Your options if you ARE eligible for Medicare:

PPO PLANS

2014

	PPO PLANS – Retirees Enrolled in Medicare							
	Wellwise Retiree		Sharewell Retiree	Sharewell Retiree	Anthem Blue Cross Custom PPO		Anthem Blue Cross Standard PPO	
	Network Provider	Non-Network Provider	Network Provider	Non-Network Provider	Network Provider	Non-Network Provider	Network Provider	Non-Network Provider
Maximum Lifetime Benefit	Unlimited		Unlimited	Unlimited	Unlimited		Unlimited	
Calendar Year Deductible	$500/individual $1,000/family	$750/individual $1,500/family	$5,000/family (combined network and non-network)	$5,000/family (combined network and non-network)	None		$300 (combined in and out of network)	
Member Co-insurance (What You Pay)	10%	30%	10%	30%	See summary of benefits for co-pays and co-insurance for each benefit		See summary of benefits for co-pays and co-insurance for each benefit	
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	$3,250	$3,250	$3,400	$3,400
Prescription Drug Benefits								
Retail Pharmacy	20%/25%/30% Drug Card Program		20%; Discounts available through Blue Shield contracted pharmacies; Covered drugs subject to plan deductible	20%; Discounts available through Blue Shield contracted pharmacies; Covered drugs subject to plan deductible	$10 co-pay generic, $15 co-pay preferred and non-preferred brands		$15 co-pay generic, $45 co-pay preferred brands; No coverage for non-preferred brands; $200 deductible	
Mail Order	20%/25%/30% Drug Card Program		20%	20%	$20 co-pay generic, $30 co-pay preferred and non-preferred brands		$30 co-pay generic, $90 co-pay preferred brands; No coverage non-preferred brands	
Hospital/Facility Benefits								
Inpatient	10%	30%	10%	30%	$100 co-pay/ admission	$100 co-pay/ admission	$200 co-pay/ admission	30% co-insurance/ admission
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	$15 co-pay	$15 co-pay	$100 co-pay	30%
Pre-certification Review	Pre-admission review required for inpatient	Without pre-admission review, inpatient co-insurance 50%	Pre-admission review required for inpatient	Without pre-admission review, inpatient co-insurance 50%	Prior Authorization Required	Prior Authorization Requested	Prior Authorization Required	Prior Authorization Requested
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	$50 co-pay	$50 co-pay	$50 co-pay	$50 co-pay
Ambulance	10%	30%	10%	30%	$0 co-pay	$0 co-pay	$100 co-pay	$100 co-pay
Physician & Professional Services								
Physician Office Visits (Primary Care)	10%	30%	10%	30%	$15 co-pay	$15 co-pay	$25 co-pay	30%
Physician Second Opinion	10%	30%	10%	30%	$15 co-pay	$15 co-pay	$40 co-pay	30%
Physician Office Visits (Specialty Care)	10%	30%	10%	30%	$15 co-pay	$15 co-pay	$40 co-pay	30%

PPO PLANS (continued)

2014

	PPO PLANS – Retirees Enrolled in Medicare							
	Wellwise Retiree		Sharewell Retiree	Sharewell Retiree	Anthem Blue Cross Custom PPO		Anthem Blue Cross Standard PPO	
	Network Provider	Non-Network Provider	Network Provider	Non-Network Provider	Network Provider	Non-Network Provider	Network Provider	Non-Network Provider
Diagnostic X-ray/Lab	10%	30%	10%	30%	$0 co-pay	$0 co-pay	$40 co-pay for x-ray & $0 co-pay for lab	30%
Immunizations (Specific)	No charge, limited coverages		No charge, limited coverages	Not covered	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Home Health Care	10%; Requires prior authorization	30%; Requires prior authorization	10%; Requires prior authorization	30%; Requires prior authorization	$0 co-pay	$0 co-pay	$0 co-pay	30%
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	$0 co-pay	$0 co-pay	$300 co-pay	30%
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)	$15 co-pay	$15 co-pay	$20 co-pay	30%
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	Annual Exam is $0 copay for in and out of network		$0 co-pay	30%
Routine Vision Exam (Refractions)	Not covered		Not covered	Not covered	$15 co-pay, eye-exam only		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)	$0 co-pay		10%	10%
Mental Health & Substance 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%	$100 co-pay per admission for in and out of network		$200 co-pay	30%
Outpatient Facility	50%		50%	50%	$15 co-pay		$25 co-pay	30%
Maximum Yearly Outpatient	Limited to a maximum of 50 visits/ calendar year		Limited to a maximum of 50 visits/calendar year	Limited to a maximum of 50 visits/calendar year	None		None	
Lifetime Maximum	Unlimited		Unlimited	Unlimited	None		None	

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.

