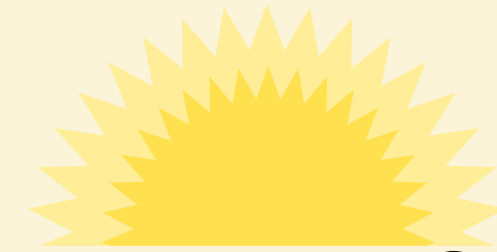


MANAGED CARE PLANS

BENEFIT	F	G	H	J	K	P	Q	R
Deductible (Calendar Year) - Individual*	\$0	\$0	\$0	\$0	\$0	\$300	\$500	\$1,000
Deductible (Calendar Year) - Family*	\$0	\$0	\$0	\$0	\$0	\$900	\$1,500	\$3,000
Coinsurance	\$0	\$0	\$0	\$0	\$0	20%	20%	20%
Out of Pocket Max (including Deductible) - Individual*	\$0	\$0	\$0	\$0	\$0	\$1,300	\$1,500	\$2,000
Out of Pocket Max (including Deductible) - Family*	\$0	\$0	\$0	\$0	\$0	\$3,900	\$4,500	\$6,000
Primary Care Physician Office Visit (PCP)	\$10	\$10	\$15	\$20	\$20	\$15	\$15	\$15
Specialty Care Physician Office Visit (SCP)	\$15	\$15	\$20	\$25	\$25	\$20	\$20	\$20
Wellness and Preventive (unlimited) **	\$10	\$10	\$15	\$20	\$20	\$15	\$15	\$15
Urgent Care	\$25	\$25	\$25	\$25	\$25	20%	20%	20%
Emergency Care	\$75	\$75	\$75	\$100	\$75	20%	20%	20%
Inpatient Hospital Services	\$250	\$0	\$500	\$750	\$500	20%	20%	20%
Outpatient Surgery Services	\$100	\$0	\$200	\$200	\$200	20%	20%	20%
Maternity Care PCP/SCP	\$100/\$150	\$100/\$150	\$150/\$200	\$200/\$250	\$200/\$250	\$150/\$200	\$150/\$200	\$150/\$200
Outpatient Labs, Pathology, Radiology, (EKG) and (EEG) MRI, CT, MRA, and PET scan	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Allergy Serum, DME, Corrective Appliances	50%	50%	50%	50%	50%	20%	20%	20%
Mental Health Inpatient	\$250	\$0	\$500	\$750	\$500	20%	20%	20%
Mental Health Outpatient	\$10	\$10	\$15	\$20	\$20	\$15	\$15	\$15
Vision (Routine Exam Only)	\$10	\$10	\$15	\$10	\$10	\$15	\$15	\$15



ADVANTAGE

...rising above the service you expectSM

PRESCRIPTION DRUG PLAN OPTIONS

RX PLAN	PHARMACY SCRIPTS	MAIL ORDER
RX 1	\$10/\$20/\$30	\$20/\$40/\$60
RX 2	\$10/\$20/\$50	\$20/\$40/\$100
RX 3	\$10/\$25/\$40	\$20/\$50/\$80
RX 4	\$10/\$30/\$50	\$20/\$60/\$100
RX 5	\$15/\$30/\$60	\$30/\$60/\$120
RX 6	\$10/\$30/50% (\$200 Max Copay)	\$20/\$60/50% (\$400 Max Copay)
RX 7	\$10/\$20/\$50/50% (\$200 Max Copay)	\$20/\$40/\$100/50% (\$400 Max Copay)

\$100 and \$250 Deductible options available.
Additional RX options are available upon request

