



Medical Benefit Summary - 1815 (hired prior to October 1, 2010)

Service	BCBSM Community Blue PPO / Buy Up		BCBSM Community Blue PPO / Core		HAP HMO Plan
	In-Network	Out-Network	In-Network	Out-Network	
PREVENTIVE SERVICES - *UNLIMITED PER MEMBER PER CALENDAR YEAR					
Health Maintenance Exam – includes chest X-ray, EKG and select lab procedures	Covered – 100%*, one per calendar	Not Covered	Covered – 100%*, one per calendar	Not Covered	Covered
Annual Gynecological Exam	Covered – 100%*, one per calendar year	Not Covered	Covered – 100%*, one per calendar year	Not Covered	Covered
Pap Smear Screening – lab services only	Covered – 100%*, one per calendar year	Not Covered	Covered – 100%*, one per calendar year	Not Covered	Covered
Well-Baby and Child Care	Covered – 100%* <ul style="list-style-type: none"> • 6 visits birth thru 12 months • 6 visits 13 months thru 23 months • 2 visits 24 months thru 35 months • 2 visits 36 months thru 47 months • Visits beyond 47 months are limited to one per year under the health maintenance exam benefit 	Not Covered	Covered – 100%* <ul style="list-style-type: none"> • 6 visits birth thru 12 months • 6 visits 13 months thru 23 months • 2 visits 24 months thru 35 months • 2 visits 36 months thru 47 months • Visits beyond 47 months are limited to one per year under the health maintenance exam benefit 	Not Covered	Covered
Immunizations	Covered – 100%* adult and child in compliance with the provisions of the Patient Protection and Affordable Care Act	Not Covered	Covered – 100%* adult and child in compliance with the provisions of the Patient Protection and Affordable Care Act	Not Covered	Covered
Fecal Occult Blood Screening	Covered – 100%*, one per calendar year	Not Covered	Covered – 100%*, one per calendar year	Not Covered	Covered
Flexible Sigmoidoscopy Exam	Covered – 100%*, one per calendar year	Not Covered	Covered – 100%*, one per calendar year	Not Covered	Covered

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Prostate Specific Antigen (PSA) Screening	Covered – 100%*, one per calendar year	Not Covered	Covered – 100%*, one per calendar year	Not Covered	Covered
Colonoscopy - no age restrictions	Covered – 100%*, one per calendar year	Covered – 80% after deductible, one per calendar year	Covered – 100%*, one per calendar year	Covered – 70% after deductible, one per calendar year	Covered
Routine Mammography Screening – no age restrictions	Covered – 100%*, one per calendar year	Covered – 80% after deductible, one per calendar year	Covered – 100%*, one per calendar year	Covered – 70% after deductible, one per calendar year	Covered
PHYSICIAN OFFICE SERVICES					
Office Visits	Covered - \$15 copay	Covered – 80% after deductible, must be medically necessary	Covered - \$20 copay	Covered – 70% after deductible, must be medically necessary	Covered – \$15 copay
Outpatient and Home Visits	Covered – 100% after deductible	Covered – 80% after deductible, must be medically necessary	Covered – 90% after deductible	Covered – 70% after deductible, must be medically necessary	Covered – \$15 copay
Office Consultations	Covered - \$15 copay	Covered – 80% after deductible, must be medically necessary	Covered - \$20 copay	Covered – 70% after deductible, must be medically necessary	Covered - \$15 copay
EMERGENCY MEDICAL CARE					
Hospital Emergency Room – approved diagnosis	Covered - \$50 copay, waived if admitted or for an accidental injury	Covered - \$50 copay, waived if admitted or for an accidental injury	Covered - \$50 copay, waived if admitted or for an accidental injury	Covered - \$50 copay, waived if admitted or for an accidental injury	Covered – 100% \$50 copay
Urgent Care Center	Covered - \$15 copay	Covered – 80% after deductible, must be medically necessary	Covered - \$20 copay	Covered – 70% after deductible, must be medically necessary	Covered – 100% \$30 copay
Ambulance Services – medically necessary	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 90% after deductible	Covered – 90% after deductible	Covered – 100%

