

2010 POS Plus Medical Plan Summary Chart	Core	In-Network	Out-Of-Network
<i>Deductible</i>			
Single	\$200	\$400	\$1,200
Family	\$600	\$1,200	\$3,600
<i>Out -Of-Pocket Maximum</i>			
Single	\$1,250	\$1,750	\$6,000
Family	\$2,500	\$3,500	\$12,000
Aggregate	Yes	Yes	Yes
<i>Physician Fees (Primary Care Office Visits)</i> Includes services of an internist, general physician, family practitioner or pediatrician. Also includes dermatologist, allergist and OB/GYN for routine services.	\$25 Copay	\$40 Copay	40% after Deductible
<i>Physician Fees (Specialist)</i>	\$25 Copay	\$50 Copay	40% after Deductible
<i>Routine Physical Exams</i>			
Routine Adult Physical Exams including immunizations (One exam every 12 months age 18 and over)	\$25 Copay	\$40 Copay	40% after Deductible
Routine GYN Exams (one visit per calendar year - includes Pap smear and related lab fees)	\$25 Copay	\$40 Copay	40% after Deductible
Routine Child Exams including immunizations	\$25 Copay	\$40 Copay	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%	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%	Plan Pays 100%	40% after Deductible
Routine Mammogram Expenses for covered females age 40 and over	Plan Pays 100%	Plan Pays 100%	40% after Deductible
<i>For Use of Urgent Care Provider - Urgent Care</i>	\$50 Copay	\$50 Copay	\$50 Copay
<i>For Emergency Room Treatment - Emergency Care</i>	\$150 Copay	\$150 Copay	\$150 Copay
<i>Ambulance Expenses</i>	\$75 co-pay	\$75 Copay	\$75 Copay
<i>For Outpatient Hospital Expenses (including surgery)</i>	10% after Deductible	20% after Deductible	40% after Deductible
<i>Physician Fees for Outpatient Surgery</i>	10% after Deductible	20% after Deductible	40% after Deductible
<i>Hospital Expenses - Inpatient Coverage</i>	10% after Deductible	20% after Deductible	40% after Deductible
Pre-Admission Testing Office Visit	\$25 Copay	Copay applies for provider type	40% after Deductible
<i>Physician Fees for Routine Eye Exam Expenses (1 exam per 12 months) Non-surgical Office</i>	\$25 Copay	\$50 Copay	40% after Deductible
<i>Physician Fees for Routine Hearing Exams (1 exam per 24 months) Only when performed by PCP</i>	\$25 Copay	\$40 Copay	40% after Deductible

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<i>Other Covered Medical Expenses</i>			
Convalescent / Skilled Nursing Facility Expenses (120 day maximum, prior hospital confinement not required)	10% after Deductible	20% after Deductible	40% after Deductible
Home Health Care Expenses	10% after Deductible	20% after Deductible	40% after Deductible
Hospice Care Expenses (Inpatient or Outpatient, no limit or dollar maximum)	Plan Pays 100%	Plan Pays 100%	40% after Deductible
Short-Term Rehabilitation / Outpatient Therapy (Speech, Physical or Occupational) 90 day maximum per year combined	\$25 Copay	\$50 Copay	40% after Deductible
Chiropractic Care / Spinal Manipulation (Limited to 20 visits per calendar year)	\$40 Copay	\$40 Copay	40% after Deductible
Durable Medical and Surgical Equipment	10% after Deductible	20% after Deductible	40% after Deductible
Allergy Testing	\$25 Copay	\$40 Copay	40% after Deductible
Allergy Serum and Injections - If a physician visit is not included then no Copay applies	\$25 Copay	\$40 Copay	40% after Deductible
<i>Family Planning</i>			
Maternity - Initial Visit and Post Natal Care Inpatient Care (Including Physician's Cost for Delivery)	\$25 Copay 10% after deductible	\$50 Copay 20% after Deductible	40% after Deductible
Vasectomy, Tubal Ligation and Voluntary Abortion	Coverage based on where services are rendered		40% after Deductible
Infertility Treatment Expenses (diagnosis and treatment of the underlying medical condition)	Coverage based on where services are rendered		40% after Deductible
Infertility Expenses includes ovulation inductions and insemination (up to 6 cycles in a lifetime)	Coverage based on where services are rendered		40% after Deductible
For Advanced Reproductive Technology Expenses (ZIFT and GIFT)	No Coverage	No Coverage	No Coverage
<i>Diagnostic Laboratory, Complex Imaging (MRI, CAT and PET scan) and X-Ray Expenses</i>			
Outpatient or Independent Lab	10% after Deductible	20% after Deductible	40% after Deductible
<i>Behavioral Health Benefits</i>			
Outpatient Treatment	\$25 Copay	\$50 Copay	40% after Deductible
Inpatient Treatment	10% after Deductible	20% after Deductible	40% after Deductible