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Company Name: ADAMS TOWNSHIP SCHOOL DISTRICT

BCN HSA SM HMO Gold $1,350 High Deductible Health Plan with 20% Coinsurance for Medical and Prescription Drug Coverage

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Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

Note: The Deductible will apply to certain services as defined below.

Deductible **Note**: Deductible is combined for both medical and prescription drug coverage. The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract	$1,350 for a one-person contract, $2,700 for a family contract (2 or more members) each calendar year (No 4th quarter carryover)
Fixed Dollar Copay **Note**: Copay amounts apply once the deductible has been met	None
Coinsurance **Note**: Coinsurance amounts apply once the deductible has been met	20% and 50% for select services as noted below
Out of Pocket Maximum – total amount paid toward medical and pharmacy services including deductible, copays and coinsurance.	$2,350 for a one-person contract, $4,700 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None

Preventive Services - as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – 80% after deductible
Online Visits	Covered – 80% after deductible
Consulting Specialist Care – when referred	Covered – 80% after deductible

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Emergency Medical Care	
Hospital Emergency Room	Covered – 80% after deductible
Urgent Care Center	Covered – 80% after deductible
Ambulance Services – medically necessary	Covered – 80% after deductible

Diagnostic Services	
Laboratory and Pathology Services	Covered – 80% after deductible
Diagnostic Tests and X-rays	Covered – 80% after deductible
Radiation Therapy	Covered – 80% after deductible

Maternity Services Provided by a Physician	
Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – 80%
Delivery and Nursery Care	Covered – 80% after deductible

Hospital Care	
General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible; unlimited days
Outpatient Surgery – see member certificate for specific surgical coinsurance	Covered – 80% after deductible

Alternatives to Hospital Care	
Skilled Nursing Care	Covered – 80% after deductible up to 45 days per calendar year
Hospice Care	Covered – 80% after deductible
Home Health Care	Covered – 80% after deductible

Surgical Services	
Surgery – includes all related surgical services and anesthesia.	Covered – 80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – Male - 50% after deductible
Elective Abortion (One procedure per two-year period of membership)	Not Covered
Human Organ Transplants (subject to medical criteria)	Covered – 80% after deductible
Reduction Mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible

Mental Health Care and Substance Use Disorder Treatment	
Inpatient Mental Health Care	Covered – 80% after deductible
Inpatient Substance Use Disorder	Covered – 80% after deductible
Outpatient Mental Health Care includes online visits **Note**: For diagnostic and therapeutic services, the medical benefit applies.	Covered – 80% after deductible
Outpatient Substance Use Disorder	Covered – 80% after deductible

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Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment through age 18	Covered – 80% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18 Unlimited visits for physical, speech and occupational therapy for autism spectrum disorder diagnosis	Covered – 80% after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visits and preventive benefit

Other Services

Allergy Testing and Therapy	Covered – 80% after deductible
Allergy office visits	Covered – 80% after deductible
Allergy Injections	Covered – 80% after deductible
Chiropractic Spinal Manipulation – when referred	Covered – 80% after deductible
Rehabilitative Services – subject to meaningful improvement within 90 days • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – 80% after deductible
Habilitative Services • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – 80% after deductible
Outpatient Cardiac and Pulmonary Rehabilitation	Covered – 80% after deductible; limited to a benefit maximum of 30 visits per calendar year
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible
Durable Medical Equipment	Covered – 50% after deductible
Prosthetic and Orthotic Appliances	Covered – 50% after deductible
Diabetic Supplies	Covered – 80% after deductible
Pediatric Vision • Eye Exam – Limited to once per calendar year through the last day of the year in which an individual turns age 19 • Prescription Glasses – Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which an individual turns age 19	Covered – 100%
Prescription Drugs	Tier 1A – Value Generics Covered – $4 copay after deductible Tier 1B – Generics Covered – $15 copay after deductible Tier 2 Preferred Brand Covered – $40 Copayment after deductible Tier 3 Non-Preferred Brand Covered – $80 Copayment after deductible Tier 4 Preferred Specialty Covered – 20% Coinsurance of the BCN Approved Amount after deductible (Maximum Copayment $200) Tier 5 Non-Preferred Specialty Covered – 20% Coinsurance of the BCN Approved Amount after Deductible (Maximum Copayment $300) Drugs for sexual dysfunction, weight loss, cough & cold Not Covered Contraceptives Covered – Tier 1A – 100% (deductible does not apply), Tier 1B – $15 copay after deductible, Tier 2 - $40 copay after deductible, Tier 3 - $80 copay after deductible Preventive Drugs Covered – 100% 90 Day Retail: 84-90 day supply Covered – 3 times the 30-day copay minus $10 after deductible Mail order: 30 day supply Covered – The applicable tiered copay applies after deductible Mail order: 31-90 day supply Covered – 3 times the 30-day copay minus $10 after deductible

