Customer name: Carleton College
Name of plan: Options Blue (AWARE) HRA
Network: Blue Cross Aware
Effective date: January 1, 2010

HEALTH PLAN		In-network	Out-of-network
Deductible	**Individual**	$1,000	$1,000
	2-Party/Family	$1,500/$2,000	$1,500/$2,000
Out-of-pocket maximum	**Individual**	$1,900	$1,900
	2-Party/Family	$2,550/$3,800	$2,550/$3,800
Coinsurance		80%	80%
Lifetime maximum		5 million	5 million
HRA	**Contribution**	$500 Individual, $750 2-Party, $1000 Family	$500 Individual, $750 2-Party, $1000 Family
	Rollover	Unused portions of your HRA account balance will be rolled over to subsequent plan year	
	Covered expenses	Health Plan Eligible Expenses	Health Plan Eligible Expenses
Covered services		**In-network**	**Out-of-network**
Preventive care	Routine cancer screening	100%	100%
	Routine physical exams	100% to max of $500. Once maximum has been reached, claims will continue to pay at 80% after deductible.	100% to max of $500. Once maximum has been reached, claims will continue to pay at 80% after deductible.
	Routine hearing exams		
	Lab and x-ray services		
	Immunizations		
	Routine vision exams		
	Well-child care (up to age 6)	100%	80% after deductible
	Immunizations (up to age 18)	100%	80% after deductible
Services received	**Inpatient care**		
	• Facility services	80% after deductible	80% after deductible
	• Professional services	80% after deductible	80% after deductible
	Outpatient care		
	• Facility services	80% after deductible	80% after deductible
	• Professional services	80% after deductible	80% after deductible
	• Lab and x-ray services	80% after deductible	80% after deductible
	Physician's office		
	• Office visits for illness	80% after deductible	80% after deductible
	• In-office surgery	80% after deductible	80% after deductible
	• Allergy-related services	80% after deductible	80% after deductible
	• Urgent care	80% after deductible	80% after deductible
	• Lab and x-ray services	80% after deductible	80% after deductible
	Emergency room care		
	• Emergency room	80% after deductible	80% after deductible
	• Physician services	80% after deductible	80% after deductible
	Ambulance services	80% after deductible	80% after deductible

Covered services		In-network	Out-of-network
Maternity care	• Prenatal care	100%	80% after deductible
	• Facility services for delivery	80% after deductible	80% after deductible
	• Professional services for delivery	80% after deductible	80% after deductible
Prescription drugs Generic Feature: If a brand name is selected when a generic is available, the member will pay the higher copay plus the difference between the cost of the brand and the generic. The difference amount does not accumulate toward the OOPM. Step Therapy Classes: Antidepressants, Cholesterol Lowering, Diabetic Monitors & Strips, Proton Pump Inhibitors.	• Retail pharmacy (31-day supply)	$15 Generic Drugs $35 Brand Name Formulary Drugs $55 Brand Name Non-formulary Drugs Prescription Drug Out of pocket maximum: $750 Individual $1,000 Family	$15 Generic Drugs $35 Brand Name Formulary Drugs $55 Brand Name Non-formulary Drugs Prescription Drug Out of pocket maximum: $750 Individual $1,000 Family
	• 90dayRx (retail or mail)	$30 Generic Drugs $70 Brand Name Formulary Drugs $110 Brand Name Non-formulary Drugs Prescription Drug Out of pocket maximum: $750 Individual $1,000 Family	$30 Generic Drugs $70 Brand Name Formulary Drugs $110 Brand Name Non-formulary Drugs Prescription Drug Out of pocket maximum: $750 Individual $1,000 Family
Medical equipment and supplies		80% after deductible	80% after deductible
Behavioral health (mental health and chemical dependency)	• Physician services	80% after deductible	80% after deductible
	• Inpatient	80% after deductible	80% after deductible
	• Outpatient	80% after deductible	80% after deductible
Rehabilitative care (physical, occupational, speech therapy)		80% after deductible	80% after deductible ($500 maximum for out-of-network PT/OT/ST providers combined)
Chiropractic care		80% after deductible	80% after deductible ($500 maximum for out-of-network Chiropractic providers)

For additional information about your benefits, call customer service at 651-662-5004.

This is only an outline of plan benefits. The contract and certificate include complete details of what is and isn't covered. Services not covered include items primarily used for non-medical purposes, over-the-counter drugs/nutritional supplements, services that are complementary, experimental, not medically necessary, or covered by workers' compensation or no-fault auto insurance. Pre-existing conditions may not be covered for a limited period of time. This limit is reduced by prior continuous coverage and doesn't apply to pregnancy, newborns, adopted children or handicapped dependents. We feature a large network of health care providers. Each provider is an independent contractor and is not our agent. Nonparticipating providers do not have contracts with Blue Cross and Blue Shield of Minnesota. Blue Cross and Blue Shield of Minnesota is an independent licensee of the Blue Cross and Blue Shield Association.