



2010 Medical Plan Comparison Chart – Pre-65 Retirees

	Aetna POS 90		CIGNA POS 90 (New) Tri-State Only		UHC POS 90 (New)		CIGNA POS 100 Tri-State Only		UHC POS 100		CIGNA Plan B*
	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*	
Physician Office Visits	\$20 copay	70% after deductible	\$20 copay	70% after deductible	\$20 copay	70% after deductible	\$20 copay	70% after deductible	\$20 copay	70% after deductible	80% after deductible
Preventive Care	100% no copay	Not covered	100% no copay	Not covered	100% no copay	Not covered	100% no copay	Not covered	100% no copay	Not covered	Not covered
Annual Deductible:	Individual: \$150 Family: \$300	Individual: \$500 Family: \$1,500	Individual: \$150 Family: \$300	Individual: \$500 Family: \$1,500	Individual: \$150 Family: \$300	Individual: \$500 Family: \$1,500	None	Individual: \$500 Family: \$1,500	None	Individual: \$500 Family: \$1,500	Individual: \$250 Family: \$500
Co-insurance/Plan Pays	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100% after copay	70% after deductible	100% after copay	70% after deductible	80% after deductible
Out-of-Pocket Maximum (excludes deductible)	Individual: \$1,000 Family: \$2,000	Individual: \$3,000 Family: \$6,000	Individual: \$1,000 Family: \$2,000	Individual: \$3,000 Family: \$6,000	Individual: \$1,000 Family: \$2,000	Individual: \$3,000 Family: \$6,000	None	Individual: \$3,000 Family: \$6,000	None	Individual: \$3,000 Family: \$6,000	Individual: \$1,000 Family: \$2,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	\$1,000,000
Hospital Services ** Precertification required for all services											
Inpatient **	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	\$250 copay per admission	70% after deductible	\$250 per admission	70% after deductible	Room & board: 100% after deductible Surgeon: 80% after deductible
Outpatient ** (non-surgical)	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100%	70% after deductible	100%	70% after deductible	Surgery: 100%, no deductible Surgeon's fees: 80% after deductible Non-surgical: 80% after deductible
Emergency Room <i>Copay waived if admitted</i>	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay	80% after deductible
Mental Health & Substance Abuse ** Precertification required for all services											
Inpatient **	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	\$250 copay per admission	70% after deductible	\$250 copay per admission	70% after deductible	100% after deductible; up to 60 days a year
Outpatient **	\$20 copay Annual maximum: 60 visits	70% after deductible Combined annual maximum: 60 visits	\$20 copay Annual maximum: 60 visits	70% after deductible Combined annual maximum: 60 visits	\$20 copay Annual maximum: 60 visits	70% after deductible Combined annual maximum: 60 visits	\$20 copay Annual maximum: 60 visits	70% after deductible Combined annual maximum: 60 visits	\$20 copay Annual maximum: 60 visits	70% after deductible Combined annual maximum: 60 visits	80% after deductible Annual limit: 60 visits



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	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*	
Vision Care											
Routine Eye Exam	100% after \$15 copay; covered once every 2 calendar years	Not covered	\$10 copay	Not covered	100% after \$20 copay; covered once every 2 calendar years	Not covered	\$10 copay	Not covered	Not covered	Not covered	Not covered
Eyeglasses and Lenses	\$100 allowance per calendar year Additional discounts off retail hardware (e.g., 40% off eyeglass frames) at participating providers. Call Aetna for details.	Not covered	Benefit allowance available once every 24 months Single lenses: \$20 Bifocal lenses: \$30 Trifocal lenses: \$40 Lenticular lenses: \$75 Contact lenses: \$75 (medically necessary)	Not covered	Not covered	Not covered	Benefit allowance available once every 24 months Single lenses: \$20 Bifocal lenses: \$30 Trifocal lenses: \$40 Lenticular lenses: \$75 Contact lenses: \$75 (medically necessary)	Not covered	Not covered	Not covered	Not covered
Eyeglass Frames	Discounts available	Not covered	Discounts available	Not covered	Discounts available	Not covered	Frames - \$30	Not covered	Not covered	Not covered	Not covered
Prescription Drugs	From Medco		From Medco		From Medco		From Medco		From Medco		From Medco
Retail Pharmacy	Generic: \$10 copay Brand: \$20 copay Up to 30-day supply		Generic: \$10 copay Brand: \$20 copay Up to 30-day supply		Generic: \$10 copay Brand: \$20 copay Up to 30-day supply		Generic: \$10 copay Brand: \$20 copay Up to 30-day supply		Generic: \$10 copay Brand: \$20 copay Up to 30-day supply		Generic: \$10 copay Brand: \$20 copay Up to 30-day supply
Home Delivery	Generic: \$15 copay Brand: \$40 copay Up to 90-day supply		Generic: \$15 copay Brand: \$40 copay Up to 90-day supply		Generic: \$15 copay Brand: \$40 copay Up to 90-day supply		Generic: \$15 copay Brand: \$40 copay Up to 90-day supply		Generic: \$15 copay Brand: \$40 copay Up to 90-day supply		Generic: \$15 copay Brand: \$40 copay Up to 90-day supply

* Reasonable and Customary (R&C) charges are the maximum amount that will be considered for reimbursement.
 All out-of-network services and CIGNA Plan B reimbursement are limited to R&C.
 You are responsible for 100% of any charges that exceed the R&C maximums.