

## Your MCSIG Medical Plan(s) At a Glance 2010-2011

Employee only – Monthly rate	789.48		738.34		503.78		440.29	
Employee + 1 – Monthly rate	1,578.97		1,476.67		1,007.56		880.58	
Family – Monthly rate	2,052.66		1,919.67		1,309.83		1,144.75	
	Option I PPO		Option II PPO		Option III PPO		EPO	
	Network		Non-Network		Network		Non-Network	
Annual Deductible <i>Excludes copays</i>	\$300 per person \$600 family deductible (2 full \$300 deductibles)	Effective Jan 1, 2011 \$ 400 / person \$ 800 family deductible (2 full \$ 400 deductibles)	\$400 per person \$800 family deductible (2 full \$400 deductibles)	Effective Jan 1, 2011 \$ 500 / person \$ 1000 family deductible (2 full \$ 500 deductibles)	\$650 per person \$1,300 family deductible (2 full \$650 deductibles)	No Change	\$650 per person \$1,300 family deductible (2 full \$650 deductibles)	\$650 per person \$1,300 family deductible (2 full \$650 deductibles)
Coinsurance <i>Percentage plan pays for most expense</i>	100% or 90% of most expenses, see below	60% of most expenses	80% of most expenses	60% of most expenses	80% of most expenses	60% of most expenses	80% of most expenses	No coverage
Out-of-Pocket Maximum (OOPM)- Calendar Yr <i>Includes deductible Excludes office/Rx copays</i>	\$1,250 per person \$2,500 per family (2 full \$1,250 OOPM)	Effective Jan 1, 2011 \$2000 / \$4000 in-network \$4000 / \$8000 out-of-network \$4,000 per family ; 2 full OOPM	\$2,000 per person \$4,000 per family (2 full \$2,000 OOPM)	Effective Jan 1, 2011 \$3000 / \$ 6000 in-network \$6000 / \$12000 out-of-network \$6000 per family ; 2 full OOPM	\$4,000 per person \$8,000 per family (2 full \$4,000 OOPM)	No Change	\$4,000 per person \$8,000 per family (2 full \$7,000 OOPM)	\$4,000 per person \$8,000 per family (2 full \$4,000 OOPM)
ER Co-pay**	\$250 per visit	\$250 per visit	\$250 per visit	\$250 per visit	\$250 per visit	\$250 per visit	\$250 per visit	\$250 per visit
Lifetime Maximum	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
Hospital Benefits	Hospital co-pays may apply see note (1) below	Hospital co-pays may apply see note (1) below	Hospital co-pays may apply see note (1) below	Hospital co-pays may apply see note (1) below	No Change	No Change	No Change	No Change
Inpatient - (1)	90% at 2-bed rate*, after deductible	60% at 2-bed rate*, after deductible	80% at 2-bed rate*, after deductible	60% at 2-bed rate*, after deductible	80% at 2-bed rate*, after deductible	60% at 2-bed rate*, after deductible	80% at 2-bed rate*, after deductible	80% at 2-bed rate*, after deductible
Outpatient Surgery	90%**, after deductible	60%**, after deductible	80%**, after deductible	60%**, after deductible	80%**, after deductible	60%**, after deductible	80%, after deductible	80%, after deductible
Physician Services								
Surgery/Anesthesia	90%, after deductible	60%, after deductible	80%, after deductible	60%, after deductible	80%, after deductible	60%, after deductible	80%, after deductible	80%, after deductible
Hospital Visits: • Inpatient • Outpatient	90%, after deductible 90%, after deductible	60%, after deductible 60%, after deductible	80%, after deductible 80%, after deductible	60%, after deductible 60%, after deductible	80%, after deductible 80%, after deductible	60%, after deductible 60%, after deductible	80%, after deductible	80%, after deductible
Office Visits	Primary Care: 100% after \$20 copay, no deductible; <u>Specialist:</u> 100% after \$30 copay, no deductible	60%, after you meet deductible	Primary Care: 100% after \$25 copay, no deductible; <u>Specialist:</u> 100% after \$35 copay, no deductible	60%, after you meet deductible	Primary Care: 100% after \$25 copay, no deductible; <u>Specialist:</u> 100% after \$35 copay, no deductible	60%, after you meet deductible	Primary Care: 100% after \$25 copay, no deductible; <u>Specialist:</u> 100% after \$35 copay, no deductible	Not covered
Physical Exam <i>per age schedule</i>	100%, up to \$250 per calendar year, no deductible (employee & spouse only)	100% of UCR, up to \$250 per calendar year, no deductible	100%, up to \$250 per calendar year, no deductible (employee & spouse only)	100% of UCR, up to \$250 per calendar year, no deductible	100%, up to \$250 per calendar year, no deductible (employee & spouse only)	100% of UCR, up to \$250 per calendar year, no deductible	100%, up to \$250 per calendar year, no deductible (employee & spouse only)	Not covered
Other Benefits								
Home Visits – no deductible	90%	60%	80%	60%	80%	60%	80%	80%
Chiropractic Care – <i>Provided through Chiropractic Health Plan of California - CHPC</i>	100% after \$10 copay, no deductible Must use CHPC provider	Not covered	100% after \$10 copay, no deductible Must use CHPC provider	Not covered	100% after \$10 copay, no deductible Must use CHPC provider	Not covered	100% after \$10 copay, no deductible Must use CHPC provider	Not covered
