This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010:

The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Preferred Provider Network</th>
<th>Non-Preferred Provider Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan deductible</td>
<td>No annual deductible</td>
<td>Individual deductible: $500 per calendar year</td>
</tr>
<tr>
<td>Individual deductible carryover</td>
<td>Not applicable</td>
<td>4th quarter carryover applies</td>
</tr>
<tr>
<td>Plan coinsurance</td>
<td>No plan coinsurance</td>
<td>Plan pays 80%, you pay 20% of the Allowed Amount.</td>
</tr>
<tr>
<td>Out-of-pocket limit</td>
<td>Individual out-of-pocket limit: $1,200</td>
<td>Shared with in-network</td>
</tr>
<tr>
<td>Pre-existing condition (PEC) waiting period</td>
<td>No PEC</td>
<td>Same as preferred provider network</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>Unlimited</td>
<td>Same as preferred provider maximum</td>
</tr>
<tr>
<td>Outpatient services (Office visits)</td>
<td>$15 co-pay</td>
<td>$15 co-pay, deductible and coinsurance apply</td>
</tr>
</tbody>
</table>
| Hospital services | Inpatient services: $100 co-pay, per day for up to 5 days per admit  
Outpatient surgery: $50 co-pay | Inpatient services: $100 co-pay, per day for up to 5 days per admit |
<p>| Deductible and coinsurance apply | Outpatient surgery: $50 co-pay, deductible and coinsurance apply |
| Prescription drugs (some injectable drugs may be covered under Outpatient services) | Preferred generic (Tier 1)/preferred brand (Tier 2)/nonpreferred (Tier 3) $4/$8/$25/$50 co-pay | Preferred generic/preferred brand/non-preferred $13/$30/$55 co-pay |
| Prescription mail order | 2 x prescription cost share per 90 day supply | Not covered |
| Acupuncture | 12 visits per calendar year $15 co-pay | Shared with preferred provider visit limit |
| Ambulance services | Plan pays 80%, you pay 20% | Same as preferred provider benefit |</p>
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| Chemical dependency | **Inpatient:** $100 co-pay, per day for up to 5 days per admit  
**Outpatient:** $0 co-pay | **Inpatient:** $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply  
**Outpatient:** $15 co-pay, deductible and coinsurance apply |
| Devices, equipment and supplies  
- Durable medical equipment  
- Orthopedic appliances  
- Post-mastectomy bras limited to two (2) every six (6) months  
- Ostomy supplies  
- Prosthetic devices | Covered at 50% | Covered at 50%, deductible applies |
| Diabetic supplies | Insulin, needles, syringes and lancets—see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies—see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits. | Insulin, needles, syringes and lancets—see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies—see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits. |
| Diagnostic lab and X-ray services | **Inpatient:** Covered under Hospital services  
**Outpatient:** Covered in full | **Inpatient:** Covered under Hospital services  
**Outpatient:** Deductible and coinsurance apply |
| Emergency services (co-pay waived if admitted) | $200 co-pay | $200 co-pay |
| Hearing exams (routine) | $15 co-pay | $15 co-pay, deductible and coinsurance apply |
| Hearing hardware | Not covered | Not covered |
| Home health services | Covered in full up to 130 visits total per calendar year | Shared with preferred provider visit limit Deductible and coinsurance apply |
| Hospice services | Covered in full | Deductible and coinsurance apply |
| Infertility services | Medical and surgical services for the treatment of sterility and infertility and all related services, including artificial insemination, in-vitro fertilization and drug therapy are covered subject to the applicable outpatient services cost shares, limited to $50,000 per lifetime maximum. Fertility drugs are covered subject to deductible and 20% plan coinsurance, limited to a lifetime maximum of $5,000 | Not covered |
| Manipulative therapy | Covered up to 12 visits per calendar year without prior authorization $15 co-pay | Shared with preferred provider visit limit $15 co-pay, deductible and coinsurance apply |
| Massage services | 12 visits per calendar year $15 co-pay | Shared with preferred provider visit limit $15 co-pay, deductible and coinsurance apply |
