

**PUBLIC RISK MANAGEMENT
Health Benefit Comparisons
Effective October 1, 2004**

	PRM - Plan 902		PRM - Plan 719		PRM - Plan 125	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Maximum Lifetime Benefit	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
Annual Ded	\$200	\$200	\$500	\$500	\$1,000	\$1,000
Family Ded	\$600	\$600	\$1,500	\$1,500	\$3,000	\$3,000
Maximum Annual Out of Pocket	\$1,500	\$1,500	\$1,500	\$1,500	\$2,000	\$2,000
Maximum Family Out of Pocket	\$4,500	\$4,500	\$4,500	\$4,500	\$6,000	\$6,000
Coinsurance	90% of allowance	70% of allowance	80% of allowance	60% of allowance	80% of allowance	50% of allowance
Physician Office Visit	\$15 Copay	Ded, the 70% of allowance	\$15 Copay	Ded, then 60% of allowance	Ded, then 80% of allowance	Ded, then 50% of allowance
Wellcare Visits - Annual exam	\$15 copay, \$250 calendar year max (combined OBGYN/adult wellness)	70% of allowance, Ded waived, \$250 calendar year max (combined OBGYN/adult wellness)	\$15 copay, \$250 calendar year max (combined OBGYN/adult wellness)	60% of allowance, Ded waived, \$250 calendar year max (combined OBGYN/adult wellness)	Ded, then 80% of allowance	Ded, then 50% of allowance
Adult / OB/GYN - Child health						
Specialist Office Visit	\$15 Copay	Ded, then 70% of allowance	\$15 Copay	Ded, then 60% of allowance	Ded, then 80% of allowance	Ded, then 50% of allowance
Combined Outpatient Cardiac Rehabilitation & Occupational, Physical, Speech, & Massage Therapies & Spinal Manipulations	Ded, then 90% of allowance up to \$10,000 lifetime max.	Ded, then 70% of allowance up to \$10,000 lifetime max.	Ded, then 80% of allowance up to \$5,000 lifetime max.	Ded, then 60% up to \$5,000 lifetime max.	Ded, then 80% of allowance up to \$1,000 lifetime max.	Ded, then 50% of allowance up to \$1,000 lifetime max.
Outpatient Surgery (hospital or surgery center)	Ded, then 90% of allowance	Ded, then 70% of allowance	Ded, then 80% of allowance	Ded, then 60% of allowance	Ded, then 80% of allowance	Ded, then 50% of allowance
Emergency Room/Hospital - Illness/Accidents	Calendar yr. Ded, then 90% of allowance (No E.R. Ded). Cal Year ded waived if accident	Calendar yr. Ded, then 70% of allowance (No E.R. Ded). Cal Year ded waived if accident	Calendar yr Ded, then 80% of allowance (No E.R. Ded). Cal year ded waived if accident	Calendar yr Ded, the 60% of allowance (No E.R. Ded). Cal year ded waived if accident	Calendar yr Ded, then 80% of allowance (\$50 E.R. Ded, waived if admitted)	Calendar Ded, then 50% of allowance (\$50 E.R. Ded, waived if admitted)
Ambulance	Ded, then 90% of allowance	Ded, then 90% of allowance	Ded, then 80% of allowance	Ded, then 80% of allowance	Ded, then 80% of allowance	Ded, then 80% of allowance
Inpatient Hospital	Ded, then 90% of allowance	\$100 per admission. Ded, then 70% of allowance	Ded, then 80% of allowance	\$300 per admission. Ded, then 60% of allowance	Ded, then 80% of allowance	\$300 per admission. Ded, then 50% of allowance
X-ray and Lab Inpatient	Ded, then 90% of allowance	Ded, then 70% of allowance	Ded, then 80% of allowance	Ded, then 60% of allowance	Ded, then 80% of allowance	Ded, then 50% of allowance
Home Health Care	Ded, then 90% of allowance. \$12,000 per calendar year	Ded, then 70% of allowance. \$12,000 per calendar year	Ded, then 80% of allowance. \$2,500 per calendar year	Ded, then 60% of allowance. \$2,500 per calendar year	Ded, then 80% of allowance. \$1,000 per calendar year.	Ded, then 50% of allowance. \$1,000 per calendar year.
Hospice	Ded, then 90% of allowance. \$7,500 lifetime max.	Ded, then 70% of allowance. \$7,500 lifetime max.	Ded, then 80% of allowance. \$7,500 lifetime max.	Ded, then 60% of allowance. \$7,500 lifetime max.	Ded, then 70% of allowance. \$7,500 lifetime max.	Ded, then 50% of allowance. \$7,500 lifetime max.
Skilled Nursing Facility	Ded, then 90% of allowance. 60 days per calendar yr.	Ded, then 80% of allowance. 60 days per calendar yr.	Ded, then 80% of allowance. 60 days per calendar yr.	Ded, then 60% of allowance. 60 days/ calendar year	Ded, then 80% of allowance. 60 days per calendar yr.	Ded, then 50% of allowance. 60 days per calendar yr.
Durable Medical Equip.	Ded, then 90% of allowance	Ded, then 80% of allowance	Ded, then 80% of allowance	Ded, then 60% of allowance	Ded, then 80% of allowance	Ded, then 50% of allowance
Maternity - Physician - Hospital	\$15 Copay Ded, then 90% of allowance	Ded, then 70% of allowance \$100 per admission. Ded, then 70% of allowance	\$15 Copay Ded, then 80% of allowance	Ded, then 60% of allowance \$300 per admission. Ded, then 60% of allowance	Ded, then 80% of allowance Ded, then 80% of allowance	Ded, then 50% of allowance Ded, then 50% of allowance
In-Patient Mental/Nervous	Ded, then 90% of allowance. 30 days per calendar yr.	Ded, then 70% of allowance. 30 days per calendar yr.	Ded, then 80% of allowance. 30 days per calendar yr.	Ded, then 60% of allowance. 30 days per calendar yr.	Ded, then 80% of allowance. 30 days per calendar yr.	Ded, then 50% of allowance. 30 days per calendar yr.
Out-Patient Mental/Nervous	Ded, then 90% of allowance. 20 visits per calendar yr.	Ded, then 70% of allowance. 20 visits per calendar yr.	Ded, then 80% of allowance. 20 visits per calendar yr.	Ded, then 60% of allowance. 20 visits per calendar yr.	Ded, then 80% of allowance. 20 days per calendar yr.	Ded, then 50% of allowance. 20 days per calendar yr.

