Brief summary of benefits proposed for the Health Insurance options effective April 1, 2010 - ACTIVE EMPLOYEES

This is only a BRIEF SUMMARY	BLUECARE 200 PLAN (Anthem BCBS)	KEYCARE 15 Plus PPO PLAN (Anthem BCBS)	HealthKeeper's HMO 15 Plan (Anthem BCBS)	Optima Vantage 10/25 Plan (Optima Health)
It is very important that you review all of your enrollment materials for more specific details.	*You and your dependents may choose any provider. When you use Anthem BCBS "participating" (PAR) providers, you may not be "balance billed" (1)*	*You and your dependents may access care from any PPO provider. The PPO network is extensive. See the provider directory.* *You pay 30% coinsurance after the annual out-of-network deductible if you go out-of-network. (1)*	*You and your dependents must access care through your designated Primary Care Physician (PCP) and within the HMO network in order to receive benefits. Care must be rendered or referred by your network PCP, except for certain OBGYN services, vision services, or emergency situations.*	*You and your dependents may access care from any participating network health professional without obtaining a referral from your designated Primary Care Physician (PCP),. In emergency situations you may use a non-participating provider if necessary.*
MONTHLY EMPLOYEE COST FOR EACH OPTION				
Employee Only	$187.80	$129.90	$106.80	$93.70
Employee + Child	$272.70	$187.80	$154.80	$136.00
Employee + Spouse	$392.70	$271.50	$223.70	$196.50
Employee + Family	$513.80	$355.10	$292.90	$257.50
Calendar Year Deductible (Ded.) (Individual/Family)	$200 Individual / $400 Family	In-Network: None Out-of-Network: $400 / $800	None	None
Your Maximum Out-of-Pocket Expense Limit Per Year	$1,000 Individual / $2,000 Family	In-Network: $2,000 / $4,000 Out-of-Network: $4,000 / $8,000	$2,000 Individual / $4,000 Family	$2,000 Individual / $4,000 Family
Referrals to Specialists by PCPs Required?	No	No	Yes	No
Physician Office Visits	20% coinsurance after Ded.	PCP - $15 copay Specialist - $30 copay	PCP - $15 copay Specialist - $35 copay	PCP - $10 copay Specialist - $25 copay
Labs, X-rays, and Other Outpatient Diagnostic Tests	20% coinsurance after Ded.	Diagnostic X-rays - $30 copay; Routine Annual Mammograms and Other Routine Lab Services and Screening Tests - No charge	PCP - $15 copay Specialist - $35 copay Separate copays are not charged for services/x-rays/tests provided by same provider on same day as office visit.	Lab/X-rays/Other - $25 copay Separate copay is not charged for services/x-rays/tests provided during physician's office visit.
Advanced Diagnostic Services	20% coinsurance after Ded.	MRI, MRA, PET Scan, CTA and CT Scans - $150 copay	MRI, MRA, PET Scan, CTA and CT Scans - $150 copay	MRI, MRA, PET Scan, CTA and CT Scans - $150 copay (regardless of where service provided)
Outpatient Surgery	20% coinsurance after Ded..	$150 copay facility, $15 or $30 copay for doctor	$150 copay	$100 copay
Well Child Care	20% coinsurance, no Ded.	$15 PCP copay	$15 PCP copay	$10 PCP copay
Well Adult Care (2)	Covered @ 100% , no annual deductible for annual check-ups, annual routine gynecological exam and PAP smear, mammogram, annual prostate exam, colorectal cancer screening, annual PSA test.	No charge for annual check-up, annual routine gynecological exam, annual prostate exam, annual colorectal cancer screening. No charge for routine lab services, annual Pap test, annual PSA test or annual mammogram.	$15 PCP or $35 Specialist copay for annual check-up, prostate exam, PSA test, colorectal cancer screening, diagnostic x-rays, lab work. $15 PCP copay for annual routine gynecological exam and Pap test.	$10 copay for annual check-up, routine annual gynecological exam, Pap test, annual prostate exam, and annual PSA test. $0 copay for annual mammogram and colorectal cancer screening.
