FOCUS STAFF

It's about the journey.

INSURANCE INFORMATIONAL BROCHURE

BlueCross BlueShield BlueCare Dental℠

Dearborn National®

EyeMed

BlueCross BlueShield

MEDICAL PLAN BASE OPTION

Carrier Name	MTBCP608 Blue Cross Blue Shield 51 + (TX)	
Plan Type	Blue Choice PPO HSA	
Network Name	Blue Choice PPO	
Metallic Level	--	
	In	Out
Individual Deductible	$5,000	$10,000
Family Deductible	$10,000	$20,000
Coinsurance	100%	70%
Individual Out of Pocket Maximum	$5,000	$20,000
Family Out of Pocket Maximum	$10,000	$40,000
PCP Copay	0% after Ded.	30% after Ded.
Specialist Copay	0% after Ded.	30% after Ded.
Lab and X-ray	0% after Ded.	30% after Ded.
Advanced Imaging	0% after Ded.	30% after Ded.
Prescription Drug Card	0% after Ded. Preferred / 30% after Ded. Non - Preferred	
In Network Specialty Medication	0% after Ded.	
Mail Order Benefit	3x	N/A
Urgent Care Copay	0% after Ded.	30% after Ded.
Emergency Room Copay	0% after Ded.	0% after Ded.
Inpatient Hospitalization	0% after Ded.	30% after Ded.
Outpatient Surgery	0% after Ded.	30% after Ded.
Telehealth	Virtual visits available from participating providers for selected services at Ded & Coins	
Employee Only	$128.00 /monthly	
Employee + Spouse	$508.90/monthly	
Employee + Child(ren)	$550.44/monthly	
Employee + Family	$1,013.31/monthly	

BlueCross BlueShield

MEDICAL PLAN MID OPTION

Carrier Name	MTBCP713 Blue Cross Blue Shield 51 + (TX)	
Plan Type	Blue Choice PPO Copay	
Network Name	Blue Choice PPO	
Metallic Level	--	
	In	Out
Individual Deductible	$5,000	$10,000
Family Deductible	$14,700	$29,400
Coinsurance	70%	50%
Individual Out of Pocket Maximum	$5,600	$20,000
Family Out of Pocket Maximum	$14,700	$60,000
PCP Copay	$45/monthly	50% after Ded.
Specialist Copay	$90/monthly	50% after Ded.
Lab and X-ray	30% after Ded.	50% after Ded.
Advanced Imaging	30% after Ded.	50% after Ded.
Prescription Drug Card	$0 / $10 / $50 / $100 / $150 / $250 - Preferred $10 / $20 / $70 / $120 / $150 / $250 - non-Preferred	
In Network Specialty Medication	$150 Preferred / $250 /monthly non-Preferred	
Mail Order Benefit	3x	N/A
Urgent Care Copay	$75/monthly	50% after Ded.
Emergency Room Copay	$500 + 30% + Ded.	$500 + 30% + Ded.
Inpatient Hospitalization	30% after Ded.	50% after Ded.
Outpatient Surgery	30% after Ded.	50% after Ded.
Telehealth	Virtual visits available from participating providers for selected services at $45	
Employee Only	$166.02/monthly	
Employee + Spouse	$480.01/monthly	
Employee + Child(ren)	$464.98/monthly	
Employee + Family	$1,202.40/monthly	

BlueCross BlueShield

MEDICAL PLAN HIGH OPTION

Carrier Name	MTBCP806 Blue Cross Blue Shield 51 + (TX)	
Plan Type	Blue Choice PPO Copay	
Network Name	Blue Choice PPO	
Metallic Level	--	
	In	Out
Individual Deductible	$2,000	$4,000
Family Deductible	$6,000	$12,000
Coinsurance	80%	60%
Individual Out of Pocket Maximum	$5,000	$10,000
Family Out of Pocket Maximum	$14,700	$30,000
PCP Copay	$30/monthly	40% after Ded.
Specialist Copay	$60/monthly	40% after Ded.
Lab and X-ray	$0.00	40% after Ded.
Advanced Imaging	20% after Ded.	40% after Ded.
Prescription Drug Card	$0 / $10 / $50 / $100 / $150 / $250 - Preferred $10 / $20 / $70 / $120 / $150 / $250 - non-Preferred	
In Network Specialty Medication	$150 Preferred / $250/monthly non-Preferred	
Mail Order Benefit	3x	N/A
Urgent Care Copay	$75/monthly	40% after Ded.
Emergency Room Copay	$500 + 20% + Ded.	$500 + 20% + Ded.
Inpatient Hospitalization	20% after Ded.	40% after Ded.
Outpatient Surgery	20% after Ded.	40% after Ded.
Telehealth	Virtual visits available from participating providers for selected services at $30	
Employee Only	$276.77/monthly	
Employee + Spouse	$735.93/monthly	
Employee + Child(ren)	$808.10/monthly	
Employee + Family	$1,412.23/monthly	

