

**2009 MEDICAL INSURANCE BENEFIT SUMMARY  
EMPLOYEE COST SHARING**

| <b>SUBlue (Levels One, Two, and Three)</b>                       |   |   |  | <b>SUOrange</b>   |
|--|---|---|--|---|
| <b>Level One<br/>POMCO/PHCS/<br/>MultiPlan<br/>With Referral</b> | <b>Level Two<br/>POMCO/PHCS/<br/>MultiPlan<br/>Without Referral</b> | <b>Level Three<br/>Out of Network</b>                         | <b>Level One<br/>POMCO/PHCS/<br/>MultiPlan<br/>With Referral</b>   |   |
| <b>Cost Sharing Definitions</b>                                  |   |   |  |   |
| <b>Annual Deductible<sup>1</sup></b>                             | No deductible   | No deductible   | \$300 per individual with a maximum of \$1,000 family  | No deductible   |
| <b>Coinsurance</b>   | No coinsurance  | 10% allowable amount  | 30% allowable amount plus the difference between provider's charge and allowable amount<br><i>(exceptions noted below)</i> | No coinsurance  |
| <b>Annual Out-of-Pocket Maximum<sup>2</sup></b>                  | \$2,000 per individual with a maximum of \$4,000 for a family       | \$4,000 per individual with a maximum of \$8,000 for a family | \$6,000 per individual with a maximum of \$12,000 for a family   | \$2,000 per individual with a maximum of \$4,000 for a family |
| <b>Your Institutional Covered Services</b>                       |   |   |  |   |
| <b>INPATIENT HOSPITAL</b>  |   |   |  |   |
| <b>Inpatient hospital</b>  | \$250 copay per admission   | \$250 copay per admission plus coinsurance                    | Deductible, \$250 copay per admission, and coinsurance   | \$250 copay per admission                                     |
| <b>Nursery care</b>  | No copay; paid in full  | Coinsurance   | Deductible and coinsurance   | No copay; paid in full  |
| <b>OUTPATIENT HOSPITAL</b>                                       |   |   |  |   |
| <b>Surgery</b>   | \$100 copay   | \$100 copay plus coinsurance                                  | Deductible, \$100 copay, and coinsurance   | \$100 copay   |
| <b>Pre-surgical testing</b>                                      | No copay; paid in full  | Coinsurance   | Deductible and coinsurance   | No copay; paid in full  |

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| <b>Routine mammography screenings (one per calendar year for ages 35 and older with exceptions if high risk)</b>     | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance              | No copay; paid in full                                 |
| <b>Routine prostate cancer screenings (one per calendar year for ages 50 and older with exceptions if high risk)</b> | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance              | No copay; paid in full                                 |
| <b>Routine cervical cancer screenings (one per calendar year for ages 18 and older)</b>                              | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance              | No copay; paid in full                                 |
| <b>Colonoscopies</b>   | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance              | No copay; paid in full                                 |
| <b>Diagnostic x-rays, radiology services</b>   | \$20 copay   | \$20 copay plus coinsurance                               | Deductible, \$20 copay, and coinsurance | \$20 copay   |
| <b>Diagnostic laboratory tests</b>   | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance              | No copay; paid in full                                 |
| <b>Diagnostic machine tests</b>  | \$25 copay   | \$25 copay plus coinsurance                               | Deductible, \$25 copay, and coinsurance | \$25 copay   |
| <b>Occupational therapy (for situations not covered through a governmental program)</b>                              | \$20 copay   | \$20 copay plus coinsurance                               | Deductible, \$20 copay, and coinsurance | \$20 copay   |
| <b>Physical therapy</b>  | \$20 copay   | \$20 copay plus coinsurance                               | Deductible, \$20 copay, and coinsurance | \$20 copay   |

