

## SUMMARY OF MEDICAL AND PHARMACY BENEFITS 2010-11 PLAN YEAR

	Med Plan 1	Med Plan 1A	Med Plan 2	Med Plan 2A
<b>Carrier (Plan Type)</b>	<b>Kaiser (HMO)</b>	<b>Kaiser (HMO)</b>	<b>Providence (POS)</b>	<b>Providence (POS)</b>
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Deductible				
In Network (Individual / Family)	None / None	None / None	None / None	None / None
Out of Network (Individual / Family)	NA	NA	\$400 / \$1,200	\$600 / \$1,800
<b>Maximum out-of-pocket costs per plan year</b>				
In Network	\$1,200 individual \$2,400 family	\$1,500 individual \$3,000 family	\$1,200 per person	\$1,800 per person
Out of Network	See EOC for detail	See EOC for detail	\$2,400 per person	\$3,600 per person
After the maximum out-of-pocket costs have been paid, the plan will pay except for Shared / Specialty Cost tier	100%	100%	100%	100%
<b>Preventive Care Services (In Network / Out of Network)</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>			
Adult, Well-child & Well-baby exams	\$0	\$0	\$0 / 50%	\$0 / 50%
Immunizations (In Network / Out of Network)	\$0 / NA	\$0 / NA	\$0 / 50%	\$0 / 50%
Preventive Care Services as described in Plan Handbooks	\$0 / NA	\$0 / NA	\$0 / 50%	\$0 / 50%
<b>Provider Services (In Network / Out of Network)</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>			
Incentive Office Visits for asthma, heart conditions (CHF, Cholesterol & High BP) & Diabetes Management	NA	NA	\$10 / 50%	\$10 / 50%
Primary Care Services as described in Plan's Handbook	\$10 / NA	\$20 / NA	\$15 / 50%	\$25 / 50%
Specialist Office Visits	\$15 / NA	\$30 / NA	\$15 / 50%	\$25 / 50%
<b>Other Services (In Network / Out of Network)</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>			
Imaging Services (CT, PET & MRI) & Sleep Studies	\$0 / NA	\$0 / NA	\$100 / 50%	\$100 / 50%
Lab / X-Ray	\$0 / NA	\$0 / NA	\$15 / 50%	\$25 / 50%
Durable Medical Equipment	20% / NA	20% / NA	\$15 / 50%	\$25 / 50%
<b>Maternity (In Network / Out of Network)</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>			
Outpatient maternity care	\$0 / NA <sup>1</sup>	\$0 / NA <sup>1</sup>	\$100 / 50%	\$100 / 50%
Delivery & Routine newborn nursery care	\$100 per day, up to \$500 per admission maximum See EOC for detail	\$200 per day, up to \$1,000 admission maximum See EOC for detail	\$100 per day / 50%	\$200 per day / 50%
<b>Mental Health &amp; Chemical Dependency Services</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>			
Outpatient Services	\$10	\$20	\$15/50%	\$25/50%
Inpatient Services	\$100 per day, up to \$500 per admission / See EOC for detail	\$200 per day, up to \$1,000 per admission / See EOC for detail	\$100 per day / 50%	\$200 per day / 50%
Residential Services	\$100 per day, up to \$500 per admission / See EOC for detail	\$200 per day, up to \$1,000 per admission / See EOC for detail	\$100 per day / 50%	\$200 per day / 50%

\* Deductible waived

\*\* ODS Med Plan 9 individual deductible applies to subscriber only. Family deductible applies to plans with two or more members. This deductible must be met before benefits will be paid and applies toward the maximum out-of-pocket.

\*\*\* ODS Med Plan 9 includes a pharmacy benefit to which the deductible and maximum out-of-pocket also apply.

<sup>1</sup> Corrected in 6/7/2010 revision.

