ASRS 2011 Renewal Comparison
Non-Medicare HMO Medical Plan

Plan Provisions	**PacifiCare HMO 2010**	**UnitedHealthcare Choice 2011**
Calendar Year Deductible	None	None
Out-of-pocket/Coinsurance Maximum	$3,000 individual $9,000 family	$3,000 individual $6,000 family
Maximum Lifetime Benefit	No maximum	No maximum
Outpatient Benefits		
PCP Office Visit	$20 copay	$20 copay
Specialist Office Visit	$40 copay	$40 copay
Routine Office Physical	$20 copay	$20 copay
Examinations/Immunizations	$20/$40 copay	$20/$40 copay
Vision Exam	$40 copay	$40 copay
Hearing Exam	$40 copay	$40 copay
Outpatient Mental Health	$40 copay	$40 copay
Outpatient Hospital Services	70%	70%
Outpatient Standard X-rays	$20 copay	$20 copay
Outpatient Specialized Scans	$150 copay	$150 copay
Outpatient Lab Tests	No charge	No charge
Durable Medical Equipment	No charge	No charge
Prosthetic Devices	50%	50%
Skilled Nursing Facility	No charge	No charge
Home Health Care	No charge	No charge
Physical, Speech and Occupational Therapy	$40 copay	$40 copay
Inpatient Benefits		
Inpatient Hospital Expenses	70%	70%
Inpatient Mental Health	70%	70%
Prescription Benefits		
Generic/Brand	$20/$40 copay	$10/$50/$75/$75 copay
Mail Order (90-day supply)	$40/$80 copay	$25/$125/$188/$188 copay
Other Benefits		
Emergency Room	$75 copay (waived if admitted)	$100 copay (waived if admitted)
Urgent Care Facility	$40 copay	$40 copay
Ambulance	No charge	No charge
Hearing Hardware Benefits		
Hearing Aids	$5000 allowance per 36 mos	$5000 allowance per 36 mos

ASRS 2011 Renewal Comparison
Non-Medicare Choice Plus Out-of-Area only

Plan Provisions	ASRS Choice Plus 2010 In-Network	ASRS Choice Plus 2010 Out-of-Network	ASRS Choice Plus 2011 In-Network	ASRS Choice Plus 2011 Out-of-Network
Offered	Out of State Only		Out of State Only	
Calendar Year Deductible	$500 individual $1,000 family	$500 individual $1,000 family	$500 individual $1,000 family	$500 individual $1,000 family
Out-of-pocket/Coinsurance Maximum	$2,000 individual $4,000 family (including deductibles)	$6,000 individual $12,000 family (including deductibles)	$2,000 individual $4,000 family (including deductibles)	$6,000 individual $12,000 family (including deductibles)
Maximum Lifetime Benefit	$5,000,000		$5,000,000	
Outpatient Benefits				
PCP Office Visit	100% after $15	60%*	100% after $15 copay	60%*
Specialist Office Visit	100% after $15	60%*	100% after $15 copay	60%*
Routine Office Physical	100% after $15	60%*	100% after $15 copay	60%*
Examinations/Immunizations	100% after $15	60%*	100% after $15 copay	60%*
Vision Exam	$15 Copy / 1 exam every 2 years	Not covered	$15 Copy / 1 exam every 2 years	Not covered
Hearing Exam	Not covered	Not covered	Not covered	Not covered
Outpatient Mental Health	$15 copay / 20 visit limit	60%* / 20 visit limit	$15 copay / 20 visit limit	60%* / 20 visit limit
Outpatient Hospital Services	80%*	60%*	80%*	60%*
Outpatient Standard X-rays	100%	60%*	100%	60%*
Outpatient Specialized Scans	80%*	60%*	80%*	60%*
Outpatient Lab Tests	100%	60%*	100%	60%*
Durable Medical Equipment	80%*	60%*	80%*	60%*
Prosthetic Devices	80%*	60%*	80%*	60%*
Skilled Nursing Facility	80%*	60%*	80%*	60%*
Home Health Care	80%*	60%*	80%*	60%*
Physical, Speech and Occupational Therapy	$15 copay / 20 visit limit	60%*	$15 copay / 20 visit limit	60%*
Inpatient Benefits				
Inpatient Hospital Expenses	80%*	60%*	80%*	60%*
Inpatient Mental Health	80%*	60%*	80%*	60%*
Prescription Benefits				
Generic/Brand	$20/$40 copay	$20/$40 copay	$10/$50/$75/$75 copay	$10/$50/$75/$75 copay
Mail Order (90-day supply)	$40/$80 copay	$40/$80 copay	$25/$125/$188/$188 copay	$25/$125/$188/$188 copay
Other Benefits				
Emergency Room	100% after $75 copay	100% after $75 copay	100% after $100 copay	100% after $100 copay
Urgent Care Facility	100% after $40 copay	60%*	100% after $40 copay	60%*
Ambulance	80%*	80%*	80%*	80%*
Hearing Hardware Benefits				
Hearing Aids	Not covered	Not covered	Not covered	Not covered

*Subject to Calendar Year Deductible