



2009

**Base Plan
HealthMate Coast-to-Coast
Coinsurance Option**

**Advanced Financial Services
Supplemental Plan**

Bi-Weekly Payroll Deductions
Individual \$34.50 Family \$78.95

1/1/2009 to 12/31/2009

AFS Pays for You

You Pay

Plan Specifics

Annual Deductible per Individual	\$2,000.00	\$2,000.00	\$0.00
Annual Deductible per Family	\$4,000.00	\$4,000.00	\$0.00
Coinsurance	20%	20%	0%
Out-of-pocket maximum per individual	\$3,000.00	\$3,000.00	\$0.00
Out-of-pocket maximum per family	\$6,000.00	\$6,000.00	\$0.00

Outpatient Preventive and Diagnostic Services

Primary Care Office Visits	\$15 per visit, no deductible		\$15 per visit, no deductible
Specialty Care Office Visits	\$25 per visit, no deductible		\$25 per visit, no deductible
Chiropractic Office Visits (Max 12 visits per year)	\$25 per visit, no deductible		\$25 per visit, no deductible
Eye Exams (One per calendar year)	\$25 per visit, no deductible		\$25 per visit, no deductible
Outpatient Mental Health & Substance Abuse treatment (limitations apply)	\$25 per visit, no deductible		\$25 per visit, no deductible
Urgent care (ie. Walk-in treatment centers)	\$25 per visit, no deductible		\$25 per visit, no deductible
Emergency room (Waived if admitted)	\$100 per visit, no deductible		\$100 per visit, no deductible
X-rays, lab tests and other tests	\$0		\$0

Prescription Drug & Vision Care

Retail Prescription Drugs	\$7/\$30/\$50/\$50	\$0	\$7/\$30/\$50/\$50
Mail Order Prescription Drugs	2.5x Retail copay for 90 day supply	\$0	2.5x Retail copay for 90 day supply
Vision Care Benefit	Not Covered	\$100	Amounts over \$100

Inpatient Services

In Patient Hospital Deductible	20% after deductible	20% and Deductible	\$0
Inpatient Mental Health (see limits)	20% after deductible	20% and Deductible	\$0
Inpatient Substance Abuse; (see limits)	20% after deductible	20% and Deductible	\$0

Outpatient Services

Surgery and related anesthesia	20% after deductible	20% and Deductible	\$0
Home health care , including hospice care	20% after deductible	20% and Deductible	\$0
Outpatient Radiation & Chemotherapy	20% after deductible	20% and Deductible	\$0
Short-term rehabilitation therapy	20% after deductible	20% and Deductible	\$0
Durable Medical Equip	20% after deductible	20% and Deductible	\$0
Prosthetic devices	20% after deductible	20% and Deductible	\$0
Infertility Services (Diagnosis, Treatment, Oral & Injectable Drugs)	20% after deductible	20% and Deductible	\$0
Ambulance Services	20% after deductible	20% and Deductible	\$0

Out-of-Network Services

Out-of-Network deductible is separate from in-network deductible.

Annual Deductible per Individual	\$2,000.00	\$0.00	\$2,000.00
Annual Deductible per Family	\$4,000.00	\$0.00	\$4,000.00
Coinsurance	40%	0%	40%
Out-of-Network coinsurance maximum combined with in-network coinsurance maximum.			
Out-of-pocket maximum per individual	\$6,000.00	\$0.00	\$6,000.00
Out-of-pocket maximum per family	\$12,000.00	\$0.00	\$12,000.00

This comparison is for descriptive purposes only. Please consult plan literature for actual benefit levels. If this summary and actual plan literature disagree, the benefits described in Evidence of Coverage will apply.