the Simply Blue PPO Plan includes additional services under "preventive care", including an annual colonoscopy, additional immunizations, and additional preventive screenings.** We believe preventive services are a critical part of keeping people healthy and so we are delighted we were able to secure these additional benefits.

- The old Community Blue PPO Plan covered a routine colonoscopy at 90% (after deductible). **The new Simply Blue PPO Plan will cover a routine colonoscopy at 100% (no deductible).**

- We will **continue to offer dental coverage through Delta Dental, and vision coverage through Blue Cross Blue Shield, using VSP Providers**. The benefits under both dental and vision will not change from your current coverage.

You will have the opportunity to participate in a Webinar with benefit representatives to have any possible questions answered. The webinar will also describe our intent to **encourage everyone to participate in an on-line personal Health Assessment with Blue Cross Blue Shield.** Participation in the Health Assessment will have a double benefit — lower costs over time and a healthier you!

Included in your enrollment package are the details of all of the benefits and coverage's under our new health care plan, as well as information on enrolling or reenrolling in our HCFSA and DCFSA plans. You will also receive information on our 401k Plan under separate cover. Should you have benefit questions, please direct those to Karen Augenstein if you live in Michigan or Ohio, direct your questions to Diane Jiggetts or Nadyah Arnold, if you live elsewhere. All 401k questions should be directed to Diane Jiggetts or Nadyah Arnold.

Sincerely yours,

Ebbie Parsons, III
Chief Operating Officer

Benefits Programs

MEI is committed to sponsoring a comprehensive benefits program for all eligible employees. In addition to receiving an equitable salary and having an equal opportunity for professional development and advancement, you may be eligible for other benefits that will enhance your job satisfaction. We are certain you will agree the benefits program described in this Employee Manual represents a very large investment by MEI.

MEI will periodically review the benefits program and will make modifications as appropriate to the company's condition. MEI reserves the right to modify, add or delete the benefits it offers.

Eligibility for Benefits

Full-time MEI employees are eligible for all of the benefits described in this Employee Manual provided you meet the eligibility requirements for each particular benefit. Coverage is available to you and your dependents as defined in the benefit explanation materials.

Part-time employees will be eligible for only those benefits specifically outlined in this Employee Manual and as required by law.

Temporary employees and employees working less than 30 hours per week on a regular basis are not eligible for benefits.

Insurance Coverage

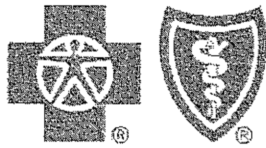
All benefit-eligible employees may participate in the Company's benefits programs which include: medical, prescription, vision, dental, life and long-term disability insurance. Initial medical benefits forms must be completed within **10 days** of your date of hire. It is your responsibility to complete and return the forms to your supervisor. Your supervisor and the Human Resource Department have current rates and information available.

Full-time employees: Mosaica will contribute 100% of full-time employees' single premium coverage during employment by Mosaica. Dependent coverage, and as of, September 1, 2009, Domestic Partner coverage is available at the expense of the employee through a payroll deduction plan. Employees do get the advantage of group discount rates for dependent coverage. Employees are eligible for coverage the first day of the month following 30 days of employment. Eligible employees who choose not to obtain medical insurance through Mosaica are eligible to receive a cash in lieu (CIL) payment of $70/pay period. The employee ***must*** submit required documentation of health coverage elsewhere.

Part-time employees: Part-time employees are not eligible for these benefit programs.

Retirement Plan:

Mosaica offers a 401(k) Retirement Plan to all **eligible** employees. All employees who work twenty (20) hours a week or more and who commenced employment on or after January 1, 2007 are automatically enrolled in the Mosaica Education, Inc. 401K Retirement Plan on the first day of the quarter following their employment and 2% of the employee's eligible salary will be deducted as a contribution to the Plan. All other employees working 20 hours or more per week are eligible to participate in the Mosaica 401(k) Retirement Plan and may enroll effective January 1st, April 1st, July 1st, and October 1st of each year. This plan is designed to help each employee to prepare for retirement years by deferring a portion of his or her pay to an investment account. Employees may defer salary in increments of 1% to 100% of eligible compensation up to the maximum allowed by law. MEI will make a contribution in an amount equal to $0.25 on every dollar you put in, up to a maximum of 4% of your salary.