Well Child Care – includes immunizations	100%, for children to age 16, no deductible	60%, for children to age 16, after deductible	100%, for children to age 16, no deductible	60%, for children to age 16, after deductible	100%, for children to age 16, no deductible	60%, for children to age 16, after deductible	100%, for children to age 16, no deductible	Not covered
Maternity Care	Normal hospital and physician benefits apply	60%	Normal hospital and physician benefits apply	60%	Normal hospital and physician benefits apply	60%	Normal hospital/physician benefits apply	Not covered
Skilled Nursing Facility - Deductible applies	100%, up to 365 days per lifetime	100%, up to 365 days per lifetime	80% up to 365 days per lifetime	80% up to 365 days per lifetime	80%, up to 365 days per lifetime	80%, up to 365 days per lifetime	80%, up to 365 days per lifetime	Not covered
Home Health Care - Deductible applies	100%, up to 120 days per disability	100%, up to 120 days per disability	80%, up to 120 days per disability	80%, up to 120 days per disability	80%, up to 120 days per disability	80%, up to 120 days per disability	80%, up to 120 days per disability	Not covered
Hospice Care	100%, up to \$15,000 / lifetime	100%, up to \$15,000 / lifetime	100%, up to \$15,000 / lifetime	100%, up to \$15,000 / lifetime	100%, up to \$15,000 / lifetime	100%, up to \$15,000 / lifetime	100% to \$15,000 lifetime	100% to \$15,000 lifetime
Physical Therapy – Deductible applies	90%, after deductible	60%, after deductible	80%, after deductible	60%, after deductible	80%, after deductible	60%, after deductible	80%, after deductible	Not covered
Outpatient Diagnostic X-rays and Lab Work	90%, no deductible	60%, after deductible	80%, no deductible	60%, after deductible	80%, no deductible	60%, after deductible	80%, no deductible	Not covered
Mammography <i>per age schedule</i>	100%, no deductible	60%, after deductible	100%, no deductible	60%, after deductible	100%, no deductible	60%, after deductible	100%, no deductible	Not covered
Radiation, Chemo & Hemodialysis Therapy	100%, after deductible	60%, after deductible	80%, after deductible	60%, after deductible	80%, after deductible	60%, after deductible	80%, after deductible	Not covered
Acupuncture – <i>Provided by any licensed acupuncturist</i>	100% up to \$65, up to 30 visits per year, no deductible	100% up to \$65, up to 30 visits per year, no deductible	100% up to \$65, up to 30 visits per year, no deductible	100% up to \$65, up to 30 visits per year, no deductible	100% up to \$65, up to 30 visits per year, no deductible	100% up to \$65, up to 30 visits per year, no deductible	100% up to \$65, up to 30 visits per year, no deductible	Not covered
Ambulance: Ground/Air – Deductible applies	80%	80%	80%	80%	80%	80%	80%	80%
Prescription Drugs: Options I, II & III • At participating network pharmacy	RETAIL – up to 30 day supply \$7 generic / \$20 ESI formulary brand / \$35 ESI non formulary brand		RETAIL MAINTENANCE DRUG – up to 30 day supply \$9.50 generic / \$29.00 formulary brand / \$44.00 non formulary brand		MAIL SERVICE – up to 90 day supply \$0 generic / \$40 ESI formulary brand / \$70 ESI non formulary brand			
◇ Specialty Drugs-(2)	\$21 generic / \$60 ESI formulary brand / \$100 ESI non formulary brand							
Durable Medical Equipment: PPO Options I, II, III & EPO	In-network – 80% after deductible. PPO out-of-network – 80% of UCR plus charges in excess of covered expense. In and out-of-network – pre-auth required any single item \$2,000 or more; \$5,000 per member per year plan limit.						Same as PPO	
ALL Non-Network coverage is paid at the Usual Customary and Reasonable (UCR) rates. All amounts above UCR are the responsibility of the participant.							EPO Plan does not coordinate benefits v with any PPO plan	

Mental and Nervous Disorders are covered separately - refer to the PacificCare Behavioral Health Brochure.

• ALL MEDICAL PLANS INCLUDE \$25000 TERM LIFE INSURANCE FOR ACTIVE EMPLOYEES

\* Private room if medically necessary.

\*\* Each visit to hospital emergency room for non-emergency reasons requires \$250 co-pay (does not apply to deductible or out-of-pocket maximum).

• This chart is for comparative purposes only. Plan document/handbook prevails

\*\*\* Emergency services rendered by non-participating hospital facilities and physicians who are hospital-based or on-call - you will receive regular Prudent Buyer EPO Option benefits for the initial treatment of the Emergency condition.

(1) Option I and II Hospital co-pay – **In-patient:** Tier 1 hospital: no co-pay, Tier II \$500 co-pay, Tier III \$1,000 co-pay. **Outpatient:** Hospital based Outpatient facilities are Tiered; Tier II \$250 co-pay Tier III \$500 co-pay

(2) Only specified specialty drugs will be available at retail – limited to 3 fills – before requiring fills through CuraScript, our current specialty drug mail-order pharmacy.