JOINT BENEFIT TRUST
Actives – Comparison of Benefits
2010

Benefit	JBT Medical Plan		Kaiser	PacifiCare
Hospital **Inpatient**	Preferred Hospital No charge for covered services after the calendar year deductible (see "Other Plan Features" at the bottom of this chart)	Non-Preferred Hospital 30% of covered charges after the calendar year deductible, up to the out-of-pocket maximum for all non-preferred providers (see "Other Plan Features" at the bottom of this chart)	10% of covered charge per admission after deductible is met	50% copay per admission
Outpatient (surgery)	Preferred Hospital 20% of covered charges after the calendar year deductible, up to the out-of-pocket maximum for all preferred providers	Non-Preferred Hospital 30% of covered charges after the calendar year deductible, up to the out-of-pocket maximum for all non-preferred providers	10% of covered charge per procedure after deductible is met	50% copay per occurrence including oral surgery
Doctor Visit **Office visit**	Preferred Provider $20 per visit for the basic office visit charges, 20% of covered charges after the deductible for any additional services that may be provided during your visit	Non-Preferred Provider 30% of covered charges after the deductible and any difference between the reasonable and customary charges and the actual charges made by the provider.	$10 copay per visit ($No copay per visit for prenatal care and first post-partum visit)	$20 copay per visit for primary care physician $40 copay per visit for specialist
Well Baby	Not covered		No copay per visit (for child 23 months old or younger)	No copay for child under 2 years of age
Prescription Drugs	Retail (30 day supply): $10 Generic $20 Brand You pay price difference between brand name drug and generic drug if you choose a brand name drug when a generic equivalent is available. Additional $15 copay is required for purchase of non-preferred drugs. Mail Order (90 day supply): $20 generic $40 brand You pay price difference between brand name drug and generic drug if you choose a brand name drug when a generic equivalent is available. Additional $30 copay is required for purchase of non-preferred drugs.		Retail (30 days): $10 Generic $30 Brand Closed formulary Mail Order (100 day supply): $20 generic $60 brand in accordance with Kaiser's formulary, 50% for drugs for treatment of sexual dysfunction	Retail (30 day supply): $15 Generic $35 Brand Closed formulary Mail Order (3 units or 90 day supply): $30 generic $70 brand Closed formulary
Physicals: **Ages 2 - 6** **Ages 7 - 17** **Over 18**	Not covered		$10 copay per visit $10 copay per visit $10 copay per visit	$20 copay (1 visit / year) $20 copay (1 visit / year) $20 copay

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Surgeon/Anesthesiologist (for surgery)	Preferred Provider 20% of covered charges after the deductible	Non-Preferred Provider 30% of covered charges after the deductible and any difference between the reasonable and customary charges and the actual charges made by the provider.	10% of covered charge per procedure after deductible is met	50% per occurrence
Laboratory/X-rays	Preferred Provider 20% of covered charges after the deductible	Non-Preferred Provider 30% of covered charges after the deductible and any difference between the reasonable and customary charges and the actual charges made by the provider.	$10 per visit after deductible is met $50 copay per procedure for MRI, PET, CT	No charge for routine diagnostic procedures $200 copay for specialized scanning
Radiation/Chemotherapy	Preferred Provider 20% of covered charges after the deductible	Non-Preferred Provider 30% of covered charges after the deductible and any difference between the reasonable and customary charges and the actual charges made by the provider.	10% of covered charge after deductible is met	No charge for standard therapy $400 copay for complex therapy
Physical/Speech/ Occupational Therapy	Preferred Provider 20% of covered charges after the deductible	Non-Preferred Provider 30% of covered charges after the deductible and any difference between the reasonable and customary charges and the actual charges made by the provider.	$10 copay per visit after deductible is met	50% copay
Supplies **Durable Medical Equipment (DME)**	Preferred Provider 20% of covered charges after the deductible	Non-Preferred Provider 30% of covered charges after the deductible and any difference between the reasonable and customary charges and the actual charges made by the provider.	20% of covered charge	$50 copay $5,000 annual benefit maximum
Prosthetic Devices: **Surgically implanted** **Other**	Preferred Provider 20% of covered charges after the deductible	Non-Preferred Provider 30% of covered charges after the deductible and any difference between the reasonable and customary charges and the actual charges made by the provider.	20% of covered charges	$100 copay per item
Orthotic devices	Not covered		20% of covered charge, except shoes arch supports not covered	Not covered
Mental Health: **Inpatient** **Outpatient** **Private Counseling** **Group Counseling**	Preferred Provider (Must be authorized by_Health Management Ctr) No charge 1-5 visits: 100% 6-10 visits: $10 copay 11-15 visits: $20 copay 16-50 visits: $30 copay No charge	Non-Preferred Provider NO benefits, unless emergency treatment is authorized by HMC at a non-network provider NO benefits NO benefits	Inpatient: 10% copay per admit (30 days per year unless severe mental illness**) Outpatient: $10 copay 1st 20 individual visits $5 copay 1st 20 grp visits $5 copay add'l visits	Carved out, same as JBT medical plan

