

# Open Enrollment for 2010 Plan Year

General Comparison of 2010 Medical Plan Options for In-Network Services		EPO	PPO Low Deductible	PPO Standard	PPO High Deductible
<b>Annual premium cost</b> — annual total payment to participate in medical plan.	Employee-Only Coverage	\$1,308	\$972	\$732	\$276
	Employee + Spouse Coverage	\$3,192	\$2,484	\$1,944	\$1,068
	Employee + Child(ren) Coverage	\$2,844	\$2,208	\$1,716	\$912
	Family Coverage	\$4,728	\$3,720	\$2,928	\$1,704
<b>Co-payment</b> <sup>1</sup> — Additional fee (or flat \$ amount) you pay the doctor or hospital at the time you receive in-network services.	\$20 PCP/\$30 specialists; \$300 per hospital stay; \$100 outpatient services. <sup>2</sup>	\$20 PCP/\$30 specialists	\$20 PCP/\$30 specialists	\$20 PCP/\$30 specialists	100% for well baby/child care; 100% for preventive office visits; other office visits covered under co-insurance after the deductible.
<b>Deductible</b> <sup>3,4</sup> — An amount you must pay for services before the plan begins to pay its co-insurance percentage of in-network services.	\$0	\$200 per person, but limited to \$400 for a family.	\$400 per person, but limited to \$800 for a family.	\$1,200 (EE-only coverage); \$2,400 (EE plus 1 or more).	
<b>Co-insurance</b> <sup>1</sup> — After deductible is met, percentage of allowable charge the plan pays and you pay for covered in-network services.	Plan pays 100%	Plan pays 90%; participant pays 10%.	Plan pays 80%; participant pays 20%.	Plan pays 80%; participant pays 20%.	
<b>Maximum out-of-pocket limit (OPL)</b> <sup>1,4</sup> — Limit on the dollar amount you are responsible for paying out of your pocket for covered medical services. Once you reach your out-of-pocket maximum, the plan pays 100% of the allowable amount for covered in-network services.	\$2,500 per person, but limited to \$5,000 for a family.	\$2,500 per person, but limited to \$5,000 for a family.	\$2,500 per person, but limited to \$5,000 for a family.	\$2,400 (EE-only coverage); \$4,800 (EE plus 1 or more).	
<b>Network restrictions</b>	Must use network providers; no coverage when services are received out-of-network.	Both in-network (90/10) and out-of-network (70/30) coverage.	Both in-network (80/20) and out-of-network (60/40) coverage.	Both in-network (80/20) and out-of-network (60/40) coverage.	
<b>Prescription drugs</b> — same for all plans	Generic formulary: \$7 retail co-pay Brand name formulary: \$25 retail co-pay Non-formulary: \$40 retail co-pay Mail-order required for maintenance medications after 3 fills at a retail pharmacy — NextRx mail order: 1-888-613-6091 PrecisionRx mail order for certain specialty medications (transplants, MS, growth hormone, etc.) — Precision Rx: 1-800-870-6419				

1) Co-payments, deductibles, co-insurance and out-of-pocket limits above assume in-network services. Actual plan document will control plan provisions.  
 2) Outpatient Surgery, MRA/MRI, PET Scans and CAT Scans.  
 3) Does **not** include annual premium cost or co-pays for prescription, vision, dental, physician office services and urgent care center.  
 4) Does **not** include annual premium cost or co-pays for prescription, vision and dental. Includes the deductible, office visit co-pays, urgent care co-pays and your co-insurance.

