

**SUBURBAN HOSPITAL EHP HIGH OPTION PLAN
MEDICAL BENEFITS AT-A-GLANCE FOR ELIGIBLE MEMBERS**

Effective Date: January 1, 2011

SERVICES PROVIDED		In-Network	Out-of-Network	Suburban Hospital (Facility charges only. May not include physician fees)
CALENDAR YEAR DEDUCTIBLE (waived if using Suburban Hospital)	Per individual	\$150	\$300	None
	Per family	\$300	\$600	None
	Per hospital admission (waived if using Suburban or for a service that Suburban does not provide)	\$300	\$300	None
OUT-OF-POCKET MAXIMUM EXPENSE PER CALENDAR YEAR (exclusions: deductibles, co-pays, and expenses incurred as a result of failure to obtain pre-certification)	Per Individual	\$2,500	\$2,500	Not applicable
	Per family	\$5,000	\$5,000	Not applicable
MAXIMUM LIFETIME BENEFIT PER PERSON	All Options Combined		Unlimited	
PRESCRIPTION DRUGS (administered through Express Scripts)	In-network pharmacy (34 day supply limit)	Generic — \$10 co-pay Preferred Formulary Brand — 20% co-insurance (\$20 minimum/\$60 maximum) Non-Preferred Formulary Brand — 20% co-insurance (\$35 minimum/\$105 maximum)		
	Home Delivery (mail order) (90 day supply limit)	Generic — \$25 co-pay Preferred Formulary Brand — \$50 co-pay Non-Preferred Formulary Brand — \$80 co-pay		
TREATMENT OF ILLNESS OF INJURY	Primary Care Office Visit	\$20 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable
	Specialty Care Office Visit	\$25 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable
	Diagnostic Services and Treatment	90%, after deductible	70% of R&C, after deductible	100%

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PREVENTIVE SERVICES				
Routine physical exam (limit one per calendar year)	\$20 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable	
Routine preventive screenings: Colonoscopy, dexascan (age 50+), PSA test and exam, and EKG	100%, (deductible waived)	70% of R&C, after deductible	Not applicable	
Routine Immunizations	100%, (deductible waived)	70% of R&C, after deductible	Not applicable	
Well child care (birth to age one: 6 visit limit, age one to age two: 2 visit limit, age two to age six: one visit per calendar year limit)	\$20 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable	
Mammogram (limited to one baseline between ages 35 to 39, one per calendar year age 40 and up)	\$20 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable	
Routine GYN exam including pap test (limit one per calendar year)	\$20 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable	
Routine Hearing Exam (limit one every 24 months)	\$20 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable	
ROUTINE VISION CARE				
Routine Vision exam (limit one per calendar year)	80% (deductible waived)	80% (deductible waived)	Not applicable	
Glasses or contact lenses (limit: one pair of glasses or one set of permanent contacts or one year supply of disposable contact lenses per calendar year)	80% (deductible waived)	80% (deductible waived)	Not applicable	
ALLERGY TESTS AND PROCEDURES	Allergy serum/injections	100%, (deductible waived)	70% of R&C, after deductible	Not applicable
LABORATORY AND X-RAY PROCEDURES	In-patient and out-patient diagnostic x-rays and lab (including prenatal)	90%, after deductible	70% of R&C, after deductible	100%
	Laboratory, including pathology and prenatal	90%, after deductible	70% of R&C, after deductible	100%
SURGICAL PROCEDURES	Primary Care Physician Office surgery	\$20 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable
	Specialist Office surgery	\$25 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable
	Other	90%, after deductible	70% of R&C, after deductible	100%
ANESTHESIOLOGY		90%, after deductible	70% of R&C, after deductible	100% (facility charge only)

