

		Maximum Lifetime Benefit	Calendar year Deductible	Member Coinsurance	Prescription Drug Benefits	
					Retail Pharmacy	Mail order
<b>HMO PLANS</b>						
CIGNA Plan		Unlimited	No Deductible	N/A	\$10 Generic; \$20 Brand; \$40 Non-Formulary (up to 30 day supply)	\$10 Generic; \$20 Brand; \$40 Non-Formulary (up to 90 day supply)
Kaiser Plan		Unlimited	No Deductible	N/A	\$10 Generic \$20 Brand (up to 100 day supply)	
Blue Cross Traditional HMO Plan		Unlimited	No Deductible	N/A	\$10 Generic; \$20 Brand; \$40 Non-Formulary (up to 30 day supply)	\$20 Generic; \$40 Brand; \$80 Non-Formulary (up to 90 day supply)
Blue Cross Select HMO Plan		Unlimited	No Deductible	N/A	\$100 deductible (waived for generic) \$10 Generic \$25 Brand \$40 Non-formulary (up to 30 day supply)	\$100 deductible (waived for generic) \$20 Generic \$50 Brand \$80 Non-formulary (up to 90 day supply)
<b>PPO PLANS</b>						
Premier Wellwise	In Network	\$3,000,000	\$300 per ind/ \$600 per family	10%	20% / 25% / 30% ; Drug Card Program	20% / 25% / 30% ; Drug Card Program
	Out of Network	\$3,000,000	\$500 per ind./ \$1,000 per family	30%		
Premier Sharewell	In Network	\$1,000,000	\$5,000 per family	10%	20%	20%
	Out of Network	\$1,000,000	\$5,000 per family	20%	20%	20%
Exclusive Care	Tier 1 Exclusive Care Network	\$1,000,000	\$250 / \$750	10%	\$15 generic, \$25 brand, \$40 non-formulary (30 day supply) deductible does not apply, Medco pharmacies only	\$30 generic, \$50 brand, \$80 non-formulary (90 day supply) Medco pharmacies only
	Tier 2 Blue Shield Network		\$500/\$1,500	20%		
	Tier 3 Out-of-Network		\$1,000 / \$3,000	40%		

Hospital / Facility Benefits						
		Inpatient	Outpatient	Pre-certification review	Emergency Services	Ambulance
<b>HMO PLANS</b>						
CIGNA Plan		\$100 per admission	\$15 copay	N/A	\$50 copay, waived if admitted	\$0 copay
Kaiser Plan		\$100 per admission	\$15 copay	N/A	\$50 copay, waived if admitted	\$0 copay
Blue Cross Traditional HMO Plan		\$100 per admission	\$0 copay, excludes ER	N/A	\$50 copay, waived if admitted	\$0 copay
Blue Cross Select HMO Plan		\$0 copay	\$0 copay, excludes ER	N/A	\$100 copay, waived if admitted	\$0 copay
<b>PPO PLANS</b>						
Premier Wellwise	In Network	10%	10%	Pre-authorization required	10%	20%
	Out of Network	30%	30%	Pre-authorization required, w/out prior authorization coverage reduced to 50%	30%	30%
Premier Sharewell	In Network	10%	10%	Pre-authorization required	10%	20%
	Out of Network	20%	20%	Pre-authorization required, w/out prior authorization coverage reduced to 60%	20%	20%
Exclusive Care	Tier 1 Exclusive Care Network	10%	10%	Without review, 50% reduction in benefits for inpatient, outpatient and outpatient diagnostic testing	\$50 copay plus 10%	10%, life threatening only
	Tier 2 Blue Shield Network	20%	20%		\$100 copay plus 20%	20%, life threatening only
	Tier 3 Out-of-Network	40%	40%		\$100 copay plus 20%	20%, life threatening only

