



September 2011

Medical Benefit Summary - Non-Union

Service	HAP HMO Plan
PREVENTIVE SERVICES - *UNLIMITED PER MEMBER PER CALENDAR YEAR	
Health Maintenance Exam – includes chest X-ray, EKG and select lab procedures	Covered
Annual Gynecological Exam	Covered
Pap Smear Screening – lab services only	Covered
Well-Baby and Child Care	Covered
Immunizations	Covered
Fecal Occult Blood Screening	Covered
Flexible Sigmoidoscopy Exam	Covered
Prostate Specific Antigen (PSA) Screening	Covered
Colonoscopy - no age restrictions	Covered
Routine Mammography Screening – no age restrictions	Covered
PHYSICIAN OFFICE SERVICES	
Office Visits	Covered – \$15 copay
Outpatient and Home Visits	Covered – \$15 copay
Office Consultations	Covered - \$15 copay
EMERGENCY MEDICAL CARE	
Hospital Emergency Room – approved diagnosis	Covered – 100% \$100 copay
Urgent Care Center	Covered – 100% \$30 copay
Ambulance Services – medically necessary	Covered – 100%
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 – \$15 copay
Delivery and Nursery Care	Covered – 100%
HOSPITAL CARE	
Semi-Private Room, Inpatient Physician/ General Nursing, Hospital Services and Supplies	Covered – 100%
Inpatient Consultations	Covered – 100%

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Chemotherapy	Covered – 100%
ALTERNATIVES TO HOSPITAL CARE	
Skilled Nursing Care	Covered – 100% up to 730 days, renewable after 60 days
Hospice Care	Covered – 100%
Home Health Care	Covered – 100%
SURGICAL SERVICES	
Surgery (includes related surgical services)	Covered – 100%; Bariatric surgery and related services subject to a \$1,000 copay
Voluntary Sterilization	Covered – 100%
MENTAL HEALTH CARE AND SUBSTANCE ABUSE	
Outpatient Mental Health Care	\$15 copay
Outpatient Substance Abuse Care (approved facilities only)	\$15 copay
Inpatient Mental Health Care and Substance Abuse Care	100%
OTHER SERVICES	
Allergy Testing and Therapy (in physician's office)	Covered – 100%
Chiropractic Spinal Manipulation	Not covered
Outpatient Physical, Speech and Occupational Therapy	Covered – 100%, 60 visits per person per benefit period
DEDUCTIBLE, COPAYS AND DOLLAR MAXIMUMS	
Annual Deductible	None
Annual Out-of-Pocket Maximums (includes deductible)	None
PRESCRIPTION DRUGS	
Prescription Drug Benefits –Retail Includes Contraceptives	\$10 Generic \$20 Brand
Prescription Drug Benefits –Mail Order (90 day supply)	Maintenance drugs: 1 x copay Non-Maintenance drugs: 3 x copay less \$5

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Dental Coverage Non-Union		
Service	In-Network Benefits	Out-of-Network Benefits
Preventive & Basic Services Office visit - twice per calendar year (CY) Cleanings - twice per calendar year Restorations (fillings) Sealants (up to and including age 14) – every 36 months Fluoride treatment (up to and including age 18) – twice per CY Space maintainers (up to and including 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	85% of approved amount	75% of reasonable & customary
Major Services Implants Bridges (full or partial) Dentures	85% of approved amount	75% of reasonable & customary
Benefit maximum for services shown above per calendar year	\$1,500	
Orthodontia (to age 19) Habit breaking appliances Minor tooth guidance appliances Full banding treatment Monthly, active treatment visits	85% of approved amount	85% of reasonable & customary
Lifetime benefit maximum for orthodontia services	\$1,700	

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Vision Plan Benefit Summary – Non-Union

ITEM	UNITEDHEALTHCARE SPECIALTY BENEFITS	
	IN-NETWORK ONLY BENEFITS	
Vision Exams	Covered at 100% once in a calendar year	
Single Vision Lenses	Covered at 100% once in a calendar year	
Bifocal Lenses	Covered at 100% once in a calendar year	
Trifocal Lenses	Covered at 100% once in a calendar year	
Lenticular Lenses	Covered at 100% once in a calendar year	
Additional Services	Sunglasses / Tints Polycarbonate Lenses Edge Coating Photochromatic Coating Scratch Resistant Coating	UV Coating Anti-Reflective Coating Transition Coating Progressive Lenses
Eyeglass Frames	Covered up to 100% once in a calendar year Applicable allowance depending on whether the frames are acquired through an independent or retail provider.	
Contact Lenses, in lieu of glasses	Covered up to the following once in a calendar year: <u>Select Contacts</u> Covered at 100%. Includes 4 boxes of disposable contact lenses, evaluation, fitting, and 2 follow-up visits for “select” contacts <u>Non-Select Contacts</u> Covered at 100% up to \$105 reimbursement. Examples of Non-Select contacts are toric, gas permeable, and bifocal	
Lasik Eye Surgery	Available at a discount	
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	

Basic Life/AD&D Benefit Summary – Non-Union

Item	Benefit
Benefit Amount / Life	1 times salary to a maximum of \$50,000
Benefit Amount / AD&D	1 times salary to a maximum of \$50,000
Reduction Schedule	Basic Life: None Basic AD&D: None

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Voluntary Short Term Disability Coverage – Non-Union	
Item	Benefit
Elimination Period (period of disability before Short Term Disability benefits are payable)	Accident, Hospital Confinement or outpatient surgery – 14 days of disability Sickness - 14 days benefits are payable on the 15th day
Benefit Amount	60% of earnings
Weekly Benefit Maximum	\$600
Duration of Benefit Period	24 weeks (4 weeks when pre-existing condition applies)
Benefit Offsets	State disability benefits, No-fault motor vehicle disability income, Family social security benefits

Long Term Disability – Non-Union	
Item	Benefit
Eligibility	Each regular full-time employee
Elimination Period	180 days (or greater of accrued sick leave)
Maximum Benefit Period	To age 65 or 3 years, whichever comes first
Benefit Amount	60% of covered earnings to a maximum of \$1,350 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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Flexible Spending Accounts – Non-Union	
Item	Benefit
Health Care Reimbursement Account (HCRA)	Annual Maximum: \$3,000
Dependent Care Reimbursement Account (DCRA)	Annual Maximum: \$5,000

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