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| <b>Speech therapy (for situations not covered through a governmental program)</b>  | \$20 copay   | \$20 copay plus coinsurance                               | Deductible, \$20 copay, and coinsurance  | \$20 copay   |
| <b>Respiratory, radiation, cardiac therapies and chemotherapy, kidney dialysis</b> | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance   | No copay; paid in full                                 |
| <b>HOSPITAL EMERGENCY ROOM</b>   |  |   |  |  |
| <b>Hospital emergency room</b>   | \$50 copay   | \$50 copay  | Deductible, \$50 copay <i>plus the difference between provider's charge and allowable amount</i> | \$50 copay   |
| <b>ADDITIONAL INSTITUTIONAL PROVIDERS</b>  |  |   |  |  |
| <b>Ambulatory surgery center</b>   | \$100 copay  | \$100 copay plus coinsurance                              | Deductible, \$100 copay, and coinsurance   | \$100 copay  |
| <b>Birth center</b>  | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance   | No copay; paid in full                                 |
| <b>Skilled nursing facility (180 inpatient days)</b>                               | \$250 copay  | \$250 copay plus coinsurance                              | Deductible, \$250 copay, and coinsurance   | \$250 copay  |
| <b>Home health agency</b>  | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance   | No copay; paid in full                                 |
| <b>Hospice</b>   | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance   | No copay; paid in full                                 |
| <b>Inpatient mental, nervous or emotional disorder (30 days/ year)<sup>3</sup></b> | \$250 copay  | \$250 copay plus coinsurance                              | Deductible, \$250 copay, and coinsurance   | \$250 copay  |

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| <b>Inpatient alcoholism/<br/>substance abuse<br/>(30 days per<br/>admission)</b>                 | \$250 copay  | \$250 copay plus<br>coinsurance                             | Deductible, \$250<br>copay, and<br>coinsurance   | \$250 copay  |
| <b>Outpatient<br/>alcoholism/<br/>substance abuse</b>  | No copay; paid<br>in full<br><i>(60 visits per<br/>year, all levels)</i> | Coinsurance <i>(60<br/>visits per year, all<br/>levels)</i> | Deductible and<br>coinsurance <i>(60 visits<br/>per year, all levels)</i>                        | No copay; paid in<br>full<br><i>(60 visits per year)</i> |
| <b>Your Professional Provider Covered Services</b>   |  |   |  |  |
| <b>Surgery and<br/>assistance at<br/>surgery</b>   | No copay; paid<br>in full  | Coinsurance   | Deductible and<br>coinsurance  | No copay; paid in<br>full                                |
| <b>Breast<br/>reconstruction<br/>surgery</b>   | No copay; paid<br>in full  | Coinsurance   | Deductible and<br>coinsurance  | No copay; paid in<br>full                                |
| <b>Second surgical<br/>opinion</b>   | No copay; paid<br>in full  | No copay; paid in<br>full                                   | Deductible <i>plus the<br/>difference between<br/>provider's charge and<br/>allowable amount</i> | No copay; paid in<br>full                                |
| <b>Cancer-related<br/>second medical<br/>opinion</b>   | \$25 copay   | \$25 copay plus<br>coinsurance                              | Deductible, \$25<br>copay, and<br>coinsurance  | \$25 copay   |
| <b>Anesthesia</b>  | No copay; paid<br>in full  | Coinsurance   | Deductible and<br>coinsurance  | No copay; paid in<br>full                                |
| <b>Maternity</b>   | No copay; paid<br>in full  | Coinsurance   | Deductible and<br>coinsurance  | No copay; paid in<br>full                                |
| <b>PROFESSIONAL PROVIDER INPATIENT VISITS</b>  |  |   |  |  |
| <b>Inpatient<br/>hospital<br/>visits by physician<br/>or other<br/>professional<br/>provider</b> | No copay; paid<br>in full  | Coinsurance   | Deductible and<br>coinsurance  | No copay; paid in<br>full                                |

