BENEFIT PLAN COMPARISONS

	LAFRA PPO		UFLAC HIGH DEDUCTIBLE HSA		UFLAC PPO		LAFRA HMO	UFLAC SELECT HMO	UFLAC VIVITY HMO
Medical Benefit	**PPO PROVIDER**	**NON-PPO PROVIDER**	**PPO PROVIDER**	**NON-PPO PROVIDER**	**PPO PROVIDER**	**NON-PPO PROVIDER**	**KAISER PROVIDERS**	**ANTHEM - SELECT PROVIDERS**	**ANTHEM - VIVITY PROVIDERS**
Annual Deductible	$250 deductible - applies to inpatient facility admissions only		Member only enrollees have a $1,500 deductible Member + 1 or Family enrollees have a $2,600 Individual and $3,000 Family deductible		Individual: $300 Individual / $900 Family		None	None	None
Annual Out-of-Pocket Max	Individual: $2,000 Family: $4,000	None	Individual: $2,600 Family: $5,000	Individual: $5,000 Family: $10,000	Individual: $1,000 Family: $3,000	Individual: $6,000 Family: $18,000	Individual: $1,500 Family: $3,000	Individual: $500 Family: $1,500	Individual: $2,500 Family: $5,000
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	Unlimited	Unlimited
Physician Office Visits	$15 copay	$30 copay	90% after deductible	70% after deductible	$15 copay	$15 copay after deductible	PCP: 100%, Specialist: 100%	PCP: $10 copay, Specialist: $10 copay	PCP: $20 copay, Specialist: $40 copay
Hospital Charges • Inpatient • Outpatient	90% of the first $5,000, 100% thereafter, after deductible $15 copay	70% after deductible $30 copay, then 80%	90% after deductible 90% after deductible	70% after deductible 70% after deductible	90% after deductible 90% after deductible	60% after deductible 60% after deductible	100% 100%	$500 copay per admission $200 copay per admission	$250 copay per day up to $750 per admission $125 copay per admission
Diagnostic X-Ray & Lab	100%	100%	90% after deductible	70% after deductible	100%	60% after deductible	100%	$10 copay	100%
Emergency Room Services (In a true emergency)	$100 copay (waived if admitted)	$100 copay (waived if admitted)	90% after deductible	90% after deductible	$100 copay (waived if admitted) then, 90%	$100 copay (waived if admitted) then, 90%	$100 copay (waived if admitted)	$50 copay (waived if admitted)	$150 copay (waived if admitted)
Chiropractic Care	$15 copay Up to $50 per day; $2,000 per year	$30 copay	90% after deductible Limited to 30 visits per year	70% after deductible	90% after deductible Limited to 30 visits per year	60% after deductible	$5 per visit Limited to 40 visits per year	$10 copay Limited to 60 visits per year (combined with Speech/Occ/PT)	$20 copay Limited to 60 visits per year (combined with Speech/Occ/PT)
Durable Medical Equip.	100%	80%	50% after deductible	50% after deductible	90% after deductible	60% after deductible	100%	100%	50% up to $1,200 per occurance
Hospice Care	$15 copay	$30 copay	90% after deductible	70% after deductible	80% after deductible	80% after deductible	100%	100%	100%
Home Health Care	$15 copay	$30 copay	90% after deductible Limited to 100 visits per year	70% after deductible	90% after deductible	60% after deductible	100% Limited to 100 visits per year	$10 copay	$20 copay Limited to 100 visits limit per year
Skilled Nursing Facility	100% after deductible	100% after deductible	90% after deductible Limited to 100 day limit per year	70% after deductible	90% after deductible	60% after deductible	100% Limited to 100 visits per year	100% Limited to 100 day limit per year	100% Limited to 100 day limit per year
Physical / Speech / Occup. Therapy	100%	100%	90% after deductible	70% after deductible	90% after deductible	60% after deductible	100%	$10 copay Limited to 60 day limit per year	$20 copay Limited to 60 day limit per year
Maternity • Physician Service • Facility Charge	100% $250 copay	100% 70% after deductible	90% after deductible 90% after deductible	70% after deductible 70% after deductible	90% after deductible 90% after deductible	60% after deductible 60% after deductible	100% 100%	100% $500 copay per admission	100% $250 copay per day up to $750 per admission
Preventative Care	100%	100%	100%	70% after deductible	100%	60% after deductible	100%	100%	100%
Mental Health /Substance Abuse • Inpatient • Outpatient	90% of the first $5,000, 100% thereafter, after deductible $15 copay	70% after deductible $30 copay	90% after deductible 90% after deductible	70% after deductible 70% after deductible	90% after deductible 90% after deductible	60% after deductible 60% after deductible	100% 100%	$500 copay per admission 100%	$250 copay per day, up to $750 per admission 100%
Prescription Drugs									
Out-of-Pocket Maximum	$5,150 individual / $10,300 family		Combined with Medical OOP		None		None	None	None
Deductible	None		Combined with Medical Deductible		None		None	None	None
Generic Copay	$10 retail / $20 mail or Walgreens		$10 retail and mail		$10 retail and mail		No Charge	$10 retail and mail	$15 Retail / $37.50 Mail
Brand Copay	Greater of 20% or $10 up to $300 per script		$30 retail / $60 mail		$30 retail / $60 mail		No Charge	$30 retail / $60 mail	$30 Retail / $90 Mail
Non-Formulary	Greater of 20% or $25 up to $300 per script		$50 retail / $100 mail		$45 retail / $90 mail		Not Covered	$45 retail / $90 mail	$50 Retail / $150 Mail
Specialty	Same as above		30% up to $150 retail / 30% up to $300 mail		20% up to $150 retail / 20% up to $300 mail		No charge - 30-day supply	20% up to $150 retail / 20% up to $300 mail	30% coinsurance up to $250 per script
Retail	30-day supply or 90-day at Walgreens		30-day supply		30-day supply		30- or 100-day supply	30-day supply	30-day supply
Mail	90-day supply		90-day supply		90-day supply		30- or 100-day supply	90-day supply	90-day supply

