

COMPARISON CHART OF RATES AND BENEFITS FOR INDEMNITY AND PPO PLANS FOR BENEFIT YEARS 2007 - 2009

The rate increases are effective October 1, 2007.

All benefit changes are retroactively effective to July 1, 2007 except for the specialist copayment for chiropractic care on the PPO plans is effective October 1, 2007.

	PPO Basic Plan 70/30	PPO Standard Plan 80/20	PPO Plus Plan 90/10	Indemnity Plan
Premium Increase	11.2%	11.2%	11.2%	11.4%
Office Visit Copayment	<ul style="list-style-type: none"> •Primary Care \$25 •Specialist \$50 	<ul style="list-style-type: none"> •Primary Care \$20 •Specialist \$40 	<ul style="list-style-type: none"> •Primary Care \$15 •Specialist \$30 	<ul style="list-style-type: none"> •Primary Care \$25 •Specialist \$25
Physical Occupational and Speech Therapies	• Unlimited Visits	• Unlimited Visits	• Unlimited Visits	•Unlimited Visits
Chiropractic	<ul style="list-style-type: none"> •30 Visits Per Benefit Year •Specialist Copayment \$50 Effective 10/01/07 	<ul style="list-style-type: none"> •30 Visits Per Benefit Year •Specialist Copayment \$40 Effective 10/01/07 	<ul style="list-style-type: none"> •30 Visits Per Benefit Year •Specialist Copayment \$30 Effective 10/01/07 	<ul style="list-style-type: none"> •\$2,000 benefit year max. •\$25 Copayment plus 20% Coinsurance after Deductible
Benefit Year Deductible	<ul style="list-style-type: none"> •\$600 Individual •\$1,800 Family 	<ul style="list-style-type: none"> •\$300 Individual •\$900 Family 	<ul style="list-style-type: none"> •\$150 Individual •\$450 Family 	<ul style="list-style-type: none"> •\$450 Individual •\$1,350 Family
Mental Health and Chemical Dependency	<ul style="list-style-type: none"> •Unlimited Visits •\$200 Inpatient Copay plus 30% Coinsurance after Deductible 	<ul style="list-style-type: none"> •Unlimited Visits •\$150 Inpatient Copay plus 20% Coinsurance after Deductible 	<ul style="list-style-type: none"> •Unlimited Visits •\$100 Inpatient Copay plus 10% Coinsurance after Deductible 	<ul style="list-style-type: none"> •Unlimited Visits •\$150 Inpatient Copay plus 20% Coinsurance after Deductible
Generic Preferred-No Generic Equivalent Preferred-Generic Equivalent Non-Preferred	<ul style="list-style-type: none"> •\$10 Rx Copay •\$30 Rx Copay •\$40 Rx Copay •\$50 Rx Copay 	<ul style="list-style-type: none"> •\$10 Rx Copay •\$30 Rx Copay •\$40 Rx Copay •\$50 Rx Copay 	<ul style="list-style-type: none"> •\$10 Rx Copay •\$30 Rx Copay •\$40 Rx Copay •\$50 Rx Copay 	<ul style="list-style-type: none"> •\$10 Rx Copay •\$30 Rx Copay •\$40 Rx Copay •\$50 Rx Copay

Red indicates a benefit change. Benefits in black have not changed. They are listed for ease of plan comparison.

2007.

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† max. us 20% Deductible
pay plus fter