



Administrative Assistants Medical Benefit Summary					
Service	BCBSM Community Blue PPO Buy-Up Plan		BCBSM Community Blue PPO Core Plan		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

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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
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 – 80% 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 – 80% after deductible, one per calendar year	Covered
PHYSICIAN OFFICE SERVICES					
Office Visits	Covered - \$10 copay	Covered – 80% after deductible, must be medically necessary	Covered - \$15 copay	Covered – 80% after deductible, must be medically necessary	Covered - \$10 co-pay
Outpatient Visits	Covered – 100%	Covered – 80% after deductible, must be medically necessary	Covered – 100% after deductible	Covered – 80% after deductible, must be medically necessary	Covered - \$10 co-pay
Office Consultations	Covered - \$10 copay	Covered – 80% after deductible, must be medically necessary	Covered - \$15 copay	Covered – 80% after deductible, must be medically necessary	Covered - \$10 co-pay

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EMERGENCY MEDICAL CARE					
Hospital Emergency Room – approved diagnosis	Covered – 100%	Covered – 100%	Covered - \$50 copay, waived if admitted or for an accidental injury	Covered - \$50 copay, waived if admitted or for an accidental injury	Covered - \$50 co-pay
Urgent Care Center	Covered - \$10 copay	Covered – 80% after deductible, must be medically necessary	Covered - \$15 copay	Covered – 80% after deductible, must be medically necessary	Covered - \$20 co-pay
Ambulance Services – medically necessary	Covered – 100%	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 100% after deductible	Covered 100%
DIAGNOSTIC SERVICES					
Laboratory and Pathology Tests	Covered – 100%	Covered – 80% after deductible	Covered – 100% after deductible	Covered – 80% after deductible	Covered 100%
Diagnostic Tests and X-rays	Covered – 100%	Covered – 80% after deductible	Covered – 100% after deductible	Covered – 80% after deductible	Covered 100%
Radiation Therapy	Covered – 100%	Covered – 80% after deductible	Covered – 100% after deductible	Covered – 80% after deductible	Covered 100%
MATERNITY SERVICES PROVIDED BY A PHYSICIAN					
Pre-Natal and Post-Natal Care	Covered – 100%, Includes care by Certified Nurse Midwife	Covered – 80% after deductible, Includes care by Certified Nurse Midwife	Covered – 100%, Includes care by Certified Nurse Midwife,	Covered – 80% after deductible, Includes care by Certified Nurse Midwife	Covered - \$10 co-pay
Delivery and Nursery Care	Covered – 100%, 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 – 80% after deductible, Includes care by Certified Nurse Midwife	Covered 100%

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HOSPITAL CARE					
Semi-Private Room, Inpatient Physician/ General Nursing, Hospital Services and Supplies	Covered – 100%	Covered – 80% after deductible	Covered – 100% after deductible	Covered – 80% after deductible	Covered 100%
Inpatient Consultations	Covered – 100%	Covered – 80% after deductible	Covered – 100% after deductible	Covered – 80% after deductible	Covered 100%
Chemotherapy	Covered – 100%	Covered – 80% after deductible	Covered – 100% after deductible	Covered – 80% after deductible	Covered 100%
ALTERNATIVES TO HOSPITAL CARE					
Skilled Nursing Care	Covered – 100%, up to 120 days per calendar year	Covered – 100%, up to 120 days per calendar year	Covered – 100% after deductible, up to 120 days per calendar year	Covered – 100% 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%	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 100% after deductible	Covered 100%
SURGICAL SERVICES					
Surgery (includes related surgical services)	Covered – 100%	Covered – 80% after deductible	Covered – 100% after deductible	Covered – 80% after deductible	Covered 100% - Bariatric surgery and related services subject to a \$1,000 co-pay
Voluntary Sterilization	Covered – 100%	Covered – 80% after deductible	Covered – 100% after deductible	Covered – 80% after deductible	Covered 100%