Physical & Professional Services					
		Physician Office Visits (Primary Care)	Physician Second Opinion	Physician Office Visits (Specialty Care)	Diagnostic X-ray / Lab
<b>HMO PLANS</b>					
CIGNA Plan		\$15 copay	\$15 copay	\$15 copay	\$0 copay
Kaiser Plan		\$15 copay	\$15 copay	\$15 copay	\$0 copay
Blue Cross Traditional HMO Plan		\$15 copay	\$15 copay	\$15 copay	\$0 copay
Blue Cross Select HMO Plan		\$15 copay	\$15 copay	\$30 copay	\$0 copay
<b>PPO PLANS</b>					
Premier Wellwise	In Network	10%	10%	10%	10%
	Out of Network	30%	30%	30%	30%
Premier Sharewell	In Network	10%	10%	10%	10%
	Out of Network	20%	20%	20%	20%
Exclusive Care	Tier 1 Exclusive Care Network	\$10 copay	\$10 PCP \$20 Speciality	\$20 copay	10%; Without review, 50% reduction in benefits for inpatient, outpatient and outpatient diagnostic testing
	Tier 2 Blue Shield Network	\$25 copay	\$25 PCP \$50 Speciality	\$50 copay	20%; Without review, 50% reduction in benefits for inpatient, outpatient and outpatient diagnostic testing
	Tier 3 Out-of-Network	40%	40%	40%	40%; Without review, 50% reduction in benefits for inpatient, outpatient and outpatient diagnostic testing

Physical & Professional Services (continued)						
	Immunizations (specific)	Home Health Care	Skilled Nursing Facility	Chiropractic Therapy	Eye Refractions	
<b>HMO PLANS</b>						
CIGNA Plan	\$0 copay	\$0 copay	\$0 copay (up to 100 days)	\$15 copay per visit (30 visits/year)	\$5 copay; Glasses \$10	
Kaiser Plan	\$0 copay	\$0 copay (100 visits/year)	\$0 copay (up to 100 days)	\$15 copay per visit (30 visits/year)	\$15 copay	
Blue Cross Traditional HMO Plan	\$0 copay	\$0 copay up to max 100 days	\$0 copay up to max 100 days	\$15 copay when ordered by PCP	\$15 copay	
Blue Cross Select HMO Plan	\$0 copay	\$0 copay (100 visits/year)	\$0 copay (100 days/year)	\$15 copay	\$15 copay	
<b>PPO PLANS</b>						
Premier Wellwise	In Network	No charge	10%	Limited 60 Days	10% coinsurance for In Network, 30% coinsurance for Out of Network, max benefit of \$1,000 per calendar year	Not covered
	Out of Network	Not covered	30%		Not covered	
Premier Sharewell	In Network	No charge	10%	Limited 60 Days	10% (50 visits/yr)	Not covered
	Out of Network	Not covered	20%		20% (50 visits/yr)	Not covered
Exclusive Care	Tier 1 Exclusive Care Network	\$10	10% (max 100 days)	10% (max 100 days)	Not covered	Not covered
	Tier 2 Blue Shield Network	\$25	20% (max 100 days)	20% (max 100 days)	Not covered	Not covered
	Tier 3 Out-of-Network	Not covered	40% (max 100 days)	40% (max 100 days)	Not covered	Not covered

