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.

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Community Blue℠ PPO – Plan 1
Benefits-at-a-Glance for Mosaica

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Deductible, copays and dollar maximums

Note: Services from a provider for which there is no 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. **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**. 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**
Deductible	None	$250 for one member, $500 for the family each calendar year
Copays • Fixed dollar copays	$15 for office visits and $15 for chiropractic/ osteopathic manipulative treatment by a network provider; $50 for emergency room visits	$50 for emergency room visits
• Percent copays	50% for mental health care, substance abuse treatment and private duty nursing	20% for general services and 50% for mental health care, substance abuse treatment and private duty nursing
Copay dollar maximums • Fixed dollar copays	None	None
• Percent copays – **excludes** mental health care, substance abuse treatment and private duty nursing copays	Not applicable	$2,000 for one member, $4,000 for two or more members each calendar year
Dollar maximums	$1 million lifetime per covered specified human organ transplant type and a **separate** $5 million lifetime per member for all other covered services and as noted for individual services	

Preventive care services – *Payment for preventive services is limited to a combined maximum of $500 per member per calendar year

	In-network	Out-of-network
Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered
Gynecological exam	Covered – 100%*, one per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100%*, one per calendar year	Not covered
Well-baby and child care	Covered – 100%* • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics	Covered – 100%*	Not covered
Fecal occult blood screening	Covered – 100%*, one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100%*, one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100%*, one per calendar year	Not covered

Mammography

	In-network	Out-of-network
Mammography screening	Covered – 100%	Covered – 80% after deductible
	One per calendar year, no age restrictions	

	In-network	Out-of-network
Physician office services		
Office visits	Covered – $15 copay	Covered – 80% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 100%	Covered – 80% after deductible, must be medically necessary
Office consultations	Covered – $15 copay	Covered – 80% after deductible, must be medically necessary
Urgent care visits	Covered – $15 copay	Covered – 80% after deductible, must be medically necessary
Emergency medical care		
Hospital emergency room	Covered – $50 copay, waived if admitted or for an accidental injury	Covered – $50 copay, waived if admitted or for an accidental injury
Ambulance services – must be medically necessary	Covered – 100%	Covered – 100%
Diagnostic services		
Laboratory and pathology services	Covered – 100%	Covered – 80% after deductible
Diagnostic tests and x-rays	Covered – 100%	Covered – 80% after deductible
Therapeutic radiology	Covered – 100%	Covered – 80% after deductible
Maternity services provided by a physician		
Prenatal and postnatal care	Covered – 100%	Covered – 80% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 100%	Covered – 80% after deductible
	Includes delivery provided by a certified nurse midwife	
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	Covered – 100%	Covered – 80% after deductible
Note: Nonemergency services must be rendered in a **participating** hospital.	Unlimited days	
Inpatient consultations	Covered – 100%	Covered – 80% after deductible
Chemotherapy	Covered – 100%	Covered – 80% after deductible
Alternatives to hospital care		
Skilled nursing care	Covered – 100%	Covered – 100%
	Up to 120 days per calendar year	
Hospice care	Covered – 100%	Covered – 100%
	Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 100%	Covered – 100%
Home infusion therapy – must be medically necessary	Covered – 100%	Covered – 100%
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	Covered – 100%	Covered – 80% after deductible
Presurgical consultations	Covered – 100%	Covered – 80% after deductible
Colonoscopy	Covered – 100%	Covered – 80% after deductible
Voluntary sterilization	Covered – 100%	Covered – 80% after deductible

