Sample PEO Benefits Plan Comparisons

Coverage Area	Plan Option 1 (HMO)	Plan Option 2 (HMO)	Plan Option 3 (HMO)	
	In-Network	In-Network	In-Network	Out-Network
Prescription Card	15 (Generic) 35 (Brand) 60/OC/N/A/2x 90/day (d)	15 (Generic) 35 (Brand) 50/OC/0/MO 0 (d)	15 (Generic) 35 (Brand) 60/OC/0/MO 0 (d)	
Major Medical				
Deductible Ind/Fam	N/A	N/A	$500/$1000	
Co-Insurance	N/A	100%	90%	
Maximum Out-of-Pocket	$1,500/$3,000	N/A	$2500 per Member	
Office Co-pay	$30 copay	$20 Copay	$25.00 Copay	
DXL/Lab Fees	$50 copay	100%	90% After Ded	
Specialist Co-pay	$50 copay	$40 Copay	$50.00 Copay	
Lifetime Maximum	Unlimited	Unlimited	Unlimited	
Hospital Benefits				
Hospital In-Patient	$300 copay per admit	100%	90% After Ded	
Hospital Out-Patient	$100 copay	100%	90% After Ded	
Emergency Room	$50 copay	$100 Copay	$100 - (Waived)	
Private Nursing	Not Covered, except under HHC		See Home Health	
Surgical Benefits				
Surgical In-Patient	Incl. Hosp Co-pay	100%	See Hospital IP	
Surgical Out-Patient	$100 copay	100%	90% After Ded	
Mental Health				
Mental Nervous In-Patient	a)$300 copay per admit 30 days per cal yr	100% 30 Days/Cal yr	$150/Day up to 5 Days 30 Visits/Year	
Substance Abuse In-Patient	a)$300 copay per admit 30d/Cal Yr/90d/lifetime	100% 30 Days/Cal yr	$150/Day up to 5 Days 30 Visits/Year	
Mental Nervous Out-Patient	a)$50 copay 20 visits/Cal Yr	$40 Copay 20 Days/Cal yr	$25.00 Copay 20 Visits/Year	
Substance Abuse Out-Patient	a)$50 copay 20 visits/Cal Yr	$40 Copay 20 Days/Cal yr	$25.00 Copay 20 Visits/Year	
Other				
Well Care(Up to 19)	$30 copay	$20 Copay	$25.00 Copay	
Routine Adult Care	$30 copay	$20 Copay	$25.00 Copay	
Chiropractic Care	$50 copay; 30 visits per Cal. Yr.	$40 Copay, 20 Visits/Cal yr	$50 Copay, 30 Visits/Year	
Home Health Care	No copay; 60 visits per cal yr	100%	90% After Ded, 60 Days/Year	
Non-Authorization	Refer to Carrier Plan Information		See Benefit Booklet	
Single	6 x 230.00	6 x 215.84	6 x 238.40	
EE with Spouse	0 x 484.00	0 x 453.27	0 x 524.47	
EE with Child(ren)	0 x 408.00	0 x 382.05	0 x 431.50	
Family	0 x 681.00	0 x 637.83	0 x 705.65	
Medicare	0 0.00	0 0.00	0 0.00	
Monthly Cost	6 1,380.00	6 1,295.04	6 1,430.38	
Annual Cost	**16,560.00**	**15,540.48**	**17,164.56**	
Incr (decr) / %				

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(d) Non-Formulary / Oral Contraceptive / Deductible / Mail Order (Wellchoice includes Mail Order Generic, Brand, and Non-Formulary costs)

(a) Biological based Mental Nervous & Alcohol Abuse/Treated same way as any other illness.