| Maternity services | **Inpatient:** $100 co-pay, per day for up to 5 days per admit  
**Outpatient:** $15 co-pay. Routine care not subject to outpatient services co-pay. | **Inpatient:** $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply  
**Outpatient:** $15 co-pay, deductible and coinsurance apply. Routine care not subject to outpatient services co-pay. |
| Mental Health | **Inpatient:** $100 co-pay, per day for up to 5 days per admit  
**Outpatient:** $0 co-pay | **Inpatient:** $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply  
**Outpatient:** $15 co-pay, deductible and coinsurance apply |
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<td>Naturopathy</td>
<td>12 visits per calendar year $15 co-pay</td>
<td>Shared with preferred provider visit limit $15 co-pay, deductible and coinsurance apply</td>
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<td>Newborn Services</td>
<td><strong>Initial hospital stay:</strong> See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.</td>
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<td>Covered at cost shares when medical criteria is met</td>
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<td>Organ transplants</td>
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|                                  | **Inpatient:** $100 co-pay, per day for up to 5 days per admit
|                                  | **Outpatient:** $15 co-pay | Not covered |
| Preventive care                  | Covered in full |
| Well-care physicals, immunizations, Pap smear exams, mammograms | Women’s preventive care services (including contraceptive drugs and devices and sterilization) are covered in full. | Women’s preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply |
| Rehabilitation services         | **Inpatient:** 60 days per calendar year. Services with mental health diagnoses are covered with no limit. $100 co-pay, per day for up to 5 days per admit
|                                  | **Outpatient:** 60 visits per calendar year. Services with mental health diagnoses are covered with no limit. $15 co-pay | **Inpatient:** Day limits shared with preferred provider benefit limit
|                                  | **Outpatient:** Visit limits shared with preferred provider benefit limit $100 co-pay, per day for up to 5 days per admit
| Skilled nursing facility         | Covered in full up to 60 days per calendar year | Day limits shared with preferred provider benefit, deductible and coinsurance apply |
| Sterilization (vasectomy, tubal ligation) | **Inpatient:** $100 co-pay, per day for up to 5 days per admit
|                                  | **Outpatient:** $15 co-pay | **Inpatient:** $100 co-pay, per day for up to 5 days per admit
|                                  | **Outpatient:** $15 co-pay, deductible and coinsurance apply | **Outpatient:** $15 co-pay, deductible and coinsurance apply
| Temporomandibular Joint (TMJ) services | **Inpatient:** $100 co-pay, per day for up to 5 days per admit
|                                  | **Outpatient:** $15 co-pay | **Inpatient:** $100 co-pay, per day for up to 5 days per admit
| Tobacco cessation counseling     | Quit for Life Program – covered in full | Applicable cost shares apply |
| Routine vision care              | $15 co-pay | $15 co-pay, deductible and coinsurance apply |
| (1 visit every 12 months)        | | |
| Optical hardware                 | Members under 19: 1 pair of frames and lenses per year or contact lenses covered at 50% coinsurance Members age 19 and over: $300 per 12 months | Shared with preferred provider benefit |
| Lenses, including contact lenses and frames | | |

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| Sterilization (vasectomy, tubal ligation) | **Inpatient:** $100 co-pay, per day for up to 5 days per admit
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| Temporomandibular Joint (TMJ) services | **Inpatient:** $100 co-pay, per day for up to 5 days per admit
|                                  | **Outpatient:** $15 co-pay | **Inpatient:** $100 co-pay, per day for up to 5 days per admit
| Tobacco cessation counseling     | Quit for Life Program – covered in full | Applicable cost shares apply |
| Routine vision care              | $15 co-pay | $15 co-pay, deductible and coinsurance apply |
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