

PLAN COMPARISONS

Plan Design Feature	PPO Basic (70/30)	
	In-Network	Out-of-Network ²
Lifetime Maximum	Unlimited	Unlimited
Benefit Year Deductible	\$600 Individual \$1,800 Family	\$1,200 Individual \$3,600 Family
Plan Coinsurance	30% of eligible expenses after deductible	50% of eligible expenses and the difference between the allowed amount and the charge
Coinsurance Maximum (does not include deductible)	\$2,500 Individual \$7,500 Family	\$5,000 Individual \$15,000 Family
Primary Care	\$25' copayment	50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Specialist	\$50' copayment	50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Urgent Care	\$75 copayment	Same as in-network benefit
Emergency Room	\$250 copayment plus 30% coinsurance after deductible	Same as in-network benefit
Inpatient	\$200 copayment then 30% coinsurance after deductible	\$200 copayment then 50% coinsurance after deductible and the difference between the allowed amount and the charge
Outpatient Hospital and Ambulatory Surgical Center	30% of eligible expenses after deductible	50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Preventive Care	\$25' copayment - primary care \$50' copayment - specialist	Not covered ²
SHORT TERM THERAPIES	Physical / Occupational / Speech	\$25' copayment - primary care \$50' copayment - specialist 30% coinsurance after deductible - outpatient hospital
	Chiropractic	\$50' copayment - specialist 30 visit limit per benefit period
Routine Eye Exam	\$25 copayment	Not covered
MENTAL HEALTH / CHEMICAL DEPENDENCY	Office Services Outpatient Services Inpatient Services	\$50' copayment - specialist 30% coinsurance after deductible \$200 copayment then 30% coinsurance after deductible
		50% coinsurance 50% coinsurance after deductible \$200 copayment then 50% coinsurance after deductible (--and the difference between the allowed amount and the charge. Applies to all out-of-network services.) Deductible does not apply to out-of-network office visits.
Generic Rx Copay	\$10 Includes preferred diabetic supplies ³	Prior authorization is required after visit 26 - combined in- and out-of-network office visits.
Preferred Rx Copay (No Generic Equivalent)	\$30	
Preferred Rx Copay (Generic Equivalent)	\$40	
Non-Preferred Rx Copay	\$50 Includes non-preferred diabetic supplies ³ \$25 copay	

1. PPO Options: In-network hospital owned or operated practices may be subject to deductible and coinsurance. Please call your physician or see the Provider Directory to determine if your physician's practice is hospital owned or operated.

All benefits are subject to medical necessity.

2007-2009 Benefits Comparison

Plan Design Feature	PPO Standard (80/20)		PPO Plus (90/10)	
	In-Network	Out-of-Network ²	In-Network	Out-of-Network ²
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Benefit Year Deductible	\$300 Individual \$900 Family	\$600 Individual \$1,800 Family	\$150 Individual \$450 Family	\$300 Individual \$900 Family
Plan Coinsurance	20% of eligible expenses after deductible	40% of eligible expenses and the difference between the allowed amount and the charge	10% of eligible expenses after deductible	30% of eligible expenses and the difference between the allowed amount and the charge
Coinsurance Maximum (does not include deductible)	\$1,750 Individual \$5,250 Family	\$3,500 Individual \$10,500 Family	\$1,000 Individual \$3,000 Family	\$2,000 Individual \$6,000 Family
Primary Care	\$20' copayment	40% of eligible expenses after deductible and the difference between the allowed amount and the charge	\$15' copayment	30% of eligible expenses after deductible and the difference between the allowed amount and the charge
Specialist	\$40' copayment	40% of eligible expenses after deductible and the difference between the allowed amount and the charge	\$30' copayment	30% of eligible expenses after deductible and the difference between the allowed amount and the charge
Urgent Care	\$50 copayment	Same as in-network benefit	\$50 copayment	Same as in-network benefit
Emergency Room	\$200 copayment plus 20% coinsurance after deductible	Same as in-network benefit	\$150 copayment plus 10% coinsurance after deductible	Same as in-network benefit
Inpatient	\$150 copayment then 20% coinsurance after deductible	\$150 copayment then 40% coinsurance after deductible and the difference between the allowed amount and the charge	\$100 copayment then 10% coinsurance after deductible	\$100 copayment then 30% coinsurance after deductible and the difference between the allowed amount and the charge
Outpatient Hospital and Ambulatory Surgical Center	20% of eligible expenses after deductible	40% of eligible expenses after deductible and the difference between the allowed amount and the charge	10% of eligible expenses after deductible	30% of eligible expenses after deductible and the difference between the allowed amount and the charge
Preventive Care	\$20' copayment - primary care \$40' copayment - specialist	Not covered ²	\$15' copayment - primary care \$30' copayment - specialist	Not covered ²
SHORT TERM THERAPIES	Physical / Occupational / Speech	\$20' copayment - primary care \$40' copayment - specialist 20% coinsurance after deductible - outpatient hospital	\$15' copayment - primary care \$30' copayment - specialist 10% coinsurance after deductible - outpatient hospital	30% of eligible expenses after deductible and the difference between the allowed amount and the charge
	Chiropractic	\$40' copayment - specialist 30 visit limit per benefit period	\$30' copayment - specialist 30 visit limit per benefit period	30% of eligible expenses after deductible and the difference between the allowed amount and the charge
Routine Eye Exam	\$20 copayment	Not covered	\$15 copayment	Not covered
MENTAL HEALTH / CHEMICAL DEPENDENCY	Office Services Outpatient Services Inpatient Services	\$40' copayment - specialist 20% coinsurance after deductible \$150 copayment then 20% coinsurance after deductible	\$30' copayment - specialist 10% coinsurance after deductible \$100 copayment then 10% coinsurance after deductible	30% coinsurance 30% coinsurance after deductible \$100 copayment then 30% coinsurance after deductible (--and the difference between the allowed amount and the charge. Applies to all out-of-network services.) Deductible does not apply to out-of-network office visits.
		40% coinsurance 40% coinsurance after deductible \$150 copayment then 40% coinsurance after deductible (--and the difference between the allowed amount and the charge. Applies to all out-of-network services.) Deductible does not apply to out-of-network office visits.		
Generic Rx Copay	\$10 Includes preferred diabetic supplies ³	Prior authorization is required after visit 26 - combined in- and out-of-network office visits.	\$10 Includes preferred diabetic supplies ³	Prior authorization is required after visit 26 - combined in- and out-of-network office visits.
Preferred Rx Copay (No Generic Equivalent)	\$30		\$30	
Preferred Rx Copay (Generic Equivalent)	\$40		\$40	
Non-Preferred Rx Copay	\$50 Includes non-preferred diabetic supplies ³ \$25 copay		\$50 Includes non-preferred diabetic supplies ³ \$25 copay	

2. The following preventive care benefits are available both in- and out-of-network: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening and prostate specific antigen tests.

All benefits are subject to medical necessity.