Brief summary of benefits proposed for the Health Insurance options effective April 1, 2007 - ACTIVE EMPLOYEES

This is only a BRIEF SUMMARY	BLUECARE 100 PLAN (Anthem BCBS)	KEYCARE 15 Plus PPO PLAN (Anthem BCBS)	HealthKeeper's HMO 15 Plan (Anthem BCBS)	Optima HMO 3500 Plan (Sentara)
It is very important that you review all of your enrollment materials for more specific details.	*You and your dependents may choose any provider. When you use Anthem BCBS "participating" (PAR) providers, you may not be "balance billed" (1)*	*You and your dependents may access care from any PPO provider. The PPO network is extensive. See the provider directory.* *You pay 30% coinsurance after the annual out-of-network deductible if you go out-of-network. (1)*	*You and your dependents must access care through your designated Primary Care Physician (PCP) and within the HMO network in order to receive benefits. Care must be rendered or referred by your network PCP, except for certain OBGYN services, vision services, or emergency situations.*	*You and your dependents may access care from any health professional without obtaining a referral from your designated Primary Care Physician (PCP), as long as the health professional you visit participates in the HMO network.*
MONTHLY EMPLOYEE COST FOR EACH OPTION				
Employee Only	**$152.20**	**$105.30**	**$86.60**	**$79.10**
Employee + Child	**$221.00**	**$152.20**	**$125.50**	**$114.80**
Employee + Spouse	**$318.20**	**$220.00**	**$181.30**	**$165.80**
Employee + Family	**$416.40**	**$287.80**	**$237.40**	**$217.30**
Calendar Year Deductible (Ded.) (Individual/Family)	**$100 Individual / $200 Family**	**In-Network: None** **Out-of-Network: $400 / $800**	**None**	**None**
Your maximum out-of-pocket expense limit per year	**$1,000 Individual / $2,000 Family**	**In-Network: $2,000 / $4,000** **Out-of-Network: $4,000 / $8,000**	**$1,500 Individual / $3,000 Family**	**$2,000 Individual / $4,000 Family**
Referrals to Specialists by PCPs Required?	**No**	**No**	**Yes**	**No**
Physician Office Visits	**20% coinsurance after Ded.**	**PCP - $15 copay** **Specialist - $30 copay**	**PCP - $15 copay** **Specialist - $35 copay**	**PCP - $10 copay** **Specialist - $25 copay**
Labs, X-rays, and Other Outpatient Diagnostic Tests	**20% coinsurance after Ded.**	**Diagnostic X-rays and Annual Mammograms - $30 copay; Other Routine Lab Services and Screening Tests - No Charge**	**PCP - $15 copay** **Specialist - $35 copay** **Separate copays are not charged for services/x-rays/tests provided by same provider on same day as office visit.**	**Lab - no charge; X-rays/Other - $25 copay** **Separate copay is not charged for services/x-rays/tests provided during physician's office visit.**
Complex Diagnostic Imaging Services	**20% coinsurance after Ded.**	**MRI, MRA, MRS, PET Scan, CTA and CT Scan - $100 copay**	**MRI, MRA, MRS, PET Scan, CTA and CT Scan - $100 copay**	**MRI, MRA, PET Scan, CT Scan - $100 copay**
Outpatient Surgery	**20% coinsurance after Ded..**	**$100 copay facility, $15 or $30 copay for doctor**	**$100 copay**	**$100 copay**
Well Child Care	**20% coinsurance after Ded..**	**$15 PCP copay**	**$15 PCP copay**	**$10 PCP copay**
Well Adult Care (2)	**Covered @ 100%, no annual deductible (annual check-ups, annual routine gynecological exam and PAP smear, mammogram, annual prostate exam, colorectal cancer screening, annual PSA test).**	**$15 PCP or $30 Specialist copay for annual check-up, annual routine gynecological exam, annual prostate exam, colorectal cancer screening, diagnostic x-rays. No Charge for lab services, annual Pap test, annual PSA test.**	**$15 PCP or $35 Specialist copay for annual check up, prostate exam, PSA test, colorectal cancer screening, diagnostic x-rays, lab work. $15 PCP copay for annual routine gynecological exam and Pap test.**	**$10 copay for annual check-ups, routine annual gynecological exam, Pap test, mammograms, colorectal cancer screening, annual prostate exam, and annual PSA test.**