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BCN65

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Deductible, Copays and Dollar Maximums

Deductible **Note:** Coinsurance and select fixed dollar copays apply once the deductible has been met.	None
Fixed dollar copays	$25 for office visits, $50 for urgent care visits, $250 for emergency room visits
Coinsurance	None
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	None

Preventive Services

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%

Mammography

Mammography Screening	Covered – 100%

Physician Office Services

Office Visits	Covered – $25 copay
Consulting Specialist Care – when referred	Covered – $25 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted, inpatient hospital benefits apply	Covered – $250 copay
Urgent Care Center	Covered – $50 copay
Ambulance Services – medically necessary	Covered – 100%, ground and air service

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%
Diagnostic Tests and X-rays	Covered – 100%
Radiation Therapy	Covered – 100%

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – $25 copay
Delivery and Nursery Care	Covered – 100%

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Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%, unlimited days (Coordinated with Medicare)
Outpatient Surgery – see member certificate for specific surgical copays	Covered – 100%

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100%, up to 100 days per benefit period
Hospice Care	Covered – 100%
Home Health Care	Covered – $25 copay

Surgical Services

Surgery – includes all related surgical services and anesthesia. See member certificate for specific surgical copays.	Covered – 100%
Voluntary Sterilization	Covered – 100%
Human Organ Transplants	Covered – 100%, subject to medical criteria

Mental Health Care and Substance Use Disorder

Inpatient Mental Health Care and Substance Use Disorder	**Mental Health Care**: Covered – 100% based on Medicare guidelines **Substance Abuse Care:** Covered – 100% based on Medicare guidelines
Outpatient Mental Health Care	Covered – 100%, based on Medicare guidelines
Outpatient Substance Use Disorder	Covered – 100%, based on Medicare guidelines

Other Services

Allergy Testing and Therapy	Covered – 100%
Allergy Injections	Covered – 100%
Chiropractic Spinal Manipulation – when referred	Covered – $25 copay
Outpatient Physical, Speech and Occupational Therapy – subject to Medicare guidelines	Covered – $25 copay
Infertility Counseling and Treatment (excluding In-vitro fertilization). Subject to Medicare guidelines	Covered – 100%
Durable Medical Equipment	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%

BCN65, 65OV25, 65UR50, 65E250, MMHSAP

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Company Name: ADAMS TOWNSHIP SCHOOL DISTRICT

Blue Dental[SM] PPO Plus 80/50/50 Pediatric SG Non-voluntary

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. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. 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.

Note: Pediatric members are members who are age 18 or younger on the plan's effective date. They remain pediatric members through the end of the calendar year in which they turn 19.

Network access information
With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network – Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**

[1] Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
[2] A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

Members who go to non-PPO dentists can still save money through our Blue Par Select arrangement.

Blue Par Select[SM] arrangement – Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services – members pay only applicable coinsurance and deductible amounts. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Member's responsibility (deductible, copays and dollar maximums)

Benefits	Coverage
Deductible Applies to Class II and Class III services only	$25 per member limited to a maximum of $75 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services)	
Class I services	20%
Class II services	50%
Class III services	50%
Class IV services	Not covered
Dollar Maximums	
Annual maximum for Class I, II and III services	None
Lifetime maximum for Class IV services	Not applicable

Company Name: ADAMS TOWNSHIP SCHOOL DISTRICT

Member's responsibility (deductible, copays and dollar maximums)

Benefits	Coverage
Out-of-pocket maximum The maximum out-of-pocket expense pediatric members will pay in a calendar year for deductible and coinsurance amounts applied to most covered in-network dental services. The out-of-pocket maximum does not apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists, or non-covered services.	$350 for one pediatric member or $700 for two or more pediatric members per calendar year **Note**: This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage (if any).

Plan's responsibility

The plan’s responsibility is subject to a review of the reported diagnosis, dental necessity verification and the availability of dental benefits at the time the claim is processed, as well as the conditions, exclusions and limitations, and deductible and coinsurance requirements under the applicable BCBSM certificates and riders.

