



Small Group POS Plans

All benefits are subject to the Calendar Year Deductible unless otherwise noted.

			200	2000SX	2001SX	2500SX	2002SX	2501SX
Lifetime Maximum		In-network	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
		Out-of-network	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
Calendar Year Deductible <i>(up to three family members)</i>	Individual	In-network	\$0	\$0	\$0	\$0	\$500	\$500
		Out-of-network	\$300	\$300	\$500	\$1,000	\$1,000	\$1,000
	Family	In-network	\$0	\$0	\$0	\$0	\$1,500	\$1,500
		Out-of-network	\$900	\$900	\$1,500	\$3,000	\$3,000	\$3,000
Coinsurance	In-network	100%	100%	100%	80%	100%	80%	
	Out-of-network	70%	70%	60%	60%	60%	60%	
Calendar Year Out-of-Pocket Maximum <i>(in addition to the Calendar Year Deductible)</i>	Individual	In-network	\$0	\$0	\$0	\$1,000	\$0	\$1,000
		Out-of-network	\$1,500	\$1,500	\$4,000	\$4,000	\$4,000	\$4,000
	Family	In-network	\$0	\$0	\$0	\$3,000	\$0	\$3,000
		Out-of-network	\$4,500	\$4,500	\$12,000	\$12,000	\$12,000	\$12,000
Physician Office Visit PCP/SPC <i>(includes x-ray and lab work in office)</i>	In-network copay	\$15/\$20	\$25/\$25	\$25/\$25	\$25/\$25	\$25/\$25	\$25/\$25	
	Out-of-network	70%	70%	60%	60%	60%	60%	
Outpatient Diagnostic X-ray/Lab	In-network	100%	100%	100%	80%	100%	80%	
	Out-of-network	70%	70%	60%	60%	60%	60%	
Outpatient Surgical Facility/ Ambulatory Surgery Center	In-network	\$100 copay; 100%	\$100 copay; 100%	\$100 copay; 100%	80%	\$100 copay; 100%	80%	
	Out-of-network	70%	70%	60%	60%	60%	60%	
Physician Outpatient Services <i>(surgeon, anesthesiologist, radiologist, etc.)</i>	In-network	100%	100%	100%	100%	100%	100%	
	Out-of-network	70%	70%	60%	60%	60%	60%	
Maternity <i>(physician fee only)</i>	<i>(1st visit only)</i>	In-network copay	\$20	\$25	\$100	\$100	\$100	\$100
		Out-of-network	70%	70%	60%	60%	60%	60%
Hospital Inpatient Services	In-network	100%	100%	100%	80%	100%	80%	
	Out-of-network	70%	70%	60%	60%	60%	60%	
Physician Inpatient Hospital Services	In-network	100%	100%	100%	100%	100%	100%	
	Out-of-network	70%	70%	60%	60%	60%	60%	
Physical and Occupational Therapy <i>(combined specialties)</i>	In-network copay	\$20	\$25	\$25	\$25	\$25	\$25	
	Out-of-network	70%	70%	60%	60%	60%	60%	
	Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits	
Chiropractic Care	In-network copay	\$15	\$15	\$15	\$15	\$15	\$15	
	Out-of-network	70%	70%	60%	60%	60%	60%	
	Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits	
Behavioral Health/Substance Abuse	Inpatient	In-network	100%	100%	100%	80%	100%	80%
		Out-of-network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
		Calendar year max	30 days	30 days	30 days	30 days	30 days	30 days
	Outpatient	In-network copay	\$25	\$25	\$25	\$25	\$25	\$25
		Out-of-network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Intermediate Level Behavioral Health - Partial Hospitalization Program/Intensive Outpatient	In-network	N/A	N/A	N/A	N/A	N/A	N/A	
	Out-of-network	N/A	N/A	N/A	N/A	N/A	N/A	
	Calendar year max	N/A	N/A	N/A	N/A	N/A	N/A	
Emergency Room	Copay*	In-network/Out-of-network	\$100	\$100	\$100	\$100	\$100	\$100
Prescription Drug Copays	Calendar year deductible per member		\$0	\$0	\$0	\$0	\$0	\$0
		Generic Formulary	\$10	\$20	\$20	\$20	\$20	\$20
		Brand Formulary	\$20	\$35	\$35	\$35	\$35	\$35
		Non-Formulary	Not Covered	\$60	\$60	\$60	\$60	\$60
		Mail Order Generic/Brand	\$40/\$40	\$60/\$60	\$60/\$60	\$60/\$60	\$60/\$60	\$60/\$60

This plan grid offers a summary of the plans. Please refer to the Benefit Summaries for further details.
* ER copay is waived if admitted to the hospital.