Maternity Care (Out-patient Services)	**20% coinsurance after Ded. for pre and postnatal care**	**$30 copay per visit for routine pre and postnatal office visits unless billed globally by the doctor (then member will pay 20% coinsurance)**	**$100 copay per pregnancy for routine pre and postnatal care.** **$35 copay/visit for ultra sounds, non-stress tests and other fetal monitor procedures.**	**$100 copay per pregnancy for prenatal and postnatal care office visits and routine ultra sounds**
Emergency Room Visit	**20% coinsurance after Ded.**	**$100 facility copay, $15 or $30 copay for services billed by the doctor**	**$100 facility copay, $35 for services billed by the doctor**	**$100 copay**
Inpatient Hospital Services	**20% coinsurance after Ded.**	**$300 copay plus 20% coinsurance for each admission**	**$150 per day not to exceed $750 for an admission**	**$100 copay per day not to exceed $500 for an admission**
Outpatient Mental Health and Substance Abuse (MHSA)	**20% coinsurance after Ded.**	**$30 copay per visit**	**Individual or group therapy or medication management - $20 copay** **Other mental health/substance abuse visits - $30 copay**	**Biologically-based illness - $25 copay** **Non-Biologically-based illness - $25 copay, limited to 20 visits/cal. year**
Inpatient MHSA Services	**20% coinsurance after Ded.**	**$300 copay plus 20% coinsurance for each admission**	**$150 per day not to exceed $750 for an admission**	**Biologically-based illness - $100 copay per day to $500 per admission** **Non-Biologically-based illness - $100 copay per day, limited to 30 days/cal. yr.**
Prescription Drug Copays(3) **Retail Copays:** **Mail Order Copays:**	 **$8/$15/$30** **$16/$30/$60**	 **$8/$15/$30** **$16/$30/$60**	 **$8/$15/$30** **$16/$30/$60**	 **$10/$20/$40/$40** **$20/$40/$80/$80**
Chiropractic Services	**20% coinsurance after Ded.** **Benefits limited to $500 per calendar year**	**$30 copay per visit** **Benefits limited to $500 per calendar year**	**$25 copay per visit (PCP referral required)** **Limited to 30 visits per calendar year**	**Discount Program (through ASHN)** **ASHN providers extend up to a 25% discount off their normal charges to Optima members**
Routine Vision Services	**Annual eye exam - $15 copay** **Discounts available for eye wear and laser vision correction surgery**	**Annual eye exam - $15 copay** **Discounts available for eye wear and laser vision correction surgery**	**Annual eye exam - $15 copay** **Discounts available for eye wear and laser vision correction surgery**	**Eye exam and covered vision materials every 24 mos. Spectacle exam - $15 copay. Contact lens exam - $15 copay plus difference between contact lens and spectacle exam. $100 allowance toward purchase of eyeglasses and contact lenses.**

(1) When services are rendered by non-participating provider, you may be "balance billed" for charges above the Anthem BCBS allowable charge for BlueCare or the network negotiated reimbursement for KeyCare.

(2) Well adult care coverage includes an annual mammography screening (at age 35+ Anthem and at age 40+ Optima), annual PSA Test and prostate exam (at age 40+), and colorectal cancer screening (annual fecal occult blood test and other services such as sigmoidoscopies and colonoscopies periodically based on age and family history recommendations established by the American College of Gastroenterology).

(3) For a list of First Tier, Second Tier, and Third Tier Drugs, refer to the applicable provider web site (www.anthem.com or www.sentara.com). Generic substition unless member pays brand copay plus difference in brand and generic drug cost. A 90-day supply of certain maintenance drugs can be filled through the Mail Order Pharmacy.