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In-Patient/Out-Patient Substance Abuse	Ded, then 90% of allowance. \$2,500 lifetime max.	Ded, then 70% of allowance. \$2,500 lifetime max.	Ded, then 80% of allowance. \$2,500 lifetime max.	Ded, then 60% of allowance. \$2,500 lifetime max.	Ded, then 80% of allowance. \$2,500 lifetime max.	Ded, then 50% of allowance. \$2,500 lifetime max.
Prescription Drugs (Includes coverage for oral contraceptives and Diaphragms)	One Month Supply		One Month Supply		One Month Supply	
- Generic	\$7 Copay	N/A	\$10 Copay	N/A	\$100 Rx Ded, then 80%	N/A
- Preferred (Brand)	\$ 14 Copay (Brand)	N/A	\$25 Copay (Brand)	N/A	\$100 Rx Ded, then 80%	N/A
- Non-Preferred	N/A	N/A	N/A	N/A	\$100 Rx Ded, then 80%	N/A
Prescription Mail Order	90 Day Supply		90 Day Supply			
- Generic	\$14 Copay	N/A	\$20 Copay	N/A		
- Preferred (Brand)	\$28 Copay (Brand)	N/A	\$50 Copay (Brand)	N/A	Not Covered	Not Covered
- Non-Preferred (Brand)	N/A	N/A	N/A	N/A		

This is a summary only and is not intended to be a complete description of covered services. More complete information is contained in the Group Contract/Certificate. If a discrepancy arises between this benefit summary and the actual Group Contract/Certificate, the actual Group Contract/Certificate will prevail in all circumstances.