

2010 Benefits Retirees- South California under 65	UNITED HEALTHCARE PPO Group # 195643	AETNA HMO Open Access Group # 813972	BLUE CROSS/BLUE SHIELD PPO Group #13570-00	KAISER PERMANENTE So. California Group # 225177
BENEFITS				
Monthly Retiree under 65 rates	Single: \$ 417.43	Single: \$ 417.43	Single: \$ 421.91	Single: \$328.44
	Two: \$ 834.86	Two: \$ 834.86	Two: \$ 843.82	Two: \$656.88
	Family: \$1,252.29	Family: \$1,252.29	Family: \$1,265.73	Family: \$929.49
In-network annual deductible	None	None	None	None
Annual out-of-pocket limit	Single, \$1,500; family \$3,000; prescription copayments per person, \$1,500	Single, \$1,500; family \$3,000; prescription copayments per person, \$1,500	Single, \$750; family \$1,500; prescription copayments per person, \$1,500	Single, \$1,500; Family, \$3,000
Lifetime maximum	\$2 million	\$2 million	\$2 million	None
Out of network option	Annual deductible: single, \$500; family \$1,500; Then 70% to Out of pocket limit (\$3,000/\$6,000) Separate/equal mental health/substance abuse deductible and limit	None	Annual deductible: single, \$500; family \$1,500; Then 70% to Out of Pocket limit (\$2,000/\$4,000)	None
HOSPITAL / Inpatient Care				
Hospital care (semi-private room), surgery, x-rays and lab	\$250 copay per admission, then 85% coverage	\$150 copay, then 100% coverage	90% coverage	100% coverage
Skilled Nursing Facility	85% coverage, up to 120 days per	\$150 copay, then 100% coverage	90% coverage	100% coverage up to 100 days per
EMERGENCY CARE				
Emergency Room	\$65 copay, then 85% coverage; copay waived if admitted	\$100 copay, then 100% coverage; copay waived if admitted	\$50 copay, then 100%	\$50 copay; copay waived if admitted
Emergency transportation	85% coverage	100% coverage	90% coverage	\$50 copay
OUTPATIENT CARE				
Office visit	\$20 copay, PCP; \$30 copay, specialist	\$20 copay, PCP; \$30 copay, specialist	\$15 copay, PCP; \$25 copay, specialist	\$15 copay
Immunizations and injections	\$7 copay	\$20 copay, PCP; \$30 copay,	90% coverage ; Adult and pediatric	100% coverage; \$15 copay, allergy
Maternity care	\$20 copay for first visit, then 15% coverage of global obstetrician's fee	Inpatient maternity care 100% after \$150 copayment.	90% coverage	100% coverage
Pediatric care	\$20 copay, includes well baby and child care	\$20 copay	\$15 copay, includes well baby and child care, 100% immunizations	100% well baby to age 23 months
X-ray, lab and diagnostic testing	Included in copay if performed in a physician's office, otherwise 85% coverage	\$30 copay	90% coverage	100% coverage when prescribed by a plan physician

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OTHER BENEFITS				
Mental health				
Outpatient	\$30 copay, visit	\$30 copay, visit	\$25 copay, then 90% coverage	\$15 copay, individual visit; \$7 copay, group therapy visit.
Inpatient	\$250 copay per admission, then 85% coverage	\$150 copay per admission, then 100% coverage	90% coverage	100% coverage
Substance abuse				
Outpatient	\$30 copay, visit	\$30 copay, visit	\$25 copay, then 90% coverage	\$15 copay, individual visit; \$5 copay, group therapy visit.
Inpatient	\$250 copay per admission, then 85% coverage	\$150 copay per admission, then 100% coverage	90% coverage	100%, detoxification
Cancer care (radiation therapy and chemotherapy)	\$30 copay, visit	\$30 copay, visit	90% coverage	100% coverage
Outpatient Short-term speech, physical, occupational and respiratory therapy	\$30 copay, visit; limited to 20 visits per calendar year	\$30 copay, 60 visits per calendar year	\$25 copay, visit; limited to 30 visits per calendar year	\$15 copay
Medical Supplies				
Prosthetics	85% coverage	100% coverage	90% coverage	100% coverage, Basic Coverage
Durable Medical	85% coverage	100% coverage	90% coverage	20% copay per covered item, Basic
Prescriptions	30-day Supply: \$10 copay, generic; \$35 copay, brand (formulary); \$55 copay, brand (non-formulary); Mail Order 90-day Supply: \$25, \$87.50 and \$137.50 copays, Oral contraceptives covered. Administered through Caremark.			30-day Supply: \$10 copay, generic; \$20 copay brand name, as directed by physician); Mandatory generic substitution; Covers oral contraceptives; Mail order, 100-day supply: \$20/\$40
Materials	None	None	None	
Chiropractic	\$30 copay, visit; \$1,500 limit	\$30 copay, limited to 20 visits per	\$25 copay, visit; limited to 20 visits	None
Website/Provider Directory	https://www.myuhc.com	http://www.aetna.com/docfind/	www.mybenefitshome.com	https://www.kaiserpermanente.org/
Product Name	Choice Plus PPO	Aetna Select (SM) Open Access		

The above contains a brief overview of the various benefit programs and does not describe any plan, its provisions or limitations in any detail. Please refer to the benefit plan booklet for more information.