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	In-network	Out-of-network
Human organ transplants		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – in designated facilities **only**
	Limited to $1 million **lifetime** maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – 80% after deductible
Specified oncology clinical trials	Covered – 100%	Covered – 80% after deductible
Kidney, cornea and skin	Covered – 100%	Covered – 80% after deductible
Mental health care and substance abuse treatment		
Inpatient mental health care	Covered – 50%	Covered – 50% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 50%	Covered – 50% after deductible
	Unlimited days, up to $15,000 annual, $30,000 lifetime maximum	
Outpatient mental health care • Facility and clinic	Covered – 50%	Covered – 50%
• Physician's office	Covered – 50%	Covered – 50% after deductible
Outpatient substance abuse treatment – in approved facilities	Covered – 50%	Covered – 50%
	Up to the state-dollar amount that is adjusted annually	
Other covered services		
Outpatient Diabetes Management Program (ODMP)	Covered – 100%	Covered – 80% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic spinal manipulation	Covered – $15 copay	Covered – 80% after deductible
	Up to 24 visits per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 100%	Covered – 80% after deductible
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 100%	Covered – 100%
Prosthetic and orthotic appliances	Covered – 100%	Covered – 100%
Private duty nursing	Covered – 50%	Covered – 50%
Prescription drugs Mail Order 2X **Copay for up to a 34 day supply:** • $10 for each generic drug • $40 for each brand name drug **Copay for a 35 to 90 day supply:** • $20 for each generic drug • $80 for each brand name drug	$10 generic/$40 brand with contraceptives	$10 for each generic drug ***plus*** 25% of the BCBSM approved amount for the drug; $40 for each brand drug ***plus*** 25% of the BCBSM approved amount for the drug.

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Healthy Blue 80 PPO℠
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.

Deductible, copays and dollar maximums

Note: Services from a provider for which there is no 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. **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**. 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
Deductible	None	None
Copays	20% of approved amount	30% of approved amount
Copay dollar maximums – excludes mental health care, substance abuse treatment and private duty nursing copays	$2,500 for one member, $5,000 for two or more members per calendar year	$5,000 for one member, $10,000 for two or more members per calendar year
Dollar maximums	$1 million lifetime per covered specified human organ transplant type and a **separate** $5 million lifetime per member for all other covered services and as noted for individual services	

Preventive care services

	In-network	Out-of-network
Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 80% One per calendar year	Covered – 70%
Gynecological exam	Covered – 80% One per calendar year	Covered – 70%
Pap smear screening – laboratory and pathology services	Covered – 80% One per calendar year	Covered – 70%
Well-baby and child care	Covered – 80% • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Covered – 70%
Pediatric and adult immunizations	Covered – 80%	Covered – 70%
Fecal occult blood screening	Covered – 80% One per calendar year	Covered – 70%
Flexible sigmoidoscopy exam	Covered – 80% One per calendar year	Covered – 70%
Colonoscopy screening exam	Covered – 80% One per calendar year	Covered – 70%
Prostate specific antigen (PSA) screening	Covered – 80% One per calendar year	Covered – 70%

Mammography

	In-network	Out-of-network
Mammography screening	Covered – 80% One per calendar year, no age restrictions	Covered – 70%

Physician office services

	In-network	Out-of-network
Office visits	Covered – 80%	Covered – 70%
Outpatient and home medical care visits	Covered – 80%	Covered – 70%
Office consultations	Covered – 80%	Covered – 70%
Urgent care visits	Covered – 80%	Covered – 70%

