Health plans at a glance

2014

The following charts contain detailed information about the benefits of your health plan options. Please review these charts carefully to make the best coverage choices for you and your family.

Your options if you ARE NOT eligible for Medicare:

PPO PLANS

	PPO PLANS – Retiree Not Enrolled in Medicare			
	Wellwise Retiree		Sharewell Retiree	
	Network Provider	Non-Network Provider	Network Provider	Non-Network Provider
Maximum Lifetime Benefit	Unlimited		Unlimited	
Calendar Year Deductible	$500/individual; $1,000/family	$750/individual; $1,500/family	$5,000/family (combined network and non-network)	
Member Co-insurance (What You Pay)	10%	30%	10%	30%
Out-of-Pocket Maximum	Plan pays 100% after $2,500 per individual or $5,000 per family in-network out of pocket expenses have been incurred	Plan pays 100% after $5,000 per individual or $10,000 per family out-of-network out of pocket expenses have been incurred	Plan pays 100% after $6,000 in out of pocket expenses per covered person has been incurred	Plan pays 100% after $12,000 in out of pocket expenses per covered person has been incurred
Prescription Drug Benefits				
Retail Pharmacy	20%/25%/30%; Drug Card Program		You pay 20%; Discounts available through Blue Shield contracted pharmacies Covered drugs subject to plan deductible	
Mail Order	20%/25%/30%; Drug Card Program		You pay 20%	
Hospital/Facility Benefits				
Inpatient	10%	30%	10%	30%
Outpatient	10%	30%; Note: plan pays up to maximum allowable amount for ambulatory surgery center and dialysis	10%	30%; Note: plan pays up to maximum allowable amount for ambulatory surgery center and dialysis
Pre-certification Review	Pre-admission review required for inpatient stays	Pre-admission review required for inpatient stays; Without pre-admission review, inpatient co-insurance 50%	Pre-admission review required for inpatient stays	Pre-admission review required for inpatient stays; Without pre-admission review, inpatient co-insurance 50%
Emergency Services	10%	10% if services meet “Emergency” definition; 30% if services do not meet “Emergency” definition	10%	10% if services meet “Emergency” definition; 30% if services do not meet “Emergency” definition
Ambulance	10%	30%	10%	30%
Physician & Professional Services				
Physician Office Visits (Primary Care)	10%	30%	10%	30%
Physician Second Opinion	10%	30%	10%	30%
Physician Office Visits (Specialty Care)	10%	30%	10%	30%
Diagnostic X-ray/Lab	10%	30%	10%	30%

2014

	PPO PLANS – Retiree Not Enrolled in Medicare			
	Wellwise Retiree		Sharewell Retiree	
	Network Provider	Non-Network Provider	Network Provider	Non-Network Provider
Immunizations (Specific)	No charge; limited coverages		No charge; limited coverages	Not covered
Home Health Care	10%; Requires prior authorization	30%; Requires prior authorization	10%; Requires prior authorization	30%; Requires prior authorization
Skilled Nursing Facility	10%; Limited 60 days; combined network and non-network	30%; Limited 60 days; combined network and non-network	10%; Limited 60 days; combined network and non-network	30%; Limited 60 days; combined network and non-network
Chiropractic Therapy	10%; ($1,000 max/year combined network and non-network)	30%; ($1,000 max/year combined network and non-network)	10% ($1,000 max/year combined network and non-network)	30% ($1,000 max/year combined network and non-network)
Preventative Services				
Annual Physical Exam Well Woman Exams	No charge for limited preventive care services set forth in the plan document.		No charge for limited preventive care services set forth in the plan document	30%; Limited to specific procedures listed under “Wellness Benefit” in the plan document
Routine Vision Exam (Refractions)	Not covered	Not covered	Not covered	Not covered
Medical Supplies & Equipment				
Durable Medical Equipment	10%; (over $5,000 requires prior authorization)	30%; (over $5,000 requires prior authorization)	10%; (over $5,000 requires prior authorization)	30%; (over $5,000 requires prior authorization)
Mental Health				
Inpatient Facility	10%; Pre-admission review required for inpatient	30%; Without pre-admission review, inpatient co-insurance 50%	10% Pre-admission review required for inpatient	30% Without pre-admission review, inpatient co-insurance 50%
Outpatient Facility	50%	50%	50%	50%
Maximum Yearly Outpatient	Limited to a maximum of 50 visits/calendar year		Limited to a maximum of 50 visits/calendar year	
Lifetime Maximum	Unlimited		Unlimited	
Alcohol & Drug Abuse				
Inpatient Facility	10%; Pre-admission review required for inpatient	30%; Without pre-admission review, inpatient co-insurance 50%	10% Pre-admission review required for inpatient	30% Without pre-admission review, inpatient co-insurance 50%
Outpatient Facility	50%		50%	
Maximum Yearly Outpatient	Limited to a maximum of 50 visits/calendar year		Limited to a maximum of 50 visits/calendar year	
Lifetime Maximum	Unlimited		Unlimited	

This benefit chart serves only as a summary of plan benefits.