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MENTAL HEALTH CARE AND SUBSTANCE ABUSE					
Outpatient Mental Health Care	Covered - 100% facility & clinic; \$10 copay physician's office	Covered - 100% after deductible facility & clinic, 80% after deductible physician's office	Covered - 100% after deductible facility & clinic; \$15 copay physician's office	Covered - 100% after deductible facility & clinic, 80% after deductible physician's office	Covered - \$10 copay
Outpatient Substance Abuse Care	Covered - 100%	Covered - 100% after deductible	Covered 100% after deductible	Covered 100% after deductible	Covered - \$10 copay
Inpatient Mental Health Care	Covered – 100%	Covered - 80% after deductible	Covered - 100% after deductible	Covered 80% after deductible	Covered
Inpatient Substance Abuse Care	Covered 100%	Covered 80%, after deductible	Covered 100% after deductible	Covered 80% after deductible	Covered
OTHER SERVICES					
Allergy Testing and Therapy (in physician's office)	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered 100%
Chiropractic Spinal Manipulation	Covered – 100% up to 24 visits per calendar year	Covered – 80% after deductible, up to 24 visits per calendar year	Covered – \$15 co-pay, up to 24 visits per calendar year	Covered – 80% after deductible, up to 24 visits per calendar year	Not Covered
Outpatient Physical, Speech and Occupational Therapy	In a facility – covered 100% 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 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	Covered 100%– 60 combined visits per person per benefit period

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July 2011

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DEDUCTIBLE, COPAYS AND DOLLAR MAXIMUMS					
Annual Deductible	None	\$250 Single \$500 Family	\$250 Single \$500 Family	\$500 Single \$1,000 Family	None
Annual Copay Dollar Maximums	None	\$2,000 Single \$4,000 Family	None	\$2,000 Single \$4,000 Family	None
PRESCRIPTION DRUGS					
Prescription Drug Benefits Includes Contraceptives	\$10 Generic \$20 Brand	Covered at 75% after applicable copay, \$10 Generic/\$20 Brand	\$10 Generic \$20 Brand	Covered at 75% after applicable copay, \$10 Generic/\$20 Brand	\$10 Generic \$20 Brand
Mail Order	1x – provides for a 90 day supply by mail.	Not covered	1x – provides for a 90 day supply by mail.	Not covered	Maintenance drugs: 1 x copay Non-Maintenance drugs: 3 x copay less \$5

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Administrative Assistants Dental Benefits Summary		
Service	In-Network DenteMax or Blue Par Select ¹	Non-Network Provider
Preventive & Basic Services Office visit - twice per CY Cleanings -twice per CY Restorations (fillings) Sealants (up to age 19) – every 36 months Fluoride treatment (up to age 18) – twice per CY Space maintainers (up to age 18) – twice per CY X-rays (bitewings) - twice per year X-rays (full mouth and panoramic) – every 36 months Oral Surgery Periodontics (gum disease) Endodontics (root canals) Extraction of Teeth Inlays / Onlays and Crowns Local Anesthetics	90% of approved amount	90% of reasonable & customary
Major Services Implants Bridges (full or partial) Dentures	90% of approved amount	90% of reasonable & customary
Benefit maximum for services shown above per calendar year	\$1,500	

¹ Members receive the deepest discounts when utilizing Dentemax PPO providers. Members can also utilize Blue Par Select providers (larger network) and receive some discounts with no balance billing. Dentists who participate in neither network can balance bill members.

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Administrative Assistants Dental Benefits Summary		
Service	In-Network DenteMax or Blue Par Select¹	Non-Network Provider
Orthodontia (Orthodontics to age 19 for dependents with no age limit for employees.) Habit breaking appliances Minor tooth guidance appliances Full banding treatment Monthly, active treatment visits	90% of approved amount	90% of reasonable & customary
Lifetime benefit maximum for orthodontia services	\$1,700	

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Administrative Assistants Basic Life Benefits Summary

Item	Benefit
Benefit Amount / Life	2 ½ times salary to a maximum of \$150,000 or flat \$50,000
Benefit Amount / AD&D	2 ½ times salary to a maximum of \$150,000
Reduction Schedule	Basic Life: None Basic AD&D: None

