

| Carrier<br>Plan Name                                       | Anthem Blue Cross                                                                                                                                                                                    |                                                                                                                                                                                                                      | Anthem Blue Cross                                                                                                                                                |                                                                                                                                                                      |
|------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                            | PPO 500 90/70 - \$10/30/10 Rx + Cost                                                                                                                                                                 |                                                                                                                                                                                                                      | HSA 1600 - \$10/30 Rx                                                                                                                                            |                                                                                                                                                                      |
|                                                            | In-Network                                                                                                                                                                                           | Out-of-Network                                                                                                                                                                                                       | In-Network                                                                                                                                                       | Out-of-Network                                                                                                                                                       |
| <b>General Plan Information</b>                            |                                                                                                                                                                                                      |                                                                                                                                                                                                                      |                                                                                                                                                                  |                                                                                                                                                                      |
| Annual Deductible/Individual                               | \$500                                                                                                                                                                                                | \$1,000                                                                                                                                                                                                              | \$1,600 medical/prescription/MH-SA in/out of network combined                                                                                                    | \$1,600 medical/prescription/MH-SA in/out of network combined                                                                                                        |
| Annual Deductible/Family                                   | \$1,500                                                                                                                                                                                              | \$3,000                                                                                                                                                                                                              | \$3,200 medical/prescription/MH-SA in/out of network combined                                                                                                    | \$3,200 medical/prescription/MH-SA in/out of network combined                                                                                                        |
| Coinsurance                                                | 90%                                                                                                                                                                                                  | 70%                                                                                                                                                                                                                  | 90%                                                                                                                                                              | 70%                                                                                                                                                                  |
| Office Visit/Exam                                          | \$30/Visit; deductible waived                                                                                                                                                                        | 70%                                                                                                                                                                                                                  | 90%                                                                                                                                                              | 70%                                                                                                                                                                  |
| Outpatient Specialist Visit                                | \$30/Visit; deductible waived                                                                                                                                                                        | 70%                                                                                                                                                                                                                  | 90%                                                                                                                                                              | 70%                                                                                                                                                                  |
| Annual Out-of-Pocket Limit/Individual                      | \$3,000 Rx not included                                                                                                                                                                              | \$6,000 Rx not included                                                                                                                                                                                              | \$3,000                                                                                                                                                          | \$9,000                                                                                                                                                              |
| Annual Out-of-Pocket Limit/Family                          | \$9,000 Rx not included                                                                                                                                                                              | \$18,000 Rx not included                                                                                                                                                                                             | \$6,000                                                                                                                                                          | \$18,000                                                                                                                                                             |
| Lifetime Plan Maximum                                      | Unlimited                                                                                                                                                                                            | Unlimited                                                                                                                                                                                                            | Unlimited                                                                                                                                                        | Unlimited                                                                                                                                                            |
| <b>Inpatient Hospital Services</b>                         |                                                                                                                                                                                                      |                                                                                                                                                                                                                      |                                                                                                                                                                  |                                                                                                                                                                      |
| Inpatient Hospitalization                                  | 90%                                                                                                                                                                                                  | 70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)                                                                                                                          | 90%                                                                                                                                                              | 70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)                                                                          |
| Semi-Private Room & Board; Including Services and Supplies | 90%                                                                                                                                                                                                  | 70%                                                                                                                                                                                                                  | 90%                                                                                                                                                              | 70%                                                                                                                                                                  |
| <b>Emergency Services</b>                                  |                                                                                                                                                                                                      |                                                                                                                                                                                                                      |                                                                                                                                                                  |                                                                                                                                                                      |
| Emergency Room                                             | 90%                                                                                                                                                                                                  | 90%                                                                                                                                                                                                                  | 90%                                                                                                                                                              | 90%                                                                                                                                                                  |
| <b>Mental Health Benefits</b>                              |                                                                                                                                                                                                      |                                                                                                                                                                                                                      |                                                                                                                                                                  |                                                                                                                                                                      |
| Inpatient Care                                             | 90% (subject to utilization review; waived for emergency admissions)                                                                                                                                 | 70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained                                                                                | 90% (subject to utilization review; waived for emergency admissions)                                                                                             | 70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained.                               |