Preventative Services					
	Annual Physical Exam	Well Woman Exams	Routine Vision Exam	Durable Medical Equipment	
<b>HMO PLANS</b>					
CIGNA Plan	\$15 copay	\$15 copay, breast and pelvic only. May self-refer w/in group	\$15 copay	\$0 copay when prescribed by PCP	
Kaiser Plan	\$15 copay	\$15 copay, may self-refer to a Kaiser provider	\$0 copay	\$0 copay	
Blue Cross Traditional HMO Plan	\$15 copay when ordered by PCP	\$15 copay	\$15 copay	\$0 copay (up to \$5,000/year)	
Blue Cross Select HMO Plan	\$15 copay	\$15 copay	\$15 copay	\$0 copay (up to \$5,000/year)	
<b>PPO PLANS</b>					
Premier Wellwise	In Network	\$750 in & out of network	\$750 in & out of network	N/A	Covered
	Out of Network	\$750 in & out of network	\$750 in & out of network	N/A	Covered
Premier Sharewell	In Network	No charge, up to a max annual benefit amount of \$250		N/A	Covered
	Out of Network	Limited to specific procedures listed under "Wellness Benefit"		N/A	Covered
Exclusive Care	Tier 1 Exclusive Care Network	\$10 copay	\$10 copay	\$10 copay	10% up to \$1,000
	Tier 2 Blue Shield Network	\$25 copay	\$25 copay	\$25 copay	20% up to \$1,000
	Tier 3 Out-of-Network	Not covered	Not covered	Not covered	40% up to \$1,000

		Mental Health			
		Inpatient Facility	Outpatient Facility	Maximum Yearly Outpatient	Lifetime maximum
<b>HMO PLANS</b>					
CIGNA Plan		\$100 Per Admission up to 30 Days p/calendar yr.	\$20 copay	N/A	N/A
Kaiser Plan		\$100 Per Admission up to 45 Days p/calendar yr.	\$15 copay	20 visits	N/A
Blue Cross Traditional HMO Plan		\$100 Per Admission up to 30 Days per Calendar year	\$20 copay	20 visits	N/A
Blue Cross Select HMO Plan		\$100 Per day up to 30 Days	\$30 copay	20 visits	N/A
<b>PPO PLANS</b>					
Premier Wellwise	In Network	10%, Pre-Admission required		Up to \$50 per visit & 50 visits per year	\$30,000 maximum benefit combined with Alcohol & Substance Abuse below
	Out of Network	30%, Pre-Admission required, out-of-network coverage reduced to 50%			
Premier Sharewell	In Network	10%, Pre-Admission required		Up to \$50 per visit & 50 visits per year	\$30,000 maximum benefit combined with Alcohol & Substance Abuse
	Out of Network	20%, Pre-Admission required, out-of-network coverage reduced to 60%			
Exclusive Care	Tier 1 Exclusive Care Network	Not covered unless a severe mental illness; then covered like any other benefit	\$20 copay up to 30 visits per year; unless a severe mental illness then covered like any other benefit	N/A	N/A
	Tier 2 Blue Shield Network			N/A	N/A
	Tier 3 Out-of-Network	Not covered	Not covered	N/A	N/A

		Alcohol & Drug Abuse			
		Inpatient Facility	Outpatient Facility	Maximum Yearly Outpatient	Lifetime maximum
<b>HMO PLANS</b>					
CIGNA Plan		\$100 Per Admission Detox Only	\$15 copay	Detox only	N/A
Kaiser Plan		\$100 Per Admission	No charge	Unlimited	N/A
Blue Cross Traditional HMO Plan		\$100 Per Admission Detox Only	No charge	N/A	N/A
Blue Cross Select HMO Plan		\$100 Per day/detox only	No charge	N/A	N/A
<b>PPO PLANS</b>					
Premier Wellwise	In Network	10%	50%	Up to \$50 per visit & 50 visits per year	\$30,000 maximum benefit combined with Mental Health
	Out of Network	30% 50 visits			
Premier Sharewell	In Network	10%	50%	Up to \$50 per visit & 50 visits per year	\$30,000 maximum benefit combined with Mental Health
	Out of Network	20% 50 visits			
Exclusive Care	Tier 1 Exclusive Care Network	Not covered unless a severe mental illness; then covered like any other benefit	\$20 copay up to 30 visits per year; unless a severe mental illness then covered like any other benefit	N/A	N/A
	Tier 2 Blue Shield Network			N/A	N/A
	Tier 3 Out-of-Network	Not covered	Not covered	N/A	N/A

These benefit charts serve only as a summary of plan benefits. These charts contain the major features of the plan and are not intended to replace the legal documents containing the complete provisions.