BlueCross BlueShield BlueCare Dental℠

DENTAL PLAN BASE OPTION

Carrier Name	DTNHM11*3 Dental #1 - Base
Employee Only	$0.00/monthly
Employee + Spouse	$15.00/monthly
Employee + Child(ren)	$26.90/monthly
Employee + Family	$46.80/monthly

Summary of Dental Benefits	
Program Basics	
Benefit Period Maximum	$750/monthly
Deductible	$25 Individual / $75 Family /monthly
Covered Services	
Diagnostic Evaluations Periodic Oral Evaluations Problem Focused Oral Evaluations Comprehensive Oral Evaluations	100% (Deductible does not apply)
Preventive Services Prophylaxis (Cleanings) Topical Fluoride Applications	100% (Deductible does not apply)
Diagnostic Radiographs Full-mouth and Panoramic Films Bitewing Films Periapical Films	100% (Deductible does not apply)
Miscellaneous Preventive Services Sealants Space Maintainers	100% (Deductible does not apply)
Basic Restorative Dental Services Amalgams Resin-based Composite Restorations	80%
Non-Surgical Extractions Removal of retained coronal remnants Removal of erupted tooth or exposed root	Not Covered
Non-Surgical Periodontal Services Periodontal Scaling and Root Planning Full-mouth Debridement Periodontal Maintenance Procedures	Not Covered
Adjunctive Services Palliative Treatment (Emergency) Deep Sedation / General Anesthesia	Not Covered
Endodontic Services Therapeutic pulpotomy and pulpal debridement Root Canal Therapy Apexification / Recalcification	Not Covered

BlueCross BlueShield BlueCare Dental℠

DENTAL PLAN BASE OPTION

CONTINUATION

Oral Surgery Services Surgical Tooth Extractions Alveoloplasty and Vestibuloplasty Excision of Bone Tissue Incision and Drainage of an Intraoral Abscess	Not Covered
Surgical Periodontal Services Gingivectomy or Gingivoplasty and Gingival Flap Procedures Clinical Crown Lengthening Osseous Surgery Osseous Grafts Soft Tissue Grafts/Allografts Distal or Proximal Wedge Procedure Anatomical Crown Exposures	Not Covered
Major Restorative Services Single Crown Restorations Gold Foil and Inlay/Onlay Restorations Labial Veneer Restorations Crowns Placed over Implants	Not Covered
Prosthodontic Services Complete and Removable Partial Dentures Denture Reline/Rebase Procedures Fixed Bridgework Prosthetics placed over Implants	Not Covered
Miscellaneous Restorative and Prosthodontic Services Prefabricated Crowns Recementations Post and Core, Pin Retention and Crown/Bridge Repairs Adjustments	Not Covered
Orthodontic Services	
Orthodontic Services Orthodontic Diagnostic Procedures and Treatment Lifetime Maximum per Participant	Not Covered

Dental Implants are not Covered.

The above is a listing of common services available through your network of Participating Dentists. The Member's share of the cost is determined by whether care is received from a Participating or Non-Participating Dentist.

Services from non-participating providers will be subject to the same allowable charges as those from participating providers. Amounts in excess of these allowances will be the full responsibility of the insured.

This plan includes BlueCare Dental Enhanced Benefits℠. The Enhanced Benefit provides additional dental benefits, such as an extra cleaning and 100% coverage for periodontal cleanings to members with specific health issues at no additional cost. Please refer to your Dental Benefit Booklet for additional benefit information.

BlueCross BlueShield BlueCare Dental℠

DENTAL PLAN HIGH OPTION

Carrier Name	DTLM08 Dental #2 – Buy Up
Employee Only	$18.00/monthly
Employee + Spouse	$54.90/monthly
Employee + Child(ren)	$57.39/monthly
Employee + Family	$99.47/monthly

Summary of Dental Benefits	
Program Basics	
Benefit Period Maximum	$750/monthly
Deductible	$25 Individual / $75 Family /monthly
Covered Services	
Diagnostic Evaluations Periodic Oral Evaluations Problem Focused Oral Evaluations Comprehensive Oral Evaluations	100% (Deductible does not apply)
Preventive Services Prophylaxis (Cleanings) Topical Fluoride Applications	100% (Deductible does not apply)
Diagnostic Radiographs Full-mouth and Panoramic Films Bitewing Films Periapical Films	100% (Deductible does not apply)
Miscellaneous Preventive Services Sealants Space Maintainers	100% (Deductible does not apply)
Basic Restorative Dental Services Amalgams Resin-based Composite Restorations	80%
Non-Surgical Extractions Removal of retained coronal remnants Removal of erupted tooth or exposed root	Not Covered
Non-Surgical Periodontal Services Periodontal Scaling and Root Planning Full-mouth Debridement Periodontal Maintenance Procedures	Not Covered
Adjunctive Services Palliative Treatment (Emergency) Deep Sedation / General Anesthesia	Not Covered
Endodontic Services Therapeutic pulpotomy and pulpal debridement Root Canal Therapy Apexification / Recalcification	Not Covered

