

| 2011  |                                | HMO-1  | HMO-4   | POS-2   |   |
|---|--------------------------------|--|---|---|---|
| <b>Health Insurance Comparison Chart</b>  |                                | Non-rep, Library<br>Locals 1035 & 1035B<br>(union monthly cap \$175) | Non-rep and Library only                                | Non-rep/Library   | Locals 1035 & 1035B<br>(union monthly cap \$250)  |
|   |                                | 10% premium contribution<br>monthly contribution amt                 | 4% premium contribution<br>monthly contribution amt     | 13% premium contribution<br>monthly contribution amt    | 12% premium contribution<br>monthly contribution amt  |
|   | Single                         | \$52.36  | \$19.08   | \$72.58   | \$66.96   |
|   | Employee/Child                 | \$96.50  | \$35.16   | \$133.69  | \$123.41  |
|   | Employee/Spouse<br>Family      | \$109.95<br>\$169.38   | \$40.07<br>\$61.72                                      | \$152.33<br>\$234.66                                    | \$140.61<br>\$216.61  |
|   |                                |  |   | In-Plan   | Out-of-Plan   |
|   | Co-Pays                        | as listed below  | as listed below   | as listed below   |   |
|   | Annual Deductibles             | n/a  | \$250 individual/<br>\$500 family                       | \$250 individual/<br>\$500 family                       | \$500 individual/<br>\$1000 family  |
|   | Co-Insurance                   | n/a  | 20% of eligible expenses,<br>unless otherwise specified | 10% of eligible expenses,<br>unless otherwise specified | 30% of eligible expenses,<br>unless otherwise specified   |
|   | Annual Out-of-Pocket Limit     | n/a  | \$2000 individual/<br>\$4000 family                     | \$500 individual/<br>\$1000 family                      | \$1500 individual/<br>\$3000 family   |
|   |                                |  |   |   | Coverage for Out-of-Network services which require Prior Authorization as listed in the Point of Service Plan Rider will have a 50% benefit reduction up to a max of \$500/occurrence if the services are not Prior Authorized. |
| <b>This comparison chart is not a guarantee of coverage, please refer to the Certificate of Coverage, and Riders for detailed benefit information restrictions, limitations and exclusions that apply to that coverage.</b> |                                |  |   |   |   |
|   |                                | HMO-1  | HMO-4   | POS-2   |   |
| <b>Services</b>   |                                |  |   | In-Plan   | Out-of-Plan   |
| <b>Wellness/<br/>Preventive Health</b>  | • Well Child Care Exams        | No Charge  | No Charge   | No Charge   | Deductible/Co-insurance   |
|   | • Periodic Physical Exams      | No Charge  | No Charge   | No Charge   | Deductible/Co-insurance   |
|   | • Immunizations                | No Charge  | No Charge   | No Charge   | Deductible/Co-insurance   |
|   | • Routine Mammography Services | No Charge  | No Charge   | No Charge   | Deductible/Co-insurance   |

|  |   | This comparison chart is not a guarantee of coverage, please refer to the Certificate of Coverage, and Riders for detailed benefit information restrictions, limitations and exclusions that apply to that coverage. |  |  |                         |
|--|---|--|--|--|-------------------------|
|  |   | HMO-1  | HMO-4  | POS-2  |                         |
| Services   |   |  |  | In-Plan  | Out-of-Plan             |
| <b>Physician and Practitioner Services</b>         | <b>Primary Care Practitioner</b>  |  |  |  |                         |
|  | • Office and Home visits  | \$10 Co-pay per visit  | \$20 Co-pay per visit  | \$15 Co-pay per visit  | Deductible/Co-insurance |
|  | • Inpatient visits  | No Charge  | No Charge  | No Charge  | Deductible/Co-insurance |
|  | <b>Specialty Physician</b>  |  |  |  |                         |
|  | • Office and Home visits  | \$10 Co-pay per visit  | \$20 Co-pay per visit  | \$15 Co-pay per visit  | Deductible/Co-insurance |
|  | • Routine Eye Exams<br><i>(limited to one per 12-month period)</i>                  | \$10 Co-pay per visit  | \$20 Co-pay per visit  | \$15 Co-pay per visit  | Deductible/Co-insurance |
|  | • Chiropractic office visits and manipulations                                      | \$10 Co-pay per visit  | \$20 Co-pay per visit  | \$15 Co-pay per visit  | Deductible/Co-insurance |
|  | • Allergy Immunizations   | No Charge  | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Accidental Dental Services  | No Charge  | No Charge  | No Charge  | No Charge               |
|  | • Radiation/Chemotherapy Services   | No Charge  | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Dialysis Services   | No Charge  | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Surgery & Anesthesiology Services   | No Charge  | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Routine Maternity<br>(pre & post natal care)                                      | No Charge  | No Charge  | No Charge  | Deductible/Co-insurance |
| • Inpatient visits                                 | No Charge   | No Charge  | No Charge  | Deductible/Co-insurance                                      |                         |
| • Injectables administered in a Physician's office | <i>Please refer to your Prescription drug benefit levels</i>                        | <i>Please refer to your Prescription drug benefit levels</i>   | <i>Please refer to your Prescription drug benefit levels</i> | <i>Please refer to your Prescription drug benefit levels</i> |                         |
| <b>Diagnostic Services</b>                         | • X-Ray, Lab, Pathology<br><i>(practitioner's office or outpatient)</i>             | No Charge  | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Diagnostic Mammography Services   | No Charge  | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • PET Scans, MRI's, MRA's, CT Scans<br><i>(no coverage if not prior authorized)</i> | No Charge  | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Stress Tests  | No Charge  | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Ultrasounds/Echocardiograms   | No Charge  | No Charge  | No Charge  | Deductible/Co-insurance |
| <b>Hospital Services</b>                           | • Inpatient Hospital<br><i>(no coverage if not prior authorized)</i>                | No Charge  | Deductible/Co-insurance                                      | Deductible/Co-insurance                                      | Deductible/Co-insurance |
|  | • Outpatient Services or Procedures<br><i>(including cardiac rehabilitation)</i>    | No Charge  | Deductible/Co-insurance                                      | Deductible/Co-insurance                                      | Deductible/Co-insurance |

