

2015 - 16 POS Plan Medical Plan Summary Chart	Emory Healthcare Network (EHN)	In-Network	Out-Of- Network*
<i>Deductible</i>			
Single	\$800	\$900	\$1,400
Family	\$2,400	\$2,700	\$4,200
<i>Out -Of-Pocket Maximum</i>			
Single	\$2,300	\$2,500	\$6,000
Family	\$4,600	\$5,000	\$12,000
Aggregate	Yes	Yes	Yes
<i>Physician Fees (Primary Care Office Visits)</i> Includes internist, general physician, family practitioner, dermatologist or allergist. <i>Pediatrician visits</i>	\$25 Copay \$25 Copay	\$35 Copay \$25 Copay	40% after Deductible 40% after Deductible
<i>Physician Fees (Specialist)</i>	\$35 Copay	\$50 Copay	40% after Deductible
<i>Routine Preventive Care</i>			
Routine Preventive Adult Physical Exams including immunizations (One exam per calendar year age 18 and over)	\$0 Copay	\$0 Copay	40% after Deductible
Routine Preventive GYN Exams (one visit per calendar year - includes Pap smear and related lab fees)	\$0 Copay	\$0 Copay	40% after Deductible
Routine Preventive Child Exams including immunizations	\$0 Copay	\$0 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 done in an outpatient setting)	Plan Pays 100%	Plan Pays 100%	40% after Deductible
Routine Mammogram Expenses for covered females	Plan Pays 100%	Plan Pays 100%	40% after Deductible
<i>For Use of Urgent Care Provider - Urgent Care</i>	\$50 Copay	\$50 Copay	40% after Deductible
<i>For Emergency Room Treatment - Emergency Care</i>	\$150 Copay	\$150 Copay	\$150 Copay
<i>Ambulance Expenses</i>	\$75 Copay	\$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	Copay applies for provider type	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>	\$0 Copay	\$0 Copay	40% after Deductible
<i>Physician Fees for Routine Hearing Exams (1 exam per 24 months) Specialist copay applies when not performed by a PCP</i>	\$25 Copay	\$25 Copay	40% after Deductible

2015 - 16 POS Plan Medical Plan Summary Chart	Emory Healthcare Network (EHN)	In-Network	Out-Of- Network*
<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 ¹ (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)	\$50 Copay	\$50 Copay	40% after Deductible
Durable Medical and Surgical Equipment	10% Coinsurance (no Deductible)	20%Coinsurance (no Deductible)	40% after Deductible
Allergy Testing	\$25 Copay	\$25 Copay	40% after Deductible
Allergy Serum and Injections - If a physician visit is not included then no Copay applies	\$25 Copay	\$25 Copay	45% after Deductible
<i>Family Planning</i>			
Maternity - Initial Visit and Post Natal Care Inpatient Care (Including Physician's Cost for Delivery)	10% after deductible	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		
<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 Benefits²</i>			
Outpatient Treatment	\$25 Copay	\$25 Copay	40% after Deductible
Inpatient Treatment	10% after Deductible	20% after Deductible	40% after Deductible
¹ Medically necessary treatment with Autism diagnosis is covered			
² Medically necessary Applied Behavioral Analysis (ABA) covered with Autism diagnosis			