MOSAICA EDUCATION
#27099

Simply Blue[SM] PPO – Plan 250 Medical Coverage Benefits-at-a-Glance

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

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

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

Note: If a PPO provider refers you to a non-network provider, all covered services obtained from that non-network provider will be subject to applicable out-of-network cost-sharing.

	In-network	Out-of-network *
Deductibles	$250 for one member, $500 for the family (when two or more members are covered under your contract) each calendar year	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also apply toward the in-network deductible.
Fixed dollar copays	• $20 copay for office visits • $20 copay for urgent care visits • $150 copay for emergency room visits	$150 copay for emergency room visits
Coinsurance amounts **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse coinsurance amounts.	• 50% of approved amount for private duty nursing • 40% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse coinsurance amounts.
Annual coinsurance dollar maximums – applies to coinsurance amounts for all covered services – including mental health and substance abuse services – but **does not** apply to fixed dollar copays and private duty nursing coinsurance amounts **Note:** For groups with 50 or fewer employees or groups that are **not** subject to the MHP law, mental health care and substance abuse treatment coinsurance amounts **do not** contribute to the coinsurance maximum.	$500 for one member, $1,000 for two or more members each calendar year	$5,000 for one member, $10,000 for two or more members each calendar year **Note:** Out-of-network coinsurance amounts also apply toward the in-network maximum.
Lifetime dollar maximum	None	

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

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

Preventive care services	In-network	Out-of-network *
Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible **Note:** Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Colonoscopy – routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
	One per member per calendar year	

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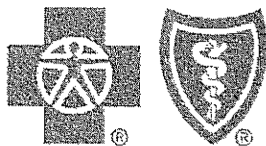
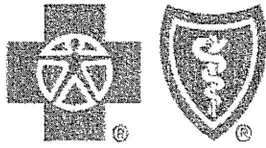


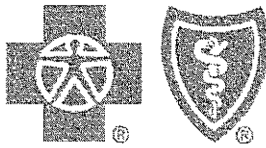
	In-network	Out-of-network *
Physician office services		
Office visits	$20 copay per office visit **Note:** Simply Blue applies deductible and coinsurance to office visit services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	80% after in-network deductible	60% after out-of-network deductible, must be medically necessary
Office consultations	$20 copay per office visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible, must be medically necessary
Urgent care visits		
Urgent care visits	$20 copay per office visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
Emergency medical care		
Hospital emergency room	$150 copay per visit (copay waived if admitted)	$150 copay per visit (copay waived if admitted)
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible
Diagnostic services		
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible
Maternity services provided by a physician		
Prenatal and postnatal care	80% after in-network deductible	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	

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



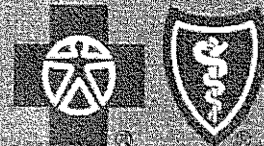
	In-network	Out-of-network *
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care – must be medically necessary and provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible
Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers	80% after in-network deductible	80% after in-network deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization	80% after in-network deductible	60% after out-of-network deductible
Human organ transplants		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) – in designated facilities **only**
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

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



	In-network	Out-of-network *
Mental health care and substance abuse treatment		
Inpatient mental health care and inpatient substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible, in participating facilities **only**
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)
Other covered services		
Outpatient Diabetes Management Program (ODMP) **Note:** Effective July 1, 2011, when you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	80% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$20 copay per office visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.	60% after out-of-network deductible
	Limited to a **combined** maximum of 12 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** maximum of 30 visits per member per calendar year	
Durable medical equipment	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible
Prescription drugs	Not covered	Not covered

