

## Benefits-at-a-Glance

HEALTH PLAN	Low Deductible PPO				High Deductible Wellness				High Deductible HSA Plan			
Employee Cost:	Biweekly		Monthly		Biweekly		Monthly		Biweekly		Monthly	
Premium includes Health, Dental & Prescription cover.	10 month (18 pays)	12 month (24 pays)	10 month	12 month	10 month (18 pays)	12 month (24 pays)	10 month	12 month	10 month (18 pays)	12 month (24 pays)	10 month	12 month
<b>Single Employee &amp; Child(ren) Family!</b>	\$128.52	\$96.39	\$231.33	\$192.78	\$55.58	\$41.69	\$100.05	\$83.38	\$19.04	\$14.28	\$34.27	\$28.56
	\$244.18	\$183.14	\$439.53	\$366.28	\$105.62	\$79.21	\$190.11	\$158.42	\$36.16	\$27.12	\$65.09	\$54.24
	\$333.61	\$250.21	\$600.51	\$500.42	\$144.28	\$108.21	\$259.71	\$216.42	\$49.41	\$37.06	\$88.94	\$74.12
<b>Annual Premium Sgl/EE &amp; Ch/Family!</b>	\$2314/\$4396/\$6005^ (^Dom. Part. is combo of pretax & after-tax)				\$1001 / \$1901/ \$2597^ (^Dom. Part. is combo of pretax & after-tax)				\$343/ \$651/ \$890^* (^Dom. Part. is combo of pretax & after-tax)			
<b>Deductibles</b>	\$300 - Single/ \$750 - EE & Child, Family (per person and per family)				\$1000 - Sgl/ \$2500 - EE & Child, Family (per person and per family)				\$1500 - Sgl/ \$3750 - EE & Child, Family (per person and per family)			
<b>Out-of Pocket Maximum after deductible (per person)</b> <i>*does not include deductible</i> <i>** includes deductible</i>	\$1500- \$2250* for In Network depending on use of endorsed or non-endorsed physicians  \$3000* for Out of Network plus \$2000 per each inpatient admission				\$2500- \$3750* for In Network depending on use of endorsed or non-endorsed physicians  \$6000* for Out of Network plus \$2000 per each inpatient admission				\$2500- \$3500** per covered person- depends on use of endorsed or non-endorsed physicians, in network and out of network facilities/physicians  \$5,000-\$7,000** per family per calendar year depends on use of endorsed or non-endorsed physicians, in network and out of network facilities/physicians			
<b>Network Inpatient Hospital Co-insurance</b>	Encircle hosp. 80%/Encore only hosp. 70% Out-of Network hospitals 50%				Encircle hosp. 80%/Encore only hosp. 70% Out-of Network hospitals 50%				Encircle hosp. 80%/Encore only hosp. 70% Out-of Network hospitals 50%			
<b>Not subject to deductible</b> Covered: <i>80% In Network endorsed physician</i> <i>70% In Network non-endorsed physician</i> <i>*100% covered</i> <i>** Network not applicable</i>	Wellness Benefits – Routine tests, immunizations and Office exams Chronic Disease Physician Office visits Quick Care Clinic * Nurse Practitioners** Diabetic, Asthma & Nutrition Training* Lab charges* (specific labs)				Wellness Benefits – Routine tests, immunizations, and Office exams Chronic Disease Physician Office visits Quick Care Clinic * Nurse Practitioners** Diabetic, Asthma & Nutrition Training* Lab charges* (specific labs)				Wellness Benefits – Routine tests, immunizations and Office exams Routine lab charges* (specific labs)			
<b>Subject to deductible</b> Covered: <i>80% In Network endorsed physician</i> <i>70% In Network non-endorsed physician</i> <i>60% Out of Network</i> <i>*100% covered</i> <i>** Network not applicable</i>	Regular Office visits/ injections for illness & accident Hospital In and Out Patient/ Surgery Mental, Nervous and Substance Abuse Diagnostic X-rays and lab expenses for routine/illness/accidents Ambulance for illness/accident Emergency room illness/ accident (not serious or life-threatening medical condition)				Regular office visits/injections for illness and accident Hospital In and Out Patient/Surgery Mental, Nervous and Substance Abuse Diagnostic X-rays and lab expenses for routine/illness/accidents Ambulance for illness/accident Emergency room illness/ accident(not serious or life-threatening medical condition)				Chronic Disease Physician Office visits Quick Care Clinic Nurse Practitioners** Diabetic, Asthma & Nutrition Training* Regular Office visits- injection illness/accident Hospital In and Out Patient/Surgery/Emergency Mental, Nervous and Substance Abuse Diagnostic x-rays and Lab expenses routine/illness/accidents Non-routine lab charges* (specific labs) Ambulance/Emergency room illness/ accident			

