

Your Health Care Plan

The benefit chart(s) in Your Benefits Guide are designed to provide you with a **summary** of the services covered under your health plan. You will need to reference the actual certificate(s) or rider(s) for detailed information about a benefit including any exclusions or limitations.

When you need to reference a certificate or rider, simply match the form number from the benefit chart (located to the left of the benefit) to the same form number on the navigation bar. Then double click on the form number in the navigation bar.

Eligibility information

Member	Form	Eligibility Criteria
Dependents	6225	Your spouse, and unmarried children until the end of the year in which they turn age 19.
Dependent Continuation	4656 - DC	Dependents between the ages of 19 and 25 provided they meet all of the requirements of this rider.
Sponsored Dependents	3326 - SD	Dependent coverage for those individuals who are financially dependent on the subscriber if they meet all of the requirements of this rider.
Domestic Partners	6209 - DP	Coverage for subscriber's same gender domestic partner and dependent children of the partner if they meet all of the requirements of this rider.

Community Blue PPO

Benefit Chart

Deductible, Copays and Dollar Maximums - \$1 million lifetime per covered specified organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted below for individual services.

Benefits	Form	In-Network	Form	Out-of-Network
Deductible	5775	\$100 per person or \$200 for the family per calendar year	6225	\$250 per person or \$500 for the family per calendar year Note: Your out-of-network deductible amount will also be applied to your in-network requirement.
Fixed Dollar Copays	6225	\$10 copay for specific office services	6225	Not applicable
	6225	\$50 copay for emergency services, waived if admitted or for an accidental injury	6225	\$50 copay for emergency services, waived if admitted or for an accidental injury
Percent Copays	577501	10 percent copay after deductible	5769	30 percent copay after deductible
Mental Health Percent Copay	5255	No copayment requirement after deductible	5255	No copay requirement after deductible, if applicable
Private Duty Nursing Percent Copay	6225	50 percent copay after deductible	6225	50 percent copay after deductible
Copay Dollar Maximums	5815	\$500 per member, \$1,000 for the family per calendar year	5857	\$1,500 per member, \$3,000 for the family per calendar year

Preventive Care Service - There is no annual maximum for covered preventive care services. - 5812

Health Maintenance Exam - includes chest X-ray, EKG and select lab procedures, one per member, per calendar year	6225	Covered - 100 percent of approved amount	6225	Not Covered
Gynecological Exam - one per member, per calendar year	6225	Covered - 100 percent of approved amount	6225	Not Covered
Pap Smear Screening, laboratory and pathology services, one per member, per calendar year	6225	Covered - 100 percent of approved amount	6225	Not Covered
Well-Baby and Child Care - 6 visits, birth through 12 months - 6 visits, 13 months through 23 months - 2 visits, 24 months through 35 months - 2 visits, 36 months through 47 months - 1 visit per birth year, 48 months through age 15	6225	Covered - 100 percent of approved amount	6225	Not Covered
Immunizations, up through age 16	6225	Covered - 100 percent of approved amount	6225	Not Covered
Fecal Occult Blood Screening, one per member, per calendar year	6225	Covered - 100 percent of approved amount	6225	Not Covered
Flexible Sigmoidoscopy Exam, one per member, per calendar year	6225	Covered - 100 percent of approved amount	6225	Not Covered
Prostate Specific Antigen (PSA) Screening, one per member, per calendar year	6225	Covered - 100 percent of approved amount	6225	Not Covered

Mammography

Benefits	Form	In-Network	Form	Out-of-Network
Mammography Screening, one per calendar year, no age restrictions	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible

Physician Office Services

Benefits	Form	In-Network	Form	Out-of-Network
Office Visits	6225	Covered - \$10 copay for specific office services	5769	Covered - 70 percent of approved amount after deductible, must be medically necessary
Outpatient and Home Visits	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible, must be medically necessary
Office Consultations	6225	Covered - \$10 copay for specific office services	5769	Covered - 70 percent of approved amount after deductible, must be medically necessary
Urgent Care Visits	6225	Covered - \$10 copay for specific office services	5769	Covered - 70 percent of approved amount after deductible, must be medically necessary