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| <b>Inpatient alcoholism/<br/>substance abuse<br/>hospital visits by<br/>physician or other<br/>professional<br/>provider</b>              | No copay; paid<br>in full                              | Coinsurance   | Deductible and<br>coinsurance  | No copay; paid in<br>full                              |
| <b>Inpatient skilled<br/>nursing facility visits<br/>by physician or other<br/>professional<br/>provider</b>                              | No copay; paid<br>in full                              | Coinsurance   | Deductible and<br>coinsurance  | No copay; paid in<br>full                              |
| <b>Inpatient mental,<br/>nervous or<br/>emotional disorder<br/>visits by physician<br/>or other professional<br/>provider<sup>3</sup></b> | No copay; paid<br>in full                              | Coinsurance   | Deductible and<br>coinsurance  | No copay; paid in<br>full                              |
| <b>PROFESSIONAL PROVIDER VISITS</b>   |  |   |  |  |
| <b>Office<br/>visits</b>  | \$20 copay<br>(PCP) or<br>\$25 copay<br>(Specialist)   | \$25 copay plus<br>coinsurance                            | Deductible, \$25<br>copay, and<br>coinsurance  | \$20 copay (PCP)<br>or \$25 copay<br>(Specialist)      |
| <b>Well child<br/>visits birth to 2<sup>nd</sup><br/>birthday<br/>(9 visits)</b>  | No copay; paid<br>in full                              | No copay; paid in<br>full                                 | Deductible <i>plus the<br/>difference between<br/>provider's charge and<br/>allowable amount</i> | No copay; paid in<br>full                              |
| <b>Well child<br/>visits 2<sup>nd</sup> birthday<br/>up to 7<sup>th</sup> birthday<br/>(5 visits)</b>                                     | No copay; paid<br>in full                              | No copay; paid in<br>full                                 | Deductible <i>plus the<br/>difference between<br/>provider's charge and<br/>allowable amount</i> | No copay; paid in<br>full                              |
| <b>Well child<br/>visits from 7<sup>th</sup><br/>birthday to 19<sup>th</sup><br/>birthday<br/>(one visit per<br/>calendar year)</b>       | \$20 copay<br>(PCP)                                    | \$25 copay plus<br>coinsurance                            | Deductible, \$25<br>copay, and<br>coinsurance  | \$20 copay (PCP)                                       |

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| <b>Routine physical</b><br><i>(one per calendar year)</i>                     | \$20 copay (PCP)<br>or \$25 copay (Specialist)         | \$25 copay plus coinsurance                               | Deductible, \$25 copay, and coinsurance | \$20 copay (PCP) or \$25 copay (Specialist)            |
| <b>Routine cervical cancer screening</b><br><i>(annual routine pap smear)</i> | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance              | No copay; paid in full                                 |
| <b>Allergy testing and treatment</b>  | \$20 copay (PCP) or \$25 copay (Specialist)            | \$25 copay plus coinsurance                               | Deductible, \$25 copay, and coinsurance | \$20 copay (PCP) or \$25 copay (Specialist)            |
| <b>Consultation service, office</b>   | \$25 copay (Specialist)                                | \$25 copay plus coinsurance                               | Deductible, \$25 copay, and coinsurance | \$25 copay (Specialist)                                |
| <b>Consultation service, hospital</b>   | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance              | No copay; paid in full                                 |
| <b>Urgent care</b>  | \$25 copay   | \$25 copay plus coinsurance                               | Deductible, \$25 copay, and coinsurance | \$25 copay   |
| <b>Kidney dialysis</b>  | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance              | No copay; paid in full                                 |
| <b>Outpatient mental health care</b><br><i>(20 visits)<sup>3</sup></i>        | \$25 copay (Specialist)                                | \$25 copay plus coinsurance                               | Deductible, \$25 copay, and coinsurance | \$25 copay (Specialist)                                |
| <b>Private duty nursing</b>   | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance              | No copay; paid in full                                 |
| <b>Diabetes education</b>   | \$20 copay (PCP) or \$25 copay (Specialist)            | \$25 copay plus coinsurance                               | Deductible, \$25 copay, and coinsurance | \$20 copay (PCP) or \$25 copay (Specialist)            |
| <b>Acupuncture</b>  | \$25 copay   | \$25 copay plus coinsurance                               | Deductible, \$25 copay, and coinsurance | \$25 copay   |

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| <b>Chiropractic services</b>  | \$25 copay   | No Coverage   | No Coverage                             | \$25 copay   |
| <b>Routine vision exam<br/>(one exam in 24 consecutive months)</b>                      | \$25 copay<br>(Specialist)                             | No Coverage   | No Coverage                             | \$25 copay<br>(Specialist)                             |
| <b>Routine hearing exam<br/>(one exam in 24 consecutive months)</b>                     | \$25 copay<br>(Specialist)                             | No Coverage   | No Coverage                             | \$25 copay<br>(Specialist)                             |
| <b>THERAPY</b>  |  |   |   |  |
| <b>Occupational therapy (for situations not covered through a governmental program)</b> | \$20 copay   | \$20 copay plus coinsurance                               | Deductible, \$20 copay, and coinsurance | \$20 copay   |
| <b>Physical therapy</b>   | \$20 copay   | \$20 copay plus coinsurance                               | Deductible, \$20 copay, and coinsurance | \$20 copay   |
| <b>Speech therapy (for situations not covered through a governmental program)</b>       | \$20 copay   | \$20 copay plus coinsurance                               | Deductible, \$20 copay, and coinsurance | \$20 copay   |
| <b>Respiratory, radiation, and cardiac therapies and chemotherapy</b>                   | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance              | No copay; paid in full                                 |
| <b>DIAGNOSTIC SERVICES</b>  |  |   |   |  |
| <b>Diagnostic x-rays</b>  | \$20 copay   | \$20 copay plus coinsurance                               | Deductible, \$20 copay, and coinsurance | \$20 copay   |
| <b>Diagnostic radiology services</b>  | \$20 copay   | \$20 copay plus coinsurance                               | Deductible, \$20 copay, and coinsurance | \$20 copay   |