|                                    |   | This comparison chart is not a guarantee of coverage, please refer to the Certificate of Coverage, and Riders for detailed benefit information restrictions, limitations and exclusions that apply to that coverage. |                         |                         |                         |
|------------------------------------|---|--|-------------------------|-------------------------|-------------------------|
|                                    |   | HMO-1  | HMO-4                   | POS-2                   |                         |
| Services                           |   |  |                         | In-Plan                 | Out-of-Plan             |
| <b>Hospital Services (cont'd)</b>  | • Ambulatory Surgical Center<br>(such as a colonoscopy)   | No Charge  | Deductible/Co-insurance | Deductible/Co-insurance | Deductible/Co-insurance |
| <b>Rehabilitation Services</b>     | • Therapy –<br>Physical/Occupational/Speech   | \$10 Co-pay per visit  | \$20 Co-pay per visit   | \$15 Co-pay per visit   | Deductible/Co-insurance |
| <b>Ambulance Services</b>          | • Land and Air  | No Charge  | No Charge               | No Charge               | No Charge               |
| <b>Home Health Care</b>            | • Limited to 40 visits<br>per 12-month period<br>(no coverage if not prior authorized)  | No Charge  | No Charge               | No Charge               | Deductible/Co-insurance |
| <b>Hospice Care</b>                | No Coverage if not prior authorized   | No Charge  | No Charge               | No Charge               | Deductible/Co-insurance |
| <b>Durable Medical Equipment</b>   | • DME, Orthotics & Prosthetics<br>(Prior authorization required for<br>Durable Medical Equipment/Orthotics<br>over \$500 and prosthetics over \$1,000.<br>No coverage if not prior authorized.) | No Charge  | Deductible/Co-insurance | Deductible/Co-insurance | Deductible/Co-insurance |
| <b>Diabetic Supplies</b>           | (Please refer to your Prescription<br>Summary of Member Responsibility<br>Table)  |  |                         |                         |                         |
| <b>Medical Supplies</b>            | Including insulin pump supplies   | No Charge  | No Charge               | No Charge               | Deductible/Co-insurance |
| <b>Health Educational Programs</b> | Please refer to the Certificate of<br>Coverage for a list of benefits and<br>limitations.   | No Charge  | No Charge               | No Charge               | Not covered             |
| <b>Behavioral Health</b>           | Mental Health and<br>Chemical Dependency Services   |  |                         |                         |                         |
|                                    | • Inpatient –<br>Limited to 10 days per calendar year<br>(no coverage if not prior authorized)  | No Charge  | No Charge               | No Charge               | Deductible/Co-insurance |
|                                    | • Transitional –<br>Limited to 20 days per calendar year  | No Charge  | No Charge               | No Charge               | Deductible/Co-insurance |
|                                    | • Outpatient –<br>Limited to 20 visits per calendar year  | No Charge  | No Charge               | No Charge               | Deductible/Co-insurance |

