

**2010 MEDICAL INSURANCE BENEFIT SUMMARY
EMPLOYEE COST SHARING**

SUBlue (Levels One, Two, and Three)				SUOrange
Level One POMCO/PHCS/ MultiPlan With Referral	Level Two POMCO/PHCS/ MultiPlan Without Referral	Level Three Out of Network	Level One POMCO/PHCS/ MultiPlan With Referral	
Cost Sharing Definitions				
Annual Deductible¹	No deductible	No deductible	\$300 per individual with a maximum of \$1,000 family	No deductible
Coinsurance	No coinsurance	10% allowable amount	30% allowable amount plus the difference between provider's charge and allowable amount <i>(exceptions noted below)</i>	No coinsurance
Annual Out-of-Pocket Maximum²	\$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
Your Institutional Covered Services				
INPATIENT HOSPITAL				
Inpatient hospital	\$250 copay per admission	\$250 copay per admission plus coinsurance	Deductible, \$250 copay per admission, and coinsurance	\$250 copay per admission
Nursery care	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
OUTPATIENT HOSPITAL				
Surgery	\$100 copay	\$100 copay plus coinsurance	Deductible, \$100 copay, and coinsurance	\$100 copay
Pre-surgical testing	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full

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

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

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

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Inpatient alcoholism/ substance abuse hospital visits by physician or other professional provider	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Inpatient skilled nursing facility visits by physician or other professional provider	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Inpatient mental, nervous or emotional disorder visits by physician or other professional provider³	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
PROFESSIONAL PROVIDER VISITS				
Office visits	\$20 copay (PCP) or \$25 copay (Specialist)	\$25 copay plus coinsurance	Deductible, \$25 copay, and coinsurance	\$20 copay (PCP) or \$25 copay (Specialist)
Well child visits birth to 2nd birthday (9 visits)	No copay; paid in full	No copay; paid in full	Deductible <i>plus the difference between provider's charge and allowable amount</i>	No copay; paid in full
Well child visits 2nd birthday up to 7th birthday (5 visits)	No copay; paid in full	No copay; paid in full	Deductible <i>plus the difference between provider's charge and allowable amount</i>	No copay; paid in full
Well child visits from 7th birthday to 19th birthday (one visit per calendar year)	\$20 copay (PCP)	\$25 copay plus coinsurance	Deductible, \$25 copay, and coinsurance	\$20 copay (PCP)

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

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

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

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Medical supplies	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full
Prosthetic devices	No copay; paid in full	Coinsurance	Deductible and coinsurance	No copay; paid in full

¹ 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.

² 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.

³ 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.

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