

Compare The Plans / July 1, 2009 - June 30, 2010

Plan Features	ENHANCED PLAN		VALUE PLAN	
	In-Network	Non-Network	In-Network	Non-Network
Annual Deductible <i>(Employee Only / EE+1 or Family)</i>	\$250 / \$500	\$500 / \$1,000	\$1,000 / \$2,000	\$2,000 / \$4,000
Annual Out-of-Pocket Maximum <i>(Employee Only / EE+1 or Family)</i>	\$1,000 / \$2,000	\$2,500 / \$5,000	\$3,000 / \$6,000	\$6,000 / \$12,000
Annual Maximum <i>(per person)</i>	\$1,000,000			
Lifetime Maximum <i>(per person)</i>	\$5,000,000			
Co-insurance <i>(after deductible) (Plan pays / You pay)</i>	90% / 10%	70% / 30%	70% / 30%	60% / 40%
Wellness <i>(Preventive Care in-network only) (annual physicals, routine eye exams, well-baby and well-child care, pap smears, mammograms, prostate exams, colonoscopies)</i>	100% No co-pay or deductible	N/A	100% No co-pay or deductible	N/A
Physicians Office Visit	\$10 co-pay	70% / 30%	70% / 30%	60% / 40%
Diagnostic X-ray and Lab (Outpatient)	90% / 10%	70% / 30%	70% / 30%	60% / 40%
Hospital** / Treatment Facility** <i>(both inpatient and outpatient)</i>	90% / 10%	70% / 30%	70% / 30%	60% / 40%
Surgery <i>(Physician's charges)</i>	90% / 10%	70% / 30%	70% / 30%	60% / 40%
Emergency Room <i>(treatment of a medical emergency; co-pay waived if admitted)</i>	\$150 co-pay***	\$150 co-pay***	70% / 30%	70% / 30%
Urgent Care	\$35 co-pay	\$35 co-pay	70% / 30%	70% / 30%
Ambulance <i>(emergency transportation only)</i>	90% / 10%	90% / 10%	70% / 30%	70% / 30%
Hospice Services	90% / 10%	90% / 10%	70% / 30%	70% / 30%
Skilled Nursing Facility** <i>(maximum 180 days)</i>	90% / 10%	70% / 30%	70% / 30%	60% / 40%
Home Health Visits** <i>(maximum 90 per year)</i> Outpatient Private Duty Nursing**	90% / 10%	70% / 30%	70% / 30%	60% / 40%
Physical Therapy <i>(short term rehab including speech therapy, physical therapy & occupational therapy – maximum 60 visits combined)</i>	\$10 co-pay	70% / 30%	70% / 30%	60% / 40%
Chiropractor <i>(no limit; medical review after 25 visits)</i>	\$10 co-pay	70% / 30%	70% / 30%	60% / 40%
Prescription Drugs:				
Retail-up to a 30 day supply:				
Generic		\$7.50 co-pay		70% / 30%; min. \$15, max. \$100
Brand Formulary		\$30.00 co-pay		70% / 30%; min. \$15, max. \$100
Non-formulary		\$50.00 co-pay		70% / 30%; min. \$15, max. \$100
Mail Order-up to a 90 day supply:				
Generic		\$15.00 co-pay		70% / 30%; min. \$30, max. \$200
Brand Formulary		\$75.00 co-pay		70% / 30%; min. \$30, max. \$200
Non-formulary		\$125.00 co-pay		70% / 30%; min. \$30, max. \$200
Monthly Employee Contributions				
Employee Only		\$49.00*		\$13.00
Employee + One Family		\$97.00* \$159.00*		\$25.00 \$40.00

*May vary based on County Agency and/or union affiliation

**Precertification required

***If you go to Urgent Care first and then to the ER within 48 hours for the same issue, simply send your Explanation of Benefits (EOB) for both services (Urgent Care and Emergency Room) to the Benefits Department. The Benefits Department will then review the EOBs and forward them to Aetna for reprocessing. Upon reprocessing, the new EOB will be sent to reflect the \$75 Emergency Room co-pay.