HMO PLANS

	HMO PLANS – Retirees Enrolled in Medicare				
	SCAN	**Kaiser Senior Advantage**	**Anthem Blue Cross Traditional HMO Plan Part B Only**	**Anthem Blue Cross Select HMO Plan Part B Only**	**Anthem Blue Cross Senior Secure Medicare HMO Plan**
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited	Unlimited	No max
Calendar Year Deductible	None	$0	None	None	None
Member Co-insurance (What You Pay)	0%	0%	None	None	See summary of benefits for co-pays and co-insurance for each benefit
Out-of-Pocket Maximum	$6,700	$1,500/Individual $3,000/Family	$1,500/Individual; $3,000/Two Party; $4,500/Family	$1,500/Individual; $3,000/Two Party; $4,500/Family	$3,000
Prescription Drug Benefits					
Retail Pharmacy	$10 Generic $20 Brand $40 Specialty (up to 30 day supply)	$10 Generic $20 Brand (up to 100-day supply)	No Deductible, Generic $10 co-pay, Brand Name $20 co-pay, Non-Formulary $40 co-pay	$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	$10 co-pay generics, $20 co-pay preferred brands, $40 co-pay non-preferred brands
Mail Order	$20 Generic $40 Brand (up to 90 day supply)	$10 Generic $20 Brand (up to 100-day supply)	No Deductible, Generic $20 co-pay, Brand Name $40 co-pay, Non-Formulary $80 co-pay	$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	$15 co-pay generics, $50 co-pay preferred brands, $100 co-pay non-preferred brands
Hospital/Facility Benefits					
Inpatient	$100 per admission	$100 co-pay per admission	$100 co-pay per admission	No co-pay	$100 co-pay per admission
Outpatient	$0 co-pay excludes ER	$15 co-pay per procedure	No co-pay	No co-pay	$100 co-pay
Pre-certification Review	N/A	N/A	IPA/PMG referral needed	IPA/PMG referral needed	Yes
Emergency Services	$50 co-pay waived if admitted	$50 co-pay waived if admitted	$50 co-pay	$100 co-pay	$50 co-pay
Ambulance	$0 co-pay	$0 co-pay	No co-pay	No co-pay	$0 co-pay
Physician & Professional Services					
Physician Office Visits (Primary Care)	$15 co-pay	$15 co-pay	$15 co-pay	$15 co-pay	$15 co-pay
Physician Second Opinion	$15 co-pay	$15 co-pay	$15 co-pay	$15 co-pay	$15 co-pay
Physician Office Visits (Specialty Care)	$15 co-pay	$15 co-pay	$15 co-pay	$30 co-pay	$15 co-pay
Diagnostic X-ray/Lab	$0 co-pay	100% covered	No co-pay	No co-pay	$15 co-pay for x-ray & $0 co-pay for lab
Immunizations (Specific)	$0 co-pay	No charge	No co-pay	No co-pay	$0 co-pay
Home Health Care	$0 co-pay (100 visits/year) see health plan for details	No charge per home visit when approved by a plan physician (part-time intermittent)	No co-pay	No co-pay	$0 co-pay
Skilled Nursing Facility	No charge (up to 100 days per benefit period)	100% (up to 100 days per benefit period)	No co-pay	No co-pay	$0 co-pay
Chiropractic Therapy	$15 co-pay (up to 20 visits/year per benefit period)	$15 co-pay (up to 30 visits/year)	$15 co-pay w/ IPA/PMG referral	$15 co-pay w/ IPA/PMG referral	$20 co-pay

HMO PLANS (continued)

2014

	HMO PLANS – Retirees Enrolled in Medicare				
	SCAN	**Kaiser Senior Advantage**	**Anthem Blue Cross Traditional HMO Plan Part B Only**	**Anthem Blue Cross Select HMO Plan Part B Only**	**Anthem Blue Cross Senior Secure Medicare HMO Plan**
Preventive Services					
Annual Physical Exam	No Charge	No co-pay	No co-pay	No co-pay	$0 co-pay
Well Woman Exams	No Charge	No Charge	No co-pay	No co-pay	$0 co-pay
Routine Vision Exam	Eye Exam $15 co-pay; Vision allowance: $100 eyewear/ $130 contact every 24 months	Eye Exam $15 charge; Vision allowance: $150 eyewear every 24 months	No co-pay	No co-pay	$15 co-pay
Medical Supplies & Equipment					
Durable Medical Equipment	100% covered in accordance with DME formulary and Medicare guidelines. See health plan for details.	100% covered covered in accord with formulary	No co-pay	No co-pay	20%
Mental Health					
Inpatient Facility	$100 co-pay/admission	$100 co-pay/admission	$100 co-pay/admission	No co-pay	$100 co-pay/admission
Outpatient Facility	$15 co-pay (individual)	$15 co-pay (individual) $7 co-pay (group)	No co-pay	No co-pay	$15 co-pay
Maximum Yearly Outpatient	N/A	No limit	None	None	None
Lifetime Maximum	N/A	No limit	Unlimited	Unlimited	None
Substance Abuse					
Inpatient Facility	$100 co-pay/admission	$100 co-pay/admission	$100 co-pay/admission	No co-pay	$100 co-pay/admission
Outpatient Facility	$10 co-pay (individual/group)	$15 co-pay individual/ $5 co-pay group	No co-pay	No co-pay	$15 co-pay
Maximum Yearly Outpatient	No limit	No limit	None	None	None
Lifetime Maximum	Unlimited	No limit	Unlimited	Unlimited	None

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