EMPLOYEE BENEFITS BOOKLET

FOR THE WORKSITE:
Concord Academy Petoskey

FULL-TIME EMPLOYEES

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ELIGIBILITY & ENROLLMENT INFORMATION

Academy Contributes: 70& towards Health premiums only

EMPLOYEE ELIGIBILITY

Full-time eligible employees

(Defined as working at least 130 hours per month)

EFFECTIVE DATE OF COVERAGE

Effective Immediately

ELECTIONS AND CHANGES IN COVERAGE

Each year during open enrollment, employees make their selections for the next plan year. The selections you make will remain in effect for the entire plan year (10/1 to 9/30), unless you have a qualifying life event.

Qualifying life events are marriage, divorce, birth or adoption of a child, death, change in your or your spouse's employment status, court orders, spousal open enrollment period, loss or addition of other health coverage. **The change must be requested within 30 days of the event and must be consistent with the change in status. Documentation is required.** If you do not notify the benefits department to complete the process **within 30 days of the qualifying event**, you must wait until open enrollment to make changes.

If you, or any of your dependents, become eligible, or are covered by Medicare, Medicaid, MIChild, Healthy Kids or any other medical assistance program within the State of Michigan, **it is your responsibility to notify your plan administrator.**

*Disclaimer: This Benefit Menu is intended to b e convenient summary of the major points of your benefit plan. The Benefit Menu does not cover all provisions, limitations and exclusions. If this document differs from any plan document(s), the plan document(s) will prevail.**

HEALTH BENEFITS:

Blue Care Network HMO $1,000/80%

Benefit Snapshots	In Network Only
Preventive Care	Covered – 100% (No Copay)
Office Visit	$20 Copay
Specialist Visit	$40 Copay
Urgent Care	$50 Copay
Emergency Room	$250 copay/visit
Referral for Specialist	Yes
Prescription Drug Coverage	
	Preferred Generics: $15 Copay **Generices:** $40 Copay **Preferred Brand:** $80 Copay **Non-Preferred Brand:** $100 Copay **Preferred Speciality::** 20% Colnsurance **Non-Preferred Speciality:** 20% Colnsurance
Annual Deductible	$1,000/member; $2,000/two or more members
Annual Out of Pocket Maximum	$8,,150/member; $16,300/two or more members

SUMMARY OF BENEFITS AND COVERAGE: The Summary of Benefits will be posted within your Payplus 360 Portal.

HEALTH BENEFITS:

Blue Care Network HMO $1,000/80%

Benefit Snapshots	**In Network Only**
If you have a test:	Diagnostic Test: 20% coinsurance Imaging (CT/PET scans, MRIs): $150 copay
If you have outpatient surgery:	Facility Fees: 20% coinsurance Physician/surgeon fees: 20% coinsurance
If you need immediate medical attention:	Emergency Room Care: $250 Copay/Visit Emergency Medical Transportation: 20% coinsurance
If you have a hospital stay:	Facility Fee: 20% coinsurance Physician/Surgeon Fee: No Charge
If you need behavioral health services:	Outpatient Services: $20 copay/visit. Deductible does not apply Inpatient Services: 20% coinsurance
If you are pregnant:	Office Visits: No Charge. Deductible does not apply Childbirth/delivery professional services: No Charge Childbirth/delivery facility services: 20% coinsurance
If you need help recovering or have other special health needs	Home Health Care: $40 copay/visit Rehabilitation Services: $40 copay/visit Habilitation Services: ABA - $20 copay per visit. $40 copay per visit for PT/OT/ST/ Deductible does not apply to ABA services. Skilled Nursing Care: 20% coinsurance Durable medical equipment: 50% coinsurance. Deductible does not apply. Hospice Services: No Charge

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Examples:

HEALTH BENEFITS:

Blue Care Network HMO $1,000/80%

Mia's Simple Fracture (in-network emergency room visit and follow up care)		Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	$1000	The plan's overall deductible	$1000	The plan's overall deductible	$1000
Specialist copayment	$40	Specialist copayment	$40	Specialist copayment	$40
Hospital (facility) coinsurance	20%	Hospital (facility) coinsurance	20%	Hospital (facility) coinsurance	20%
Other coinsurance	20%	Other coinsurance	20%	Other coinsurance	20%
This EXAMPLE event includes services like:		This EXAMPLE event includes services like:		This EXAMPLE event includes services like:	
Emergency room care (*including medical supplies*)		Specialist office visits (*prenatal care*)		Primary care physician office visits (*including disease education*)	
Diagnostic tests (*x-ray*)		Childbirth/Delivery Professional Services		Diagnostic tests (*blood work*)	
Durable medical equipment (*crutches*)		Childbirth/Delivery Facility Services		Prescription drugs	
Rehabilitation services (*physical therapy*)		Diagnostic tests (*ultrasounds and blood work*)		Durable medical equipment (*glucose meter*)	
		Specialist visit (*anesthesia*)			
Total Example Cost	**$2,800**	**Total Example Cost**	**$12,700**	**Total Example Cost**	**$5,600**
In this example, Mia would pay:		In this example, Peg would pay:		In this example, Joe would pay:	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$1,000	Deductibles	$1,000	Deductibles	$0
Copayments	$500	Copayments	$10	Copayments	$1,300
Coinsurance	$200	Coinsurance	$1,400	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$0	Limits or exclusions	$60	Limits or exclusions	$20
The total Mia would pay is	**$1,700**	**The total Peg would pay is**	**$2,470**	**The total Joe would pay is**	**$1,320**

DENTAL

Delta Dental PPO

Covered Services:	In Network	Out of Network
Preventive Services *(Exams, cleanings, fluoride, Emergency Palliative treatment, Brush Biopsy, X-Rays)*	100%	100%
Basic Services *(Fillings and Crown repairs, Root Canals, Extractions and Dental Surgery, Repairs to Bridges, implants and Dentures)*	80%	80%
Major Services *(Major Restorative Services to Crowns, Prosthodontic Services: Bridges, Implants, and Dentures)*	50%	50%
Orthodontia Services Dependent children up to age 19	50%	50%
	Oral Exams are payable twice per calendar year Prophylaxes (cleanings) are payable twice per calendar year	
Annual Deductible	$50 per person to $150 per family	$50 per person to $150 per family
Annual Maximum Per person per Calendar Year	$1,000	$1,000

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Vision

VSP Plan 1		
Covered Charges	**Benefit**	**Frequency**
Examinations	$10 Copay	Once Every 12 Months
Prescription Lenses *Single Vision* *Bifocal* *Trifocal*	$25 Copay	Once Every 12 Months
Prescription Frames	20% Off Amount Over the $130 Allowance	Once Every 12 Months
Necessary Contacts *Available to members with specific conditions*	$0 Copay	Once Every 12 Months *Instead of lens benefit*
Glasses & Sunglasses	Average of 35-40% savings on all non-covered lens options	Once Every 12 Months
Laser Vision Correction Discount	Up to 15% off the usual charge of 5% off promotional price	
Covered Charges	**Benefit**	**Frequency**

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