

| <b>2010 HRA Medical Plan Summary Chart</b>  | <b>In-Network</b>    | <b>Out-Of-Network</b> |
|---|----------------------|-----------------------|
| <b><i>Deductible</i></b>  |                      |                       |
| Single  | \$1,800              | \$2,500               |
| Family  | \$3,600              | \$5,000               |
| <b><i>Out -Of-Pocket Maximum</i></b>  |                      |                       |
| Single  | \$3,000              | \$6,000               |
| Family  | \$6,000              | \$12,000              |
| Aggregate   | Yes                  | Yes                   |
| <b>This plan does not have a Core Network. But, if you use a core provider and the service is subject to coinsurance, the you will only pay 10%, not 20%</b>  |                      |                       |
| <b><i>Physician Fees (Primary Care Office Visits)</i></b> Includes services of an internist, general physician, family practitioner or pediatrician. Also includes dermatologist, allergist and OB/GYN. | 20% after Deductible | 40% after Deductible  |
| <b><i>Physician Fees (Specialist)</i></b>   | 20% after Deductible | 40% after Deductible  |
| <b><i>Routine Physical Exams</i></b>  |                      |                       |
| Routine Adult Physical Exams including immunizations (One exam every 12 months age 18 and over)   | Plan Pays 100%       | 40% after Deductible  |
| Routine GYN Exams (one visit per calendar year - includes Pap smear and related lab fees)   | Plan Pays 100%       | 40% after Deductible  |
| Routine Child Exams including immunizations   | Plan Pays 100%       | 40% after Deductible  |
| Routine Cancer Screening Expenses (includes routine rectal exam/prostate-specific antigen test for covered males age 40 and over)   | Plan Pays 100%       | 40% after Deductible  |
| Routine Cancer Screening Expenses (colorectal cancer screening for members age 50 and over done in an outpatient setting)   | Plan Pays 100%       | 40% after Deductible  |
| Routine Mammogram Expenses for covered females age 40 and over  | Plan Pays 100%       | 40% after Deductible  |
| <b><i>For Use of Urgent Care Provider - Urgent Care</i></b>   | 20% after Deductible | 40% after Deductible  |
| <b><i>For Emergency Room Treatment - Emergency Care</i></b>   | \$150 Copay          | \$150 Copay           |
| <b><i>Ambulance Expenses</i></b>  | 20% after Deductible | 40% after Deductible  |
| <b><i>For Outpatient Hospital Expenses (including surgery)</i></b>  | 20% after Deductible | 40% after Deductible  |
| <b><i>Physician Fees for Outpatient Surgery</i></b>   | 20% after Deductible | 40% after Deductible  |
| <b><i>Hospital Expenses - Inpatient Coverage</i></b>  | 20% after Deductible | 40% after Deductible  |
| Pre-Admission Testing Office Visit  | 20% after Deductible | 40% after Deductible  |
| <b><i>Physician Fees for Routine Eye Exam Expenses (1 exam per 12 months) and Hearing (1 exam per 24 months)Non-surgical Office</i></b>   | Plan pays 100%       | 40% after Deductible  |

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| <b><i>Other Covered Medical Expenses</i></b>   |                      |                       |
| Convalescent / Skilled Nursing Facility Expenses (120 day maximum, prior hospital confinement not required)                      | 20% after Deductible | 40% after Deductible  |
| Home Health Care Expenses  | 20% after Deductible | 40% after Deductible  |
| Hospice Care Expenses (Inpatient or Outpatient, no limit or dollar maximum)  | Plan pays 100%       | 40% after Deductible  |
| Short-Term Rehabilitation / Outpatient Therapy (Speech, Physical or Occupational) 90 day maximum per year combined               | 20% after Deductible | 40% after Deductible  |
| Chiropractic Care / Spinal Manipulation (Limited to 20 visits per calendar year)   | 20% after Deductible | 40% after Deductible  |
| Durable Medical and Surgical Equipment   | 20% after Deductible | 45% after Deductible  |
| Allergy Testing  | 20% after Deductible | 40% after Deductible  |
| Allergy Serum and Injections - If a physician visit is not included then no co-pay applies                                       | 20% after Deductible | 40% after Deductible  |
| <b><i>Family Planning</i></b>  |                      |                       |
| Maternity - Initial Visit and Post Natal Care<br>Inpatient Care  | 20% after Deductible | 40% after Deductible  |
| Vasectomy, Tubal Ligation and Voluntary Abortion   | 20% after Deductible | 40% after Deductible  |
| Infertility Treatment Expenses (diagnosis and treatment of the underlying medical condition)                                     | 20% after Deductible | 40% after Deductible  |
| Infertility Expenses includes ovulation inductions and insemination (up to 6 cycles in a lifetime)                               | 20% after Deductible | 40% after Deductible  |
| For Advanced Reproductive Technology Expenses (ZIFT and GIFT)  | No Coverage          | No Coverage           |
| <b><i>Diagnostic Laboratory, Complex Imaging (MRI, CAT and PET scan) and X-Ray Expenses</i></b><br>Outpatient or Independent Lab | 20% after Deductible | 40% after Deductible  |
| <b><i>Diagnostic X-Ray For Complex Imaging Services (MRI, CAT scan and PET scan)</i></b>   | 20% after Deductible | 40% after Deductible  |
| <b><i>Behavioral Health Benefits</i></b>   |                      |                       |
| Outpatient Treatment   | 20% after Deductible | 40% after Deductible  |
| Inpatient Treatment  | 20% after Deductible | 40% after Deductible  |