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# SUMMARY OF MEDICAL AND PHARMACY BENEFITS 2010-11 PLAN YEAR

	Med Plan 3	Med Plan 4	Med Plan 5	Med Plan 6	Med Plan 7	Med Plan 8	Med Plan 9
<b>Carrier (Plan Type)</b>	<b>ODS (PPO)</b>	<b>ODS (PPO)</b>	<b>ODS (PPO)</b>	<b>ODS (PPO)</b>	<b>ODS (PPO)</b>	<b>ODS (PPO)</b>	<b>ODS MAJOR MED</b>
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Deductible							
In Network (Individual / Family)	\$200 / \$600	\$200 / \$600	\$200 / \$600	\$300 / \$900	\$500 / \$1,500	\$1,000 / \$3,000	\$1,500 / \$3,000**
Out of Network (Individual / Family)	Combined in / out network	Combined in / out network	Combined in / out network	Combined in / out network	Combined in / out network	Combined in / out network	Combined in / out network
<b>Maximum out-of-pocket costs per plan year</b>	<b>ODS Non-Pharmacy Copayments and Plans 3-8 Deductibles do not apply to Out-of-Pocket Maximums</b>						
In Network	\$1,200 per person	\$1,500 per person	\$1,800 per person	\$2,000 per person	\$2,000 per person	\$2,000 per person	\$5,000 individual \$10,000 family
Out of Network	\$2,400 per person	\$3,000 per person	\$3,600 per person	\$4,000 per person	\$4,000 per person	\$4,000 per person	\$5,000 individual \$10,000 family
After the maximum out-of-pocket costs have been paid, the plan will pay except for Shared / Specialty Cost tier	100%	100%	100%	100%	100%	100%	100%
<b>Preventive Care Services (In Network / Out of Network)</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>						
Adult, Well-child & Well-baby exams	0%* / 30%	0%* / 40%	0%* / 40%	0%* / 40%	0%* / 40%	0%* / 40%	0%* / 40%
Immunizations (In Network / Out of Network)	0%* / 30%	0%* / 40%	0%* / 40%	0%* / 40%	0%* / 40%	0%* / 40%	0%* / 40%
Preventive Care Services as described in Plan Handbooks	0%* / 30%	0%* / 40%	0%* / 40%	0%* / 40%	0%* / 40%	0%* / 40%	0%* / 40%
<b>Provider Services (In Network / Out of Network)</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>						
Incentive Office Visits for asthma, heart conditions (CHF, Cholesterol & High BP) & Diabetes Management	\$10* / 30%	\$10* / 40%	\$10* / 40%	20%* / 40%	20% / 40%	20% / 40%	20% / 40%
Primary Care Services as described in Plan's Handbook	\$15* / 30%	\$25* / 40%	\$25* / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
Specialist Office Visits	\$15* / 30%	\$25* / 40%	\$25* / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
<b>Other Services (In Network / Out of Network)</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>						
Imaging Services (CT, PET & MRI) & Sleep Studies	\$100 + 10% / \$100 + 30%	\$100 + 20% / \$100 + 40%	\$100 + 20% / \$100 + 40%	\$100 + 20% / \$100 + 40%	\$100 + 20% / \$100 + 40%	\$100 + 20% / \$100 + 40%	20% / 40%
Lab / X-Ray	10% / 30%	20% / 40%	20% / 40%	20% / 40%	20%/40%	20%/40%	20% / 40%
Durable Medical Equipment	10%/30%	20% / 40%	20% / 40%	20% / 40%	20%/40%	20%/40%	20% / 40%
<b>Maternity (In Network / Out of Network)</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>						
Outpatient maternity care	10% / 30%	20% / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
Delivery & Routine newborn nursery care	10% / 30%	20% / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
<b>Mental Health &amp; Chemical Dependency Services</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>						
Outpatient Services	\$15* / 30%	\$25* / 40%	\$25* / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
Inpatient Services	10% / 30%	20% / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
Residential Services	10% / 30%	20% / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%

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	Med Plan 1	Med Plan 1A	Med Plan 2	Med Plan 2A
<b>Carrier (Plan Type)</b>	<b>Kaiser (HMO)</b>	<b>Kaiser (HMO)</b>	<b>Providence (POS)</b>	<b>Providence (POS)</b>
<b>Weight Management</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>			
Up to four 13-week Weight Watchers Sessions per Plan Year (subscriber only)	No Charge	No Charge	No Charge	No Charge
12 Health Coaching Sessions per Plan Year & Online Educational Resources	No Charge	No Charge	No Charge	No Charge
<b>Hospital &amp; Outpatient Services</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>			
Inpatient Care (In Network / Out of Network)	\$100 per day, up to \$500 admission / NA	\$200 per day, up to \$1,000 admission / NA	\$100 per day / 50%	\$200 per day / 50%
Outpatient Surgery (In Network / Out of Network)	\$50 / NA	\$75 / NA	\$100 / 50%	\$100 / 50%
Outpatient Rehabilitation - Physical, Occupational & Speech Therapy (In Network / Out of Network)	\$15 / NA (20 visits per therapy per plan year)	\$30 / NA (20 visits per therapy per plan year)	\$15 / 50% (30 visits per plan year)	\$25 / 50% (30 visits per plan year)
Shared / Specialty Cost Tier	NA	NA	\$500 + Inpatient Copay / 50%	\$500 + Inpatient Copay / 50%
Ambulance	\$75	\$100	\$100	\$100
Emergency Room Copay (waived if admitted)	\$100 per visit	\$100 per visit	\$100 per visit	\$100 per visit
<b>Urgent Care (In Network / Out of Network)</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>			
Urgent Care Visit	\$10	\$20	\$25	\$25
<b>Tobacco Cessation Program</b>	<b>Available to age 18 and over</b>			
Telephone Consults, Web-Coaching, Patches or Gum & Prescribed Medications	Unlimited calls to Free & Clear, Patches, Gum & Prescribed Medications are subject to Rx Copays. Limited to 5 calls from Free and Clear. See Plan Specific summary for details.			
<b>Alternative Care Services (In Network / Out of Network)</b>	<b>\$2,000 Maximum Combined Benefit* \$ and % shown is the Member Cost; \$ Amounts = Copayment</b>			
Acupuncture, Chiropractic & Naturopathic Services	\$10 / NA	\$20 / NA	\$15 / NA	\$25 / NA
	* Cost of lab, x-rays, supplies & procedures performed in Alternative Care Provider's office applies to Benefit Maximum			
<b>Pharmacy (Rx) Services</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayment</b>			
<b>Carrier and Plan Option</b>	<b>Kaiser Rx Plan</b>		<b>Providence Rx Plan</b>	
Out of Pocket Maximum	\$1,000		\$1,000	
<b>Retail</b>	(up to a 30-day supply)		(up to a 31-day supply)	
Value	NA		\$4	
Generic	\$5		\$8	
Preferred	\$25		\$25	
Non-preferred	\$25 if criteria met		50%	
<b>Mail</b>	(up to a 90-day supply)		(up to a 90-day supply)	
Value	NA		\$8	
Generic	\$10		\$16	
Preferred	\$50		\$50	
Non-preferred	\$50 if criteria met		50%	
<b>Specialty</b>	NA		(a 30-day supply)	
Generic	NA		\$8	
Preferred	NA		\$25	
Non-preferred	NA		50%	