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	In-network	Out-of-network
Emergency medical care		
Hospital emergency room	Covered – 80%	Covered – 70%
Ambulance services – must be medically necessary	Covered – 80%	Covered – 70%
Diagnostic services		
Laboratory and pathology services	Covered – 80%	Covered – 70%
Diagnostic tests and x-rays	Covered – 80%	Covered – 70%
Therapeutic radiology	Covered – 80%	Covered – 70%
Maternity services provided by a physician		
Prenatal and postnatal care	Covered – 80%	Covered – 70%
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 80%	Covered – 70%
	Includes delivery provided by a certified nurse midwife	
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note**: Nonemergency services must be rendered in a **participating** hospital.	Covered – 80%	Covered – 70%
	Unlimited days	
Inpatient consultations	Covered – 80%	Covered – 70%
Chemotherapy	Covered – 80%	Covered – 70%
Alternatives to hospital care		
Skilled nursing care	Covered – 80%, in **participating** skilled nursing facilities **only** Up to 90 days per calendar year	
Hospice care	Covered – 80%, **participating** hospice program **only** Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 80%, by a **participating** home health care agency **only**	
Home infusion therapy – must be medically necessary	Covered – 80%, by **participating** providers **only**	
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	Covered – 80%	Covered – 70%
Presurgical consultations	Covered – 80%	Covered – 70%
Voluntary sterilization	Covered – 80%	Covered – 70%
Human organ transplants		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 80%, in designated facilities **only**, limited to $1 million **lifetime** maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 80%	Covered – 70%
Specified oncology clinical trials	Covered – 80%	Covered – 70%
Kidney, cornea and skin transplants	Covered – 80%	Covered – 70%
Mental health care and substance abuse treatment		
Inpatient mental health care and substance abuse treatment	Covered – 80%	Covered – 70%
	Limited to a **combined** 60-day maximum per calendar year with a 120-day lifetime maximum	
Outpatient mental health care	Covered – 80%	Covered – 70%
	Limited to 120 visits per calendar year	
Outpatient substance abuse treatment – in approved facilities **only**	Covered – 80%	Covered – 80%, in approved facilities **only**
	Up to annual state-dollar amount (that combines outpatient and residential substance abuse)	

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Other covered services	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	Covered – 80%	Covered – 70%
Allergy testing and therapy	Covered – 80%	Covered – 70%
Osteopathic manipulative therapy	Not covered	Not covered
Chiropractic spinal manipulation	Not covered	Not covered
Outpatient physical, speech and occupational therapy	Covered – 80%	Covered – 70% **Note:** Outpatient physical therapy is **not** covered at nonparticipating facilities.
	Limited to a **combined** 60-visit maximum per calendar year Each treatment date counts as one visit even when two or more therapies are provided and when two or more conditions are treated (the initial evaluation is not counted as a visit)	
Durable medical equipment	Covered – 80%	Covered – 70%
Prosthetic and orthotic appliances	Covered – 80%	Covered – 70%
Private duty nursing	Covered – 80%	Covered – 70%
Prescription drugs Prescription drugs Mail Order 2X **Copay for up to a 34 day supply:** • $10 for each generic drug • $40 for each brand name drug **Copay for a 35 to 90 day supply:** • $20 for each generic drug • $80 for each brand name drug	$10 generic/$40 brand with contraceptives	$10 for each generic drug ***plus*** 25% of the BCBSM approved amount for the drug; $40 for each brand drug ***plus*** 25% of the BCBSM approved amount for the drug.

Blue Care Network
Mosaica Eduction
BCN 5

This is intended as an easy-to-read summary. It is not a contract. An official description of benefits is contained in 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.**

Preventive Services

Health Maintenance Exam	Covered – $10 copay
Annual Gynecological Exam	Covered – $10 copay
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – $10 copay
Immunizations – pediatric and adult	Covered – Office visit copay may apply per member, per visit
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit

Mammography

Mammography Screening	Covered – Office visit copay may apply per member, per visit

Physician Office Services

Office Visits	Covered – $10 copay
Consulting Specialist Care – when referred	Covered – $10 copay

Emergency Medical Care

Hospital Emergency Room (copay waived if admitted)	Covered – $50 copay
Physician's Office	Covered – $10 copay
Urgent Care Center	Covered – $10 copay
Ambulance Services – medically necessary	Covered – 100%, ground and air services

Diagnostic Services

Laboratory and Pathology Tests	Covered – Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – Office visit copay may apply per member, per visit
Radiation Therapy	Covered – Office visit copay may apply per member, per visit

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – $10 copay
Delivery and Nursery Care	Covered – 100%