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



Mosaica Education

Blue Preferred® Rx Prescription Drug Coverage Benefits-at-a-Glance

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 Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

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

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (copays)	Network pharmacy	Non-network pharmacy
Tier 1 – Generic or prescribed over-the-counter drugs	$10 copay	$10 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
Tier 2 – Formulary brand-name drugs	$40 copay	$40 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
Tier 3 – Nonformulary brand-name drugs	$80 copay	$80 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	**Copay for up to a 30 day supply:** • $10 copay for Tier 1 (generic) drugs • $40 copay for Tier 2 (formulary brand) drugs • $80 copay for Tier 3 (nonformulary brand) drugs **Copay for a 31 to 90 day supply:** • $20 copay for Tier 1 (generic) drugs • $80 copay for Tier 2 (formulary brand) drugs • $160 copay for Tier 3 (nonformulary brand) drugs	No coverage

Note: If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic **plus** the applicable copay.

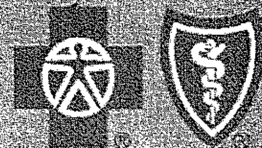
Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

Note: A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a Medco pharmacy outside Michigan. Medco is an independent company providing pharmacy benefit services for Blues members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or Medco networks.

Underwritten by

Administered by:

Blue Cross Blue Shield of Michigan



Covered services	Network pharmacy	Non-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug
Mail order (home delivery) prescription drugs – up to a 90-day supply of medication by mail from Medco (BCBSM network mail order provider)	100% of approved amount less plan copay	No coverage

Features of your prescription drug plan

Feature	Description
BCBSM custom formulary	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost. ▪ **Tier 1 (generic)** – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. ▪ **Tier 2 (formulary brand)** – Tier 2 includes brand-name drugs from the Custom Formulary. Formulary options are also safe and effective, but require a higher copay. ▪ **Tier 3 (nonformulary brand)** – Tier 3 contains brand-name drugs not included in the Custom Formulary. Members pay the highest copay for these drugs.
Drug interchange and generic copay waiver	Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at **bcbsm.com**. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at **bcbsm.com**.
Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications **before** prescribing a more expensive brand-name drug, It applies only to prescriptions being filed for the first time of a targeted medication. Before filling your **initial** prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at **bcbsm.com, along with the preferred medications.** If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect **all** targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.

Underwritten by:

Administered by:

Blue Vision^{SM} 12/12/12
Benefits-at-a-Glance for Mosaica

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 Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blue members. To find a VSP doctor, call **800-877-7195** or log onto the VSP Web site at **vsp.com.**

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

Copays

	VSP network doctor	Non-VSP provider
Eye exam	$10 copay	$10 copay applies to charge
Prescription glasses (lenses and/or frames)	A **combined** $25 copay	Member responsible for difference between approved amount and provider's charge, less a $25 copay
Medically necessary contact lenses	$25 copay	Member responsible for difference between approved amount and provider's charge, less a $25 copay

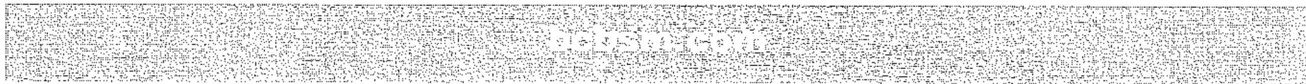
Eye exam

	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Covered – $10 copay	Reimbursement up to $35, less a $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	

Lenses and frames

	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note**: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	Covered – $25 copay (one copay applies to both lenses and frames)	Reimbursement up to predetermined amount based on lense type after copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	Covered – $25 copay (one copay applies to both frames and lenses)	Reimbursement up to $45, less a $25 copay (member responsible for any difference)
	One frame in any period of 12 **consecutive** months	

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



Contact lenses

	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	Covered – $25 copay	Reimbursement up to $210 after a $25 copay (member responsible for any difference)
	One pair of contact lenses in any period of 12 **consecutive** months	
Elective contact lenses that improve vision (prescribed, but do **not** meet criteria of medically necessary)	Covered – $120 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	Covered – $105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	One pair of contact lenses in any period of 12 **consecutive** months	

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 0433
Mosaica Education, Inc.

