

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

|  | <b>SU Pro (In-Network and Out-of-Network)</b>   |   |
|--|---|---|
|  | <b>In-Network<br/>POMCO/PHCS/Multiplan</b>  | <b>Out-of-Network</b>   |
| <b>Cost Sharing Definitions</b>  |   |   |
| <b>Annual Deductible<sup>1</sup></b>   | \$200 per individual with a maximum of \$400 for a family   | \$300 per individual with a maximum of \$1,000 for a family   |
| <b>Coinsurance</b>   | 5% of allowable amount for inpatient hospitalization<br>- or -<br>20% of allowable amount for all other services<br><br>All preventive services covered in full | 5% of allowable amount for inpatient hospitalization<br>- or -<br>30% of allowable amount for all other services<br>- plus -<br>Difference between submitted charges and allowable amount |
| <b>Annual Out-of-Pocket Maximum<sup>2</sup></b>  | \$1,500 per individual with a maximum of \$3,000 for a family   | \$6,000 per individual with a maximum of \$12,000 for a family  |
| <b>Your Institutional Covered Services</b>   |   |   |
| <b>INPATIENT HOSPITAL</b>  |   |   |
| <b>Inpatient hospital</b>  | Deductible plus coinsurance   | Deductible plus coinsurance   |
| <b>Nursery care</b>  | Deductible plus coinsurance   | Deductible plus coinsurance   |
| <b>OUTPATIENT HOSPITAL</b>   |   |   |
| <b>Surgery</b>   | Deductible plus coinsurance   | Deductible plus coinsurance   |
| <b>Pre-surgical testing</b>  | Deductible plus coinsurance   | Deductible plus coinsurance   |
| <b>Routine mammography screenings (one per calendar year for ages 35 and older with exceptions if high risk)</b>     | No coinsurance; paid in full  | Deductible plus coinsurance   |
| <b>Routine prostate cancer screenings (one per calendar year for ages 50 and older with exceptions if high risk)</b> | No coinsurance; paid in full  | Deductible plus coinsurance   |
| <b>Routine cervical cancer screenings (one per calendar year for ages 18 and older)</b>                              | No coinsurance; paid in full  | Deductible plus coinsurance   |
| <b>Colonoscopies</b>   | No coinsurance; paid in full  | Deductible plus coinsurance   |
| <b>Diagnostic x-rays, radiology services</b>   | Deductible plus coinsurance   | Deductible plus coinsurance   |

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|   | <b>In-Network<br/>POMCO/PHCS/Multiplan</b>    | <b>Out-of-Network</b>       |
| <b>Diagnostic laboratory tests</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Diagnostic machine tests</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Occupational therapy (for situations not covered through a governmental program)</b> | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Physical therapy</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Speech therapy (for situations not covered through a governmental program)</b>       | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Respiratory, radiation, cardiac therapies and chemotherapy, kidney dialysis</b>      | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>HOSPITAL EMERGENCY ROOM</b>  |   |                             |
| <b>Hospital emergency room</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>ADDITIONAL INSTITUTIONAL PROVIDERS</b>   |   |                             |
| <b>Ambulatory surgery center</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Birth center</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Skilled nursing facility<br/>(180 inpatient days)</b>                                | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Home health agency</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Hospice</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Inpatient mental, nervous or emotional disorder<br/>(30 days/ year)<sup>3</sup></b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Inpatient alcoholism/ substance abuse<br/>(30 days per admission)</b>                | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Outpatient alcoholism/ substance abuse<br/>(60 visits per year, all levels)</b>      | Deductible plus coinsurance                   | Deductible plus coinsurance |

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|   | <b>In-Network<br/>POMCO/PHCS/Multiplan</b>    | <b>Out-of-Network</b>       |
| <b>Your Professional Provider Covered Services</b>  |   |                             |
| <b>Surgery and assistance at surgery</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Breast reconstruction surgery</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Second surgical opinion</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Cancer-related second medical opinion</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Anesthesia</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Maternity</b>  | No coinsurance; paid in full                  | Deductible plus coinsurance |
| <b>PROFESSIONAL PROVIDER INPATIENT VISITS</b>   |   |                             |
| <b>Inpatient hospital visits by physician or other professional provider</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Inpatient alcoholism/ substance abuse hospital visits by physician or other professional provider</b>              | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Inpatient skilled nursing facility visits by physician or other professional provider</b>                          | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Inpatient mental, nervous or emotional disorder visits by physician or other professional provider<sup>3</sup></b> | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>PROFESSIONAL PROVIDER VISITS</b>   |   |                             |
| <b>Office visits</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Well child visits birth to 2<sup>nd</sup> birthday (9 visits)</b>  | No coinsurance; paid in full                  | Deductible plus coinsurance |
| <b>Well child visits 2<sup>nd</sup> birthday up to 7<sup>th</sup> birthday (5 visits)</b>                             | No coinsurance; paid in full                  | Deductible plus coinsurance |
| <b>Well child visits from 7<sup>th</sup> birthday to 19<sup>th</sup> birthday (one visit per calendar year)</b>       | No coinsurance; paid in full                  | Deductible plus coinsurance |