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REPRODUCTIVE HEALTH			
Maternity Office visit	\$25 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable
Hospitalization, physician and ancillary services for labor and delivery (including licensed birthing centers and nursery/newborn care)	100% (\$300 inpatient co-pay waived, deductible waived)	70% of R&C, after deductible	Not applicable
Voluntary Sterilization	90%, after deductible	70% of R&C, after deductible	Not applicable
Interruption of pregnancy	90%, after deductible	70% of R&C, after deductible	100%
Artificial Insemination (6 attempts lifetime maximum)	\$25 co-pay, then 100% (deductible waived)	70% of R&C, after deductible	Not applicable
URGENT CARE CENTERS			
Physician visit	\$20 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable
EMERGENCY SERVICES (Non-emergency use of the emergency room is not covered)			
Facility (co-pay waived if admitted)	\$75 co-pay, then 90% (deductible waived)	\$75 co-pay, then 90% of R&C (deductible waived)	100%
Physician	90% (deductible waived)	90% of R&C (deductible waived)	100%
AMBULANCE TRANSPORT			
Air or ground transportation	90%, after deductible	70% of R&C, after deductible	Not applicable
HOSPITAL CARE			
Inpatient care	90% (after \$300 co-pay per admission and deductible)	70% of R&C (after \$300 co-pay per admission and deductible)	100%
Preadmission testing	90%, after deductible	70% of R&C, after deductible	100%
Short-term rehabilitation (60 days per calendar year maximum)	90%, after deductible	70% of R&C, after deductible	Not applicable
Skilled nursing/Extended Rehabilitation facility (90 days per calendar year maximum)	90%, after deductible	70% of R&C, after deductible	Not applicable
Outpatient Surgery/Ambulatory Surgical Center	90%, after deductible	70% of R&C, after deductible	100%
INFUSION THERAPY			
Includes physician services and materials	\$20 co-pay, then 100%, (deductible waived)	70% of R&C, after deductible	100%
ACUPUNCTURE			
Medically necessary for anesthesia or therapeutic purposes (\$1,000 calendar year maximum)	90%, after deductible	70% of R&C, after deductible	Not applicable

Reasonable & Customary Charge (R&C) is the usual fee charged by similar providers for the same services or supplies in the same geographic area.

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HOME HEALTH SERVICES	Medically necessary services coordinated by Clinical Case Managers (120 visit per calendar year maximum)	\$20 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable
PODIATRY SERVICES	Office visit	\$25 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable
	Office surgery	\$25 co-pay (deductible waived)	70% of R&C, after deductible	Not applicable
	Other services	90%, after deductible	70% of R&C, after deductible	Not applicable
PRIVATE DUTY NURSING		90%, after deductible	70% of R&C, after deductible	Not applicable
HOSPICE CARE	Inpatient and home	90%, after deductible	70% of R&C, after deductible	Not applicable
SPEECH THERAPY	Non-developmental medically necessary services	90%, after deductible	70% of R&C, after deductible	100%
PHYSICAL/OCCUPATIONAL THERAPY	Medically necessary services	90%, after deductible	70% of R&C, after deductible	100%
CHEMOTHERAPY/RADIATION THERAPY	Includes physician services & materials	90%, after deductible	70% of R&C, after deductible	100%
CHIROPRACTIC CARE	Restricted to initial consultation, x-rays and treatment (not maintenance care) \$1,000 maximum per calendar year	90%, after deductible	70% of R&C, after deductible	Not applicable
DURABLE MEDICAL EQUIPMENT	Medically necessary equipment, prosthetic devices, and medical supplies	90%, after deductible	70% of R&C, after deductible	100%
MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER SERVICES	Inpatient Care for Mental Health and Substance Abuse/Alcohol Abuse	90% (after \$300 per hospital admission co-pay and deductible)	70% of R&C, after \$300 per hospital admission co-pay and deductible	100%
	Outpatient Care for Mental Health and Substance/Alcohol Abuse Disorders	\$25 co-pay, then 100%, (deductible waived)	70% of R&C, after deductible	100%
	Biofeedback	\$25 co-pay, then 100%, (deductible waived)	70% of R&C, after deductible	100%

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