BENEFIT	100	101	102	103	104	105	106	107	108	109
Deductible (Calendar Year) - Individual*	\$500	\$500	\$1,000	\$1,000	\$1,500	\$1,500	\$2,000	\$2,000	\$3,000	\$3,000
Deductible (Calendar Year) - Family*	\$1,500	\$1,500	\$3,000	\$3,000	\$4,500	\$4,500	\$6,000	\$6,000	\$9,000	\$9,000
Coinsurance	10%	20%	20%	30%	10%	20%	20%	30%	10%	20%
Out of Pocket Max (including Deductible) - Individual*	\$1,500	\$1,500	\$3,000	\$3,000	\$4,500	\$4,500	\$6,000	\$6,000	\$8,000	\$8,000
Out of Pocket Max (including Deductible) - Family*	\$4,500	\$4,500	\$9,000	\$9,000	\$13,500	\$13,500	\$18,000	\$18,000	\$24,000	\$24,000
Primary Care Physician Office Visit (PCP)	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20
Specialty Care Physician Office Visit (SCP)	\$40	\$40	\$40	\$40	\$40	\$40	\$40	\$40	\$40	\$40
Wellness and Preventive (unlimited)	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20
Urgent Care	10%	20%	20%	30%	10%	20%	20%	30%	10%	20%
Emergency Care	10%	20%	20%	30%	10%	20%	20%	30%	10%	20%
Inpatient Hospital	10%	20%	20%	30%	10%	20%	20%	30%	10%	20%
Outpatient Surgery Services	10%	20%	20%	30%	10%	20%	20%	30%	10%	20%
Maternity Care PCP/SCP	\$200/\$400	\$200/\$400	\$200/\$400	\$200/\$400	\$200/\$400	\$200/\$400	\$200/\$400	\$200/\$400	\$200/\$400	\$200/\$400
Outpatient Labs, Pathology, Radiology, (EKG) and (EEG) MRI, CT, MRA and PET scan	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Allergy Serum, DME, Corrective Appliances	10%	20%	20%	30%	10%	20%	20%	30%	10%	20%
Mental Health Inpatient	10%	20%	20%	30%	10%	20%	20%	30%	10%	20%
Mental Health Outpatient	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20
Vision (Routine Exam Only)	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15

AVAILABLE RIDERS

TYPE	COVERED
Chiropractic	20 Visit Limit - Not available with Consumer Driven Plans
Morbid Obesity	Surgical Treatment Covered
Family Planning	Sterilization & Contraceptive Devices
Life & Disability	Available upon request
Dental & Vision	Available upon request

Where Coinsurance (%) is listed, it is assumed that Deductible is paid first (if Deductible plan).

Co-pays do not count toward Deductible and Out of Pocket Max.
Most out of network and/or non-referred non-emergency benefits require you to seek prior authorization by calling the Pre-Cert phone number listed on your ID card.

* Other Deductible and Out of Pocket Max options for groups of 51+ available upon request.

**Only when office visit is billed separately

This benefit description is intended to be a brief outline of coverage. The entire provision of benefits and exclusions are contained in the Group Service Agreement and Certificate of Coverage. In the event of a conflict between those documents and this, the terms of the Group Service Agreement and Certificate of Coverage will prevail.

Diabetic Supplies are covered under prescription drug benefit unless otherwise noted.

MANAGED CARE POINT OF SERVICE PLANS (POS)