Emergency Medical Care

Benefits	Form	In-Network	Form	Out-of-Network
Hospital Emergency Room	6225	\$50 copay for emergency services, waived if admitted or for an accidental injury	6225	\$50 copay for emergency services, waived if admitted or for an accidental injury
Ambulance Services when medically necessary	577501	Covered - 90 percent of approved amount after deductible	577501	Covered - 90 percent of approved amount after deductible

Diagnostic Services

Benefits	Form	In-Network	Form	Out-of-Network
Laboratory and Pathology Services	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Diagnostic Tests and X-rays	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Therapeutic Radiology	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible

Maternity Services Provided by a Physician

Benefits	Form	In-Network	Form	Out-of-Network
Prenatal and Postnatal Care	6225	Covered - 100 percent of approved amount	5769	Covered - 70 percent of approved amount after deductible
Delivery and Nursery Care	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible

Hospital Care

Benefits	Form	In-Network	Form	Out-of-Network
Semiprivate Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies Note: Nonemergency services must be rendered in a participating hospital	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Inpatient Consultations	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Chemotherapy	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible

Alternatives to Hospital Care

Benefits	Form	In-Network	Form	Out-of-Network
Skilled Nursing Care - Up to 120 days per member, per calendar year	577501	Covered - 90 percent of approved amount after deductible	577501	Covered - 90 percent of approved amount after deductible
Hospice Care - limited to dollar maximum which is reviewed and adjusted periodically	6225	Covered - 100 percent of approved amount	6225	Covered - 100 percent of approved amount
Home Health Care	577501	Covered - 90 percent of approved amount after deductible	577501	Covered - 90 percent of approved amount after deductible

Surgical Services

Benefits	Form	In-Network	Form	Out-of-Network
Surgery - includes related surgical services - Participating Ambulatory Surgery Facility	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Voluntary Sterilization	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible

Human Organ Transplants

Benefits	Form	In-Network	Form	Out-of-Network
Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504), up to \$1 million lifetime maximum per transplant type	6225	Covered - 100 percent of approved amount	6225	Covered - 100 percent of approved amount in designated facilities only
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Kidney, Cornea and Skin	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible after deductible

Mental Health Care and Substance Abuse Treatment

Benefits	Form	In-Network	Form	Out-of-Network
Inpatient Mental Health Care	5255	Covered - 100 percent of the approved amount after deductible, if applicable after deductible	5255	Covered - 100 percent of the approved amount after deductible, if applicable
Inpatient Substance Abuse Treatment - limited to \$15,000 annually and \$30,000 lifetime.	6225	Covered - 50 percent of approved amount after deductible	5255	50 percent of the approved amount after deductible, if applicable
Outpatient Mental Health Care - Facility and Clinic - Physician's Office	5255	Covered - 100 percent of the approved amount after deductible, if applicable after deductible	5255	Covered - 100 percent of the approved amount after deductible, if applicable
Outpatient Substance Abuse Treatment in approved facilities, up to the state dollar amount which is adjusted annually	6225	Covered - 50 percent of approved amount after deductible	6225	Covered - 50 percent of approved amount after deductible

Other Services

Benefits	Form	In-Network	Form	Out-of-Network
Outpatient Diabetes Management Program (ODMP)	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Allergy Testing and Therapy	6225	Covered - 100 percent of approved amount	5769	Covered - 70 percent of approved amount after deductible
Prescription Contraceptive Devices	9973	Covered - 100 percent of approved amount after deductible	9973	Covered - 70 percent of approved amount after deductible
Contraceptive Injections	5315	Covered - 90 percent of approved amount after deductible	5315	Covered - 70 percent of approved amount after deductible
Chiropractic Spinal Manipulation Note: Up to 24 visits per member, per calendar year	6225	Covered - 100 percent of approved amount	5769	Covered - 70 percent of approved amount after deductible
Outpatient Physical, Speech and Occupational Therapy Note: A combined 60-visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physician's office - Facility and Clinic	577501	Covered - 90 percent of approved amount after deductible	577501	Covered - 90 percent of approved amount after deductible
- Physician's Office - excludes speech and occupational therapy	6225	Covered - 100 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Durable Medical Equipment	577501	Covered - 90 percent of approved amount after deductible	577501	Covered - 90 percent of approved amount after deductible
Prosthetic and Orthotic Appliances	577501	Covered - 90 percent of approved amount after deductible	577501	Covered - 90 percent of approved amount after deductible
Private Duty Nursing	6225	Covered - 50 percent of approved amount after deductible	6225	Covered - 50 percent of approved amount after deductible