Small Group POS Plans, *continued*

All benefits are subject to the Calendar Year Deductible unless otherwise noted.

			2010SX	2003SX	2011SX	2502SX	2510SX	2004SX
Lifetime Maximum		In-network	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
		Out-of-network	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
Calendar Year Deductible <i>(up to three family members)</i>	Individual	In-network	\$1,000	\$1,000	\$2,000	\$1,000	\$2,000	\$1,500
		Out-of-network	\$2,000	\$1,000	\$4,000	\$1,000	\$4,000	\$1,500
	Family	In-network	\$3,000	\$3,000	\$6,000	\$3,000	\$6,000	\$4,500
		Out-of-network	\$6,000	\$3,000	\$12,000	\$3,000	\$12,000	\$4,500
Coinsurance		In-network	100%	100%	100%	80%	80%	100%
		Out-of-network	60%	60%	60%	60%	60%	60%
Calendar Year Out-of-Pocket Maximum <i>(in addition to the Calendar Year Deductible)</i>	Individual	In-network	\$0	\$0	\$0	\$1,000	\$2,000	\$0
		Out-of-network	\$4,000	\$4,000	\$4,000	\$4,000	\$4,000	\$4,000
	Family	In-network	\$0	\$0	\$0	\$3,000	\$6,000	\$0
		Out-of-network	\$12,000	\$12,000	\$12,000	\$12,000	\$12,000	\$12,000
Physician Office Visit PCP/SPC <i>(includes x-ray and lab work in office)</i>		In-network copay	\$25/\$25	\$40/\$40	\$25/\$25	\$40/\$40	\$25/\$25	\$40/\$40
		Out-of-network	60%	60%	60%	60%	60%	60%
Outpatient Diagnostic X-ray/Lab		In-network	100%	100%	100%	80%	80%	100%
		Out-of-network	60%	60%	60%	60%	60%	60%
Outpatient Surgical Facility/ Ambulatory Surgery Center		In-network	100%	\$100 copay; 100%	100%	80%	80%	\$100 copay; 100%
		Out-of-network	60%	60%	60%	60%	60%	60%
Physician Outpatient Services <i>(surgeon, anesthesiologist, radiologist, etc.)</i>		In-network	100%	100%	100%	100%	80%	100%
		Out-of-network	60%	60%	60%	60%	60%	60%
Maternity <i>(physician fee only)</i>	<i>(1st visit only)</i>	In-network copay	\$100	\$100	\$100	\$100	\$100	\$100
		Out-of-network	60%	60%	60%	60%	60%	60%
Hospital Inpatient Services		In-network	100%	100%	100%	80%	80%	100%
		Out-of-network	60%	60%	60%	60%	60%	60%
Physician Inpatient Hospital Services		In-network	100%	100%	100%	100%	80%	100%
		Out-of-network	60%	60%	60%	60%	60%	60%
Physical and Occupational Therapy <i>(combined specialties)</i>		In-network copay	\$25	\$40	\$25	\$40	\$25	\$40
		Out-of-network	60%	60%	60%	60%	60%	60%
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Chiropractic Care		In-network copay	\$15	\$15	\$15	\$15	\$15	\$15
		Out-of-network	60%	60%	60%	60%	60%	60%
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Behavioral Health/Substance Abuse	Inpatient	In-network	100%	100%	100%	80%	80%	100%
		Out-of-network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
		Calendar year max	30 days	30 days	30 days	30 days	30 days	30 days
	Outpatient	In-network copay	\$25	\$40	\$25	\$40	\$25	\$40
		Out-of-network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Intermediate Level Behavioral Health - Partial Hospitalization Program/Intensive Outpatient		In-network	100%	N/A	100%	N/A	80%	N/A
		Out-of-network	Not Covered	N/A	Not Covered	N/A	Not Covered	N/A
		Calendar year max	5 days/visits	N/A	5 days/visits	N/A	5 days/visits	N/A
Emergency Room	Copay*	In-network/Out-of-network	\$100	\$100	\$100	\$100	\$100	\$100
Prescription Drug Copays	Calendar year deductible per member		\$0	\$0	\$0	\$0	\$0	\$0
	Generic Formulary		\$15	\$20	\$15	\$20	\$15	\$20
	Brand Formulary		\$30	\$35	\$30	\$35	\$30	\$35
	Non-Formulary		\$60	\$60	\$60	\$60	\$60	\$60
	Mail Order Generic/Brand		\$30/\$60	\$60/\$60	\$30/\$60	\$60/\$60	\$30/\$60	\$60/\$60

This plan grid offers a summary of the plans. Please refer to the Benefit Summaries for further details.
* ER copay is waived if admitted to the hospital.