| Outpatient Care                                            | 90%                                                                                                                                                                                                  | 70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.                                                                           | 90%                                                                                                                                                              | 70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.                           |
| <b>Substance Abuse</b>                                     |                                                                                                                                                                                                      |                                                                                                                                                                                                                      |                                                                                                                                                                  |                                                                                                                                                                      |
| <b>Inpatient Care</b>                                      |                                                                                                                                                                                                      |                                                                                                                                                                                                                      |                                                                                                                                                                  |                                                                                                                                                                      |
| Inpatient Hospitalization                                  | 90% (subject to utilization review; waived for emergency admissions)                                                                                                                                 | 70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained                                                                                | 90% (subject to utilization review; waived for emergency admissions)                                                                                             | 70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained.                               |
| Inpatient Detoxification Services                          | 90% (subject to utilization review; waived for emergency admissions)                                                                                                                                 | 70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained                                                                                | 90% (subject to utilization review; waived for emergency admissions)                                                                                             | 70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained.                               |
| <b>Outpatient Care</b>                                     |                                                                                                                                                                                                      |                                                                                                                                                                                                                      |                                                                                                                                                                  |                                                                                                                                                                      |
| Outpatient Services                                        | 90%                                                                                                                                                                                                  | 70%                                                                                                                                                                                                                  | 90%                                                                                                                                                              | 70%                                                                                                                                                                  |
| <b>Prescription Drug Benefits</b>                          |                                                                                                                                                                                                      |                                                                                                                                                                                                                      |                                                                                                                                                                  |                                                                                                                                                                      |
| Prescription Drug Deductible                               |                                                                                                                                                                                                      |                                                                                                                                                                                                                      | \$1,600 ind/\$3200 fam medical/prescription/MH-SA in/out of network combined                                                                                     | \$1,600 ind/\$3200 fam medical/prescription/MH-SA in/out of network combined                                                                                         |
| Generic                                                    | \$10 copay/Tier 1 Pharmacy \$10 copay +\$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)                                                                   | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)                                                                  | \$10 after deductible Tier 1 Pharmacy \$10 copay after deductible + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)  | 50% after deductible + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies) |
| Brand (Formulary/Preferred)                                | \$30 copay/Tier 1 Pharmacy \$30 copay +\$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)                                                                   | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)                                                                  | \$30 after deductible /Tier 1 Pharmacy \$30 copay after deductible + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies) | 50% after deductible + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies) |
| Brand (Non-Formulary/Non-preferred)                        | \$10 copay/Tier 1 Pharmacy \$10 copay +\$15/Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available; (see www.express-scripts.com for a list of pharmacies) | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available; (see www.express-scripts.com for a list of pharmacies) | N/A                                                                                                                                                              | N/A                                                                                                                                                                  |
| Number of Days Supply                                      | 30 days                                                                                                                                                                                              | 30 days                                                                                                                                                                                                              | 30 days                                                                                                                                                          | 30 days                                                                                                                                                              |
| <b>Mail Order</b>                                          |                                                                                                                                                                                                      |                                                                                                                                                                                                                      |                                                                                                                                                                  |                                                                                                                                                                      |
| Generic                                                    | \$20 copay provided by Express Scripts                                                                                                                                                               | Not covered                                                                                                                                                                                                          | \$20 copay after deductible; provided by Express Scripts                                                                                                         | Not covered                                                                                                                                                          |
| Brand (Formulary/Preferred)                                | \$60 copay provided by Express Scripts                                                                                                                                                               | Not covered                                                                                                                                                                                                          | \$60 copay after deductible; provided by Express Scripts                                                                                                         | Not covered                                                                                                                                                          |
| Brand (Non-Formulary/Non-preferred)                        | \$20 copay plus cost difference between generic and brand when generic equivalent is available; provided by Express Scripts                                                                          | Not covered                                                                                                                                                                                                          | N/A                                                                                                                                                              | N/A                                                                                                                                                                  |
| Number of Days Supply for Mail Order                       | 90 days                                                                                                                                                                                              | Not covered                                                                                                                                                                                                          | 90 days                                                                                                                                                          | Not covered                                                                                                                                                          |
| <b>Other Services and Supplies</b>                         |                                                                                                                                                                                                      |                                                                                                                                                                                                                      |                                                                                                                                                                  |                                                                                                                                                                      |
| Chiropractic Services                                      | 90% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined                                                                                                  | 70% chiro/phys/occ therapy combined; in/out of network combined                                                                                                                                                      | 90% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined                                                                      | 70% limited to 24 visits/calendar year; phys/occ/chiro combined; in/out of network combined                                                                          |

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