Note: Temporary benefits for hospital services – When a hospital chooses to terminate its participating contract with BCBSM, your coverage provides temporary benefits for emergency care and for certain services for up to six months from the date the hospital terminates its participating contract with Blue Cross Blue Shield of Michigan. Please refer to rider Temporary Benefits for Hospital Services (form #1700) for covered benefits under this arrangement.

Blue Preferred RX Benefit Chart for Prescription Drug Coverage

The following benefit chart is designed to provide you with a **summary** of the services covered under your plan. You will need to reference the actual certificate(s) or rider(s) for detailed information about a benefit including any exclusions or limitations

Choosing your pharmacy

The amount you pay in out-of-pocket costs depends on whether or not you use a network or non-network pharmacy. You will have the least out-of-pocket costs when you use network pharmacies.

Important: Pharmacies outside of Michigan must use the MedImpact BIN and PC number below to verify your eligibility, not the five-digit group number on your ID card.

MedImpact Rx BIN 003585/Rx PCN 23615

If the pharmacist needs assistance, he or she may call the MedImpact Provider Help Desk at 1-800-239-1023.

Copay Requirements

Benefits	Form	Network Pharmacy	Form	Non-Network Pharmacy
Dollar Copay	3509	Covered - \$10 copay	3509	Covered - \$10 copay, less 25 percent of approved amount
Brand Name Drugs	5163	Covered - Increase copay by \$10 for brand name drugs	5163	Covered - Increase copay by \$10 for brand name drugs
Mail Order (Home Delivery) Prescription Drugs	2138	Covered - Copay is a separate copay amount for covered drugs up to 34 days supply for prescription or refill Copay is double for drugs more than a 35 up to 90 day supply for prescription or refill.	2138	Not Covered

Preferred RX Drug Plan

Benefits	Form	Network Pharmacy	Form	Non-Network Pharmacy
Federal Legend Drugs	3607	Covered - 100 percent of approved amount less plan copay	3607	Covered - 75 percent of approved amount less plan copay
State-controlled Drugs	3607	Covered - 100 percent of approved amount less plan copay	3607	Covered - 75 percent of approved amount less plan copay
Disposable Needles and Syringes – dispensed with insulin	3607	Covered - 100 percent of approved amount less plan copay for insulin	3607	Covered - 75 percent of approved amount less plan copay for insulin
Contraceptive Medications	5138	Covered - 100 percent of approved amount less plan copay	5138	Covered - 75 percent of approved amount less plan copay
Mail Order (Home Delivery) Prescription Drugs	2138	Covered - 100 percent of the approved amount less plan copay	2138	Not Covered

Vision Care Coverage

Your vision coverage is designed to encourage regular eye examinations and help pay the cost of corrective eyewear.

Choosing Your Vision Provider

When you need vision care, it is important to find out whether or not your provider participates with Blue Cross Blue Shield of Michigan.

Participating Providers

Blue participating providers have signed agreements with us to accept our approved amount, less your copayment (if applicable), as payment in full for covered services.

Nonparticipating Providers

Nonparticipating vision care providers do not have signed agreements with us and can choose not to accept our approved amount as payment in full. This means you are responsible for any difference between our approved amount and the provider's charges. This amount is in addition to your copayments.

