



Employee Benefit Summary - 2010

	Premier		Base		Value	
	In PPO	Outside PPO	In PPO	Outside PPO	In PPO	Outside PPO
Deductibles						
Individual – Calendar Year	\$200	\$400	\$250	\$500	\$500	N/A
Family – Calendar Year (Aggregate)	\$400	\$900	\$500	\$1,200	\$1,000	N/A
Individual Out-of-Pocket Maximum	\$1,900	\$5,000	\$2,100	\$6,000	\$2,500	N/A
Family Out-of-Pocket Maximum (Aggregate)	\$3,800	\$10,000	\$4,200	\$12,000	\$5,000	N/A
Lifetime Maximum Benefit	\$2 million		\$2 million		\$2 million	

Service	Premier		Base		Value	
	In PPO	Outside PPO	In PPO	Outside PPO	In PPO	Outside PPO
Hospital Room and Board and Ancillary	90% 100% @ CGH	70%	80% 100% @ CGH	60%	70%	Not Covered
Hospital Outpatient Surgery Services	90% 100% @ CGH	70%	80% 100% @ CGH	60%	70%	Not Covered
Emergency Services (Including Ambulance) NO EMERGENCY = NO COVERAGE	\$100 Co-pay then 100%		\$125 Co-pay then 100%		70%	
Immediate/Urgent Care Facility	90%	70%	80%	60%	60%	Not Covered
Physician In-Hospital Visits	90%	70%	80%	60%	70%	Not Covered
Physician Inpatient Surgical Services	90%	70%	80%	60%	70%	Not Covered
Physician Outpatient Surgical Services	90%	70%	80%	60%	70%	Not Covered
Physician Office Visits and Consultation	\$15 co-pay then 100%	70%	\$25 co-pay then 100%	60%	\$35 co-pay then 100%	Not Covered
Annual Physical	100%	Not Covered	100%	Not Covered	100%	Not Covered
Immunizations, inoculations, mammograms, PAP smears, cholesterol screening, prostate cancer screening	100%	Not Covered	100%	Not Covered	100%	Not Covered
Well Child Care	\$15 co-pay then 100%	Not Covered	\$25 co-pay then 100%	Not Covered	\$35 co-pay then 100%	Not Covered
Eye Exams	\$15 co-pay then 100%	70%	\$25 co-pay then 100%	60%	\$35 co-pay then 100%	Not Covered
Routine Prenatal	90%	70%	80%	60%	70%	Not Covered
Pre-Admission Testing	90%	70%	80%	60%	70%	Not Covered
Diagnostic Testing	90%	70%	80%	60%	70%	Not Covered
Physical, Speech & Occupational Therapy – limited to 60 combined visits per Calendar Year	\$15 co-pay then 100%	70%	80%	50%	70%	Not Covered
Allergy Injection	90%	70%	80%	60%	70%	Not Covered
Home Health Care/Home Infusion	90%	70%	80%	50%	70%	Not Covered
Hospice	90%	70%	80%	50%	70%	Not Covered
Skilled Nursing Facility – Limited to 120 Days Per Calendar Year	90%	70%	80%	50%	70%	Not Covered



Employee Benefit Summary - 2010

Service	Premier		Base		Value	
	In PPO	Outside PPO	In PPO	Outside PPO	In PPO	Outside PPO
Recombinant Biological Pharmaceuticals	90% ded waived	Not Covered	80% ded waived	Not Covered	70% ded waived	Not Covered
Prosthetics	90%	Not Covered	80%	Not Covered	70%	Not Covered
Durable Medical Equipment	80%	Not Covered	70%	Not Covered	50%	Not Covered
Transplant Services	90%	Not Covered	80%	Not Covered	70%	Not Covered
Chiropractic Services – Limited to \$500 per Calendar Year	50%	50%	50%	50%	Not Covered	Not Covered
Podiatric Care	90%	Not Covered	80%	Not Covered	70%	Not Covered
TMJ – Limited to \$500 lifetime	90%	Not Covered	80%	Not Covered	70%	Not Covered
Infertility Services – Limited to \$12,500 lifetime	90%	Not Covered	80%	Not Covered	70%	Not Covered
Mental Health Services/Alcohol & Substance Abuse Inpatient (Limits Removed)	90%	70%	80%	60%	70%	Not Covered
Outpatient (Limits Removed)	\$15 co-pay then 100%	70%	\$25 co-pay then 100%	60%	\$35 co-pay then 100%	Not Covered
Outpatient Prescription Drugs – Mandatory Generic Substitution Tier 1 = Generic Tier 2 = Brand, Formulary Tier 3 = Brand, Non-Formulary	Retail (31 Days) \$5 Tier 1 \$20 Tier 2 50% Tier 3 Mail Order (90 Days) \$10 Tier 1 \$40 Tier 2 50% Tier 3	Not Covered	Retail (31 Days) \$8 Tier 1 \$30 Tier 2 50% Tier 3 Mail Order (90 Days) \$16 Tier 1 \$60 Tier 2 50% Tier 3	Not Covered	Retail (31 Days) \$15 Tier 1 \$40 Tier 2 50% Tier 3 Mail Order (90 Days) \$30 Tier 1 \$80 Tier 2 50% Tier 3	Not Covered

Dental Coverage

Coverage levels are as follows:

Services Provided/Billed	Coverage Level
\$1 to \$260	100%
\$261 to \$760	80%
Over \$760	50%

The maximum benefit per calendar year is \$1,200

Orthodontics is also covered under the plan at 50% of the billed cost and is subject to a \$1,250 lifetime maximum.