

Southern Health Benefit Comparison Medical Plan Benefits - Effective 10/1/10

	Care POS \$25/\$50/\$150 Per Day	Value POS \$25/\$50/20%
IN NETWORK BENEFITS		
Deductible	None	\$200 / \$400
Out-of-Pocket Maximum	\$2,000 / \$4,000	\$3,000 / \$6,000
Inpatient Benefits	Member Pays	Member Pays
Hospital	\$150 Per Day (up to \$750 per admission)	20%, after Deductible
Physician Charges	\$0	20%, after Deductible
Maternity	\$150 Per Day (up to \$750 per admission)	20%, after Deductible, plus \$50 PCP/OBGYN charge
Mental Health & Substance Abuse	\$150 Per Day (up to \$750 per admission)	20%, after Deductible
Outpatient Benefits	Member Pays	Member Pays
Referrals to Specialist Required	No	No
Primary Care Office Visit (including OBGYN)	\$25	\$25
Specialist Office Visit	\$50	\$50
Urgent Care Center	\$25 PCP / \$50 Specialist	\$25 PCP / \$50 Specialist
Allergy Testing	\$25 PCP / \$50 Specialist	\$25 PCP / \$50 Specialist
Allergy Serum and Injections	\$0	\$0
Therapeutic Injectable Medication (insulin and chemotherapy not included)	20%	20%
Mammogram	\$0	\$0
Diagnostic Services (including, but not limited to, Xrays, EKG and DEXA Scans)		
Primary Care Diagnostic Services (including OBGYN)	\$25	20%, after Deductible
Specialist Diagnostic Services	\$50	20%, after Deductible
Facility	\$50	20%, after Deductible
Lab Services		
Primary Care Lab Services (including OBGYN)	\$25	20%, after Deductible
Specialist Lab Services	\$50	20%, after Deductible
Facility	\$50	20%, after Deductible
Specialty Diagnostic Services (including, but not limited to, MRA, MRI, CAT and PET Scans and Sleep Studies)	\$125	\$175, after Deductible
Maternity Outpatient Services		
Prenatal Care (after initial visit for diagnosis of pregnancy)	\$0	\$0
Maternity Ultrasounds	\$0	20%
Emergency Room	\$125	20%
Outpatient Surgery	\$125	20%, after Deductible
Occupational, Speech and Physical Therapy	\$25	20%, after Deductible
Outpatient Mental Health & Substance Abuse	\$50	\$50
Spinal Manipulations (30 visits per Benefit Year)	\$25	\$25, after Deductible
Durable Medical Equipment (\$2500 Maximum per Benefit Year)	\$0	\$0, after Deductible
Home Health Care	\$0	\$0, after Deductible
Skilled Nursing (100 days per Benefit Year)	\$0	\$20%, after Deductible
Hospice Care	\$0	\$0, after Deductible
Prescription Drugs	Mandatory Generic	Mandatory Generic
Preferred Generic Tier 1	\$10	\$10
Preferred Brand Tier 2	\$30	\$30
Non-Preferred Tier 3	\$50	\$50
Self Injecatables Tier 4 (Enbrel, Humira, etc.)	\$100	\$100
Mail Order (90 Day Supply)	\$20/\$60/\$100	\$20/\$60/\$100
Other		
Lifetime Maximum	Unlimited	Unlimited
Routine Vision Care (through VSP)		
Routine Eye Exam (one exam per Benefit Year)	\$15	\$15
OUT-OF-NETWORK BENEFITS		
Deductible	\$750 / \$1,500	\$1,000 / \$2,000
Coinsurance	30%	30%
Out-of-Pocket Maximum (combined with In Network)	\$2,000 / \$4,000	\$3,000 / \$6,000