Copay Requirements

Benefits	Form	Requirement
Eye Examinations - one every 24 months	4770	\$5 copay requirement

Frames

Benefits	Form	Requirement
Standard eyeglass frames - once every 24 months	4770	\$7.50 copay requirement

Lenses

Benefits	Form	Requirement
Standard lenses - once every 24 months when prescribed and dispensed by an physician, optometrist or optician. Lenses may be molded or ground, glass or plastic.	4770	\$7.50 copay requirement

Contact Lenses

Benefits	Form	Requirement
Contact lenses (that meet medically necessary criteria) - once every 24 months	4770	\$7.50 copay requirement

Medicare Supplement Coverage Benefit Chart

The following benefit chart is designed to provide you with a summary of the services covered under your plan. You will need to reference the actual certificate(s) or rider(s) for detailed information about a benefit including any exclusions or limitations.

About your supplemental coverage

As your secondary coverage, Blue Cross Blue Shield pays your Medicare deductible and coinsurance or fixed dollar copay if the service is a Supplemental benefit.

Note: When you reach 65 and become eligible for Medicare, but are still working for an employer of 20 or more persons, you have options for health care coverage. Please see your human resource area for more information on these options.

Preventive Care Services

Benefits	Form	Medicare	Form	BCBSM Traditional Supplemental Coverage
Pap Smear Screening – laboratory services only	0800	Covered at Medicare approved amount, once every 24 months	0800	Covered in full by Medicare
Immunizations - Flu Shots and Pneumonia Vaccines	0800	Covered at Medicare approved amount	0800	Covered in full by Medicare
- Hepatitis B Vaccines – for those at risk of contracting the disease	0800	Covered at Medicare approved amount less Part B deductible and coinsurance	0800	Not covered
Prostate Specific Antigen (PSA) Test	0800	Covered at Medicare approved amount, once every 12 months at age 50 and older	0800	Covered in full by Medicare

Mammography

Benefits	Form	Medicare	Form	BCBSM Traditional Supplemental Coverage
Mammography Screening	0800	Covered at Medicare approved amount less Part B coinsurance, once every 12 months at age 40 and older	0800	Covers Medicare coinsurance

Physician Office Services

Benefits	Form	Medicare	Form	BCBSM Traditional Supplemental Coverage
Office Visits	0800	Covered at Medicare approved amount less Part B deductible and coinsurance	0800	Not covered
Outpatient and Home Visits	0800	Covered at Medicare approved amount less Part B deductible and coinsurance	0800	Not covered
Office Consultations	0800	Covered at Medicare approved amount less Part B deductible and coinsurance	0800	Not covered

Emergency Medical Care

Benefits	Form	Medicare	Form	BCBSM Traditional Supplemental Coverage
Hospital Emergency Room (professional services) – must be medically necessary	0800	Covered at Medicare approved amount less Part B deductible and coinsurance or set copayment	0800	Covers Medicare deductible and coinsurance or set copayment
Ambulance Services – must be medically necessary	0800	Covered at Medicare approved amount less Part B deductible and coinsurance	0800	Covers Medicare deductible and coinsurance

Clinical Laboratory Services

Benefits	Form	Medicare	Form	BCBSM Traditional Supplemental Coverage
Laboratory and Pathology Tests – used in the diagnosis and treatment of an illness or injury	0800	Covered at Medicare approved amount	0800	Covered in full by Medicare

Hospital Care

Benefits	Form	Medicare	Form	BCBSM Traditional Supplemental Coverage
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies - Days 1-60	2017	Covered at Medicare approved amount less Part A deductible	2017	Covers Medicare deductible
- Days 61-90	2017	Covered at Medicare approved amount less Part A daily coinsurance	2017	Covers Medicare daily coinsurance
- Lifetime Reserve Days (60 days)	2017	Covered at Medicare approved amount less Part A daily coinsurance	2017	Covers Medicare daily coinsurance
- Additional days	2017	Not covered	2017	Covered at BCBSM approved amount, up to an additional 275 days
Chemotherapy	2017	Covered for administration and drugs, at Medicare approved amount less deductible and coinsurance; must meet Medicare criteria	2017	Covers Medicare deductible and coinsurance; pays chemotherapy drugs which Medicare does not cover; must meet BCBSM criteria for payment