Sample PEO Benefits Plan Comparisons

Coverage Area	Plan Option 4 (HMO)	Plan Option 5 (POS)		Plan Option 6 (HMO)
	In-Network	In-Network	Out-Network	In-Network
Prescription Card	15 (Generic) 30 (Brand) 60/OC/0/MO (d)	15 (Generic) 30 (Brand) 60/OC/0/MO (d)		12 (Generic) 25 (Brand) 40/OC/0/MO (d)
Major Medical				
Deductible Ind/Fam	N/A	N/A	$1,000/$2,000	N/A
Co-Insurance	100%	100%	70%	100%
Maximum Out-of-Pocket	$5,000 PMPCY	$5,000 PMPCY	$3700/$7400	$5000/$10,000
Office Co-pay	$30 Copay	$30 Copay	70% After Ded.	$20 Copay
DXL/Lab Fees	No Charge	No Charge	70% After Ded.	No Charge
Specialist Co-pay	$30 Copay	$30 Copay	70% After Ded.	$20 Copay
Lifetime Maximum	Unlimited	Unlimited	$5,000,000	Unlimited
Hospital Benefits				
Hospital In-Patient	No Charge	No Charge	70% After Ded.	No Charge
Hospital Out-Patient	$30 Copay	$30 Copay	70% After Ded.	$20 Copay
Emergency Room	$50 - (Waived)	$50 - (Waived)	$50 - (Waived)	$50 - (Waived)
Private Nursing	See Home Health	See Home Health	See Home Health	Preauthorization Required
Surgical Benefits				
Surgical In-Patient	No Charge	No Charge	70% After Ded.	No Charge
Surgical Out-Patient	$30 Copay	$30 Copay	70% After Ded.	$20 Copay
Mental Health				
Mental Nervous In-Patient	No Charge 30 Days Combined Benefit	No Charge 30 Days Combined Benefit	70% After Ded.	No Charge 30 days per calendar year limit
Substance Abuse In-Patient	No Charge 30 Days Combined Benefit	No Charge 30 Days Combined Benefit	70% After Ded.	No Charge
Mental Nervous Out-Patient	$30 Copay 20 Visits/Cal.Yr. Combined Benefit	$30 Copay 20 Visits/Cal.Yr. Combined Benefit	70% After Ded.	$20 Copay 20 Visits/Cal.Yr.
Substance Abuse Out-Patient	$30 Copay 20 Visits/Cal.Yr. Combined Benefit	$30 Copay 20 Visits/Cal.Yr. Combined Benefit	70% After Ded.	$20 Copay
Other				
Well Care(Up to 19)	0-1 & 1+ $30 Copay	0-1 & 1+ $30 Copay	0-1 $750/Person/Cal.Yr.	$20 Copay
Routine Adult Care	$30 Copay	$30 Copay	1+$500/Member/Cal.Yr	$20 Copay
Chiropractic Care	$30/30 Vsts.	$30/30 Vsts.	70%/vst comb.innet	$20 Copay / 30 Visits
Home Health Care	No Charge	No Charge	70% After Ded.	No Charge
Non-Authorization	No Reduction	No Reduction	No Reduction	Full-Responsibility
Single	6 x 328.57	6 x 353.21		6 x 265.82
EE with Spouse	0 x 722.89	0 x 777.09		0 x 555.74
EE with Child(ren)	0 x 607.87	0 x 653.44		0 x 450.29
Family	0 x 985.74	0 x 1,059.65		0 x 755.24
Medicare	0 0.00	0 0.00		0 0.00
Monthly Cost	6 1,971.42	6 2,119.24		6 1,594.92
Annual Cost	**23,657.04**	**25,430.88**		**19,139.04**
Incr (decr) / %				

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(d) Non-Formulary / Oral Contraceptive / Deductible / Mail Order (Wellchoice includes Mail Order Generic, Brand, and Non-Formulary costs)

(a) Biological based Mental Nervous & Alcohol Abuse/Treated same way as any other illness.