|  |   | This comparison chart is not a guarantee of coverage, please refer to the Certificate of Coverage, and Riders for detailed benefit information restrictions, limitations and exclusions that apply to that coverage. |   |   |                         |
|--|---|--|---|---|-------------------------|
|  |   | HMO-1  | HMO-4   | POS-2   |                         |
| Services   |   |  |   | In-Plan   | Out-of-Plan             |
| <b>Emergency/Urgent Care</b><br><i>(Emergency room or hospital based urgent care facility)</i> | • Emergency Room Services<br><i>(co-pay waived if admitted inpatient within 24 hours)</i> | \$50 Co-pay per visit  | \$50 Co-pay per visit   | \$50 co-pay per visit   | \$50 co-pay per visit   |
|  | • Urgent Care   | \$10 Co-pay per visit  | \$20 Co-pay per visit   | \$15 Co-pay per visit   | Deductible/Co-insurance |
| <b>Maximum Policy Benefit</b>  |   | \$5,000,000 per Member per Lifetime  | \$5,000,000 per Member per Lifetime   | \$5,000,000 per Member per Lifetime   |                         |
| <b>Prescription</b>  |   | Retail Pharmacy:<br>\$10/25/50/50/80 co-pay<br><br>Mail Order Pharmacy:<br>\$25/60/150 co-pay  | Retail Pharmacy:<br>\$10/25/50/50/80 co-pay<br><br>Mail Order Pharmacy:<br>\$25/60/150 co-pay | Retail Pharmacy: \$10/25/50/50/80 co-pay<br><br>Mail Order Pharmacy: \$25/60/150 co-pay |                         |

| 2011                                     |                                | HMO-1  | POS-C   |   |
|--|--------------------------------|--|---|---|
| <b>Health Insurance Comparison Chart</b> |                                | Local 603 only                                 | Local 603 only  |   |
|  |                                | (2008 monthly cap \$95)                        | (2008 monthly cap \$160)                              |   |
|  |                                | 6% prem contribution<br>(2008 prem contr rate) | 9% prem contribution<br>(2008 prem contributate rate) |   |
|  | Single                         | 31.41  | \$53.94   |   |
|  | Employee/Child                 | 57.9   | \$113.27  |   |
| Employee/Spouse                          | 65.97                          | \$99.40  |   |   |
| Family                                   | 101.63                         | \$174.48                                       |   |   |
|  |                                |  | In-Plan   | Out-of-Plan   |
|  | Co-Pays                        | as listed below                                | as listed below                                       |   |
|  | Annual Deductibles             | n/a  |   | \$300 individual/<br>\$600 family   |
|  | Co-Insurance                   | n/a  |   | 20% of eligible expenses,<br>unless otherwise specified   |
|  | Annual Out-of-Pocket Limit     | n/a  |   | \$700 individual/<br>\$1400 family  |
|  |                                |  |   | Coverage for Out-of-Network<br>services which require Prior<br>Authorization as listed in the<br>Point of Service Plan Rider<br>will have a 50% benefit<br>reduction up to a max of<br>\$500/occurrence if the<br>services are not Prior<br>Authorized. |
|  |                                |  |   |   |
|  |                                | HMO-1<br>Local 603                             | POS-2<br>Local 603                                    |   |
| <b>Services</b>                          |                                |  | In-Plan   | Out-of-Plan   |
| <b>Wellness/<br/>Preventive Health</b>   | • Well Child Care Exams        | No Charge                                      | No Charge   | Deductible/Co-insurance   |
|  | • Periodic Physical Exams      | No Charge                                      | No Charge   | Deductible/Co-insurance   |
|  | • Immunizations                | No Charge                                      | No Charge   | Deductible/Co-insurance   |
|  | • Routine Mammography Services | No Charge                                      | No Charge   | Deductible/Co-insurance   |

|  |   | HMO-1<br>Local 603   | POS-2<br>Local 603   |                         |
|--|---|--|--|-------------------------|
| Services   |   |  | In-Plan  | Out-of-Plan             |
| <b>Physician and Practitioner Services</b>         | <b>Primary Care Practitioner</b>  |  |  |                         |
|  | • Office and Home visits  | \$10 Co-pay per visit  | \$15 Co-pay per visit  | Deductible/Co-insurance |
|  | • Inpatient visits  | No Charge  | No Charge  | Deductible/Co-insurance |
|  | <b>Specialty Physician</b>  |  |  |                         |
|  | • Office and Home visits  | \$10 Co-pay per visit  | \$15 Co-pay per visit  | Deductible/Co-insurance |
|  | • Routine Eye Exams<br><i>(limited to one per 12-month period)</i>                  | \$10 Co-pay per visit  | \$15 Co-pay per visit  | Deductible/Co-insurance |
|  | • Chiropractic office visits and manipulations                                      | \$10 Co-pay per visit  | \$15 Co-pay per visit  | Deductible/Co-insurance |
|  | • Allergy Immunizations   | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Accidental Dental Services  | No Charge  | No Charge  | No Charge               |
|  | • Radiation/Chemotherapy Services   | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Dialysis Services   | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Surgery & Anesthesiology Services   | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Routine Maternity<br>(pre & post natal care)                                      | No Charge  | No Charge  | Deductible/Co-insurance |
| • Inpatient visits                                 | No Charge   | No Charge  | Deductible/Co-insurance                                      |                         |
| • Injectables administered in a Physician's office | <i>Please refer to your Prescription drug benefit levels</i>                        | <i>Please refer to your Prescription drug benefit levels</i> | <i>Please refer to your Prescription drug benefit levels</i> |                         |
| <b>Diagnostic Services</b>                         | • X-Ray, Lab, Pathology<br><i>(practitioner's office or outpatient)</i>             | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Diagnostic Mammography Services   | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • PET Scans, MRI's, MRA's, CT Scans<br><i>(no coverage if not prior authorized)</i> | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Stress Tests  | No Charge  | No Charge  | Deductible/Co-insurance |
|  | • Ultrasounds/Echocardiograms   | No Charge  | No Charge  | Deductible/Co-insurance |
| <b>Hospital Services</b>                           | • Inpatient Hospital<br><i>(no coverage if not prior authorized)</i>                | No Charge  | Deductible/Co-insurance                                      | Deductible/Co-insurance |
|  | • Outpatient Services or Procedures<br><i>(including cardiac rehabilitation)</i>    | No Charge  | Deductible/Co-insurance                                      | Deductible/Co-insurance |

