

|  | In-Network   | Out-of-Network  |
|--|--|---|
| <b>Access</b>  |  | Open Access   |
| <b>Benefit Year</b>  |  | Contract Year**   |
| <b>Deductible</b>  | \$2,000 individual/\$4,000 family  | \$10,000 individual/\$20,000 family                                 |
| <b>Coinsurance</b>   | 70/30% after deductible  | 50% after deductible  |
| <b>Maximum Out-of-Pocket</b> —based on approved charges (excludes pharmacy deductible)   | \$4,250 individual/\$8,500 family  | \$20,000 individual/\$40,000 family                                 |
| <b>Coinsurance Limit</b> (not including deductible or in-network co-payments)  | \$2,250 individual/\$4,500 family  | \$10,000 individual; \$20,000 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)                      | 30% after deductible   | 50% after deductible  |
| <b>Outpatient Medical Services</b>   |  |   |
| Routine Physical Exams (including immunizations)   | Covered in full  | 50% after deductible  |
| Medical Office Visits —includes office visits associated with mental/nervous and substance abuse   | \$30 PCP; Specialist 30% after deductible  | 50% after deductible  |
| Routine OB/GYN Exam — 1 visit annually   | Routine/preventive services covered in full  | 50% after deductible  |
| Routine Mammography (subject to age limitations)   | Routine/preventive services covered in full  | 50% after deductible  |
| Routine Colonoscopy (subject to age limitations)   | Routine/preventive services covered in full  | Not covered   |
| Routine Vision Exam  | CtCare: 30% after deductible; one exam per year<br>Oxford: \$50 reimbursement for exam; one exam per 24 months   | CtCare: 50% after deductible<br>Oxford: \$50 reimbursement for exam |
| Diagnostic X-ray   | 30% after deductible   | 50% after deductible  |
| Laboratory (May be covered in full in accordance with federal healthcare reform provisions when considered routine/preventive, determined by carrier at time of claim processing.) | 30% after deductible at participating labs   | 50% after deductible  |
| Outpatient Surgery (doctor's office or other facility)   | 30% after deductible   | 50% after deductible  |
| <b>Other Services</b>  |  |   |
| Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable visits varies by carrier.)  | 30% after deductible   | 50% after deductible  |
| Durable Medical Equipment  | 30% after deductible   | 50% after deductible  |
| Prescription Drugs (Retail) (MAC-A: Mandatory Generic***)<br>See formularies for each health plan company.<br>See explanation of benefits by carrier.                              | \$200 deductible on tiers 2 and 3 only, then co-pays apply. Oxford: 3X deductible max per family. CtCare: 2X deductible max per family. Three-tier co-pay \$10/\$30/\$40 | Not covered. Members must use participating pharmacy                |
| Mail-order Pharmacy  | Subject to \$200 pharmacy deductible, then 2X retail co-pays   | Not covered   |
| Urgent Care (includes walk-in centers)   | 30% after deductible   | 50% after deductible  |
| Emergency Room Services  | 30% after deductible   | 30% after in-network deductible                                     |
| Ambulance Services   | 30% after deductible   | 30% after in-network deductible                                     |
| <b>Lifetime Maximum</b>  | Unlimited  | Unlimited   |

\*Oxford available 3/1/12

\*\* For Oxford, new-business is contract year; in-force groups may be contract year or calendar year, determined at a group's renewal. Contract year: medical and pharmacy deductibles accrue on contract year; all other benefits and limits accrue on calendar year. Calendar year: medical deductibles and all other benefits and limits accrue on calendar year; pharmacy deductibles accrue on contract 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.

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).