This Summary of Dental Plan Benefits should be read in conjunction with your Dental Care Certificate. Your Dental Care Certificate will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. The percentages below will be applied to the lesser of the dentist's submitted fee and Delta Dental's allowance for each service. Delta Dental's allowance may vary by the dentist's network participation. PLEASE NOTE - If you choose a Nonparticipating Dentist, you will be responsible for any difference between the amount Delta Dental allows and the amount the Nonparticipating Dentist charges, in addition to any Copayment or Deductible.

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services -

	PPO Dentist	Premier Dentist	Non-participating Dentist
	Plan Pays	**Plan Pays**	**Plan Pays***
Class I			
Diagnostic and Preventive Services - includes 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%
Class II			
Minor Restorative Services - fillings and crown repair	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Relines and Repairs - to bridges and dentures	80%	80%	80%
Class III			
Major Restorative Services - crowns	50%	50%	50%
Prosthodontic Services - includes bridges, implants, and dentures	50%	50%	50%
Class IV			
Orthodontic Services - includes 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. This Nonparticipating Dentist Fee may be less than what your dentist charges, which means that you will be responsible for the difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Bitewing X-rays are payable twice per calendar year and full-mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.

- Sealants are only payable once per tooth per lifetime for the occlusal surface of first permanent molars up to age nine and second permanent molars up to age 14. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.
- People with certain high-risk medical conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.

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

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

Waiting Period – Employees who are eligible for dental benefits are covered on the first day of the month following 30 days of employment.

Eligible People – All full-time employees of the Contractor working at least 30 hours per week of Mosaica Education Inc.-NY Office (0001), Mosaica Education-Lansing Office (0002), Ahwatukee Foothills Prep (0003), Phoenix Advantage Charter School (0004), Riverbend Prep School (0005), Mercury Online Academy (0006), Banning Lewis Ranch Academy (0007), Northern Colorado TR Paul Academy (0008), STAR Academy (0009), Atlanta Preparatory Academy (0010), Frazier Preparatory Academy (0011), Bay County Public School Academy (0012), Bingham Arts Academy (0013), Capital Area Academy (0014), Discovery Arts Technology Academy (0015), Grand Blanc Academy (0016), Jackson Arts & Technology Academy (0017), Pontiac Arts & Technology Academy (0018), Richfield Academy (0019), Academy of Arts and Humanities (0020), Arts and Science Preparatory Academy (0021), Cleveland Arts and Social Science (0022), Columbus Arts and Technology (0023), Columbus Cornerstone Academy (0024), Columbus Humanities, Arts & Tech (0025), Columbus Preparatory Academy (0026), Foundation Academy (0027), Academy of Arts and Science (0028), Lorain Preparatory Academy (0029), Youngstown Academy of Excellence (0030), STAR Academy of Toledo, OH (0031) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable. The Contractor pays the full cost of this plan for Subscribers. The Subscriber pays the additional cost of dependent coverage.

Also eligible at your option are your legal spouse, your dependent children to the end of the calendar year in which they attain the age of 19, your dependent unmarried children who are eligible to be claimed by you as a dependent under the U.S. Internal Revenue code during the current calendar year and your domestic partners as defined in the contract. You and your eligible dependents must enroll for a minimum of 12 months. If coverage is terminated after 12 months, you may not re-enroll prior to the open enrollment that occurs at least 12 months from the date of termination. Your dependents may only enroll if you are enrolled (except under COBRA) and must be enrolled in the same plan as you. Plan changes are only allowed during open enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

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

Benefits will cease on the last day of the month in which the employee is terminated.

