



**Medical Benefit Summary - 1815 (hired after October 1, 2010)**

Service	BCBSM Community Blue PPO	
	In-Network	Out-Network
<b>PREVENTIVE SERVICES - *UNLIMITED PER MEMBER PER CALENDAR YEAR</b>		
Health Maintenance Exam – includes chest X-ray, EKG and select lab procedures	Covered – 100%*, one per calendar	Not Covered
Annual Gynecological Exam	Covered – 100%*, one per calendar year	Not Covered
Pap Smear Screening – lab services only	Covered – 100%*, one per calendar year	Not Covered
Well-Baby and Child Care	Covered – 100%* <ul style="list-style-type: none"> <li>• 6 visits birth thru 12 months</li> <li>• 6 visits 13 months thru 23 months</li> <li>• 2 visits 24 months thru 35 months</li> <li>• 2 visits 36 months thru 47 months</li> <li>• Visits beyond 47 months are limited to one per year under the health maintenance exam benefit</li> </ul>	Not Covered
Immunizations	Covered – 100%* adult and child in compliance with the provisions of the Patient Protection and Affordable Care Act	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
Colonoscopy - no age restrictions	Covered – 100%*, one per calendar year	Covered – 70% after deductible, one per calendar year
Routine Mammography Screening – no age restrictions	Covered – 100%*, one per calendar year	Covered – 70% after deductible, one per calendar year
<b>PHYSICIAN OFFICE SERVICES</b>		
Office Visits	Covered - \$30 copay	Covered – 70% after deductible, must be medically necessary
Outpatient and Home Visits	Covered – 90% after deductible	Covered – 70% after deductible, must be medically necessary
Office Consultations	Covered - \$30 copay	Covered – 70% after deductible, must be medically necessary
<b>EMERGENCY MEDICAL CARE</b>		
Hospital Emergency Room – approved diagnosis	Covered - \$100 copay, waived if admitted or for an accidental injury	Covered - \$100 copay, waived if admitted or for an accidental injury



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Urgent Care Center	Covered - \$30 copay	Covered – 70% after deductible, must be medically necessary
Ambulance Services – medically necessary	Covered – 90% after deductible	Covered – 90% after deductible
<b>DIAGNOSTIC SERVICES</b>		
Laboratory and Pathology Tests	Covered – 90% after deductible	Covered – 70% after deductible
Diagnostic Tests and X-rays	Covered – 90% after deductible	Covered – 70% after deductible
Radiation Therapy	Covered – 90% after deductible	Covered – 70% after deductible
<b>MATERNITY SERVICES PROVIDED BY A PHYSICIAN</b>		
Pre-Natal and Post-Natal Care	Covered – 100% after deductible. Includes care by Certified Nurse Midwife,	Covered – 70% after deductible, Includes care by Certified Nurse Midwife
Delivery and Nursery Care	Covered – 90% after deductible. Includes care by Certified Nurse Midwife	Covered – 70% after deductible, Includes care by Certified Nurse Midwife
<b>HOSPITAL CARE</b>		
Semi-Private Room, Inpatient Physician/ General Nursing, Hospital Services and Supplies	Covered – 90% after deductible	Covered – 70% after deductible
Inpatient Consultations	Covered – 90% after deductible	Covered – 70% after deductible
Chemotherapy	Covered – 90% after deductible,	Covered – 70% after deductible
<b>ALTERNATIVES TO HOSPITAL CARE</b>		
Skilled Nursing Care	Covered – 90% after deductible, up to 120 days per calendar year	Covered – 90%, after deductible, up to 120 days per calendar year
Hospice Care	Covered – 100%	Covered – 100%
Home Health Care	Covered – 90% after deductible	Covered – 90%, after deductible
<b>SURGICAL SERVICES</b>		
Surgery (includes related surgical services)	Covered – 90% after deductible	Covered – 70% after deductible
Voluntary Sterilization	Covered – 90% after deductible	Covered – 70% after deductible
<b>MENTAL HEALTH CARE AND SUBSTANCE ABUSE</b>		
Outpatient Mental Health Care	90% after deductible facility & clinic, \$30 office visit physician's office	90% after deductible facility & clinic, 70% after deductible physician's office
Outpatient Substance Abuse Care (approved facilities only)	90% after deductible	90% after deductible
Inpatient Mental Health Care and Substance Abuse Care	90% after deductible	70% after deductible



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<b>OTHER SERVICES</b>		
Allergy Testing and Therapy (in physician's office)	Covered – 90%	Covered – 90%
Chiropractic Spinal Manipulation	Covered – \$30 copay, up to 24 visits per calendar year	Covered – 70% after deductible, up to 24 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy	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
<b>DEDUCTIBLE, COPAYS AND DOLLAR MAXIMUMS</b>		
Annual Deductible	\$500 Single \$1,000 Family	\$1,000 Single \$2,000 Family
Annual Out-of-Pocket Maximums (includes deductible)	\$1,000 Single \$2,000 Family	\$3,000 Single \$6,000 Family
<b>PRESCRIPTION DRUGS</b>		
Prescription Drug Benefits –Retail** Includes Contraceptives	\$10 Generic \$40 Brand	Covered at 75% after applicable copay, \$10 Generic/\$40 Brand
Prescription Drug Benefits –Mail Order** (90 day supply)	\$10 Generic \$40 Brand	Not Covered

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



July 2011

<b>Dental Coverage - 1815</b>		
<b>Service</b>	<b>In-Network Benefits</b>	<b>Out-Network</b>
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	



July 2011

### 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



<b>Basic Life/AD&amp;D Benefit Summary - 1815</b>	
<b>Item</b>	<b>Benefit</b>
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

<b>Short Term Disability Coverage - 1815</b>	
<b>Item</b>	<b>Benefit</b>
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

<b>Long Term Disability – 1815</b>	
<b>Item</b>	<b>Benefit</b>
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



July 2011

<b>Flexible Spending Accounts – 1815</b>	
<b>Item</b>	<b>Benefit</b>
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 HCRA or DCRA