BlueCross BlueShield BlueCare Dental℠

DENTAL PLAN HIGH OPTION

CONTINUATION

Oral Surgery Services Surgical Tooth Extractions Alveoloplasty and Vestibuloplasty Excision of Bone Tissue Incision and Drainage of an Intraoral Abscess	50%
Surgical Periodontal Services Gingivectomy or Gingivoplasty and Gingival Flap Procedures Clinical Crown Lengthening Osseous Surgery Osseous Grafts Soft Tissue Grafts/Allografts Distal or Proximal Wedge Procedure Anatomical Crown Exposures	50%
Major Restorative Services Single Crown Restorations Gold Foil and Inlay/Onlay Restorations Labial Veneer Restorations Crowns Placed over Implants	50%
Prosthodontic Services Complete and Removable Partial Dentures Denture Reline/Rebase Procedures Fixed Bridgework Prosthetics placed over Implants	50%
Miscellaneous Restorative and Prosthodontic Services Prefabricated Crowns Recementations Post and Core, Pin Retention and Crown/Bridge Repairs Adjustments	50%
Orthodontic Services	
Orthodontic Services Orthodontic Diagnostic Procedures and Treatment Lifetime Maximum per Participant	50% $1000/monthly (Deductible does not apply)

Dental Implants are not Covered.

The above is a listing of common services available through your network of Participating Dentists. The Member's share of the cost is determined by whether care is received from a Participating or Non-Participating Dentist.

Services from non-participating providers will be subject to the same allowable charges as those from participating providers. Amounts in excess of these allowances will be the full responsibility of the insured.

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Dearborn National | EyeMed

VISION PLAN

Vision Care Service	Member Cost In-Network	Out of Network Reimbursement
Exam with Dilation as Necessary	$10/monthly Copay	Up to $30/monthly
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
Exam Options:		
Standard Contact Lens Fit and Follow Up:	Up to $40/monthly for Standard; 10% off retail price for Premium	N/A
Frames:		
Any available frame at provider location	$0 Copay; $130 Allowance, $20 off balance over $130/monthly	Up to $65/monthly
Standard Plastic Lenses		
Single Vision	$10/monthly Copay	Up to $25/monthly
Bifocal	$10/monthly Copay	Up to $40/monthly
Trifocal	$10/monthly Copay	Up to $55/monthly
Lenticular	$10/monthly Copay	Up to $55/monthly
Standard Progressive Lens	$75/monthly Copay	Up to $40/monthly
Premium Progressive Lens	See Table on Page 2	Up to $40/monthly
Lens Options		
UV Treatment	$15/monthly	N/A
Tint (Solid and Gradient)	$15/monthly	N/A
Standard Plastic Scratch Coating	$0	Up to $5/monthly
Standard Polycarbonate – Adults	$40/monthly	N/A
Standard Polycarbonate – Kids under 19	$0	Up to $5/monthly
Standard Anti-Reflective Coating	$45/monthly	N/A
Polarized	20% off retail price	N/A
Photochromatic/Transitions Plastic	$75/monthly	N/A
Premium Anti-Reflective	See Below Table	N/A
Contact Lenses (Contact lens allowance includes materials only)		
Conventional	$0 Copay; $130 allowance, 15% off balance over $130/monthly	Up to $104/monthly
Disposable	$0 Copay; $130 allowance, plus balance over $130/monthly	Up to $104/monthly
Medically Necessary	$0 Copay, Paid in Full	Up to $210/monthly
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off Promotional Price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchase and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A

Progressive Price List*	Member Cost In-Network
Standard Progressive	$75/monthly Copay
Premium Progressives as Follows:	
Tier 1	$95/monthly Copay
Tier 2	$105/monthly Copay
Tier 3	$120/monthly Copay
Tier 4	$75/monthly Copay, 80% of charge less $120 Allowance
Anti-Reflective Coating Price List*	**Member Cost In-Network**
Standard Anti-Reflective Coating	$45/monthly
Premium Anti-Reflective Coating as Follows:	
Tier 1	$57/monthly
Tier 2	$68/monthly
Tier 3	80% of charge
Other Add-Ons Price List	**Member Cost In-Network**
Photochromic (plastic)	$75/monthly
Polarized	80% of charge