Class I services

Benefits	Coverage
Most diagnostic and preventive services:	
Routine oral examinations/evaluations – twice per calendar year	80% of approved amount
Routine prophylaxes (cleanings) – three times per calendar year	80% of approved amount
Fluoride treatments – twice per calendar year in conjunction	80% of approved amount
Topical fluoride varnish for moderate- to high-risk caries patients – four times per calendar year for members age 3 and younger and two times per calendar year for members age 4 to 14 only in conjunction with fluoride treatments.	80% of approved amount
Dental sealants – once per tooth per 36 months for first and second permanent molars	80% of approved amount
Bitewing X-rays One set (up to four films) per calendar year	80% of approved amount
Oral brush biopsy sample collection Twice per calendar year	80% of approved amount

Class II services

Benefits	Coverage
Other diagnostic and preventive services:	
Diagnostic tests and laboratory examinations	50% of approved amount after deductible

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Class II services

Benefits	Coverage
Space maintainers – once per quadrant per lifetime for missing posterior primary teeth (recementation of a space maintainer is payable three times per quadrant per lifetime)	50% of approved amount after deductible
Panoramic or full-mouth X-rays Once per 60 months	50% of approved amount after deductible
Emergency palliative treatment	50% of approved amount after deductible
Minor restorative services:	
Amalgam and resin-based composite fillings and fillings of similar materials – once per tooth and surface per 48 months for permanent teeth; once per tooth and surface per 24 months for primary teeth	50% of approved amount after deductible
Recementation or repair of posts, crowns, veneers, inlays and onlays – three times per tooth per calendar year	50% of approved amount after deductible
Extractions and surgical removal of non-impacted teeth	50% of approved amount after deductible
Non-surgical endodontic services:	
Root canal treatments – once per tooth per lifetime (retreatment of a root canal 12 or more months after the initial root canal treatment is payable once per tooth per lifetime)	50% of approved amount after deductible
Therapeutic pulpotomies or pulpal debridement	50% of approved amount after deductible
Vital pulpotomies on primary teeth	50% of approved amount after deductible
Apexification	50% of approved amount after deductible
Non-surgical periodontic services:	
Periodontal maintenance – three times per calendar year in conjunction with routine dental prophylaxis	50% of approved amount after deductible
Periodontal scaling and root planing – once per quadrant per 24 months	50% of approved amount after deductible
Adjustments, repairs, relines, rebases and tissue conditioning for removable prosthetic appliances:	
Relines or rebases of partial dentures or complete dentures – once per 36 months per arch	50% of approved amount after deductible
Tissue conditioning – once per 36 months per arch	50% of approved amount after deductible
Adjunctive general services:	
General anesthesia or IV sedation	50% of approved amount after deductible
Office visits after regularly scheduled hours	50% of approved amount after deductible

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Class III services

Benefits	Coverage
Major restorative services:	
Onlays, crowns and veneers – once per permanent tooth per 60 months for members age 12 and older only	50% of approved amount after deductible
Substructures, including cores and posts	50% of approved amount after deductible
Oral surgery services:	
Surgical exposure and facilitation of eruption of unerupted teeth	50% of approved amount after deductible
Incision and drainage of celluliitis or fascial space abscesses of intraoral soft tissue	50% of approved amount after deductible
Removal of exostoses (excess bony growths of the upper and lower jaw)	50% of approved amount after deductible
Excision of hyperplastic tissue per arch	50% of approved amount after deductible
Soft tissue biopsies	50% of approved amount after deductible
Frenulectomies	50% of approved amount after deductible
Surgical endodontic services:	
Apical surgeries on permanent teeth	50% of approved amount after deductible
Hemisections – once per tooth per lifetime	50% of approved amount after deductible
Surgical periodontic services:	
Gingivectomies and gingivoplasties	50% of approved amount after deductible
Clinical crown lengthening – hard tissue	50% of approved amount after deductible
Gingival flap procedures	50% of approved amount after deductible
Soft tissue grafts	50% of approved amount after deductible
Prosthodontic services:	
Complete dentures – once per 84 months	50% of approved amount after deductible
Removable partial dentures and fixed partial dentures (bridges), including abutment crowns and pontics – once per 84 months for members age 16 and older only	50% of approved amount after deductible
Recementation and repairs of bridges	50% of approved amount after deductible
Stayplates to replace recently extracted permanent anterior (front) teeth	50% of approved amount after deductible