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| <b>Diagnostic laboratory</b>   | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance  | No copay; paid in full                                 |
| <b>Machine tests</b>   | \$25 copay   | \$25 copay plus coinsurance                               | Deductible, \$25 copay, and coinsurance   | \$25 copay   |
| <b>Routine mammography screenings (one per calendar year for ages 35 and older with exceptions if high risk)</b>     | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance  | No copay; paid in full                                 |
| <b>Routine prostate cancer screenings (one per calendar year for ages 50 and older with exceptions if high risk)</b> | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance  | No copay; paid in full                                 |
| <b>Routine cervical cancer screenings (one per calendar year for ages 18 and older)</b>                              | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance  | No copay; paid in full                                 |
| <b>Colonoscopies</b>   | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance  | No copay; paid in full                                 |
| <b>Additional Health Services</b>  |  |   |   |  |
| <b>Ambulance</b>   | \$25 copay   | \$25 copay  | \$25 copay  | \$25 copay   |
| <b>Diabetic equipment and supplies</b>   | \$20 copay   | \$20 copay plus coinsurance                               | Deductible, \$20 copay, and coinsurance   | \$20 copay   |
| <b>Durable medical equipment</b>   | <i>10% allowable amount</i>                            | <i>20% allowable amount</i>                               | <i>Deductible and 40% allowable amount plus the difference between provider's charge and allowable amount</i> | <i>10% allowable amount</i>                            |

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| <b>Medical supplies</b>   | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance    | No copay; paid in full                                 |
| <b>Prosthetic devices</b> | No copay; paid in full                                 | Coinsurance   | Deductible and coinsurance    | No copay; paid in full                                 |

<sup>1</sup> Level Three coverage requires the employee to pay an annual deductible before any other cost sharing is determined. The annual deductible is \$300 per individual with a maximum of \$1,000 for a family. After the annual deductible is satisfied, the employee must pay the copay, if applicable. The coinsurance is then applied to the balance of the allowable amount. The employee is also responsible for the difference between the provider's charge and the allowable amount based on participating providers in the POMCO network.

<sup>2</sup> Out-of-pocket maximum refers to the maximum amount of out-of-pocket expenses an employee would pay in a calendar year. The out-of-pocket expenses are defined as the deductibles, coinsurance, and copayment amounts, exclusive of coinsurance amounts for prescription medicines. The differences between provider charges and the allowable amounts under level three are not subject to the out-of-pocket maximum.

<sup>3</sup> Limits waived consistent with Timothy's Law.

Each medical program is governed by the plan document. If there is any difference between the information on these summary sheets and the plan document, the plan document will rule.

| <b>Prescription Drugs</b>         |   |
|-----------------------------------|---|
| <b>Annual Deductible</b>          | No Deductible   |
| <b>Out-of-Pocket Maximum</b>      | \$2,000 per individual with a maximum of \$4,000 for a family |
| <b>Retail Generic</b>             | 20% coinsurance   |
| <b>Retail Brand Formulary</b>     | 20% coinsurance   |
| <b>Retail Brand Non-Formulary</b> | 40% coinsurance   |
| <b>Mail Generic</b>               | \$20  |
| <b>Mail Brand Formulary</b>       | \$40  |
| <b>Mail Brand Non-Formulary</b>   | \$80  |
| <b>Specialty Mail Order (All)</b> | Same as Mail Order except 30 day supply                       |
| <b>Contraceptives</b>             | 50% for both generic and brand formulary only                 |

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