

|   | <b>In-Network</b>   | <b>Out-of-Network</b>                                   |
|---|---|---|
| <b>Access</b>   |   | Open Access   |
| <b>Benefit Year</b>   |   | Contract Year*  |
| <b>Deductible</b>   | \$2,000 individual/\$4,000 family   | \$3,000 individual/\$6,000 family                       |
| <b>Coinsurance</b>  | 100%  | 70/30% after deductible                                 |
| <b>Coinsurance Limit</b> (not including deductible or in-network co-payments)   | N/A   | \$2,000 individual/\$4,000 family                       |
| <b>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)  | N/A   | \$5,000 individual/\$10,000 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) | Subject to deductible, then covered in full.  | 70/30% after deductible                                 |
| <b>Outpatient Medical Services</b>  |   |   |
| Routine Physical Exams (adults and children based on schedules)   | Covered in full   | No coverage, except for well-child care through age 6   |
| Medical Office Visits—includes office visits associated with mental/nervous and substance abuse   | Routine/preventive services covered in full. All other services subject to deductible, then covered in full.                | 70/30% after deductible                                 |
| Routine OB/GYN Exam—1 visit annually  | Routine/preventive services covered in full.  | Not covered   |
| Routine Mammography (subject to age limitations)  | Routine/preventive services covered in full.  | Not covered   |
| Routine Colonoscopy (subject to age limitations)  | Routine/preventive services covered in full.  | Not covered   |
| Routine Vision Exam   | Covered in full as part of routine physical exam. Otherwise not covered.  | Not covered   |
| Immunizations   | Covered in full if routine/preventive. Otherwise subject to deductible.   | Not covered   |
| Diagnostic X-ray  | Subject to deductible, then covered in full.  | 70/30% after deductible                                 |
| Laboratory  | Covered in full as part of routine/preventive services. Otherwise subject to deductible.                                    | 70/30% after deductible                                 |
| Outpatient Surgery (doctor's office or other facility)  | Subject to deductible, then covered in full.  | 70/30% after deductible                                 |
| <b>Other Services</b>   |   |   |
| Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)                         | Subject to deductible, then covered in full.  | 70/30% after deductible                                 |
| Prescription Drugs (Retail) (MAC-A: Mandatory Generic**) See formularies for each health plan company. See explanation of benefits by carrier.                | \$100 deductible on tiers 2 and 3 only, then co-pays apply. 3X deductible max. per family. Three-tier co-pay \$15/\$30/\$40 | Not covered. Members must use participating pharmacy.   |
| Mail-order Pharmacy   | Subject to \$100 pharmacy deductible, then 2X retail co-pays.   | Not available unless member uses in-network vendor.     |
| Urgent Care (includes walk-in centers)  | Subject to deductible, then covered in full.  | 70/30% after deductible                                 |
| Emergency Room Services   | Subject to in-network deductible, then covered in full.   | Subject to in-network deductible, then covered in full. |
| Ambulance Services  | Subject to in-network deductible, then covered in full.   | Subject to in-network deductible, then covered in full. |
| <b>Lifetime Maximum</b>   | Unlimited   | Unlimited   |

\*Contract year effective July 1, 2009 for new business. In-force groups may be contract year or calendar year, determined at a group's renewal. NOTE: Deductibles will run on a contract year. All other benefits will operate on a calendar year.

\*\*Generic substitution required when available. If member purchases brand drug when a generic is available, member pays the co-pay plus the difference in cost between brand and generic. Information relative to "Preferred Brand" drugs may be found on each health plan's Web site or by contacting each health plan's Member Services Department.

Oxford USA is our "out-of-area" option and is available in most states EXCLUDING: ID, ME, MS, MT, OK, SD, WY. Greater metro NY, NJ, DE and some parts of PA are considered in-area. See the Enrollment Brochure for plan designs.

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).