BENEFIT	L POS		M POS		N POS		P POS		Q POS		R POS	
	In Network Referred	Out of Network / Non-referred	In Network Referred	Out of Network / Non-referred	In Network Referred	Out of Network / Non-referred	In Network Referred	Out of Network / Non-referred	In Network Referred	Out of Network / Non-referred	In Network Referred	Out of Network / Non-referred
Deductible (Calendar Year) - Individual*	\$0	\$500	\$0	\$750	\$250	\$1,000	\$300	\$500	\$500	\$1,000	\$1,000	\$1,000
Deductible (Calendar Year) - Family*	\$0	\$1,500	\$0	\$2,250	\$750	\$3,000	\$900	\$1,500	\$1,500	\$3,000	\$3,000	\$3,000
Coinsurance	NA	30%	NA	30%	20%	30%	20%	30%	20%	30%	20%	30%
Out of Pocket Max (including Deductible) - Individual*	\$0	NA	\$0	NA	\$1,250	NA	\$1,300	NA	\$1,500	NA	\$2,000	NA
Out of Pocket Max (including Deductible) - Family*	\$0	NA	\$0	NA	\$3,750	NA	\$3,900	NA	\$4,500	NA	\$6,000	NA
Primary Care Physician Office Visit (PCP)	\$10	30%	\$15	30%	\$10	30%	\$15	30%	\$15	30%	\$15	30%
Specialty Care Physician Office Visit (SCP)	\$15	30%	\$20	30%	\$15	30%	\$20	30%	\$20	30%	\$20	30%
Wellness and Preventative (unlimited)**	\$10	30%	\$15	30%	\$10	30%	\$15	30%	\$15	30%	\$15	30%
Urgent Care	\$25	30%	\$25	30%	\$25	30%	20%	30%	20%	30%	20%	30%
Emergency Care	\$75	NA	\$75	NA	20%	NA	20%	NA	20%	NA	20%	NA
Inpatient Hospital Services	\$250	30%	\$500	30%	20%	30%	20%	30%	20%	30%	20%	30%
Outpatient Surgery Services	\$100	30%	\$200	30%	20%	30%	20%	30%	20%	30%	20%	30%
Maternity Care PCP/SCP	\$100/\$150	30%	\$150/\$200	30%	\$100/\$150	30%	\$150/\$200	30%	\$150/\$200	30%	\$150/\$200	30%
Outpatient Labs, Pathology, Radiology, (EKG) and (EEG) MRI, CT, MRA, and PET scan	\$0	30%	\$0	30%	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Allergy Serum	30%	30%	30%	30%	20%	30%	20%	30%	20%	30%	20%	30%
DME & Corrective Appliances	30%	NA	30%	NA	20%	NA	20%	NA	20%	NA	20%	NA
Mental Health Inpatient	\$250	30%	\$500	30%	20%	30%	20%	30%	20%	30%	20%	30%
Mental Health Outpatient	\$10	30%	\$15	30%	\$10	30%	\$15	30%	\$15	30%	\$15	30%
Vision (Routine Exam Only)	\$10	NA	\$15	NA	\$10	NA	\$15	NA	\$15	NA	\$15	NA

