2010 POS Value Medical Plan Summary Chart	**Core**	**In-Network**	**Out-Of-Network**
Deductible			
Single	$400	$800	$1,600
Family	$1,200	$2,400	$4,800
Out -Of-Pocket Maximum			
Single	$2,500	$3,000	$6,000
Family	$5,000	$6,000	$12,000
Aggregate	Yes	Yes	Yes
Physician Fees (Primary Care Office Visits) Includes services of an internist, general physician, family practitioner or pediatrician. Also includes dermatologist, allergist and OB/GYN for routine services.	$35 Copay	$50 Copay	45% after Deductible
Physician Fees (Specialist)	$35 Copay	$60 Copay	45% after Deductible
Routine Physical Exams			
Routine Adult Physical Exams including immunizations (One exam every 12 months age 18 and over)	$35 Copay	$50 Copay	45% after Deductible
Routine GYN Exams (one visit per calendar year - includes Pap smear and related lab fees)	$35 Copay	$50 Copay	45% after Deductible
Routine Child Exams including immunizations	$35 Copay	$50 Copay	45% 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%	45% 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%	45% after Deductible
Routine Mammogram Expenses for covered females age 40 and over	Plan Pays 100%	Plan Pays 100%	45% after Deductible
For Use of Urgent Care Provider - Urgent Care	$60 Copay	$60 Copay	$60 Copay
For Emergency Room Treatment - Emergency Care	$150 Copay	$150 Copay	$150 Copay
Ambulance Expenses	$75 co-pay	$75 Copay	$75 Copay
For Outpatient Hospital Expenses (including surgery)	20% after Deductible	30% after Deductible	45% after Deductible
Physician Fees for Outpatient Surgery	20% after Deductible	30% after Deductible	45% after Deductible
Hospital Expenses - Inpatient Coverage	20% after Deductible	30% after Deductible	45% after Deductible
Pre-Admission Testing Office Visit	$35 Copay	Copay applies for provider type	45% after Deductible
Physician Fees for Routine Eye Exam Expenses (1 exam per 12 months) Non-surgical Office	$35 Copay	$50 Copay	45% after Deductible
Physician Fees for Routine Hearing Exams (1 exam per 24 months) Only when performed by PCP	$35 Copay	$50 Copay	45% after Deductible

2010 POS Value Medical Plan Summary Chart	Core	In-Network	Out-Of-Network
Other Covered Medical Expenses			
Convalescent / Skilled Nursing Facility Expenses (120 day maximum, prior hospital confinement not required)	20% after Deductible	30% after Deductible	45% after Deductible
Home Health Care Expenses	20% after Deductible	30% after Deductible	45% after Deductible
Hospice Care Expenses (Inpatient or Outpatient, no limit or dollar maximum)	Plan Pays 100%	Plan Pays 100%	45% after Deductible
Short-Term Rehabilitation / Outpatient Therapy (Speech, Physical or Occupational) 90 day maximum per year combined	$35 Copay	$60 Copay	45% after Deductible
Chiropractic Care / Spinal Manipulation (Limited to 20 visits per calendar year)	$50 Copay	$50 Copay	40% after Deductible
Durable Medical and Surgical Equipment	20% after Deductible	30% after Deductible	45% after Deductible
Allergy Testing	$35 Copay	$50 Copay	45% after Deductible
Allergy Serum and Injections - If a physician visit is not included then no Copay applies	$35 Copay	$50 Copay	45% after Deductible
Family Planning			
Maternity - Initial Visit and Post Natal Care Inpatient Care (Including Physician's Cost for Delivery)	$35 Copay 20% after deductible	$60 Copay 30% after Deductible	45% after Deductible
Vasectomy, Tubal Ligation and Voluntary Abortion	Coverage based on where services are rendered		45% after Deductible
Infertility Treatment Expenses (diagnosis and treatment of the underlying medical condition)	Coverage based on where services are rendered		45% after Deductible
Infertility Expenses includes ovulation inductions and insemination (up to 6 cycles in a lifetime)	Coverage based on where services are rendered		45% after Deductible
For Advanced Reproductive Technology Expenses (ZIFT and GIFT)	No Coverage	No Coverage	No Coverage
Diagnostic Laboratory, Complex Imaging (MRI, CAT and PET scan) and X-Ray Expenses Outpatient or Independent Lab	20% after Deductible	30% after Deductible	45% after Deductible
Behavioral Health Benefits Outpatient Treatment	$35 Copay	$60 Copay	45% after Deductible
Inpatient Treatment	20% after Deductible	30% after Deductible	45% after Deductible