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Administrative Assistants Long-Term Disability Benefits Summary	
Item	Benefit
Elimination Period	180 days (or greater of accrued sick leave)
Maximum Benefit Period	Under age 69: 10 years or to age 70, whichever is greater
Benefit Amount	60% of covered earnings to a maximum of \$4,000 per month
Benefit Offsets	Benefits may be offset by the following: Canada and Quebec Pension Plans Railroad Retirement Act Government disability or retirement plan Sick leave or salary continuation plan of the Employer No-fault auto insurance Workers' compensation Occupational disease Unemployment compensation law or similar state or federal law Social Security disability or retirement benefits Retirement Plan benefits funded by the Employer Franchise or group insurance or similar plan

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Administrative Assistants Vision Plan Benefits Summary

ITEM	UNITEDHEALTHCARE SPECIALTY BENEFITS	
	IN-NETWORK	OUT-NETWORK
Vision Exams	Covered at 100% once every 12 months	Covered at 100% once every 12 months up to the following: \$ 65 for an OD Exam \$100 for an MD or DO Exam: \$100 for an Exam for Contacts
Single Vision Lenses	Covered at 100% once every 12 months	Covered at 100% once every 12 months up to: \$100 per pair of Glass Lenses \$130 per pair of Plastic Lenses
Bifocal Lenses	Covered at 100% once every 12 months	Covered at 100% once every 12 months up to: \$165 per pair of Glass Lenses \$260 per pair of Plastic Lenses
Trifocal Lenses	Covered at 100% once every 12 months	Covered at 100% once every 12 months up to: \$165 per pair of Glass Lenses \$260 per pair of Plastic Lenses
Lenticular Lenses	Covered at 100% once every 12 months	Paid at 100% to the maximums shown above for Single, Bi-Focal, and Tri-Focal Lenses
Additional Services	Sunglasses / Tints UV coating Polycarbonate lenses Anti-reflective coating Edge coating Transition coating Photochromatic coating Progressive lenses Scratch resistant coating	The plan covers all procedures as long as the total cost of materials and services do not exceed the maximum fee allowance
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.	Covered at 100% once every 12 months up to the following: \$ 65 per pair of Plastic Frames \$195 per pair of Metal Frames

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Administrative Assistants Vision Plan Benefits Summary

ITEM	UNITEDHEALTHCARE SPECIALTY BENEFITS	
	IN-NETWORK	OUT-NETWORK
Contact Lenses, in lieu of glasses	<p>Covered up to the following once every 12 months: <u>Select Contacts</u> Covered at 100%. Includes 4 boxes of disposable contact lenses, evaluation, fitting, and 2 follow-up visits for "select" contacts</p> <p><u>Non-Select Contacts</u> Covered at 100% up to \$105 reimbursement. Examples of Non-Select contacts are toric, gas permeable, and bifocal</p>	<p>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</p>
Contact Lenses (medically necessary) in lieu of glasses	<p>Covered at 100% once every 12 months to a maximum allowance of \$400</p>	<p>Covered at 100% once every 12 months up to the following: \$455 per pair for soft contacts \$230 per pair for hard contacts</p>
Lasik Eye Surgery	<p>Available at a discount</p>	<p>Not available</p>
Miscellaneous	<p>No claim forms are required There is no outlay of cash for covered services up to the maximum benefit There is no balance billing</p>	<p>You need to submit a claim to UHC to get your claim paid. UHC will reimburse you directly for the services Your provider may balance bill you for amounts above the plan benefit level</p>

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Administrative Assistants Flexible Spending Account Summary

Item	Benefit
Health Care Reimbursement Account (HCRA)	Annual Maximum: \$3,000
Dependent Care Reimbursement Account (DCRA)	Annual Maximum: \$5,000
Annual Employer Funded Contribution	\$700 to either the HCRA or the DCRA

Administrative Assistants Voluntary Long Term Care Summary

Item	Benefit
Benefit	\$6,000 monthly maximum benefit (Indemnity Model)
Duration	5 years
Elimination Period	90 days
Includes	Nursing Home Care benefit 50% Professional Home Health Care rider 5% Simple Inflation rider All Employees provided coverage on Guarantee Issue basis (Spouses subject to E of I) Additional Care Rider Bed Reservation Benefit Respite Care Benefit Contingent Non-Forfeiture Benefit Waiver of Premium provision

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