Final Plan selected by Committee vote 5/11/2010

HMO 4G NOT Open Access, All Plans include smoking cessation drugs and Healthy Lifestyles Coaching; Bariatric Surgery covered under HSA OA MC 4B only

	Current Plans				Aetna Triple Option 7B			
	Current Basic HMO	Current Premium HMO	Current HDHP		HMO 4g	OA HMO 4c	HDHP /HSA OA MC 4b	
TYPE OF SERVICE	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK BASIC HMO	IN-NETWORK PREMIUM HMO	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE	$500/$1000	$0	$1,250/$2,500	$2,500/$5,000	$2,000 Individual $4,000 Family	$1,000 Individual $2,000 Family	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family
COINSURANCE	20%	0%	10%	30%	30%	20%	10%	30%
ANNUAL OUT OF POCKET MAXIMUM	$4,000/individual $8,000/family	$4,000/individual $8,000/family	$3,000/$6,000 (deductibles and Rx copays credit toward out-of-pocket limit)	$5,000/$10,000 (deductibles and Rx copays credit toward out-of-pocket limit)	$6,000 Individual $12,000 Family	$2,000 Individual $4,000 Family	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Is Deductible included in OOP MAX?	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Cross Accumulation in/out network?	Yes	Yes	Yes	Yes	N/A	N/A	Yes	Yes
Embedded Deductible/OOP**	Yes	NA	No	No	Yes	Yes	Yes	Yes
Primary Care office visit	$40 per visit	$35 per visit	10% after deductible	30% after deductible	$45 per visit, deductible waived	$35 per visit, deductible waived	10% after deductible	30% after deductible
Referral require to Specialist	Yes	No	No	No	Yes	No	No	No
Specialist office visit	$55 per visit	$50 per visit	10% after deductible	30% after deductible	$60 per visit, deductilble waived	$50 per visit, deductible waived	10% after deductible	30% after deductible
Allergy Testing	$0	$0	10% after deductible	30% after deductible	$0 copay, deductible waived	Included in office visit copay	10% after deductible	30% after deductible
Allergy Injections (not by physician)	$0	$0	10% after deductible	30% after deductible	$0 copay, deductible waived	Included in office visit copay	10% after deductible	30% after deductible
PREVENTIVE CARE								
Routine Physical Exams	$40 per visit	$35 per visit	0%, deductible waived	30% after deductible	$45 copay, deductible waived	$35 copay, deductible waived	Covered 100%, deductible waived	30% after deductible
Well-child checkups	$40 per visit	$35 per visit	0%, deductible waived	30% after deductible	$45 copay, deductible waived	$35 copay, deductible waived	Covered 100%, deductible waived	30% after deductible
Pediatric immunizations	$40 per visit	$35 per visit	0%, deductible waived	30% after deductible	$45 copay, deductible waived	$35 copay, deductible waived	Covered 100%, deductible waived	30% after deductible
Routine gynecological exams	$40 per visit	$35 per visit	0%, deductible waived	30% after deductible	$45 copay, deductible waived	$35 copay, deductible waived	Covered 100%, deductible waived	30% after deductible
Mammography screening	$0 per visit	$0 per visit	0%, deductible waived	30% after deductible	$0 copay, deductible waived	$0 copay, deductible waived	Covered 100%, deductible waived	30% after deductible
INPATIENT HOSPITAL								
Unlimited days	$200 copay, then 20% after deductible	$300 per day; up to 5 days per adminssion	10% after deductible	30% after deductible	30% after deductible	20% after deductible	10% after deductible	30% after deductible
OUTPATIENT HOSPITAL	$100 copay, then 20% after deductible	$300 per visit	10% after deductible	30% after deductible	30% after deductible	20% after deductible	10% after deductible	30% after deductible

Actual benefits will be based on carrier documentation.