Small Group POS Plans, *continued*

All benefits are subject to the Calendar Year Deductible unless otherwise noted.

			2503SX	2804SX	2504SX	2800SX	2801SX
Lifetime Maximum		In-network	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
		Out-of-network	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
Calendar Year Deductible <i>(up to three family members)</i>	Individual	In-network	\$1,500	\$3,000	\$1,000	\$1,000	\$2,000
		Out-of-network	\$1,500	\$6,000	\$3,000	\$3,000	\$4,000
	Family	In-network	\$4,500	\$9,000	\$3,000	\$3,000	\$6,000
		Out-of-network	\$4,500	\$18,000	\$9,000	\$9,000	\$12,000
Coinsurance	In-network	80%	70%	80%	70%	70%	
	Out-of-network	60%	50%	60%	60%	60%	
Calendar Year Out-of-Pocket Maximum <i>(in addition to the Calendar Year Deductible)</i>	Individual	In-network	\$1,000	\$3,000	\$3,000	\$3,000	\$3,000
		Out-of-network	\$4,000	\$6,000	\$15,000	\$15,000	\$8,000
	Family	In-network	\$3,000	\$9,000	\$9,000	\$9,000	\$9,000
		Out-of-network	\$12,000	\$18,000	\$45,000	\$45,000	\$24,000
Physician Office Visit PCP/SPC <i>(includes x-ray and lab work in office)</i>	In-network copay	\$40/\$40	\$25/\$25	\$40/\$40	\$40/\$40	\$40/\$40	
	Out-of-network	60%	50%	60%	60%	60%	
Outpatient Diagnostic X-ray/Lab	In-network	80%	70%	80%	70%	70%	
	Out-of-network	60%	50%	60%	60%	60%	
Outpatient Surgical Facility/ Ambulatory Surgery Center	In-network	80%	70%	\$500 copay; 80%	\$500 copay; 70%	\$1,000 copay; 70%	
	Out-of-network	60%	50%	60%	60%	60%	
Physician Outpatient Services <i>(surgeon, anesthesiologist, radiologist, etc.)</i>	In-network	100%	70%	80%	70%	70%	
	Out-of-network	60%	50%	60%	60%	60%	
Maternity (physician fee only) <i>(1st visit only)</i>	In-network copay	\$100	\$150	\$500	\$500	\$1,000	
	Out-of-network	60%	50%	60%	60%	60%	
Hospital Inpatient Services	In-network	80%	70%	\$500 copay per admission; 80%	\$500 copay per admission; 70%	\$1,000 copay per admission; 70%	
	Out-of-network	60%	50%	60%	60%	60%	
Physician Inpatient Hospital Services	In-network	100%	70%	80%	70%	70%	
	Out-of-network	60%	50%	60%	60%	60%	
Physical and Occupational Therapy <i>(combined specialties)</i>	In-network copay	\$40	\$25	\$40	\$40	\$40	
	Out-of-network	60%	50%	60%	60%	60%	
	Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	
Chiropractic Care	In-network copay	\$15	\$15	\$15	\$15	\$15	
	Out-of-network	60%	50%	60%	60%	60%	
	Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits	
Behavioral Health/Substance Abuse	Inpatient	In-network	80%	70%	\$500 copay per admission; 80%	\$500 copay per admission; 70%	\$1,000 copay per admission; 70%
		Out-of-network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
		Calendar year max	30 days	30 days	30 days	30 days	30 days
	Outpatient	In-network copay	\$40	\$25	\$40	\$40	\$40
		Out-of-network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
		Calendar year max	20 visits	20 visits	20 visits	20 visits	20 visits
Intermediate Level Behavioral Health - Partial Hospitalization Program/Intensive Outpatient	In-network	N/A	70%	N/A	N/A	N/A	
	Out-of-network	N/A	Not Covered	N/A	N/A	N/A	
	Calendar year max	N/A	5 days/visits	N/A	N/A	N/A	
Emergency Room	Copay*	In-network/Out-of-network	\$100	\$150	\$150	\$150	\$150
Prescription Drug Copays	Calendar year deductible per member		\$0	\$0	\$250	\$250	\$250
		Generic Formulary	\$20	\$15	\$20	\$20	\$20
		Brand Formulary	\$35	\$30	\$35	\$35	\$35
		Non-Formulary	\$60	\$60	Not Covered	Not Covered	Not Covered
		Mail Order Generic/Brand	\$60/\$60	\$30/\$60	\$60/\$60	\$60/\$60	\$60/\$60

This plan grid offers a summary of the plans. Please refer to the Benefit Summaries for further details.

* ER copay is waived if admitted to the hospital.