Hospital Care

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%, unlimited days

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100%, up to 45 days per calendar year
Hospice Care	Covered – 100%, in a facility, $10 copay per home visit
Home Health Care	Covered – $10 copay

Surgical Services

Surgery – includes all related surgical services and anesthesia – see member certificate for specific surgical copays	Covered – 100%
Voluntary Sterilization	Covered – 50% on all associated costs
Human Organ Transplants	Covered – 100%, subject to medical criteria

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	**Mental Health Care:** Covered – 100%, up to 30 days per calendar year **Substance Abuse Care:** Covered – 50%, one program per 12-month period
Outpatient Mental Health Care	Covered – 50%, up to 20 visits per calendar year
Outpatient Substance Abuse Care	Covered – 50%, up to 20 visits per calendar year

Other Services

Allergy Testing and Therapy	Covered – 50%, $10 copay for allergy injections
Chiropractic Spinal Manipulation	Covered – $10 copay
Outpatient Physical, Speech and Occupational Therapy	Covered – $10 copay, limited to 60 consecutive days per episode
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Prescription Drugs – includes contraceptives and mail order prescription drugs	$10generic/$20brand copay with contraceptives Mail order 2x $20generic/$40brand copay

Deductible, Copays and Dollar Maximums

Deductible	None
Copays • Fixed Dollar Copay	$10 for allergy injections, office visits, and urgent care visits, and $50 for emergency room visits
• Percent Copay	50% for select services as noted above
Copay Dollar Maximums • Fixed Dollar Copay	None
• Percent Copay	None
Dollar Maximums	None

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Traditional Plus Dental Coverage Benefits-at-a-Glance for Mosaica

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Network access information

- **DenteMax PPO network** – DenteMax PPO dentists agree to accept our approved amount as payment in full and participate on all claims. DenteMax is an independent company that leases its network to BCBSM to provide access to Blues members. You'll also receive discounts on noncovered services when you use PPO dentists. You can choose from more than 83,000 dentist access points* nationwide where dental services are available through our partnership with the **DenteMax** PPO network. To find a **DenteMax** dentist, please call 800-752-1547 or go to the DenteMax Web site at **dentemax.com.**

  ** A dentist access point is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two locations would be two access points.*
- **Blue Par Select**^{SM} – Most dentists participate with the Blues on a "per claim" basis, so you should ask your dentist if he or she participates before every procedure. These dentists accept payment in full from BCBSM for covered services and you pay the dentist only applicable copays and deductibles, and any fees for noncovered services. You won't be balanced billed for any difference between our approved amount and the dentist's charge. We call this arrangement "Blue Par Select." To find a dentist who may participate with BCBSM, go to **bcbsm.com**. Select the **Dental Professionals** subsection of "**Where You Can Go for Care**" page.

Note: If you receive care from a nonparticipating dentist, you may be billed for the difference between our approved amount and the dentist's charge.

Deductible, copays and dollar maximums

Deductible (per calendar year)	$50 for one member or $150 for the family for Class II and Class III services
Copays	20% for Class II services and 50% for Class III and Class IV services
Dollar maximums • Annual maximum (for Class I, II and III services)	 $1,000 per member for all covered services
• Lifetime maximum (for Class IV services)	$1,000 lifetime per member

Class I services

Oral exams	Covered – 100%, twice per calendar year
A set (up to 4) of bitewing x-rays	Covered – 100%, twice per calendar year
Full-mouth and panoramic x-rays	Covered – 100%, once every 60 months
Prophylaxis (teeth cleaning)	Covered – 100%, twice per calendar year
Pit and fissure sealants – for members age 19 or under	Covered – 100%, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	Covered – 100%
Fluoride treatment	Covered – 100%, two per calendar year
Space maintainers – missing posterior (back) primary teeth	Covered – 100%, once per quadrant per lifetime, for members under age 19