Alternatives to Hospital Care

Benefits	Form	Medicare	Form	BCBSM Traditional Supplemental Coverage
Skilled Nursing Facility Care – specific criteria applies - Days 1-20	2017	Covered at Medicare approved amount	2017	Covered in full by Medicare
- Days 21-100	2017	Covered at Medicare approved amount less daily coinsurance	2017	Covers Medicare coinsurance
- Days 101 and after	2017	Not covered	2017	Not covered
Hospice Care	2017	Covered at Medicare approved amount less small copayment for outpatient drugs and less small coinsurance for inpatient respite care	2017	Covers limited costs not covered by Medicare
Home Health Care – medically necessary	2017	Covered at Medicare approved amount	2017	Covered in full by Medicare

Surgical Services Provided by a Physician

Benefits	Form	Medicare	Form	BCBSM Traditional Supplemental Coverage
Surgery – includes related surgical services	0800	Covered at Medicare approved amount less Part B deductible and coinsurance	0800	Covers Medicare deductible and coinsurance

Human Organ Transplants

Note: Payment is based on medical necessity and must be rendered in an approved facility.

Benefits	Form	Medicare	Form	BCBSM Traditional Supplemental Coverage
Heart and Liver	990965	Covered at Medicare approved amount less deductible and coinsurance	990965	Covers Medicare deductible and coinsurance
Lung and Heart-lung	990965	Covered at Medicare approved amount less deductible and coinsurance	990965	Covers Medicare deductible and coinsurance
Pancreas	990965	Not covered Note: Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	990965	Not covered Note: Covers Medicare deductible and coinsurance when covered by Medicare.
Cornea	990965	Covered at Medicare approved amount less deductible and coinsurance	990965	Covers Medicare deductible and coinsurance
Bone Marrow and Kidney	990965	Covered at Medicare approved amount less deductible and coinsurance	990965	Covers Medicare deductible and coinsurance

Mental Health Care

Benefits	Form	Medicare	Form	BCBSM Traditional Supplemental Coverage
<p>Inpatient Mental Health Care in psychiatric hospital</p> <p>- Days 1-190 Lifetime</p>	2017	<p>Covered at Medicare approved amount less deductible and coinsurance</p> <p>Note: In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.</p>	2017	Covers Medicare deductible and coinsurance
<p>- Additional days after 190 lifetime days are used</p>	2017	Not covered	2017	Not covered
<p>Outpatient Mental Health Care</p>	2017	<p>Covered at Medicare approved amount less Part B deductible and coinsurance or set copayment for therapeutic services. Diagnostic services are covered at the approved amount less Part B deductible and coinsurance.</p>	2017	Covers Medicare deductible and coinsurance or set copayment

Other Services

Benefits	Form	Medicare	Form	BCBSM Traditional Supplemental Coverage
Allergy Testing and Therapy - with approved diagnosis	0800	Covered at Medicare approved amount less Part B deductible and coinsurance	0800	Covers Medicare deductible and coinsurance for testing; injections are not covered
Chiropractic Spinal Manipulation - must be medically necessary	0800	Covered when medically necessary, at Medicare approved amount less Part B deductible and coinsurance	0800	Not covered
Outpatient Physical, Speech and Occupational Therapy	0800	Covered at Medicare approved amount less Part B deductible and coinsurance or set copayment Note: Services of independent physical or occupational therapist subject to annual dollar limit.	0800	Covers Medicare deductible and coinsurance or set copayment
Durable Medical Equipment	0800	Covered at Medicare approved amount less Part B deductible and coinsurance	0800	Covers Medicare deductible and coinsurance
Prosthetic Appliances	0800	Covered at Medicare approved amount less Part B deductible and coinsurance	0800	Covers Medicare deductible and coinsurance
Oral Cancer Drugs	0800	Approved drugs are covered	0800	Covered in full by Medicare

Foreign Travel

Benefits	Form	Medicare	Form	BCBSM Traditional Supplemental Coverage
Hospital Services	2017	Not covered, except for inpatient hospital services in Canada or Mexico in rare situations	2017	Covered at BCBSM approved amount, up to 30 days for covered services
Physician Services	0800	Not Covered, except for services rendered in Canada or Mexico in connection with a covered inpatient stay	0800	Covered up to BCBSM approved amount