BENEFIT	100 POS		101 POS		102 POS		103 POS		104 POS		105 POS		106 POS		107 POS		108 POS		109 POS	
	In Network Referred	Out of Network/ Non-referred	In Network Referred	Out of Network/ Non-referred	In Network Referred	Out of Network/ Non-referred	In Network Referred	Out of Network/ Non-referred	In Network Referred	Out of Network/ Non-referred	In Network Referred	Out of Network/ Non-referred	In Network Referred	Out of Network/ Non-referred	In Network Referred	Out of Network/ Non-referred	In Network Referred	Out of Network/ Non-referred	In Network Referred	Out of Network/ Non-referred
Deductible (Calendar Year) - Individual*	\$500	\$1,000	\$500	\$1,000	\$1,000	\$2,000	\$1,000	\$2,000	\$1,500	\$3,000	\$1,500	\$3,000	\$2,000	\$4,000	\$2,000	\$4,000	\$3,000	\$6,000	\$3,000	\$6,000
Deductible (Calendar Year) - Family*	\$1,500	\$3,000	\$1,500	\$3,000	\$3,000	\$6,000	\$3,000	\$6,000	\$4,500	\$9,000	\$4,500	\$9,000	\$6,000	\$12,000	\$6,000	\$12,000	\$9,000	\$18,000	\$9,000	\$18,000
Coinsurance	10%	30%	20%	40%	20%	40%	30%	50%	10%	30%	20%	40%	20%	40%	30%	50%	10%	30%	20%	40%
Out of Pocket Max (including Deductible) - Individual*	\$1,500	NA	\$1,500	NA	\$3,000	NA	\$3,000	NA	\$4,500	NA	\$4,500	NA	\$6,000	NA	\$6,000	NA	\$8,000	NA	\$8,000	NA
Out of Pocket Max (including Deductible) - Family*	\$4,500	NA	\$4,500	NA	\$9,000	NA	\$9,000	NA	\$13,500	NA	\$13,500	NA	\$18,000	NA	\$18,000	NA	\$24,000	NA	\$24,000	NA
Primary Care Physician Office Visit (PCP)	\$20	30%	\$20	40%	\$20	40%	\$20	50%	\$20	30%	\$20	40%	\$20	40%	\$20	50%	\$20	30%	\$20	40%
Specialty Care Physician Office Visit (SCP)	\$40	30%	\$40	40%	\$40	40%	\$40	50%	\$40	30%	\$40	40%	\$40	40%	\$40	50%	\$40	30%	\$40	40%
Wellness and Preventative (unlimited)**	\$20	30%	\$20	40%	\$20	40%	\$20	50%	\$20	30%	\$20	40%	\$20	40%	\$20	50%	\$20	30%	\$20	40%
Urgent Care	10%	30%	20%	40%	20%	40%	30%	50%	10%	30%	20%	40%	20%	40%	30%	50%	10%	30%	20%	40%
Emergency Care	10%	NA	20%	NA	20%	NA	30%	NA	10%	NA	20%	NA	20%	NA	30%	NA	10%	NA	20%	NA
Inpatient Hospital Services	10%	30%	20%	40%	20%	40%	30%	50%	10%	30%	20%	40%	20%	40%	30%	50%	10%	30%	20%	40%
Outpatient Surgery Services	10%	30%	20%	40%	20%	40%	30%	50%	10%	30%	20%	40%	20%	40%	30%	50%	10%	30%	20%	40%
Maternity Care PCP/SCP	\$200/\$400	30%	\$200/\$400	40%	\$200/\$400	40%	\$200/\$400	50%	\$200/\$400	30%	\$200/\$400	40%	\$200/\$400	40%	\$200/\$400	50%	\$200/\$400	30%	\$200/\$400	40%
Outpatient Labs, Pathology, Radiology, (EKG) and (EEG) MRI, CT, MRA and PET scan	\$0	30%	\$0	40%	\$0	40%	\$0	50%	\$0	30%	\$0	40%	\$0	40%	\$0	50%	\$0	30%	\$0	40%
Allergy Serum	10%	30%	20%	40%	20%	40%	30%	50%	10%	30%	20%	40%	20%	40%	30%	50%	10%	30%	20%	40%
DME & Corrective Appliances	10%	NA	20%	NA	20%	NA	30%	NA	10%	NA	20%	NA	20%	NA	30%	NA	10%	NA	20%	NA
Mental Health Inpatient	10%	30%	20%	40%	20%	40%	30%	50%	10%	30%	20%	40%	20%	40%	30%	50%	10%	30%	20%	40%
Mental Health Outpatient	\$20	30%	\$20	40%	\$20	40%	\$20	50%	\$20	30%	\$20	40%	\$20	40%	\$20	50%	\$20	30%	\$20	40%
Vision (Routine Exam Only)	\$15	NA	\$15	NA	\$15	NA	\$15	NA	\$15	NA	\$15	NA	\$15	NA	\$15	NA	\$15	NA	\$15	NA

Where Coinsurance (%) is listed, it is assumed that Deductible is paid first (if Deductible plan).
 Co-pays do not count toward Deductible and Out of Pocket Max on Managed Care Plans.
 Most out of network and/or non-referred non-emergency benefits require you to seek prior authorization by calling the Pre-Cert phone number listed on your ID card.

* Other Deductible and Out of Pocket Max options available upon request.