

**MEDICAL BENEFIT SUMMARY**  
Effective July 1, 2010

| GENERAL SERVICES   | STANDARD PLAN  |   | BASIC PLAN  |   |
|--|--|---|---|---|
|  | NETWORK SERVICES   | NON-NETWORK SERVICES  | NETWORK SERVICES  | NON-NETWORK SERVICES  |
| <b>Plan Year Deductible</b><br>(excludes copays)   | \$500 Individual<br>\$1,000 Family   | \$6,000 Individual<br>\$12,000 Family                             | \$1,500 Individual<br>\$3,000 Family  | \$6,000 Individual<br>\$12,000 Family                             |
| <b>Coinsurance</b>   | 20%  | 50%   | 20%   | 50%   |
| <b>Out of Pocket Maximum</b><br>(includes deductible)  | \$2,750 Individual<br>\$5,500 Family   | \$13,500 Individual<br>\$27,000 Family                            | \$4,500 Individual<br>\$9,000 Family  | \$13,500 Individual<br>\$27,000 Family                            |
| <b>Lifetime Maximum</b>  | \$5,000,000 per member   |   | \$5,000,000 per member  |   |
| <b>Physician Visit</b>   | \$25 Copay   | 50% after deductible  | \$25 Copay  | 50% after deductible  |
| <b>Specialist Visit</b>  | \$50 Copay   | 50% after deductible – up to Out-of-Pocket Maximum                | 20% after deductible<br>Up to Out-of-Pocket Maximum   | 50% after deductible – up to Out-of-Pocket Maximum                |
| <b>Preventive Care</b><br>• Immunizations<br>• Routine physicals<br>• X-Ray & Lab (excluding High Tech Radiology)<br>• Basic Gynecological care<br>Routine Mammogram | \$25 Copay Physician<br>\$50 Copay Specialist<br><b>Please note:</b> X-ray & Lab must be billed as preventive to be covered at 100% after co-pay   | 50% after deductible – Up to Out-of-Pocket Maximum                | \$25 Copay Physician<br><b>Please note:</b> X-ray & Lab must be billed as preventive to be covered at 100% after co-pay   | 50% after deductible – Up to Out-of-Pocket Maximum                |
| <b>Colonoscopy</b>   | \$70 Copay   | 50% after deductible – Up to Out-of-Pocket Maximum                | \$70 Copay  | 50% after deductible – Up to Out-of-Pocket Maximum                |
| <b>Managed by Express Scripts</b><br><b>Pharmacy Plan (includes contraceptives)</b><br>Tier 1 = Generic<br>Tier 2 = Preferred<br>Tier 3 = Non-preferred              | Retail Pharmacy ~ 30 day supply<br>\$5: Generic Copay<br>\$25: Tier 2 brand<br>\$50: Tier 3 brand<br>Retail Pharmacy ~ 90 day supply<br>\$15: Generic Copay<br>\$75: Tier 2 brand<br>\$150: Tier 3 brand<br>Home Delivery ~ 90 day supply<br>\$12.50: Generic Copay<br>\$62.50 Tier 2 brand<br>\$125: Tier 3 brand | Appropriate copay level +50% of the full cost of the prescription | Retail Pharmacy ~ 30 day supply<br>\$5: Generic Copay<br>\$25: Tier 2 brand<br>\$50: Tier 3 brand<br>Retail Pharmacy ~ 90 day supply<br>\$15: Generic Copay<br>\$75: Tier 2 brand<br>\$150: Tier 3 brand<br>Home Delivery ~ 90 day supply<br>\$12.50: Generic Copay<br>\$62.50: Tier 2 brand<br>\$125: Tier 3 brand | Appropriate copay level +50% of the full cost of the prescription |