Mosaica Education, Inc.

Plan Selection Form for Plan Year 9/1/11 to 8/31/12

Employee Name:______________________________ Social Security #:________________

School/Office Location:______________________________

- Returning employees who are not making any changes DO NOT have to complete this form.
- Returning employees who are making any changes must complete both sides of this form.
- ALL new employees enrolling for the first time must complete both sides of this form.

MEDICAL/RX BENEFITS		Total Monthly Premium	Employer Monthly Contribution	Employee Monthly Contribution	Employee Cost Per Pay Period	
		Check the coverage you wish to enroll in				
BCBS Simply Blue PPO Plan 250						
$20 Office Visit Copay	Single	*$431.82*	*$431.82*	$0.00	$0.00	☐
$10/$40/$80 RX Copay	Two Person	*$1,036.38*	*$431.82*	$604.56	$302.28	☐
$250/$500 Deductible	Family	*$1,295.47*	*$431.82*	$863.65	$431.83	☐
$500/$1000 Coinsurance Max						
VISION (You must be enrolled in the Medical Plan to enroll in the Vision Plan)						
		Check the coverage you wish to enroll in				
Blue Vision VSP						
$10 Exam Copay	Single	*$5.82*	*$5.82*	$0.00	$0.00	☐
$25 Lens/Frame Copay	Two Person	*$13.98*	*$5.82*	$8.16	$4.08	☐
12/12/12 Frequency	Family	*$17.47*	*$5.82*	$11.65	$5.83	☐
DENTAL						
		Check the coverage you wish to enroll in				
Delta Dental PPO						
$50/$150 Deductible; $1,000 Max	Single	*$28.06*	*$28.06*	$0.00	$0.00	☐
100%; 80%; 50% Covered	Two Person	*$61.75*	*$28.06*	$33.69	$16.85	☐
Ortho Covered 50% to $1,000 Max	Family	*$86.98*	*$28.06*	$58.92	$29.46	☐
LIFE/AD&D - Included at No Cost to Employee						
$10,000 Life Benefit						
LONG TERM DISABILITY - Included at No Cost to Employee						
Benefits begin after 90 days of continuous disability						

Waiving Medical & Vision * *$140.00* ☐

* Employees waiving medical coverage will receive of an opt out credit of $140 per month, dispersed as $70 per pay period. Please complete the "Cash-In-Lieu" section below and include a copy of proof of other coverage.

Cash-In-Lieu of Medical Insurance

To be eligible, you must provide written proof of other health care coverage. The required proof is an official document verifying you are insured under a group health insurance plan. For example, a letter or official website document from your spouse's employer stating you are currently covered under their health insurance plan, which lists **your name** as an eligible dependent, **and** the **effective date** of coverage.

1. In lieu of medical coverage, I will be paid opt out cash per pay period based on my selection above.
2. This option is a taxable benefit and is subject to FICA, federal, state, and city tax.
3. If during the plan year I lose my other medical coverage and want to establish coverage through Mosaica Education, I must notify the HR Administrator within 30 days of lost coverage. I will be required to provide proof of loss of coverage (ie. insurance cancellation notice, divorce decree, etc...), and my enrollment will be subject to the plan's eligibility and enrollment rules.

Signature: ______________________________ Date:________________

For employees enrolling in coverage, your contribution will be deducted from your pay check on a pre-tax basis.

I have received and read all of the materials explaining this plan. I understand that I am making an election concerning my benefits for the full plan year and authorize any required salary reduction in accordance with my elections above. My elections are binding subject to any changes required to comply with federal law, such as a change in my family status. A change in family status may include, but is not limited to, marriage; divorce; death of a spouse or dependent; birth or adoption of a child; or a change in my (or my spouse's) employment status. I understand that my share of the cost of this coverage may be adjusted from time to time to reflect the change in rates charged by the carriers. I hereby apply for the options listed above.

Signature: ______________________________ **Date:** ________________