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DIAGNOSTIC SERVICES					
Laboratory and Pathology Tests	Covered – 100% after deductible	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%
Diagnostic Tests and X-rays	Covered – 100% after deductible	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%
Radiation Therapy	Covered – 100% after deductible	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%
MATERNITY SERVICES PROVIDED BY A PHYSICIAN					
Pre-Natal and Post-Natal Care	Covered – 100% after deductible. Includes care by Certified Nurse Midwife	Covered – 80% after deductible, Includes care by Certified Nurse Midwife	Covered – 100% after deductible. Includes care by Certified Nurse Midwife	Covered – 70% after deductible, Includes care by Certified Nurse Midwife	Covered – \$15 copay
Delivery and Nursery Care	Covered – 100% after deductible. Includes care by Certified Nurse Midwife	Covered – 80% after deductible, Includes care by Certified Nurse Midwife	Covered – 90% after deductible. Includes care by Certified Nurse Midwife	Covered – 70% after deductible, Includes care by Certified Nurse Midwife	Covered – 100%
HOSPITAL CARE					
Semi-Private Room, Inpatient Physician/ General Nursing, Hospital Services and Supplies	Covered – 100% after deductible	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%
Inpatient Consultations	Covered – 100% after deductible	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%
Chemotherapy	Covered – 100% after deductible	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%

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ALTERNATIVES TO HOSPITAL CARE					
Skilled Nursing Care	Covered – 100% after deductible, up to 120 days per calendar year	Covered – 100% after deductible, up to 120 days per calendar year	Covered – 90% after deductible, up to 120 days per calendar year	Covered – 90% after deductible, up to 120 days per calendar year	Covered – 100% up to 730 days, renewable after 60 days
Hospice Care	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Home Health Care	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 90% after deductible	Covered – 90% after deductible	Covered – 100%
SURGICAL SERVICES					
Surgery (includes related surgical services)	Covered – 100% after deductible	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%
Voluntary Sterilization	Covered – 100% after deductible	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%
MENTAL HEALTH CARE AND SUBSTANCE ABUSE					
Outpatient Mental Health Care	100% after deductible facility & clinic, \$15 office visit physician's office	100% after deductible facility & clinic, 80% after deductible physician's office	90% after deductible facility & clinic, \$20 office visit physician's office	90% after deductible facility & clinic, 70% after deductible physician's office	\$15 copay
Outpatient Substance Abuse Care (approved facilities only)	100% after deductible	100% after deductible	90% after deductible	90% after deductible	\$15 copay

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Inpatient Mental Health Care and Substance Abuse Care	100% after deductible	80% after deductible	90% after deductible	70% after deductible	100%
OTHER SERVICES					
Allergy Testing and Therapy (in physician's office)	Covered – 100%	Covered – 100%	Covered – 90%	Covered – 90%	Covered
Chiropractic Spinal Manipulation	Covered – 100% after deductible, up to 24 visits per calendar year	Covered – 80% after deductible, up to 24 visits per calendar year	Covered – \$20 copay, up to 24 visits per calendar year	Covered – 70% after deductible, up to 24 visits per calendar year	Not covered
Outpatient Physical, Speech and Occupational Therapy	In a facility – covered 100% after deductible, up to a combined maximum of 60 visits per calendar year	In a facility – covered 80% after deductible, up to a combined maximum of 60 visits per calendar year	In a facility – covered 90% after deductible, up to a combined maximum of 60 visits per calendar year	In a facility – covered 70% after deductible, up to a combined maximum of 60 visits per calendar year	Covered – 100%, 60 visits per person per benefit period
DEDUCTIBLE, COPAYS AND DOLLAR MAXIMUMS					
Annual Deductible	\$100 Single \$200 Family	\$250 Single \$500 Family	\$250 Single \$500 Family	\$500 Single \$1,000 Family	None
Annual Out-of-Pocket Maximums (includes deductible)	\$100 Single \$200 Family	\$2,250 Single \$4,500 Family	\$750 Single \$1,500 Family	\$2,500 Single \$5,000 Family	None
PRESCRIPTION DRUGS					
Prescription Drug Benefits – Retail** Includes Contraceptives	\$10 Generic \$40 Brand	Covered at 75% after applicable copay, \$10 Generic/\$40 Brand	\$10 Generic \$40 Brand	Covered at 75% after applicable copay, \$10 Generic/\$40 Brand	\$10 Generic \$40 Brand
Prescription Drug Benefits – Mail Order** (90 day supply)	\$10 Generic \$40 Brand	Not Covered	\$10 Generic \$40 Brand	Not Covered	Maintenance drugs: 1 x copay Non-Maintenance drugs: 3 x copay less \$5

