

**SUMMARY OF PLAN CHANGE TO
MIEHIP BAY-ARENAC ISD
MEDICAL BENEFIT PLAN
AS AMENDED AND RESTATED
EFFECTIVE JULY 1, 2011**

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The Overview of Benefits on pages 9 through 13 is deleted and replaced with:

OVERVIEW OF BENEFITS

The plan is designed to provide levels of benefits based on the choices you make. Benefits that are payable are subject to the terms and conditions of the plan.

	Network	Non-Network
Deductible applies to essential and non-essential benefits <ul style="list-style-type: none"> • Individual • Family 	\$0 \$0	\$250 \$500
Out-Of-Pocket (Excluding deductible) applies to essential and non-essential benefits <ul style="list-style-type: none"> • Individual • Family 	\$0 \$0	\$2,000 \$4,000
Annual Maximum for essential benefits	\$5,000,000	
	The annual maximum will not be reduced by charges paid for non-essential benefits as listed below.	
Pre-Certification	All transplant procedures must be pre-certified. Failure to pre-certify a transplant procedure may result in a reduction in benefits.	
MEDICAL EXPENSES – ESSENTIAL BENEFITS		
	Network	Non-Network
Hospital-Inpatient	100%	80%, after deductible
Surgery	100%	80%, after deductible
Hospital Visits	100%	80%, after deductible
Emergency Room <ul style="list-style-type: none"> • Accidental Injury • Emergency Illness 	100% 100%, after \$50 co-pay (Co-pay waived if admitted)	100% 100%, after \$50 co-pay (Co-pay waived if admitted)
Urgent Care <ul style="list-style-type: none"> • Illness/Accidental Injury 	100%, after \$10 co-pay	80%, after deductible

MEDICAL EXPENSES – ESSENTIAL BENEFITS		
	Network	Non-Network
Allergy Testing & Injections	100%	80%, after deductible
Ambulance	100%	100%
Anesthesia	100%	80%, after deductible
Blood	100%	80%, after deductible
Cardiac Rehabilitation	100%	80%, after deductible
Chemotherapy	100%	80%, after deductible
Chiropractic Care <ul style="list-style-type: none"> Office Visits, Spinal Manipulation, Adjustments, Physical Therapy and X-rays (24 visits in a calendar year)	100%	80%, after deductible
Consultations <ul style="list-style-type: none"> Inpatient and Outpatient Office 	100% 100%, after \$10 co-pay	80%, after deductible 80%, after deductible
Contraceptives Devices, IUD and diaphragms	100%	80%, after deductible
Diabetes Management Program - Outpatient	100%	80%, after deductible
Dialysis	100%	80%, after deductible
Fertility Testing <ul style="list-style-type: none"> Counseling 	100% 100%, after \$10 co-pay	80%, after deductible 80%, after deductible
Hearing <ul style="list-style-type: none"> Hearing Aids (Limited to 1 per ear every 3 years up to a maximum of \$1,610)	100%	Not Covered
Home Health Care	100%	100%
Hospice (Respite care limited to 5 days during a 30 day period) (210 days in a lifetime)	100%	100%
Implants	100%	80%, after deductible
Injections, Including administration of a covered medication (When an office visit is not billed)	100%, after \$10 co-pay	80%, after deductible
Laboratory Testing	100%	80%, after deductible
Medical Equipment and Supplies, Including insulin pumps and blood glucose monitors	100%	100%