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<b>Carrier (Plan Type)</b>	ODS (PPO)	ODS (PPO)	ODS (PPO)	ODS (PPO)	ODS (PPO)	ODS (PPO)	ODS MAJOR MED
<b>Weight Management</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>						
Up to four 13-week Weight Watchers Sessions per Plan Year (subscriber only)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
12 Health Coaching Sessions per Plan Year & Online Educational Resources	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
<b>Hospital &amp; Outpatient Services</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>						
Inpatient Care (In Network / Out of Network)	10% / 30%	20% / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
Outpatient Surgery (In Network / Out of Network)	10% / 30%	20% / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
Outpatient Rehabilitation - Physical, Occupational & Speech Therapy (In Network / Out of Network)	\$15* / 30% (30 visits per plan year)	\$25* / 40% (30 visits per plan year)	\$25* / 40% (30 visits per plan year)	20% / 40% (30 visits per plan year)			
Shared / Specialty Cost Tier	\$500 + 10% / \$500 + 30%	\$500 + 20% / \$500 + 40%	\$500 + 20% / \$500 + 40%	\$500 + 20% / \$500 + 40%	\$500 + 20% / \$500 + 40%	\$500 + 20% / \$500 + 40%	20% / 40%
Ambulance	10%	20%	20%	20%	20%	20%	20%
Emergency Room Copay (waived if admitted)	\$100 per visit then 10%	\$100 per visit then 20%	\$100 per visit then 20%	\$100 per visit then 20%	\$100 per visit then 20%	\$100 per visit then 20%	20%
<b>Urgent Care (In Network / Out of Network)</b>	<b>\$ and % shown is the Member Cost; \$ Amounts = Copayments</b>						
Urgent Care Visit	\$15*	\$25*	\$25*	20%	20%	20%	20%
<b>Tobacco Cessation Program</b>	<b>Available to age 18 and over</b>						
Telephone Consults, Web-Coaching, Patches or Gum & Prescribed Medications	Unlimited calls to Free & Clear, Patches, Gum & Prescribed Medications are subject to Rx Copays. Limited to 5 calls from Free and Clear. See Plan Specific summary for details.						
<b>Alternative Care Services (In Network / Out of Network)</b>	<b>\$2,000 Maximum Combined Benefit* \$ and % shown is the Member Cost; \$ Amounts = Copayment</b>						
Acupuncture, Chiropractic & Naturopathic Services	\$15* / 30%	\$25* / 40%	\$25* / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
	* Cost of lab, x-rays, supplies & procedures performed in Alternative Care Provider's office applies to Benefit Maximum						
<b>Pharmacy (Rx) Services</b>	<b>ODS Rx Plans A-C may only be combined with ODS Med Plans 3-8***</b>						
<b>Carrier and Plan Option</b>	<b>ODS Rx Option A</b>	<b>ODS Rx Option B</b>	<b>ODS Rx Option C</b>				
Out of Pocket Maximum	\$1,000	\$1,000	\$1,000				
<b>Retail</b>	(up to a 31-day supply)	(up to a 31-day supply)	(up to a 31-day supply)				
Value	\$4	\$4	50%				
Generic	\$8	\$8	50%				
Preferred	20%	\$25	50%				
Non-preferred	50%	50%	50%				
<b>Mail</b>	(up to a 90-day supply)	(up to a 90-day supply)	(up to a 90-day supply)				
Value	\$8	\$8	50%				
Generic	\$16	\$16	50%				
Preferred	20%	\$50	50%				
Non-preferred	50%	50% (\$100 max copay)	50%				
<b>Specialty</b>	(up to a 31-day supply)	(up to a 31-day supply)	(up to a 31-day supply)				
Generic	\$16	\$16	50%				
Preferred	20%	\$50	50%				
Non-preferred	50%	50% (\$100 max copay)	50%				



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