Sample PEO Benefits Plan Comparisons

Coverage Area	Plan Option 7 (POS)		Plan Option 8 (HMO)	Plan Option 9 (HMO)
	In-Network	Out-Network	In-Network	In-Network
Prescription Card	10 (Generic) 20 (Brand) 35/OC/0/MO (d)		10 (Generic) 25 (Brand) 50/OC/0/MO (d)	10 (Generic) 25 (Brand) 50/OC/0/MO (d)
Major Medical				
Deductible Ind/Fam	N/A	$1000/$2000	N/A	N/A
Co-Insurance	100%	70%	N/A	N/A
Maximum Out-of-Pocket	$4,000/$8,000	$4,000/$8,000	N/A	N/A
Office Co-pay	$20.00	70% After Ded.	$15.00	$15.00
DXL/Lab Fees	No Charge	70% After Ded.	No Charge/Part. Lab ONLY	No Charge/Part. Lab ONLY
Specialist Co-pay	$20.00 Co-pay	70% After Ded.	$30.00	$30.00
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Hospital Benefits				
Hospital In-Patient	No Charge	70% After Ded.	No Charge	No Charge
Hospital Out-Patient	$20.00 Co-pay	70% After Ded.	No Charge	No Charge
Emergency Room	$50 Co-pay	$50-70% After Ded.	$100 - (Waived if Admitted)	$100 - (Waived if Admitted)
Private Nursing	Preauthorization Required	Preauthorization Required	See Home Health	See Home Health
Surgical Benefits				
Surgical In-Patient	100%	70% After Ded.	See Hospital IP	See Hospital IP
Surgical Out-Patient	$20.00 Co-pay	70% After Ded.	No Charge	No Charge
Mental Health				
Mental Nervous In-Patient	No Charge 30 Days/Cal. Yr.	70% 30 Days/Cal. Yr.	No Charge 30 days/Year	No Charge 30 days/Year
Substance Abuse In-Patient	No Charge 30 Days/Cal. Yr.	70% 30 Days/Cal. Yr.	No Charge 30 days/Year	No Charge 30 days/Year
Mental Nervous Out-Patient	$20 Co-pay 20 Visits/Cal. Yr.	70% 20 Visits/Cal. Yr.	$30.00 20 Visits Combined between Mental Health/Substance Abuse $30.00	$30.00 20 Visits Combined between Mental Health/Substance Abuse $30.00
Substance Abuse Out-Patient	$20 Co-pay 20 Visits/Cal. Yr.	70% 20 Visits/Cal. Yr.	20 Visits Combined between Mental Health/Substance Abuse	20 Visits Combined between Mental Health/Substance Abuse
Other				
Well Care(Up to 19)	100% after office copay	$750/First Year; $500 1+	No Charge	No Charge
Routine Adult Care	100% after office copay	$500	No Charge	No Charge
Chiropractic Care	30 Vsts. $20 Copay	70% After Ded-30 Vst.	$30.00	$30.00
Home Health Care	No Charge	70% After Ded.	No Charge	No Charge
Non-Authorization	Full Responsibility	No Coverage	See Benefit Booklet	See Benefit Booklet
Single	6 x 306.20		6 x 272.13	6 x 293.15
EE with Spouse	0 x 639.53		0 x 585.08	0 x 630.27
EE with Child(ren)	0 x 516.83		0 x 517.05	0 x 556.99
Family	0 x 867.14		0 x 843.60	0 x 908.77
Medicare	0 0.00		0 0.00	0 0.00
Monthly Cost	6 1,837.20		6 1,632.78	6 1,758.90
Annual Cost	**22,046.40**		**19,593.36**	**21,106.80**
Incr (decr) / %				

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(a) Biological based Mental Nervous & Alcohol Abuse/Treated same way as any other illness.