In case of any discrepancy between this document and the actual plan documents and insurance contracts, the plan documents and insurance contracts will prevail.

PPO PLANS

	LAFRA PPO			UFLAC HIGH DEDUCTIBLE HSA*			UFLAC PPO*		
COVERAGE TIER	**MONTHLY PREMIUM**	**CITY SUBSIDY**	**MONTHLY MEMBER OOP**	**MONTHLY PREMIUM**	**CITY SUBSIDY**	**MONTHLY MEMBER OOP**	**MONTHLY PREMIUM**	**CITY SUBSIDY**	**MONTHLY MEMBER OOP**
Member Only	$667.75	$667.75	**$0.00**	$767.20	$767.20	**$0.00**	$958.26	$867.20	**$91.06**
Member + 1	$1,262.98	$1,262.98	**$0.00**	$1,190.00	$1,190.00	**$0.00**	$1,802.56	$1,290.00	**$512.56**
Family	$1,564.88	$1,290.00	**$274.88**	$1,190.00	$1,190.00	**$0.00**	$2,136.86	$1,290.00	**$846.86**

HMO PLANS

	LAFRA KAISER HMO			UFLAC SELECT HMO*			UFLAC VIVITY HMO*		
COVERAGE TIER	**MONTHLY PREMIUM**	**CITY SUBSIDY**	**MONTHLY MEMBER OOP**	**MONTHLY PREMIUM**	**CITY SUBSIDY**	**MONTHLY MEMBER OOP**	**MONTHLY PREMIUM**	**CITY SUBSIDY**	**MONTHLY MEMBER OOP**
Member Only	$685.44	$685.44	**$0.00**	$867.20	$867.20	**$0.00**	$891.32	$867.20	**$24.12**
Member + 1	$1,360.86	$1,290.00	**$70.86**	$1,372.62	$1,290.00	**$82.62**	$1,405.62	$1,290.00	**$115.62**
Family	$1,718.82	$1,290.00	**$428.82**	$1,416.92	$1,290.00	**$126.92**	$1,453.02	$1,290.00	**$163.02**

*All UFLAC rates are based off of the rates posted on the UFLAC website