	Network	Non-Network
Mental Disorders and/or Substance Abuse Expenses <ul style="list-style-type: none"> • Inpatient • Outpatient 	<p>100%</p> <p>100%, after \$10 co-pay</p>	<p>90%, after deductible</p> <p>90%, after deductible</p>
Nursing - Private Duty	50%	50%
Occupational Therapy <ul style="list-style-type: none"> • Facility and Clinic • Office (Limited to 60 visits in a calendar year combined with speech and physical therapy)	<p>100%</p> <p>100%</p>	<p>100%</p> <p>80%, after deductible</p>
Office Visits , including related services rendered during the physician's office visit <ul style="list-style-type: none"> • Home Visit 	<p>100%, after \$10 co-pay</p> <p>100%</p>	<p>80%, after deductible</p> <p>80%, after deductible</p>
Orthotics	100%	100%
Physical Therapy <ul style="list-style-type: none"> • Facility and Clinic • Office (Limited to 60 visits in a calendar year combined with occupational and speech therapy)	<p>100%</p> <p>100%</p>	<p>100%</p> <p>80%, after deductible</p>
Pregnancy Related Expenses-Mother <ul style="list-style-type: none"> • Pre and Post Natal Care • Delivery 	<p>100%</p> <p>100%</p>	<p>80%, after deductible</p> <p>80%, after deductible</p>
Prescription Drugs <u>Retail</u> <ul style="list-style-type: none"> • Generic • Preferred • Non-Preferred <u>Mail Order</u> <ul style="list-style-type: none"> • Generic • Preferred • Non-Preferred <p><u>DAW Penalty:</u> When a generic drug is available and a Preferred or Non-Preferred brand drug is chosen, in addition to the co-pay, you will also be responsible for the cost difference between the Preferred or Non-Preferred brand drug and the generic drug.</p> Please note that mandatory mail order is required after 3 refills at the retail pharmacy.	<p><u>34-day supply or 100 units whichever is greater</u></p> <p>\$5 co-pay</p> <p>\$20 co-pay</p> <p>\$40 co-pay</p> <p><u>90-day supply</u></p> <p>\$5 co-pay</p> <p>\$20 co-pay</p> <p>\$40 co-pay</p> <p>Insulin, Needles, Syringes \$5.00 / \$20.00 / \$40.00</p> <p>Oral Contraceptives \$5.00 / \$20.00 / \$40.00</p> <p>Biotech/Injectibles \$5.00 / \$20.00 / \$40.00</p> <p>Lifestyle Medications \$5.00 / \$20.00 / \$40.00</p>	<p><u>34-day supply or 100 units whichever is greater</u></p> <p>\$5 co-pay</p> <p>\$20 co-pay</p> <p>\$40 co-pay</p>

	Network	Non-Network
Preventive Care <ul style="list-style-type: none"> • Required preventive care as defined by PPACA including but not limited to: <ul style="list-style-type: none"> – Immunizations – Well child care – Routine physical exams – Screening for high blood pressure – Screening for cervical cancer – Screening for cholesterol – Screening for diabetes – Screening for colorectal cancer • Prostate Specific Antigen (PSA) exam and related testing • Routine mammogram • Routine colonoscopy <p>NOTE: For additional information including any limitations go to the website www.uspreventiveservicestaskforce.org</p> <p>(Immunizations received at the local health department will be covered at the Network benefit)</p>	<p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>Not Covered</p> <p>Not Covered</p> <p>80%, after deductible</p> <p>80%, after deductible</p>
Prosthetic Devices (Specially designed prosthetic bras are limited to 4 in a calendar year)	100%	100%
Radiation Therapy	100%	80%, after deductible
Skilled Nursing Facility (120 days in a calendar year)	100%	100%, after deductible
Speech Therapy <ul style="list-style-type: none"> • Facility and Clinic • Office (Limited to 60 visits in a calendar year combined with occupational and physical therapy)	<p>100%</p> <p>100%</p>	<p>100%</p> <p>80%, after deductible</p>
Transplants Human Organs (Cornea, Kidney, Skin)	100%	80%, after deductible

	Network	Non-Network
Transplants Bone Marrow	100%	80% after deductible
Transplants Specified Human Organs: Liver, Heart, Lung, Pancreas, Heart-Lung	100% (Designated Transplant Network)	Not Covered
Weight Management for Morbid Obesity	Payment is based as service rendered (e.g. office visits will be covered as stated under the office visit listing)	Payment is based as service rendered (e.g. office visits will be covered as stated under the office visit listing)
X-rays	100%	80%, after deductible
All Other Covered Expenses	100%	80%, after deductible
MEDICAL EXPENSES – NON ESSENTIAL BENEFITS		
Transplants \$10,000 maximum for transportation, meals and lodging for patient and 1 companion (2 if the patient is a minor)	100%	80%, after deductible

NOTE: This is only a brief overview of benefits. Please refer to the sections of the plan for complete information on the eligibility provisions, limitations and for all other terms of the plan. Any maximums listed are applicable to all plan levels.