Master Medical 65 Coverage Benefits-at-a-Glance

Copayment, Deductible and Maximum

Benefits are addition to your Medicare and Traditional plans. Services are payable after exhausting benefits in your basic Medicare and Traditional plans

Benefits	Form	Requirements
Deductible	MMPD65	\$100 per person per calendar year
Percent Copay	MMPD65	20 percent copay requirement
Private Duty Nursing Copay	MMPD65	50 percent copay requirement
Copay Dollar Maximum	MMPD65	\$2,500 per calendar year up to a lifetime maximum of \$5,000 Note: Once the \$5,000 lifetime maximum has been reached, an additional \$1,000 allowance is restored for each calendar year of continuous coverage.

Hospital Coverage

Benefits	Form	Requirements
Additional days for Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	MMPD65	Covered – 100 percent of the approved amount, no copay or deductible requirement

Mental Health Care

Benefits	Form	Requirements
Inpatient Mental Health Care in psychiatric facility	MMPD65	Covered – 80 percent of the approved amount after deductible and after Medicare and Traditional coverage has been exhausted

Other Services

Benefits	Form	Requirements
Private duty nursing in the hospital or at home	MMPD65	Covered – 50 percent of the approved amount after deductible

These are the codes for your Certificates and Riders and are for internal use by BCBSM:

0428-ASC MOD 2998	0738-65 OPTION 1
1700-TBHD	2138L1-MOPD2XBC10\$10
2138L2-MOPD2XBC10\$10 5	3509-PD-CR \$10.00
350965-PD-CR \$10.00-65	3607-PREFERRED RX
360765-PREFERRED RX 65	408703-RDR GPC SAT II
4397-EBMT	477004-AUTO 80 VISION
477065-AUTO 80 VISION	513814-PDCM PDCR\$10.00
5163-BC\$10 W/\$10PREF	516365-BC\$10-65W/\$10PR
5216-ECIP	5255-CB-MHP 0%
5315-CI	5385-CRNA
5769-CBC 30% NP	577501-CBD\$100P 90/10
5812-CB-PCM	5815-CB-CMP \$500/90
5857-CBCMNP1500	6209-DOMESTIC PART.
6225-COMM BLUE BASIC	6502-65 OPT 2
6600-CNM	6603-CB-PCB
993009-GLE-1	9973-PCD
K032-K032	K03265-K032-65
MMPD65-CATASTROPHIC 65	

Tracking Number 207408

Service Key	Effective Date
C1AGQZ	07/01/2004
S1ACNC	07/01/2004

These are the codes for your Certificates and Riders and are for internal use by BCBSM:

0428-ASC MOD 2998	0738-65 OPTION 1
1700-TBHD	2138L1-MOPD2XBC10\$10
2138L2-MOPD2XBC10\$10 5	3509-PD-CR \$10.00
350965-PD-CR \$10.00-65	3607-PREFERRED RX
360765-PREFERRED RX 65	408703-RDR GPC SAT II
4397-EBMT	477004-AUTO 80 VISION
477065-AUTO 80 VISION	513814-PDCM PDCR\$10.00
5163-BC\$10 W/\$10PREF	516365-BC\$10-65W/\$10PR
5216-ECIP	5255-CB-MHP 0%
5315-CI	5385-CRNA
5769-CBC 30% NP	577501-CBD\$100P 90/10
5812-CB-PCM	5815-CB-CMP \$500/90
5857-CBCMNP1500	6209-DOMESTIC PART.
6225-COMM BLUE BASIC	6502-65 OPT 2
6600-CNM	6603-CB-PCB
993009-GLE-1	9973-PCD
K032-K032	K03265-K032-65
MMPD65-CATASTROPHIC 65	

Tracking Number 207408

Service Key	Effective Date
C1AGQZ	07/01/2004
S1ACNC	07/01/2004

This handbook is not a contract. It is intended as a brief description of benefits. Every effort has been made to ensure the accuracy of the information within. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail.

Tracking Number 207408
CompuSet9112006749.txt

Group No:68343/020 Eff:05/01/66



Sales Office B:715 Pr:9/12/2006 Qty:5