

**REEP for Benefits JPA**

**Summary of PPO & HMO Plans**

	Current	Current
Effective Date	07/01/2015	7/1/2015
Renewal Date	07/01/2016	7/1/2016
Carrier Name	Anthem Blue Cross	Kaiser Permanente Insurance Company
Plan Name	PPO MVP	HMO MVP w/Chiro
Eligible Class	Eligible Employees	Eligible Employees

	In-Network Benefits	Out-of-Network Benefits	Schedule of Benefits
<b>General Plan Information</b>			
Annual Deductible/Individual	\$5,900	\$11,800	\$4,500
Annual Deductible/Family	\$11,800	\$23,600	\$9,000
Coinsurance	100% after the deductible has been satisfied	50%	60%
Office Visit/Exam	\$35 copay; deductible waived first 3 visits/combined services	50%	\$50 copay; after deductible
Outpatient Specialist Visit	\$35 copay; deductible waived first 3 visits/combined services	50%	\$50 copay; after deductible
Annual Out-of-Pocket Limit/Individual	\$6,100 Rx not included	\$12,700 Rx not included	\$6,000
Annual Out-of-Pocket Limit/Family	\$12,200 Rx not included	\$25,400 Rx not included	\$12,000
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited
<b>Inpatient Hospital Services</b>			
Inpatient Hospitalization	100% after the deductible has been satisfied	50%	60% after deductible
Semi-Private Room & Board; Including Services and	100% after the deductible has been satisfied	50%	60% after deductible
<b>Emergency Services</b>			
	0		
Emergency Room	100%	100%	\$250 copay; after deductible
<b>Mental Health Benefits</b>			
Inpatient Care	100% after the deductible has been satisfied; subject to utilization review; waived for emergency	50% subject to utilization review; waived for emergency	60% after deductible
Outpatient Care	\$35 copay; deductible waived for the first 3 visits/combined services	50%	\$50 copay; after deductible
<b>Alcohol Abuse</b>			
<b>Inpatient Care</b>			
Inpatient Hospitalization	70%	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency).	80% after deductible
<b>Outpatient Care</b>			
Outpatient Services	\$40 copay; deductible waived	50%	\$20 copay; deductible waived
<b>Substance Abuse</b>			
<b>Inpatient Care</b>			
Inpatient Hospitalization	100% after the deductible has been satisfied; subject to utilization review; waived for emergency	50% subject to utilization review; waived for emergency	60% after deductible
<b>Outpatient Care</b>			
Outpatient Services	\$35 copay; deductible waived first 3	50%	\$50 copay; after deductible

CONFIDENTIAL: The information in this chart is intended for the exclusive use of the recipient in connection with the recipient's review of this proposal. It is not intended for any other purpose. The information described on this page is only intended to be a summary of your benefits. It does not include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD) for a complete summary of your benefits. If the information on this page conflicts in any way with the SPD, the contract provisions of the appropriate policy or plan document (available through your employer) will prevail.

**REEP for Benefits JPA**

**Summary of PPO & HMO Plans**

	Current	Current	
<b>Effective Date</b>	07/01/2015	7/1/2015	
<b>Renewal Date</b>	07/01/2016	7/1/2016	
<b>Carrier Name</b>	Anthem Blue Cross	Kaiser Permanente Insurance Company	
<b>Plan Name</b>	PPO MVP	HMO MVP w/Chiro	
<b>Eligible Class</b>	Eligible Employees	Eligible Employees	
	In-Network Benefits	Out-of-Network Benefits	Schedule of Benefits
<b>Prescription Drug Benefits</b>			
Prescription Drug Deductible	N/A	N/A	\$250 per Member/calendar year
Annual Out of Pocket Limit Individual	\$500	\$500	
Annual Out of Pocket Limit Family	\$1,000	\$1,000	
Generic	\$19 copay/Tier 1 Pharmacy; \$19 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$19 copay/Tier 1 Pharmacy; \$19 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$15 copay; deductible waived
Brand (Formulary/Preferred)	\$50 copay/Tier 1 Pharmacy; \$50 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$50 copay/Tier 1 Pharmacy; \$50 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$35 copay; after prescription deductible
Brand (Non-Formulary/Non-preferred)	\$19 copay/Tier 1 Pharmacy; \$19 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$19 copay/Tier 1 Pharmacy; \$19 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	
Number of Days Supply	30 days	30 days	30 days
<b>Mail Order</b>			
Generic	\$38 copay provided by Express Scripts	Not covered	\$30 copay; deductible waived
Brand (Formulary/Preferred)	\$100 copay provided by Express Scripts	Not covered	\$70 copay; after prescription deductible
Brand (Non-Formulary/Non-preferred)	\$38 copay provided by Express Scripts	Not covered	
Number of Days Supply for Mail Order	90 days	N/A	100 days
<b>Other Services and Supplies</b>			
Chiropractic Services	\$35 copay; limited to 24 visits/calendar year; chiro/phys/occ therapy combined; deductible waived first 3 visits/combined services; in/out of	50% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined	\$10 copay; 30 visits/calendar year; provided through American Specialty Health

CONFIDENTIAL: The information in this chart is intended for the exclusive use of the recipient in connection with the recipient's review of this proposal. It is not intended for any other purpose. The information described on this page is only intended to be a summary of your benefits. It does not include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD) for a complete summary of your benefits. If the information on this page conflicts in any way with the SPD, the contract provisions of the appropriate policy or plan document (available through your employer) will prevail.