



<b>Warren Education Association (WEA) Medical Benefit Comparison</b>			
<b>Service</b>	<b>BCBSM Community Blue PPO</b>		<b>HAP HMO Plan</b>
	<b>In-Network</b>	<b>Out-Network</b>	
<b>PREVENTIVE SERVICES - *UNLIMITED PER MEMBER PER CALENDAR YEAR</b>			
Health Maintenance Exam	Covered – 100%, one per calendar year	Not Covered	Covered
Annual Gynecological Exam	Covered – 100%, one per calendar year	Not Covered	Covered
Pap Smear Screening – lab services only	Covered – 100%, one per calendar year	Not Covered	Covered
Well-Baby and Child Care - PPACA	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	Covered
Immunizations - PPACA	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
Flexible Sigmoidoscopy Exam	Covered – 100%, one per calendar year	Not Covered	Covered
Prostate Specific Antigen (PSA) Screening	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, no age restrictions	Covered
Routine Mammography Screening – no age restrictions	Covered – 100%, one per calendar year	Covered – 80% after deductible, one per calendar year	Covered
<b>PHYSICIAN OFFICE SERVICES</b>			
Office Visits	Covered - \$10 copay	Covered – 80% after deductible, must be medically necessary	Covered (\$10 copay effective January 1, 2012)

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Outpatient Visits	Covered – 100%	Covered – 80% after deductible, must be medically necessary	Covered (\$10 copay effective January 1, 2012)
Office Consultations	Covered - \$10 copay	Covered – 80% after deductible, must be medically necessary	Covered (\$10 copay effective January 1, 2012)
<b>EMERGENCY MEDICAL CARE</b>			
Hospital Emergency Room – approved diagnosis	Covered – 100% (\$100 copay waived if admitted or for an accidental injury effective January 1, 2012)	Covered – 100% after deductible (\$100 copay waived if admitted or for an accidental injury effective January 1, 2012)	Covered (\$100 copay waived if admitted effective January 1, 2012)
Urgent Care Center	Covered - \$10 copay	Covered – 80% after deductible, must be medically necessary	Covered (\$10 copay effective January 1, 2012)
Ambulance Services – medically necessary	Covered – 100% (after deductible effective January 1, 2012)	Covered – 100% after deductible	Covered (after deductible effective January 1, 2012)
<b>DIAGNOSTIC SERVICES</b>			
Laboratory and Pathology Tests	Covered – 100% (after deductible effective January 1, 2012)	Covered – 80% after deductible	Covered (after deductible effective January 1, 2012)
Diagnostic Tests and X-rays	Covered – 100% (after deductible effective January 1, 2012)	Covered – 80% after deductible	Covered (after deductible effective January 1, 2012)
Radiation Therapy	Covered – 100% (after deductible effective January 1, 2012)	Covered – 80% after deductible	Covered (after deductible effective January 1, 2012)
<b>MATERNITY SERVICES PROVIDED BY A PHYSICIAN</b>			
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 (\$10 copay effective January 1, 2012)
Delivery and Nursery Care	Covered – 100%, Includes care by Certified Nurse Midwife (after deductible effective January 1, 2012)	Covered – 80% after deductible, Includes care by Certified Nurse Midwife	Covered (after deductible effective January 1, 2012)
<b>HOSPITAL CARE</b>			
Semi-Private Room, Inpatient Physician/ General Nursing, Hospital Services and Supplies	Covered – 100% (after deductible effective January 1, 2012)	Covered – 80% after deductible	Covered (after deductible effective January 1, 2012)

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	<b>In-Network</b>	<b>Out-Network</b>	
Inpatient Consultations	Covered – 100% (after deductible effective January 1, 2012)	Covered – 80% after deductible	Covered (after deductible effective January 1, 2012)
<b>ALTERNATIVES TO HOSPITAL CARE</b>			
Skilled Nursing Care	Covered – 100% up to 120 days per calendar year (after deductible effective January 1, 2012)	Covered – 100% after deductible, up to 120 days per calendar year	Covered – 100% up to 730 days (after deductible effective January 1, 2012)
Hospice Care	Covered – 100%	Covered – 100%	Covered (after deductible effective January 1, 2012)
Home Health Care	Covered – 100% (after deductible effective January 1, 2012)	Covered – 100% after deductible	Covered (after deductible effective January 1, 2012)
<b>SURGICAL SERVICES</b>			
Surgery (includes related surgical services)	Covered – 100% (after deductible effective January 1, 2012)	Covered – 80% after deductible	Covered (after deductible effective January 1, 2012)
Voluntary Sterilization	Covered – 100% (after deductible effective January 1, 2012)	Covered – 80% after deductible	Covered (after deductible effective January 1, 2012)
<b>MENTAL HEALTH AND SUBSTANCE ABUSE</b>			
Outpatient Mental Health Care	Covered 100%, facility & clinic (after deductible effective January 1, 2012)  Covered 80% after deductible, physician's office (\$10 copay effective January 1, 2012)	Covered 100%, after deductible, facility & clinic  Covered 80% after deductible, physician's office	Covered (\$10 copay effective January 1, 2012)
Outpatient Substance Abuse Care	Covered – 100% (after deductible effective January 1, 2012)	Covered 100% after deductible	Covered (\$10 copay effective January 1, 2012)
Inpatient Mental Health Care and Substance Abuse Care	Covered – 100% (after deductible effective January 1, 2012)	Covered 80% after deductible	Covered (after deductible effective January 1, 2012)
<b>OTHER SERVICES</b>			
Allergy Testing and Therapy (in physician's office)	Covered – 100%	Covered – 100%	Covered (after deductible effective January 1, 2012)
Chiropractic Spinal Manipulation	Covered – 100% up to 24 visits per calendar year (\$10 copay effective January 1, 2012)	Covered – 80% after deductible, up to 24 visits per calendar year	Not Covered