The chart highlights the major features of the plans and is not intended to replace the legal documents containing the complete provisions.

Your options if you ARE NOT eligible for Medicare (continued):

HMO PLANS

2014

	HMO PLANS – Retiree Not Enrolled in Medicare		
	Kaiser Plan	**Anthem Blue Cross Select HMO Plan**	**Anthem Blue Cross Traditional HMO Plan**
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited
Calendar Year Deductible	None	None	None
Member Co-insurance (What You Pay)	N/A	None	None
Out-of-Pocket Maximum	$1,500/$3,000	$1,500 Individual, $3,000 Two Party, $4,500 Family	$1,500 Individual, $3,000 Two Party, $4,500 Family
Prescription Drug Benefits			
Retail Pharmacy	Generic/$10 co-pay for up to 100 day supply Brand/$20 co-pay for up to 100 day supply	$100 Deductible, Generic, 50% negotiated rate up to $10 co-pay, Brand Name 45% negotiated rate up to $25 co-pay, Non-Formulary 45% negotiated rate up to $40 co-pay	No Deductible, Generic $10 co-pay, Brand Name $20 co-pay, Non-Formulary $40 co-pay
Mail Order	Generic/$10 co-pay for up to 100 day supply Brand/$20 co-pay for up to 100 day supply	$100 Deductible, Generic, 50% negotiated rate up to $20 co-pay, Brand Name 45% negotiated rate up to $50 co-pay, Non-Formulary 45% negotiated rate up to $80 co-pay	No Deductible, Generic $20 co-pay, Brand Name $40 co-pay, Non-Formulary $80 co-pay
Hospital/Facility Benefits			
Inpatient	$100/admission	No co-pay	$100 co-pay/admission
Outpatient	$15 co-pay/procedure	No co-pay	No co-pay
Pre-certification Review	N/A	IPA/PMG referral needed	IPA/PMG referral needed
Emergency Services	$50 co-pay waived if admitted	$100 co-pay waived if admitted	$100 co-pay waived if admitted
Ambulance	$0 co-pay	$0 co-pay	$0 co-pay
Physician & Professional Services			
Physician Office Visits (Primary Care)	$15 co-pay	$15 co-pay	$15 co-pay
Physician Second Opinion	$15 co-pay	$15 co-pay	$15 co-pay
Physician Office Visits (Specialty Care)	$15 co-pay	$30 co-pay	$15 co-pay
Diagnostic X-ray/Lab	Covered at 100%	No co-pay	No co-pay
Immunizations (Specific)	No charge	No co-pay	No co-pay
Home Health Care	No charge per home visit for up to 100 visits per calendar year when approved by a plan physician	No co-pay	$15 co-pay per home visit for up to 100 visits per calendar year when approved by a plan physician
Skilled Nursing Facility	100% covered up to 100 days per benefit period	No co-pay	No co-pay limited to 100 days per calendar year
Chiropractic Therapy	$15 per visit, up to 30 visits per calendar year	$15 co-pay IPA/PMG referral needed	$15 co-pay IPA/PMG referral needed

HMO PLANS (continued)

2014

	HMO PLANS – Retiree Not Enrolled in Medicare		
	Kaiser Plan	**Anthem Blue Cross Select HMO Plan**	**Anthem Blue Cross Traditional HMO Plan**
Preventive Services			
Annual Physical Exam	$15 co-pay	No co-pay	No co-pay
Well Woman Exams	$15 co-pay	No co-pay	No co-pay
Routine Vision Exam (Refractions)	$15 co-pay	No co-pay	No co-pay
Medical Supplies & Equipment			
Durable Medical Equipment	100% covered in accord with formulary	No co-pay	No co-pay
Mental Health			
Inpatient Facility	$100 co-pay/admission, no limit	No co-pay	$100 co-pay/admission
Outpatient Facility	$15 co-pay per visit, no limit	No co-pay	No co-pay
Maximum Yearly Outpatient	N/A	None	None
Lifetime Maximum	N/A	Unlimited	Unlimited
Alcohol & Drug Abuse			
Inpatient Facility	$100 co-pay/admission, no limit	No co-pay	$100 co-pay/admission
Outpatient Facility	$15 co-pay/visit, no limit	No co-pay	No co-pay
Maximum Yearly Outpatient	N/A	None	None
Lifetime Maximum	N/A	Unlimited	Unlimited