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|--|---|-----------------------------|
|  | <b>In-Network<br/>POMCO/PHCS/Multiplan</b>    | <b>Out-of-Network</b>       |
| <b>Routine physical<br/>(one per calendar year)</b>  | No coinsurance; paid in full                  | Deductible plus coinsurance |
| <b>Routine cervical cancer screening<br/>(annual routine pap smear; one per<br/>calendar year)</b> | No coinsurance; paid in full                  | Deductible plus coinsurance |
| <b>Allergy testing and treatment</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Consultation service, office</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Consultation service, hospital</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Urgent care</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Kidney dialysis</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Outpatient mental health care<br/>(20 visits)<sup>3</sup></b>                                   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Private duty nursing</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Diabetes education</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Acupuncture</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Chiropractic services</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Routine vision exam<br/>(one exam in 24 consecutive months)</b>                                 | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Routine hearing exam<br/>(one exam in 24 consecutive months)</b>                                | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>THERAPY</b>   |   |                             |
| <b>Occupational therapy (for situations<br/>not covered through a governmental<br/>program)</b>    | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Physical therapy</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Speech therapy (for situations not<br/>covered through a governmental<br/>program)</b>          | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Respiratory, radiation, and cardiac<br/>therapies and chemotherapy</b>                          | Deductible plus coinsurance                   | Deductible plus coinsurance |

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|--|---|-----------------------------|
|  | <b>In-Network<br/>POMCO/PHCS/Multiplan</b>    | <b>Out-of-Network</b>       |
| <b>DIAGNOSTIC SERVICES</b>   |   |                             |
| <b>Diagnostic x-rays</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Diagnostic radiology services</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Diagnostic laboratory</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Machine tests</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Routine mammography screenings<br/>(one per calendar year for ages 35 and<br/>older with exceptions if high risk)</b>     | No coinsurance; paid in full                  | Deductible plus coinsurance |
| <b>Routine prostate cancer screenings<br/>(one per calendar year for ages 50 and<br/>older with exceptions if high risk)</b> | No coinsurance; paid in full                  | Deductible plus coinsurance |
| <b>Routine cervical cancer screenings<br/>(one per calendar year for ages 18 and<br/>older)</b>                              | No coinsurance; paid in full                  | Deductible plus coinsurance |
| <b>Colonoscopies</b>   | No coinsurance; paid in full                  | Deductible plus coinsurance |
| <b>Additional Health Services</b>  |   |                             |
| <b>Ambulance</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Diabetic equipment and supplies</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Durable medical equipment</b>   | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Medical supplies</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Prosthetic devices</b>  | Deductible plus coinsurance                   | Deductible plus coinsurance |
| <b>Prescription medicines</b>  | Covered through Medco                         | Covered through Medco       |

<sup>1</sup> Coverage requires the employee to pay an annual deductible before any other cost sharing is determined. The annual in-network deductible is \$200 per individual with a maximum of \$400 for a family. The annual out-of-network 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 coinsurance, if applicable. The coinsurance is then applied to the balance of the allowable amount. For out-of-

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network services, 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 and coinsurance amounts, exclusive of coinsurance amounts for prescription medicines. The differences between provider charges and the allowable amounts under the out-of-network level are not subject to the out of pocket maximum.

<sup>3</sup> Limits waived subject to 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>      | \$2000 single/\$4000 family                      |
|                                   |  |
| <b>Retail Generic</b>             | 15% coinsurance                                  |
| <b>Retail Brand Formulary</b>     | 25% coinsurance                                  |
| <b>Retail Brand Non-Formulary</b> | 40% coinsurance                                  |
|                                   |  |
| <b>Mail Generic</b>               | Lesser of \$15 or 15% coinsurance                |
| <b>Mail Brand Formulary</b>       | Lesser of \$45 or 25% coinsurance                |
| <b>Mail Brand Non-Formulary</b>   | Lesser of \$90 or 40% coinsurance                |
|                                   |  |
| <b>Specialty Mail Order (All)</b> | Same as Mail Order except 30 day supply          |
|                                   |  |
| <b>Contraceptives</b>             | Follows above schedule for retail and mail order |