CPEhr Benefits At A Glance

Plan Type - Medical	ANTHEM BLUE CROSS - HMO†					KAISER - HMO†				
	HMO			SELECT HMO		HMO			HDHP (HMO)	
Plan Name	HIGH	MEDIUM	LOW	HIGH	LOW	HIGH	MEDIUM	LOW	HIGH	LOW
Deductible/Member	None	None	None	None	None	None	$500	$1,000	$1,500	$2,000
Max Members	-	-	-	-	-	-	2	2	2	2
Max Out-of-Pocket/Member	$1,500	$2,500	$3,500	$2,000	$5,000	$1,500	$3,000	$3,000	$1,500	$3,000
Max Members	3	2	2	2	2	2	2	2	2	2
Preventative Care Visits	$10	$20	$25	$10	$30	$15	$20	$30	No Charge	$30
Well Baby/Child Visits	$10	$20	$25	$10	$30	$15	$20	$30	No Charge	$30
Office Visit	$10	$20	$25	$10	30%	$15	$20	$30	No Charge after ded	$30 after ded
Specialist Visit	$20	$40	$40	$30	$40	$15	$20	$30	No Charge after ded	$30 after ded
Lab & Xray	No Charge	$0	$0	No Charge	30%	$5	$10 after ded	$10 after ded	No Charge after ded	$10 after ded
Inpatient Hospital	$250/admit + 20%	$250/day, 3x max	$750/day, 3x max	$100/day	30%	$250/admit	20% after ded	30% after ded	No Charge after ded	$250/admit after ded
Outpatient Surgery	No Charge	20%	30%	No Charge	30%	$100	20% after ded	30% after ded	No Charge after ded	$150/surgery after ded
Maternity Care (Inpatient)	$250/admit + 20%	$250/day, 3x max	$750/day, 3x max	$100/day	30%	$250/admit	20% after ded	30% after ded	No Charge after ded	$250/admit after ded
Urgent Care	$10	$20	$25	$10	$30	$15	$20	$30	No Charge after ded	$30 after ded
Emergency Room*	$100	$125	$100	$100	$100	$100	20% after ded	30% after ded	No Charge after ded	$100 after ded
RX: Generic	$15	$20	$20	$15	$20	$15	$15	$10	No Charge after ded	$10 after ded
RX: Brand	$25	$35	$35	$25	$35	$30	$30	$30 + $100 ded	No Charge after ded	$30 after ded
RX: Non-Formulary	$40	$50	$50	$50	$50	-	-	-	-	-
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

Plan Type - Medical	ANTHEM BLUE CROSS - PPO††							
	PPO				HDHP (PPO)***			
Plan Name	HIGH		LOW		HIGH		LOW	
Network	In	Out	In	Out	In	Out	In	Out
Deductible/Member	$250	$1,000	$500	$1,000	$1,500		$2,500	
Max Members	3	3	3	3	2		2	
Max Out-of-Pocket/Member	$2,500	$4,000	$3,500	$5,000	$3,000	$6,000	$5,000	$10,000
Max Members	3	3	3	3	2	2	2	2
Preventative Care Visits	$20	40%	$35	40%	No Charge, No Ded	30%	No Charge, No Ded	40%
Well Baby/Child Visits	$20	40%	$35	40%	No Charge, No Ded	30%	No Charge, No Ded	40%
Office Visit	$20	40%	$35	40%	10%	30%	20%	40%
Specialist Visit	$20	40%	$35	40%	10%	30%	20%	40%
Lab & Xray	10%	40%	20%	40%	10%	30%	20%	40%
Inpatient Hospital	10%	40%**	20%	$650/day max ben**	10%	30%	20%	40%
Outpatient Surgery	10%	40%**	20%	$350/day max ben**	10%	30%	20%	40%
Maternity Care (Inpatient)	10%	40%**	20%	$650/day max ben**	10%	30%	20%	40%
Urgent Care	$20	40%	$35	40%	10%	30%	20%	40%
Emergency Room*	$150 ded + 10%		$150 ded + 20%		10%		20%	
RX: Generic	$15	$15 + 50%	$20	$20 + 50%	$15	$15 + 30%	$20	$20 + 40%
RX: Brand	$25	$25 + 50%	$40	$40 + 50%	$25	$25 + 30%	$40	$40 + 40%
RX: Non-Formulary	$40	$50 + 50%	$70	$70 + 50%	$40	$40 + 30%	$70	$70 + 40%
Lifetime Maximum	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000

† Available in California only.
†† Available nationally.
*** Waived if admitted.**
**** $500/admission deductible applies.**
***** All cost sharing for HDHP options are post-deductible except where noted.**

CPEhr Benefits At A Glance

DENTAL, VISION, LIFE

METLIFE

Plan Type - Dental	DHMO[†]	DPPO[††]			
Plan Name		LOW		HIGH	
Network		In	Out	In	Out
Deductible/Member	None	$50	$50	$25	$50
Max Members	-	3	3	3	3
Max Annual Benefit	None	$1,000	$1,000	$1,500	$1,500
Office Copay	$5	No Charge	No Copay*	No Charge	20%
Preventative Care	No Charge	No Charge	No Copay*	No Charge	20%
Basic Services	Varies	20%	20%	No Charge	20%
Major Services	Varies	50%	50%	30%	50%
Orthodontics	$1,695	50%, $1000 max	50%, $1000 max	50%, $1500 max	50%, $1500 max

VSP

Plan Type - Vision	VISION
Plan Name	VSP
Network	
Deductible/Member	None
Exam	$10
Frames	$20, Up to $120
Single Vision Lenses	$20, Up to $120
Bifocal Lenses	$20, Up to $120
Trifocal Lenses	$20, Up to $120
Contact Lenses	Up to $105
Benefit per 12 months?	Yes

RELIANCE STANDARD

Plan Type - Group Life, AD&D, LTD				
Plan Name	Pkg. 1	Pkg. 2	Pkg. 3	Pkg. 4
Life	$15,000	$25,000	$50,000	$100,000
AD&D	$15,000	$25,000	$50,000	$100,000
EAP Included	Yes	Yes	Yes	Yes
Standard LTD	60% $2,000 2 years	60% $2,000 2 years	60% $2,000 2 years	60% $2,000 2 years
Enhanced LTD	60% $5,000 Age 65	60% $5,000 Age 65	60% $5,000 Age 65	60% $5,000 Age 65

Plan Type - Supplemental		
Plan Name	Carrier	Description
Pre-Tax Healthcare Funding	Eflex	Section 125, FSA, HRA, HSA & Dependent Care available.
Life - AD&D (Group Voluntary)	Reliance	Term Life - AD&D.
Life - AD&D (Individual Voluntary)	TransAmerica	Universal & Term Life - AD&D.
Cancer, Accident & STD	Humana	Section 125, FSA, HRA, HSA & Dependent Care available.
Pre-Paid Legal	Legal Access	Section 125, FSA, HRA, HSA & Dependent Care available.
Limited Medical	Reliance	Affordable healthcare without any minimum employer contributions.
Chiropractic	American Specialty Health	Chiropractic coverage for employees enrolling in a medical plan.
401(k)	TransAmerica	Over 60 mutual fund investment choices.

† Available in California only.
†† Available nationally.
*** No copay of negotiated rate.**