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Outpatient Physical, Speech and Occupational Therapy	In a facility – covered 100% up to a combined maximum of 60 visits per calendar year (after deductible effective January 1, 2012)	In a facility – covered 80% after deductible, up to a combined maximum of 60 visits per calendar year	Covered – 60 visits per person per benefit period
<b>DEDUCTIBLE, COPAYS AND DOLLAR MAXIMUMS</b>			
Annual Deductible	None (\$100 Single / \$200 Family effective January 1, 2012)	\$250 Single \$500 Family	None (\$100 Single / \$200 Family effective January 1, 2012)
Annual Copay Dollar Maximums	None	\$2,000 Single \$4,000 Family	None
<b>PRESCRIPTION DRUGS</b>			
Prescription Drug Benefits – Includes Contraceptives	\$10 Generic \$20 Brand Includes 90 day retail option (\$10 Generic / \$40 Brand effective January 1, 2012)	Covered at 75% after applicable copay, \$10 Generic/\$20 Brand. (\$10 Generic / \$40 Brand effective January 1, 2012)	\$10 Generic \$20 Brand (\$10 Generic / \$40 Brand effective January 1, 2012)
Mail Order	2x copay, 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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<b>Warren Education Association (WEA) Dental Benefits Summary</b>		
<b>Service</b>	<b>In-Network DenteMax Provider</b>	<b>Non-Network Provider</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 Anesthesia	85% of approved amount	85% of reasonable & customary
Benefit maximum for services shown above per calendar year	\$1,500	
Orthodontia (braces) for persons under age 19 and no age limit for employee	85% of approved amount	85% of reasonable & customary
Lifetime benefit maximum for orthodontia services	\$1,700 (\$2,300 effective January 1, 2012)	

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<b>Warren Education Association (WEA) Basic Life/AD&amp;D Benefit Summary</b>	
<b>Item</b>	
Benefit Amount / Life	1.5 times salary to a maximum of \$200,000 or flat \$50,000
Benefit Amount / AD&D	1.5 times salary to a maximum of \$200,000
Reduction Schedule	Basic Life: None Basic AD&D: None

<b>Warren Education Association (WEA) Long-Term Disability Benefit Summary</b>	
<b>Item</b>	
Elimination Period	180 days (or greater of accrued sick leave)
Maximum Benefit Period	Plan will terminate at age 70 or retirement, whichever comes first
Benefit Amount	60% of covered earnings to a maximum of \$8,000 per month
Benefit Offsets	If the Benefit Amount and payments from other sources is more than 70% of the pre-disability salary, the benefit will be reduced by the excess

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**Warren Education Association (WEA) Vision Plan Benefit Summary**

ITEM	UHC SPECIALTY BENEFITS	
	IN-NETWORK	OUT-NETWORK
Vision Exams	Covered at 100% once every calendar year	Covered at 100% once every calendar year up to: \$ 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 calendar year	Covered at 100% once every calendar year up to: \$100 per pair of Glass Lenses \$130 per pair of Plastic Lenses
Bifocal Lenses	Covered at 100% once every calendar year	Covered at 100% once every calendar year up to: \$165 per pair of Glass Lenses \$260 per pair of Plastic Lenses
Trifocal Lenses	Covered at 100% once every calendar year	Covered at 100% once every calendar year up to: \$165 per pair of Glass Lenses \$260 per pair of Plastic Lenses
Lenticular Lenses	Covered at 100% once every calendar year	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 calendar year. Applicable allowance depending on whether the frames are acquired through an independent or retail provider.	Covered at 100% once every calendar year up to: \$ 65 per pair of Plastic Frames \$195 per pair of Metal Frames

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## Warren Education Association (WEA) Vision Plan Benefit Summary

ITEM	UHC SPECIALTY BENEFITS	
	IN-NETWORK	OUT-NETWORK
Contact Lenses, in lieu of glasses	<p>Covered up to the following once every calendar year:</p> <p><u>Select Contacts</u> Covered at 100%. Includes 8 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 \$200 reimbursement. Examples of Non-Select contacts are toric, gas permeable, and bifocal</p>	<p>Covered at 100% once every calendar year up to:</p> <p>\$200 per pair for elective contacts \$455 per pair for medically necessary soft contacts \$230 per pair for medically necessary hard contacts</p>
Lasik Eye Surgery	Available at a discount	Not available
Miscellaneous	<p>No claim forms are required</p> <p>There is no outlay of cash for covered services up to the maximum benefit</p> <p>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</p> <p>Your provider may balance bill you for amounts above the plan benefit level</p>

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<b>Flexible Spending Accounts - WEA</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	\$230 to either the HCRA or the DCRA (\$400 effective November 1, 2011)
Any employee less than 1.0 full-time equivalent (FTE) will be entitled to a pro-rated employer ceded dollar amount. A debit card is provided.	

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