Class II services

Fillings – permanent teeth	Covered – 80% after deductible, replacement fillings covered after 24 months or more after initial filling
Fillings – primary teeth	Covered – 80% after deductible, replacement fillings covered after 12 months or more after initial filling
Recementing of crowns, veneers, inlays, onlays and bridges	Covered – 80% after deductible, three times per tooth per calendar year after six months from original restoration

Class II services, *continued*

Oral surgery including extractions	Covered – 80% after deductible
Root canal treatment – permanent tooth	Covered – 80% after deductible, once every 12 months for tooth with one or more canals
Scaling and root planing	Covered – 80% after deductible, once every 24 months per quadrant
Limited occlusal adjustments	Covered – 80% after deductible, **limited** occlusal adjustments covered up to five times in a 60-month period
Occlusal biteguards	Covered – 80% after deductible, once every 12 months
General anesthesia or IV sedation	Covered – 80% after deductible, when medically necessary and performed with oral or dental surgery
Adjustment of dentures	Covered – 80% after deductible, six months or more after it is delivered
Relining or rebasing of partials or complete dentures	Covered – 80% after deductible, once every 36 months per arch
Tissue conditioning	Covered – 80% after deductible, once every 36 months per arch
Repair and adjustments of partial or complete dentures	Covered – 80% after deductible

Class III services

Onlays, crowns and veneer fillings – permanent teeth	Covered – 50% after deductible, once every 60 months per tooth, payable for members age 12 or older
Removable dentures (complete and partial)	Covered – 50% after deductible
Bridges (fixed partial dentures) – for members age 16 or older	Covered – 50% after deductible, once every 60 months after original was delivered
Endosteal implants – for members age 16 or older who are covered at the time of the actual implant replacement	Covered – 50% after deductible, once per tooth in a member's lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	Covered – 50%
Minor treatment to control harmful habits	Covered – 50%
Interceptive and comprehensive orthodontic treatment	Covered – 50%
Post-treatment stabilization	Covered – 50%
Cephalometric film (skull) and diagnostic photos	Covered – 50%

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

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

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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

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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	

RELIANCE STANDARD
Life Insurance Company
a DELPHI company

Mosaica Education, Inc.
Employee Benefits

Basic Life and Accidental Death & Dismemberment Benefit Summary

Eligibility:	As an active full-time employee, you are provided with the following coverage at no cost to you.
Benefit:	Flat $10,000.
AD&D Schedule:	The AD&D (accidental death & dismemberment) benefit provides double indemnity for loss of life which occurs as the result of an accident. It also provides benefits for other losses (e.g. loss of limb, sight, speech, etc.)
Waiver of Premium:	If you become disabled for more than six months, your coverage may be continued without payment of premium. ***Basic Life only**
Reduction Schedule:	Benefits reduce by 35% at age 65, an additional 25% at age 70, and an additional 20% at age 75.
Living Benefit:	Terminally ill patients may cash out up to 75% of the life benefit.
Critical Illness:	Will pay an additional 10% of the employee's benefit up to $100,000 if the employee qualifies for waiver of premium as a result of cancer, heart attack, stroke, kidney failure, or major organ transplant.
Conversion:	Terminated employees may convert to an individual whole life policy.
Travel Assistance:	Included

This is only a summary of your benefits. Please consult your benefit booklet for a more detailed description of the program.

RELIANCE STANDARD
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Mosaica Education, Inc.
Employee Benefits