**Routine tests:** Mammograms, Pap Smears, PSA tests, Colonoscopy, Sigmoidoscopy

**Wellness Office Visits:** exam only, maximum benefit \$200.00 per visit

**Chronic Diseases:** Specific diseases that are approved by Plan – see Chronic Disease list

**! Family is defined as employee, spouse or same-sex domestic partner with or without children.**

<b>DENTAL Coverage</b>	<b>Low Deductible PPO</b>	<b>High Deductible Wellness</b>	<b>High Deductible HSA Plan</b>
Deductible	\$50 Single/ \$100 EE & Child/ \$100 Family	\$50 Single/ \$100 EE & Child/ \$100 Family	\$50 Single/ \$100 EE & Child/ \$100 Family
Maximum Benefits	\$1500 per person per year	\$1500 per person per year	\$1500 per person per year
Coverage:	Covers 100% of first preventive visit to \$50 per person per year, balance of charge at 80% (after deductible is met)	Covers 100% of first preventive visit to \$50 per person per year, balance of charge at 80% (after deductible is met)	Covers 100% of first preventive visit to \$50 per person per year, balance of charge at 80% (after deductible is met)
	80% usual and customary to maximum benefit	80% usual and customary to maximum benefit	80% usual and customary to maximum benefit
Orthodontia	\$500 per person per year (separate from Dental Benefit maximum)	\$500 per person per year (separate from Benefit Dental maximum)	\$500 per person per year (separate from Dental Benefit maximum)

<b>Prescription Coverage</b>	<b>Low Deductible PPO</b>		<b>High Deductible Wellness</b>		<b>High Deductible HSA Plan</b>	
Deductible (Effective Jan.1, 2011)	Eliminated		Eliminated		Included in Medical deductible All drugs subject to deductible except preventive medication*	
Maximum Out of Pocket Expense	\$1500 per person per year for mail order only; <b>retail costs do not apply to out-of-pocket maximums</b>		\$1500 per person per year for mail order only; <b>retail costs do not apply to out-of-pocket maximums</b>		Included in Medical out of pocket maximum	
Covered: Retail Non-Maintenance Drugs	<u>Generic Drugs</u> 80%	<u>Name Brand Drugs</u> 70%	<u>Generic Drugs</u> 80%	<u>Name Brand Drugs</u> 70%	<u>Generic Drugs</u> 80%	<u>Name Brand Drugs</u> 70%
Maintenance Drugs After 3 <sup>rd</sup> refill at Pharmacy	80%	70%	80%	70%	80%	70%
	65%	55%	65%	55%	65%	55%
Covered: Mail Order Maintenance Drugs only	<u>Generic Drugs</u> 80%	<u>Name Brand Drugs</u> 70%	<u>Generic Drugs</u> 80%	<u>Name Brand Drugs</u> 70%	<u>Generic Drugs</u> 80%	<u>Name Brand Drugs</u> 70%

\***Preventive medication:** Medicines taken to prevent or reduce more serious episodes/ illnesses such as migraines, asthma, high blood pressure and high cholesterol. IRS regulations allow this classification of medications for **High Deductible HSA Plans only** to be exempted from satisfying the deductible before paid by the plan.