



Highlights of the Reta Trust Medical Plans July 1, 2010 - June 30, 2011

BENEFITS	PPO 80%/60% (Anthem Blue Cross)	Network Only/EPO 90% \$500 Ded \$25 Office Visit (Anthem Blue Cross)	Reta HMO \$300 Deductible 90% Coinsurance (Kaiser)
Lifetime Maximum	\$5,000,000	\$5,000,000	No Limit
Coinsurance Percentage <i>(Network/Non-network)</i>	20% / 40% Coinsurance	10% Coinsurance in-network only	10% Coinsurance
Office Visit Copay	20% / 40% Coinsurance	\$25 Copay Deductible waived	\$25 Copay
Hospital Copay Per Admission	20% / 40% Coinsurance	10% Coinsurance No Coverage Out of Network	10% Coinsurance
Emergency Room Copay	20% + \$100 Copay <i>Copay waived if admitted</i>	10% Coinsurance In & out for initial 48 hours No OON coverage thereafter	10% Coinsurance
Annual Deductible			
▪ Individual	None	\$500	\$300
▪ Family	None	\$1,000	\$600
Annual Out-of-Pocket Maximum			
▪ Individual	\$4,000	\$2,500	\$4,000
▫ Family	\$8,000	\$5,000	\$8,000
Chemical Dependency / Alcoholism Treatment	Same as Mental Health	Same as Mental Health	10% Coinsurance
Mental Health			
▪ Inpatient	20% / 40% Coinsurance	10% Copay	10% Coinsurance
▪ Outpatient	20% / 40% Coinsurance	\$25/Visit Deductible waived	\$25 Single Visit / \$5 Group Visit
Chiropractic	20% / 40% Coinsurance 24 visits per calendar year	\$25 Copay / 24 visits per calendar year	N/A
Allergy Visit and Serums	20% / 40% Coinsurance	\$25 Copay Deductible waived	\$0 Copay after deductible

IMPORTANT NOTE: This comparison is designed to be a brief overview of the health plan offerings of the Reta Trust. See the plan description for a full description of covered provisions, limitations and exclusion, including customary and reasonable charges.

*Prepared by: Gallagher Benefit Services
CA License No. OD36879*



Highlights of the Reta Trust Medical Plans July 1, 2010 – June 30, 2011

BENEFITS	PPO 80%/60% (Anthem Blue Cross)	Network Only/EPO 90% \$500 Ded \$25 Office Visit (Anthem Blue Cross)	Reta HMO \$300 Deductible 90% Coinsurance (Kaiser)	
Skilled Nursing Facility	20% / 40% Coinsurance <i>(limited to 120 days/calendar year)</i>	10% Coinsurance <i>(limited to 120 days/calendar year)</i>	10% Coinsurance	
Routine Physical Exam	\$500 Cal Yr Max 20% / 40% Coinsurance	\$500 Cal Yr Max \$ 25 Copay Deductible waived	\$25 Copay	
Outpatient Surgery	20% / 40% Coinsurance	10% In Network Only	10% Coinsurance	
Diagnostic Laboratory, X-Ray and Exams	20% / 40% Coinsurance	10% In Network Only	\$10 per procedure Deductible does apply	
Well Baby Care	20% / 40% Coinsurance	\$25 Copay Deductible waived	\$0 Copay	
Prescription Drugs	Generic / Formulary / Non-formulary		Generic /Preferred Brand	
	▪ Retail	\$10/ 30% /50% – 30 days \$2,000 annual out of pocket max	\$10/ 30% /50% – 30 days \$2,000 annual out of pocket max	\$10 / \$30 – (2x for 31-60 day / 3x for 61-100 day supply)
	▪ Mail Order	\$20/30%/50% – 90 days	\$20/30%/50% – 90 days	2x Retail (31-100 day supply)

Employee Health Insurance Premiums-MONTHLY			
	<i>RETA PPO</i>	<i>RETA EPO</i>	<i>RETA Kaiser</i>
Employee ONLY	\$185.00	\$160.00	\$90.00
Employee + Spouse	\$685.00	\$555.00	\$340.00
Employee + Child(ren)	\$585.00	\$490.00	\$310.00
Family	\$1,080.00	\$880.00	\$540.00

Benefit Provider Contact Information			
Reta PPO/EPO	Anthem Blue Cross	(888) 722-1077	www.anthem.com
Prescriptions	RxSolutions	(866) 870-3469	www.prescriptionsolutions.com
Vision	Medical Eye Services	(800) 877-6372	www.mesvision.com
Reta KAISER (includes Rx and Vision)	Kaiser Permanente	(800) 464-4000	www.kp.org

IMPORTANT NOTE: This comparison is designed to be a brief overview of the health plan offerings of the Reta Trust. See the plan description for a full description of covered provisions, limitations and exclusion, including customary and reasonable charges.

Prepared by: Gallagher Benefit Services
CA License No. OD36879
Page 2