Sample PEO Benefits Plan Comparisons

Coverage Area	Plan Option 10 (PPO)		Plan Option 11 (PPO)		Plan Option 12 (HMO)
	In-Network	Out-Network	In-Network	Out-Network	In-Network
Prescription Card	10 (Generic) 25 (Brand) 50/OC/0/MO (d)		10 (Generic) 25 (Brand) 50/OC/0/MO (d)		10/25/50/OC/0/MO
Major Medical					
Deductible Ind/Fam	N/A	$1000/$2000	N/A	$1000/$2000	N/A
Co-Insurance	None	70%	None	70%	100%
Maximum Out-of-Pocket	$5000/$10000	$4000/$8000	$5000/$10000	$4000/$8000	N/A
Office Co-pay	$30.00	Ded & Coins	$30.00	Ded & Coins	$30.00
DXL/Lab Fees	N/C(Quest/Diag)	70% After Ded.	N/C(Quest/Diag)	70% After Ded.	$30.00
Specialist Co-pay	$30.00	Ded & Coins	$30.00	Ded & Coins	$30.00 Co-pay
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Hospital Benefits					
Hospital In-Patient	No Charge	70% After Ded.	No Charge	70% After Ded.	No Charge
Hospital Out-Patient	$30.00 Copay	70% After Ded.	$30.00 Copay	70% After Ded.	$30.00 Co-pay
Emergency Room	$75 - (Waived)	$75 - (Waived)	$75 - (Waived)	$75 - (Waived)	$50 Co-pay
Private Nursing	See Home Health	See Home Health	See Home Health	See Home Health	No Charge
Surgical Benefits					
Surgical In-Patient	See Hospital IP	70% After Ded.	See Hospital IP	70% After Ded.	See Hospital
Surgical Out-Patient	$30.00	70% After Ded.	$30.00	70% After Ded.	$30.00 Co-pay
Mental Health					
Mental Nervous In-Patient	No Charge 30 Visits/Year	70% After Deductible 30 Visits/Year	No Charge 30 Visits/Year	70% After Deductible 30 Visits/Year	See Hospital In-Patient 30 Days/Cal. Yr.
Substance Abuse In-Patient	No Charge 30 Visits/Year	70% After Deductible 30 Visits/Year	No Charge 30 Visits/Year	70% After Deductible 30 Visits/Year	See Hospital In-Patient 30 Days/Cal. Yr.
Mental Nervous Out-Patient	$30.00 Copay 20 Visits/Year	70% After Deductible 20 Visits/Year	$30.00 Copay 20 Visits/Year	70% After Deductible 20 Visits/Year	20 Visits/Cal.Yr. $30 Co-pay
Substance Abuse Out-Patient	$30.00 Copay 20 Visits/Year	70% After Deductible 20 Visits/Year	$30.00 Copay 20 Visits/Year	70% After Deductible 20 Visits/Year	Combined with Mental/Nervous Out-patient
Other					
Well Care(Up to 19)	0-1 & 1+ No Charge	0-1 $750/Person/Cal.Yr	0-1 & 1+ No Charge	0-1 $750/Person/Cal.Yr	$30.00 Co-pay
Routine Adult Care	No Charge	1+ $500/Person/Cal.Yr	No Charge	1+ $500/Person/Cal.Yr	$30.00 Co-pay
Chiropractic Care	$30/30 Vsts.	70% After Ded.	$30/30 Vsts.	70% After Ded.	30 Vst./$30 Co-pay
Home Health Care	No Charge	70% After Ded.	No Charge	70% After Ded.	No Charge
Non-Authorization	See Benefit Booklet	See Benefit Booklet	See Benefit Booklet	See Benefit Booklet	Full Responsibility
Single	6 x 318.88		6 x 350.89		6 x 282.08
EE with Spouse	0 x 685.59		0 x 754.41		0 x 564.17
EE with Child(ren)	0 x 605.87		0 x 666.69		0 x 507.75
Family	0 x 988.53		0 x 1,087.76		0 x 846.25
Medicare	0 0.00		0 0.00		0 0.00
Monthly Cost	6 1,913.28		6 2,105.34		6 1,692.48
Annual Cost	**22,959.36**		**25,264.08**		**20,309.76**
Incr (decr) / %					

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(a) Biological based Mental Nervous & Alcohol Abuse/Treated same way as any other illness.