Long Term Disability Benefit Summary

Eligibility:	As an active full-time employee, you are provided with the following coverage.
Benefit:	**60 %** of monthly earnings up to a maximum monthly benefit of **$10,000.**
Elimination Period:	You must be disabled for at least **90** days before benefits begin.
Interruption Period:	The elimination period will not be interrupted unless the employee returns to work for 30 days or longer.
Definition of Disability:	You must be unable to perform the material duties of your occupation.
Maximum Benefit Duration:	As long as you continue to meet the definition of disability, benefits may continue to your Social Security Normal Retirement Age (SSNRA).
Own-Occ Duration:	Twenty four (24) months.
Partial Disability (rehabilitative employment):	Benefits are paid for employees who are partially disabled or who elect rehabilitative employment.
Integration:	Benefits will be reduced by worker's compensation and any social security distribution an insured is entitled to receive.
Limitations:	Benefits are limited to two years (unless hospital confined) for mental/nervous, drug/alcohol claims, and self-reported condition claims.
Pre-Existing Conditions:	An employee who was treated for a condition 3 months prior to their effective date, and becomes disabled as a result of such condition, will not be eligible for disability payments for such condition until covered on the plan for six (6) months.
Survivor Benefit:	A lump sum award of three (3) times your gross monthly benefit will be paid to an eligible survivor if you die after being disabled for six (6) months or longer.

Medical Insurance Option

Cash-In-Lieu (CIL)

If you have medical insurance from another source such as your spouse or a previous employer, Mosaica offers you an option to accepting the company provided medical insurance.

Upon presentation of proof of other insurance coverage, we will provide you $140 per month to be disbursed as follows:

$70 per pay period, added to your gross pay.

If you lose coverage through the other source during the course of the plan year, you may be eligible to enroll in the company/school plan. This is not guaranteed and is subject to restrictions regarding eligibility and timing. If you become a member of the company/school medical plans, the cash-in lieu payments would terminate. This does not affect coverage in the company sponsored dental, life, and disability plans.

To qualify, please complete the information below and send it to your Human Resources Administrator. Please include a copy of proof of other coverage (either a copy of the front and back of your insurance card <u>if it includes your name and a current effective date</u>, or a letter from your insurance company, or a letter from the company or organization through which the insurance is provided). This signed form and the proof of other coverage must be submitted during the open enrollment period or within 30 days after your date of hire or attainment of eligibility for medical coverage with Mosaica.

Name____________________________________

Social Security No.________________

I am asking Mosaica or my school to NOT enroll me in the company medical insurance plan because I have coverage in effect from another source (proof of coverage attached). In return, the company will provide me with $70 per pay period as outlined above.

Signature__________________________________ Date_________________________

MOSAICA EDUCATION, INC.

Benefit Insurance Rates - 2009 - 2010

Blue Cross Blue Shield PPO 1	Plan Cost PPO 1	Employer Cost	Monthly Employee Cost	Employee Cost Per Pay Period
Employee	$409.52	$409.52	$ -	$ -
Employee + 1	$921.40	$409.52	$511.88	$255.94
Employee + Family	$1,160.75	$409.52	$751.23	$375.62
Family Continuation (Student 19+)	$214.93		$214.93	$107.47

Healthy Blue 80 PPO	Plan Cost HB 80 PPO	Employer Cost	Monthly Employee Cost	Employee Cost Per Pay Period
Employee	$336.90	$336.90	$ -	$ -
Employee + 1	$757.98	$409.52	$348.46	$174.23
Employee + Family	$909.62	$409.52	$500.10	$250.05
Family Continuation (Student 19+)	$168.45		$168.45	$84.23

BCBS/VSP - Vision Service Plan	Plan Cost	Employer Cost	Monthly Employee Cost	Employee Cost Per Pay Period
Employee	$4.71	$4.71	$ -	$ -
Employee + 1	10.60	$4.71	$5.89	$2.95
Employee + Family	12.71	$4.71	$8.00	$4.00
Family Continuation (Student 19+)	2.36	-	$2.36	$1.18

BCBS TRADITIONAL DENTAL PLAN	Plan Cost	Employer Cost	Monthly Employee Cost	Employee Cost Per Pay Period
Employee	$23.56	$23.56	$ -	$ -
Employee + 1	53.02	$23.56	$ 29.46	$ 14.73
Employee + Family	63.62	$23.56	$ 40.06	$ 20.03
Family Continuation (Student 19+)	11.79			11.79