|                                    |   | HMO-1<br>Local 603    | POS-2<br>Local 603      |                         |
|------------------------------------|---|-----------------------|-------------------------|-------------------------|
| Services                           |   |                       | In-Plan                 | Out-of-Plan             |
| <b>Hospital Services (cont'd)</b>  | • Ambulatory Surgical Center<br>(such as a colonoscopy)   | No Charge             | Deductible/Co-insurance | Deductible/Co-insurance |
| <b>Rehabilitation Services</b>     | • Therapy –<br>Physical/Occupational/Speech   | \$10 Co-pay per visit | \$15 Co-pay per visit   | Deductible/Co-insurance |
| <b>Ambulance Services</b>          | • Land and Air  | No Charge             | No Charge               | No Charge               |
| <b>Home Health Care</b>            | • Limited to 40 visits<br>per 12-month period<br>(no coverage if not prior authorized)  | No Charge             | No Charge               | Deductible/Co-insurance |
| <b>Hospice Care</b>                | No Coverage if not prior authorized   | No Charge             | No Charge               | Deductible/Co-insurance |
| <b>Durable Medical Equipment</b>   | • DME, Orthotics & Prosthetics<br>(Prior authorization required for<br>Durable Medical Equipment/Orthotics<br>over \$500 and prosthetics over \$1,000.<br>No coverage if not prior authorized.) | No Charge             | Deductible/Co-insurance | Deductible/Co-insurance |
| <b>Diabetic Supplies</b>           | (Please refer to your Prescription<br>Summary of Member Responsibility<br>Table)  |                       |                         |                         |
| <b>Medical Supplies</b>            | Including insulin pump supplies   | No Charge             | No Charge               | Deductible/Co-insurance |
| <b>Health Educational Programs</b> | Please refer to the Certificate of<br>Coverage for a list of benefits and<br>limitations.   | No Charge             | No Charge               | Not covered             |
| <b>Behavioral Health</b>           | Mental Health and<br>Chemical Dependency Services   |                       |                         |                         |
|                                    | • Inpatient –<br>Limited to 10 days per calendar year<br>(no coverage if not prior authorized)  | No Charge             | No Charge               | Deductible/Co-insurance |
|                                    | • Transitional –<br>Limited to 20 days per calendar year  | No Charge             | No Charge               | Deductible/Co-insurance |
|                                    | • Outpatient –<br>Limited to 20 visits per calendar year  | No Charge             | No Charge               | Deductible/Co-insurance |

|  |   | HMO-1<br>Local 603  | POS-2<br>Local 603  |                         |
|--|---|---|---|-------------------------|
| Services   |   |   | In-Plan   | Out-of-Plan             |
| <b>Emergency/Urgent Care</b><br><i>(Emergency room or hospital based urgent care facility)</i> | • Emergency Room Services<br><i>(co-pay waived if admitted inpatient within 24 hours)</i> | \$50 Co-pay per visit   | \$50 co-pay per visit   | \$50 co-pay per visit   |
|  | • Urgent Care   | \$10 Co-pay per visit   | \$15 Co-pay per visit   | Deductible/Co-insurance |
| <b>Maximum Policy Benefit</b>  |   | \$5,000,000 per Member per Lifetime   | \$5,000,000 per Member per Lifetime   |                         |
| <b>Prescription</b>  |   | Retail Pharmacy:<br>\$10/25/50/50/80 co-pay<br><br>Mail Order Pharmacy:<br>\$25/60/150 co-pay | Retail Pharmacy: \$10/25/50/50/80 co-pay<br><br>Mail Order Pharmacy: \$25/60/150 co-pay |                         |