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	Current Plans				Aetna Triple Option 7B			
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TYPE OF SERVICE	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK BASIC HMO	IN-NETWORK PREMIUM HMO	IN-NETWORK	OUT-OF-NETWORK
BARIATRIC SURGERY					Not Covered	Not Covered	**10% after deductible**	Not Covered
DIAGNOSTIC XRAY / LAB								
Physicians office	$0 with PCP referral	$0 with doctors orders	10% after deductible	30% after deductible	$0 with PCP referral	Included with office visit copay	10% after deductible	30% after deductible
Lab	$0	$0	10% after deductible	30% after deductible	Covered 100%, deductible waived	Covered 100%, deductible waived	10% after deductible	30% after deductible
X-Ray	$55 copay	$50 copay	10% after deductible	30% after deductible	$60 copay, deductible waived	$50 copay, deductible waived	10% after deductible	30% after deductible
Complex Imaging	$100 copay	$250 copay	10% after deductible	30% after deductible	$300 copay, deductible waived	$150 copay; deductible waived	10% after deductible	30% after deductible
URGENT CARE	$100 per visit	$100 per visit	10% after deductible	30% after deductible	$75 copay; deductible waived	$75 copay; deductible waived	10% after deductible	30% after deductible
EMERGENCY ROOM	$150 per visit	$175 per visit	10% after deductible	30% after deductible	$200 copay, deductible waived	$200 copay, deductible waived	10% after deductible	30% after deductible
COLONOSCOPY	Based on type & place of service; deductible waived. Outpatient $100 copay, then 20% after deductible	$300 per visit	10% after deductible	30% after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived for preventive only	Preventive covered 100% deductible waived; Diagnostic: 10% after deductible	30% after deductible
Ambulance	Covered 100% after deductible	Covered 100%	10% after deductible	30% after deductible	Covered 100% after deductible	20% after deductible	10% after deductible	30% after deductible
MATERNITY/GYN								
Prenatal and Postpartum office visits	$55 for initial visit	$50 for initial visit	10% after deductible	30% after deductible	$60 for initial visit	$50 for initial visit	10% after deductible	30% after deductible
Delivery	$200 copay, then 20% after deductible	$300 per day; up to 5 days per adminssion	10% after deductible	30% after deductible	30% after deductible	20% after deductible	10% after deductible	30% after deductible
Infertility treatment (for underlying medical reason only)	Based on Place of Service**	Based on Place of Service*	10% after deductible	30% after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	20% after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered	30% after deductible
Short Term Rehab (PT, ST, OT,etc)	$0 copay after deductible and initial $55 specialist copay; Limited to 60 visits combined per calendar year	$0 copay after deductible and initial $50 specialist copay; Limited to 60 visits combined per calendar year	10% after deductible; Limited to 60 visits combined per calendar year	30% after deductible; Limited to 60 visits combined per calendar year	$60 copay per visit after deductible, 60 visits per year	$60 copay per visit after deductible, 60 visits per year	10% after deductible, 60 visits per year	30% after deductible
PRESCRIPTION DRUG								
Prescription Drug Deductible					**$200 Sgl / $400 Fam**	**None**	**Calendar Year Deductible Applies**	
Generic	$20	$15	$15 after deductible	$15 after deductible	$20	$20	$20	$20 copay, then 30%

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TYPE OF SERVICE	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK BASIC HMO	IN-NETWORK PREMIUM HMO	IN-NETWORK	OUT-OF-NETWORK
Brand (Formulary)	$40	$35	$20 after deductible	$20 after deductible	$40	$40	$40	$40 copay, then 30%
Brand (Non-formulary	$70	$60	$40 after deductible	$40 after deductible	$70	$70	$70	$70 copay, then 30%
Mail Order Pharmacy	2x retail copay	2x retail copay	2x retail copay	No coverage	2x retail copay	2x retail copay	2x retail copay	Not applicable
MENTAL HEALTH								
Inpatient	$200 copay, then 20% after deductible	$300 per day; up to 5 days per adminssion	10% after deductible	30% after deductible	30% after deductible	20% after deductible	10% after deductible	30% after deductible
Outpatient	$55 per visit	$50 per visit	10% after deductible	30% after deductible	$60 per visit after deductible	$50 office visit copay	10% after deductible	30% after deductible
SUBSTANCE ABUSE								
Inpatient	$200 copay, then 20% after deductible	$300 per day; up to 5 days per adminssion	10% after deductible	30% after deductible	30% after deductible	20% after deductible	10% after deductible	30% after deductible
Outpatient	$55 per visit	$50 per visit	10% after deductible	30% after deductible	$60 per visit after deductible	$50 office visit copay	10% after deductible	30% after deductible
POLICY MAXIMUM	$2,000,000	Unlimited	Unlimited except where there are limits on specific benefits		Unlimited	Unlimited	Unlimited	Unlimited
DEPENDENT COVERAGE	To age 30	To age 30	To age 30	To age 30	To age 30	To age 30	To age 30	To age 30
Premiums/Enrollment	**Current Basic HMO**	**Current Premium HMO**	**Current HDHP**		**Aetna 4G**	**Aetna 4C**	**Aetna 4B**	
Employee only	$416.89	$489.51	$514.55		$426.98	$525.13	$504.69	
Employee + Spouse	$805.51	$945.71	$994.12		$825.01	$1,014.53	$975.02	
Employee + Child(ren)	$768.44	$902.13	$948.32		$787.04	$967.78	$930.09	
Family	$1,055.57	$1,239.41	$1,302.84		$1,081.12	$1,329.60	$1,277.78	
Total Enrolled/Total Monthly Cost	$1,025,239.46	$694,890.93	$147,686.46		**$1,050,054.37**	**$745,456.78**	**$144,853.28**	
Total Annual Plan Cost	**$22,413,802**				**$23,284,373**			
$ Difference from current					**$870,571**			
% Difference from current					**3.9%**			

* Immunizations are available through age 16

** Embedded deductible = Individual will not have to pay more than individual deductible. Deductible counts toward Family Deductible.