Benefit	JBT Medical Plan		Kaiser	PacifiCare
Chiropractic	Preferred Provider $20 per visit for the office visit charges, then 20% of covered charges after the deductible for any x-rays $680 maximum benefit per calendar year for all chiropractic	Non-Preferred Provider 30% of the first $50 in charges after the deductible and any charges in excess of $50 per visit.	Not covered	Not covered
Emergency Care **Contract (HMO) Provider** **Emergency Room** **Urgent Care Center**	See Hospital Inpatient and Outpatient benefits above. Emergency Room and Urgent Care Center charges will be paid the same as inpatient care if you are admitted directly to a hospital, otherwise they will be paid as any other outpatient service.		10% of covered charge after deduct met. If urgent & srvc can be scheduled, then office visit copay applies	$100 copay per visit* $100 copay per visit*
Non-Contract Provider **Emergency Room**	Will be paid at preferred provider benefit level if the visit is to treat a medical emergency. Non-emergency treatment will be paid at the non-preferred level.		10% of covered charge after deductible met	$100 copay per visit*
Out of Network Benefit **(if HMO services not used)**	Not applicable		No coverage	No coverage
Other Plan Features ***Calendar Year Deductible***	Preferred Provider $200 per individual $500 per family	Non-Preferred Provider $400 per individual $1,000 per family	$500 per individual[1] $1,000 per family	No separate deductible
Calendar Year Out-of-Pocket Maximum	$2,000 per individual	$4,000 per individual	$3,000 per individual $6,000 per family	$5,000 per individual[2] 3 individual maximums per family
Other			Covered infertility: Office visits 50% Other infertility svcs: 50% after deductible is met No charge for allergy injections after deductible is met $150 copay for Ambulance after deductible is met.	Infertility services not covered $100 copay for infusion therapy $50 copay for inject-table drugs

* Notification to PCP within 24 hours; PacifiCare - copay not waived, even if admitted

** Severe mental illness includes Schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder, autism, anorexia nervosa and bulimia nervosa

Note 1: The $500 Calendar Year Deductible under Kaiser applies only to charges incurred for: hospitalization, emergency room, outpatient surgery and certain other chgs.

Note 2: Once the patient reaches $2,000 in annual out-of-pocket expenses under PacifiCare, claims can be submitted to the JBT Medical Plan for reimbursement until the patient is out-of-pocket $5,000. Thereafter, PacifiCare will pay covered expenses at 100%.

This summary chart is provided to facilitate comparison only. Refer to JBT 1400 Hour Employee Summary Plan Description for exclusions, limitations, and exact terms and conditions. Each HMO contains exclusions and limitations not listed above. Each HMO's Plan Contract and Combined Evidence of Coverage and Disclosures must be consulted to determine the exact terms and conditions. HMOs furnish these documents upon request.