** Lifestyle drugs which are cosmetic or performance enhancing are excluded, unless medically necessary.

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July 2011

Dental Coverage 1815		
Service	In-Network Benefits	Out-of-Network Benefits
Office visit Cleanings Sealants (children under age 14) Fluoride treatment X-rays Periodontics (gum disease) Endodontics (root canals) Extraction of Teeth Anesthetics Inlays / Onlays Pontics Crowns Bridges (full or partial) Dentures Local Anesthetics	85% of approved amount	85% of reasonable & customary
Benefit maximum for services shown above per calendar year	\$1,500	
Orthodontia (braces) for children under age 19 and no age limit for employees	85% of approved amount	85% of reasonable & customary
Lifetime benefit maximum for orthodontia services	\$1,700	

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Vision Plan Benefit Summary - 1815

ITEM	UNITEDHEALTHCARE SPECIALTY BENEFITS
	IN-NETWORK ONLY BENEFITS
Vision Exams	Covered at 100% once every 12 months
Single Vision Lenses	Covered at 100% once every 12 months
Bifocal Lenses	Covered at 100% once every 12 months
Trifocal Lenses	Covered at 100% once every 12 months
Lenticular Lenses	Covered at 100% once every 12 months
Additional Services	Sunglasses / Tints UV coating Polycarbonate lenses Anti-reflective coating Edge coating Transition coating Photochromatic coating Progressive lenses Scratch resistant coating
Eyeglass Frames	Covered up to 100% once every 12 months. Applicable allowance depending on whether the frames are acquired through an independent or retail provider.
Contact Lenses, in lieu of glasses	Covered at 100% once every 12 months up to the following: \$200 per pair for elective contacts \$455 per pair for medically necessary soft contacts \$230 per pair for medically necessary hard contacts
Lasik Eye Surgery	Not available
Miscellaneous	No claim forms are required There is no outlay of cash for covered services up to the maximum benefit There is no balance billing

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Basic Life/AD&D Benefit Summary – 1815	
Item	Benefit
Benefit Amount / Life	2 times salary to a maximum of \$150,000 or flat \$50,000
Benefit Amount / AD&D	2 times salary to a maximum of \$150,000
Reduction Schedule	Basic Life: None Basic AD&D: None

Short Term Disability Coverage – 1815	
Item	Benefit
Elimination Period (period of disability before Short Term Disability benefits are payable)	Accident, Hospital Confinement or outpatient surgery – first day of disability Sickness - 14 days (benefits are payable on the 15th day)
Benefit Amount	60% of earnings
Weekly Benefit Maximum	\$750
Duration of Benefit Period	26 weeks (when you may become eligible for Long Term Disability benefits)
Benefit Offsets	State disability benefits, No-fault motor vehicle disability income, Family social security benefits

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Long Term Disability - 1815	
Item	Benefit
Elimination Period	180 days (or greater of accrued sick leave)
Maximum Benefit Period	<69 10 years or to age 70, whichever is greater
Benefit Amount	60% of covered earnings to a maximum of \$1,650 per month

Flexible Spending Accounts – 1815	
Item	Benefit
Health Care Reimbursement Account (HCRA)	Annual Maximum: \$3,000
Dependent Care Reimbursement Account (DCRA)	Annual Maximum: \$5,000
Annual Employer Funded Contribution	\$530 to either the HCRA or the DCRA

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