

**IN-NETWORK SERVICES**

In-network Medical Deductible / Coinsurance / Maximums		
	2009	2010
<b>In-network deductible and coinsurance</b>	Applies to most inpatient and outpatient facility services and office surgeries - see below for details	Applies to most inpatient and outpatient facility services, plus certain treatments and specialty drugs provided by a clinician - see below for details
Individual	\$1,000 deductible, then 15% coinsurance, up to out-of-pocket max	\$1,500 deductible, then 20% coinsurance, up to out-of-pocket max
Family	Two \$1,000 individual deductibles, then 15% coinsurance, up to out-of-pocket max	Two \$1,500 individual deductibles, then 20% coinsurance, up to out-of-pocket max
<b>In-network out-of-pocket maximum</b>	Maximum you pay annually towards deductible and coinsurance	Maximum you pay annually towards deductible and coinsurance
Individual	\$4,000	\$6,000
Family	\$8,000	\$12,000

Preventive Care (subject to age limitations and other guidelines)		
	2009	2010
Annual physical exam	\$30 copayment	\$0 copayment
Colorectal cancer screenings (age 50-74)	Deductible and coinsurance apply (up to out-of-pocket max)	\$0 copayment

Doctor Visits		
	2009	2010
<b>Primary care office visits</b>	\$30 copayment	\$25 copayment
<b>Specialist office visits</b>	\$40 copayment	\$50 copayment
Chiropractor visits		
Allergy consultation / testing		
All other specialists		

Surgical procedures	Deductible and coinsurance apply (up to out-of-pocket max)	Included in office visit copayment
Lab tests in a provider's office or freestanding lab	\$0 copayment	\$10 copayment
Cardiac rehabilitation	\$0 copayment	\$10 copayment
Pulmonary rehabilitation	\$40 copayment	\$10 copayment
Physical / occupational therapy	\$40 copayment (60 visits per year combined with speech / vision)	\$50 copayment (30 visits per year)
Speech / vision therapy	\$40 copayment (60 visits per year combined with physical / occupational)	\$50 copayment (20 visits per year)

Outpatient Facility Services	2009	2010
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Physician services	\$0 copayment	Deductible and coinsurance apply (up to out-of-pocket max)
Lab tests	\$0 copayment	Deductible and coinsurance apply (up to out-of-pocket max)

Inpatient Facility Services	2009	2010
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Physician Services	\$0 copayment	Deductible and coinsurance apply (up to out-of-pocket max)
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Treatments and Supplies (regardless of place of service)	2009	2010
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Chemotherapy (see Pharmacy section for oral)	\$0 copayment for outpatient; deductible and coinsurance apply (up to out-of-pocket max for in-patient)	Deductible and coinsurance apply regardless of place of service (up to out-of-pocket max).  * Please note: Certain specialty drugs are covered only through Accredo, Medco's specialty mail order pharmacy.
Radiation therapy		
Hemodialysis		
Specialty drugs provided and administered by a physician or other provider*		

Medical supplies	20% coinsurance (no out-of-pocket max)	30% coinsurance (no out-of-pocket max)
Durable medical equipment		
Prosthetics / orthotics (\$15,000 benefit limit per year)		
<b>Mental Health</b>	<b>2009</b>	<b>2010</b>
Outpatient mental health	\$40 copayment (60 visits per year, unless biologically-based)	\$50 copayment (30 visits per year, unless biologically-based)
<b>Sustance Abuse</b>	<b>2009</b>	<b>2010</b>
Outpatient chemical dependency (60 visits per year)	\$40 copayment	\$50 copayment
<b>Home Care</b>	<b>2009</b>	<b>2010</b>
Home care visit (40 visits per year)	\$10 copayment	\$25 copayment
<b>Urgent and emergency care</b>	<b>2009</b>	<b>2010</b>
Ambulance & pre-hospital emergency services	Deductible and coinsurance apply (up to out-of-pocket max)	Deductible and coinsurance apply (up to out-of-pocket max)
Emergency room visit	\$100 copayment (waived if admitted within 24 hours)	\$250 copayment (waived if admitted within 24 hours)
Urgent care center	\$50 copayment	\$100 copayment
<b>Pharmacy</b>	<b>2009</b>	<b>2010</b>
Deductible	\$100 deductible	\$200 deductible
Generic drugs	\$10 copayment	\$15 copayment
Brand formulary drugs	\$35 copayment	\$50 copayment

Brand non-formulary drugs	\$60 copayment	\$100 copayment
Brand specialty drugs obtained through the pharmacy program	Copay depends on whether drug is formulary or non-formulary	\$100 copayment (for formulary and non-formulary)
Diabetic supplies	20% coinsurance	\$15 copayment for a 1-month supply
Mail order prescriptions	2 copayments for a 3-month supply	3 copayments for a 3-month supply

## OUT-OF-NETWORK SERVICES

Out-of-Network Medical Deductible / Coinsurance / Maximums	2009	2010
<b>Out-of-network deductible and coinsurance</b>	Applies to all out-of-network services; emergencies treated as in-network	Applies to all out-of-network services; emergencies treated as in-network
Individual	\$3,000 deductible, then 45% coinsurance, up to out-of-pocket max	\$3,000 deductible, then 50% coinsurance, up to out-of-pocket max
Family	Two \$3,000 individual deductibles, then 45% coinsurance, up to out-of-pocket max	Two \$3,000 individual deductibles, then 50% coinsurance, up to out-of-pocket max
<b>Out-of-network out-of-pocket maximum</b>	Maximum you pay annually towards deductible and coinsurance	Maximum you pay annually towards deductible and coinsurance
Individual	\$14,000	\$15,000
Family	\$28,000	\$30,000