Maternity Care - Outpatient (Refer to Inpatient Hospital Services below for inpatient maternity benefits)	20% coinsurance after Ded. for pre and postnatal care. Inpatient hospital services are an additional cost (shown below).	If the OB submits one bill for all services (pre-natal care, routine ultra sounds, delivery, and post-natal care), the member pays 20% coinsurance. If the OB bills for these services separately, the member's payment will be determined by the services received ($30 per visit and $30 per ultrasound).	$100 global copay per pregnancy for routine pre and postnatal care and delivery. Inpatient hospital services are an additional cost (shown below). $35 copay/visit for ultra sounds, non-stress tests and other fetal monitor procedures.	$100 global copay per pregnancy for delivering obstetrician, prenatal care, routine ultra sounds in OB's office, delivery, postpartum services, and home health visits. Inpatient hospital services are an additional cost (shown below).
Urgent Care	20% coinsurance after Ded.	$15 PCP copay/$30 Specialist copay at doctor's office (urgent care centers will bill as PCP or Specialist based on contract with Anthem)	$15 PCP copay/$35 Specialist copay at doctor's office; $35 copay if use an urgent care center not designated as your PCP or if you receive urgent care out of service area	$25 copay doctor's office or urgent care center
Emergency Room Visit	20% coinsurance after Ded.	$150 facility copay, $15 or $30 copay for services billed by the doctor	$150 facility copay, $35 for services billed by the doctor	$200 copay
Inpatient Hospital Services	20% coinsurance after Ded.	$300 copay plus 20% coinsurance per stay	$200 per day not to exceed $1,000 for each admission	$100 copay per day not to exceed $500 for each admission
Outpatient Mental Health and Substance Abuse (MHSA)	20% coinsurance after Ded.	$30 copay per visit	Individual or group therapy or medication management - $20 copay Other mental health/substance abuse visits - $30 copay	$25 copay
Inpatient MHSA Services	20% coinsurance after Ded.	$300 copay plus 20% coinsurance per stay	$200 copay per day not to exceed $1,000 for each admission	$100 copay per day not to exceed $500 for each admission
Prescription Drug Copays (3) Retail Copays: Mail Order Copays:	 $8/$15/$30 $8/$30/$90	 $8/$15/$30 $8/$30/$90	 $8/$15/$30 $8/$30/$90	 $10/$20/$40/$40 $20/$40/$80/$80
Chiropractic Services	20% coinsurance after Ded. Benefits limited to $500 per calendar year	$30 copay per visit Benefits limited to $500 per calendar year	$25 copay per visit (PCP referral required) Limited to 30 visits per calendar year	Discount Program (through ASHN) ASHN providers extend up to a 25% discount off their normal charges to Optima members
Routine Vision Services	Annual eye exam - $15 copay Discounts available for eye wear and laser vision correction surgery	Annual eye exam - $15 copay Discounts available for eye wear and laser vision correction surgery	Annual eye exam - $15 copay Discounts available for eye wear and laser vision correction surgery	Eye exam and covered vision materials every 12 mos. Spectacle exam - $15 copay. Contact lens exam - $15 copay plus difference between contact lens and spectacle exam. $100 retail allowance toward purchase of eyeglasses and contact lenses.

(1) When services are rendered by non-participating provider, you may be "balance billed" for charges above the Anthem BCBS allowable charge for BlueCare or the network negotiated reimbursement for KeyCare.

(2) Well adult care includes coverage for mammography screenings, annual PSA test and prostate exam, and colorectal cancer screenings (i.e., fecal occult blood test, sigmoidoscopies and colonoscopies). Anthem does not apply frequency or age limitations to these services. Optima follows nationally-recognized guidelines in applying frequency and age limitations.

(3) For a list of First Tier, Second Tier, and Third Tier Drugs, refer to the applicable provider web site (www.anthem.com or www.sentara.com). Generic substition is required by both Anthem and Optima. A 90-day supply of certain maintenance drugs can be filled through the Mail Order Pharmacy.