

| Carrier Plan Name Benefit Summary | Anthem Blue Cross | | Anthem Blue Cross | | Anthem Blue Cross | | Anthem Blue Cross | |
|------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------------|
| | PPO 500 90/70 - \$10/30/10 Rx + Cost | | PPO 750 - \$15/50/15 Rx + Cost | | PPO Essentials - \$15/50/15 Rx + Cost | | PPO MVP | |
| | Eligible Employees | | Eligible Employees | | Eligible Employees | | Eligible Employees | |
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| General Plan Information | | | | | | | | |
| Annual Deductible/Individual | \$500 | \$1,000 | \$750 | \$1,500 | \$1,250 | \$1,250 | \$5,900 | \$11,800 |
| Annual Deductible/Family | \$1,500 | \$3,000 | \$2,250 | \$4,500 | \$3,750 | \$3,750 | \$11,800 | \$23,600 |
| Coinsurance | 90% | 70% | 80% | 60% | 70% | 50% | 100% after the deductible is met | 50% after the deductible is met |
| Office Visit/Exam | \$30/Visit; deductible waived | 70% | \$40/Visit; deductible waived | 60% | \$40 copay; deductible waived | 50% | \$35 copay first 3 visits, then 100% after the deductible is met | 50% after the deductible is met |
| Outpatient Specialist Visit | \$30/Visit; deductible waived | 70% | \$40/Visit; deductible waived | 60% | \$40 copay; deductible waived | 50% | \$35 copay first 3 visits, then 100% after the deductible is met | 50% after the deductible is met |
| Annual Out-of-Pocket Limit/Individual | \$3,000 Rx not included | \$6,000 Rx not included | \$3,000 Rx not included | \$6,000 Rx not included | \$3,000 Rx not included | \$6,000 Rx not included | \$6,100 Rx not included | \$12,700 Rx not included |
| Annual Out-of-Pocket Limit/Family | \$9,000 Rx not included | \$18,000 Rx not included | \$9,000 Rx not included | \$18,000 Rx not included | \$9,000 Rx not included | \$18,000 Rx not included | \$12,200 Rx not included | \$25,400 Rx not included |
| Lifetime Plan Maximum | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |
| Inpatient Hospital Services | | | | | | | | |
| Inpatient Hospitalization | 90% | 70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) | 80% | 60% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) | 70% | 50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) | 100% after the deductible is met | 50% plus \$500 admission fee after the deductible is met (waived for emergency) |
| Semi-Private Room & Board; Including Services and Supplies | 90% | 70% | 80% | 60% | 70% | 50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) | 100% after the deductible is met | 50% plus \$500 admission fee after the deductible is met (waived for emergency) |
| Emergency Services | | | | | | | | |
| Emergency Room | 90% | 90% | 80% | 80% | 70% | 70% | 100% after the deductible is met | 100% after the deductible is met |

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| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Mental Health Benefits | | | | | | | | |
| 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. | 70% (subject to utilization review; waived for emergency admissions) | 50% (subject to utilization review; waived for emergency admissions) | 100% after the deductible is met (pre authorization required) | 50% plus \$500 admission fee after the deductible is met (waived for emergency) pre authorization required |
| 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. | \$40 copay; deductible waived (Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review) | 50% | \$35 copay first 3 visits, then 100% after the deductible is met | 50% after the deductible is met |
| Substance Abuse | | | | | | | | |
| Inpatient Care | | | | | | | | |
| 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. | 70% (subject to utilization review; waived for emergency admissions) | 50% (subject to utilization review; waived for emergency admissions) | 100% after the deductible is met (pre authorization required) | 50% plus \$500 admission fee after the deductible is met (waived for emergency) pre authorization required |
| 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. | 70% (subject to utilization review; waived for emergency admissions) | 50% (subject to utilization review; waived for emergency admissions) | 100% after the deductible is met (pre authorization required) | 50% plus \$500 admission fee after the deductible is met (waived for emergency) pre authorization required |
| Outpatient Care | | | | | | | | |
| Outpatient Services | 90% | 70% | 90% | 70% | \$40 copay; deductible waived | 50% | \$35 copay first 3 visits, then 100% after the deductible is met | 50% after the deductible is met |

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| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Prescription Drug Benefits | | | | | | | | |
| Generic | \$10 copay/Tier 1 Pharmacy \$10 copay +\$15/Tier 2 Pharmacy provided by ESI | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI | \$15 copay/Tier 1 Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy provided by ESI | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI | \$15 copay/Tier 1 Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy provided by ESI | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI | \$19 copay/Tier 1 Pharmacy; \$19 copay + \$15/Tier 2 Pharmacy provided by ESI | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI |
| Brand (Formulary/Preferred) | \$30 copay/Tier 1 Pharmacy \$30 copay +\$15/Tier 2 Pharmacy provided by ESI | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI | \$50 copay/Tier 1 Pharmacy; \$50 copay + \$15/Tier 2 Pharmacy provided by ESI | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI | \$50 copay/Tier 1 Pharmacy; \$50 copay + \$15/Tier 2 Pharmacy provided by ESI | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI | \$50 copay/Tier 1 Pharmacy; \$50 copay + \$15/Tier 2 Pharmacy provided by ESI | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI |
| 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 | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available | \$15 copay/Tier 1 Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available | \$15 copay/Tier 1 Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available | \$75 copay/Tier 1 Pharmacy; \$75 copay + \$15/Tier 2 Pharmacy provided by ESI | 50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI |
| Number of Days Supply | 30 days | 30 days | 30 days | 30 days | 30 days | 30 days | 30 days | 30 days |
| Mail Order | | | | | | | | |
| Generic | \$20 copay provided by Express Scripts | Not covered | \$30 copay provided by Express Scripts | Not covered | \$30 copay provided by Express Scripts | Not covered | \$38 copay provided by Express Scripts | Not covered |
| Brand (Formulary/Preferred) | \$60 copay provided by Express Scripts | Not covered | \$100 copay provided by Express Scripts | Not covered | \$100 copay provided by Express Scripts | Not covered | \$100 copay 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 | \$30 copay plus cost difference between generic and brand when generic equivalent is available; provided by Express Scripts | Not covered | \$30 copay plus cost difference between generic and brand when generic equivalent is available; provided by Express Scripts | Not covered | \$150 copay provided by Express Scripts | Not covered |
| Number of Days Supply for Mail Order | 90 days | Not covered | 90 days | N/A | 90 days | N/A | 90 days | N/A |
| Other Services and Supplies | | | | | | | | |
| 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 | 80% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined | 60% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined | 70% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined | 50% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined | Not covered | Not covered |

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