

|   | In-Network   | Out-of-Network  |
|---|--|---|
| <b>Access</b>   |  | Open Access   |
| <b>Benefit Year</b>   |  | Contract Year   |
| <b>Deductible</b>   | \$2,500 individual plan deductible<br>\$5,000 family plan deductible*  | \$4,000 individual plan deductible<br>\$8,000 family plan deductible*   |
|   | *Note: For Family coverage, the ConnectiCare plan requires that the family plan deductible must be met completely prior to any member of the family becoming eligible for benefits after the deductible.                             |   |
| <b>Coinsurance</b>  | 100%   | 30%   |
| <b>Coinsurance Limit</b> (not including deductible or in-network co-payments)   | N/A  | \$2,000 individual plan/\$4,000 family plan (individual plan coinsurance limit is determined by member paying 30% of approved charges totaling \$6,667) |
| <b>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)  | \$3,500 individual (2X family)   | \$6,000 individual (2X family)  |
| <b>Hospital Inpatient</b>   |  |   |
| Hospital Services: Semi-private room & board, medications, and related hospital services (includes inpatient services for mental/nervous and substance abuse) | 100% after plan deductible   | 30% after plan deductible   |
| <b>Outpatient Medical Services</b>  |  |   |
| Routine Physical Exams (adults and children based on schedules)   | Covered in full  | 30% after plan deductible   |
| Medical Office Visits—includes office visits associated with mental/nervous and substance abuse   | 100% after plan deductible   | 30% after plan deductible   |
| Routine OB/GYN Exam—1 visit annually  | Covered in full  | 30% after plan deductible   |
| Routine Mammography (subject to age limitations)  | Routine/preventive services covered in full  | 30% after plan deductible   |
| Routine Colonoscopy (subject to age limitations)  | Routine/preventive services covered in full  | 30% after plan deductible   |
| Routine Vision Exam   | Covered in full;<br>One exam per contract year   | Not covered   |
| Immunizations   | Covered in full (based on schedules)   | 30% after plan deductible   |
| Diagnostic X-ray  | 100% after plan deductible   | 30% after plan deductible   |
| Laboratory  | Covered in full as part of routine physical exam; otherwise subject to deductible  | 30% after plan deductible   |
| Outpatient Surgery (doctor's office or other facility)  | 100% after plan deductible   | 30% after plan deductible   |
| <b>Other Services</b>   |  |   |
| Physical Therapy: Includes physical, speech and occupational. Prior authorization required.   | 100% after plan deductible (up to 20 visits combined)  | 30% after plan deductible   |
| Prescription Drugs (Retail) (MAC-A mandatory generic)*<br>See formularies for each health plan company.   | Subject to plan deductible. Once deductible is met, then \$15/\$25/\$40 (Tier 1/2/3) up to a pharmacy co-pay maximum of \$1,000 individual plan/\$2,000 family plan per contract year. Maximum does not include the plan deductible. | Not Covered   |
| Mail-order Pharmacy   | Subject to plan deductible. Then 2X retail co-pay for up to a 90-day supply.   | Not Covered   |
| Urgent Care (includes walk-in centers)  | 100% after plan deductible   | 100% after plan deductible  |
| Emergency Room Services   | 100% after plan deductible   | 100% after in-network plan deductible   |
| Ambulance Services  | 100% after plan deductible   | 100% after in-network plan deductible   |
| <b>Lifetime Maximum</b>   | Unlimited  | Unlimited   |

\* Generic substitution required when available. If member purchases brand drug when a generic is available, the member pays the difference in cost between brand and generic.

The services described are only an overview of the entire benefit package. For a more detailed plan description prior to enrolling, please contact the health plan company that interests you. Health plan company phone numbers can be obtained from your employer. Services provided by the health plan company under the benefit plan you select will be fully described in the proof of coverage document you'll receive once you are enrolled in the program. The benefits are subject to various limitations, exclusions and conditions as fully described in each health plan company's Certificate of Coverage. The services identified are covered as described only when they are provided based on the guidelines of the program; in other words, when they are provided, prescribed or directed by the health plan company you have selected (except in cases of emergencies).