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|   | NETWORK SERVICES  | NON-NETWORK SERVICES                               | NETWORK SERVICES  | NON-NETWORK SERVICES                               |
| Durable Medical Equipment - including oxygen (\$10,000 Lifetime Maximum) life sustaining oxygen not applicable to maximum | 100% - No Deductible  |  | 20% after network deductible  |  |
| Lab & X-ray Services – outpatient, independent lab or related to an office visit  | 20% after deductible – Up to Out-of-Pocket Maximum (except for preventive care – covered at 100%, must be billed as preventive) | 50% after deductible – Up to Out-of-Pocket Maximum | 20% after deductible – Up to Out-of-Pocket Maximum (except for preventive care – covered at 100%, must be billed as preventive) | 50% after deductible – Up to Out-of-Pocket Maximum |
| High Tech Radiology (MRI, Pet, CAT scans)   | 20% after deductible – Up to Out-of-Pocket Maximum  | 50% after deductible – Up to Out-of-Pocket Maximum | 20% after deductible – Up to Out-of-Pocket Maximum  | 50% after deductible – Up to Out-of-Pocket Maximum |
| Spinal Adjustment Treatment<br>• 60 visit Maximum per Plan Year   | \$50 Copay  | 50% after deductible                               | 20% after deductible  | 50% after deductible                               |
| Emergency Room Care   | \$200 Copay (exception of high tech radiology)  |  | 20% after network deductible – Up to Out-of-Pocket Maximum  |  |
| Urgent Care   | \$100 Copay (exception of high tech radiology)  | 50% after deductible – Up to Out-of-Pocket Maximum | 20% after deductible – Up to Out-of-Pocket Maximum  | 50% after deductible – Up to Out-of-Pocket Maximum |
| Ambulance   | 20% after deductible – Up to Out-of-Pocket Maximum  |  | 20% after deductible – Up to Out-of-Pocket Maximum  |  |
| Eye Exam  | Not Covered   |  | Not Covered   |  |



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| HOSPITAL SERVICES   | STANDARD PLAN  |  | BASIC PLAN   |  |
|---|--|--|--|--|
|   | NETWORK SERVICES   | NON-NETWORK SERVICES                               | NETWORK SERVICES                                   | NON-NETWORK SERVICES                               |
| <b>Inpatient Hospital Services</b> <ul style="list-style-type: none"> <li>Including anesthesia</li> <li>Requires pre-certification</li> <li>Lab &amp; X-Ray based on Facility Network Status</li> </ul>   |  |  |  |  |
| <b>Outpatient Hospital Services</b> <ul style="list-style-type: none"> <li>Outpatient Surgery</li> <li>Including anesthesia</li> <li>Requires pre-certification</li> <li>Ambulatory Surgery</li> <li>Lab &amp; X-Ray paid based on Facility Network Status</li> </ul> | 20% after deductible – Up to Out-of-Pocket Maximum                                     | 50% after deductible – Up to Out-of-Pocket Maximum | 20% after deductible – Up to Out-of-Pocket Maximum | 50% after deductible – Up to Out-of-Pocket Maximum |
| <b>Outpatient Surgery</b>   | 20% after deductible – Up to Out-of-Pocket Maximum                                     | 50% after deductible – Up to Out-of-Pocket Maximum | 20% after deductible – Up to Out-of-Pocket Maximum | 50% after deductible – Up to Out-of-Pocket Maximum |
| <b>Hospice Care</b> <ul style="list-style-type: none"> <li>Inpatient</li> <li>Outpatient</li> </ul>   | 20% after deductible – Up to Out-of-Pocket Maximum<br><br>100% Covered - no deductible | 50% after deductible – Up to Out-of-Pocket Maximum | 20% after deductible – Up to Out-of-Pocket Maximum | 50% after deductible – Up to Out-of-Pocket Maximum |
| <b>Skilled Nursing Facility Care</b> <ul style="list-style-type: none"> <li>100 days per Plan Year Maximum</li> <li>Requires pre-certification</li> </ul>   | 20% after deductible   | 50% after deductible                               | 20% after deductible                               | 50% after deductible                               |
| <b>Home Health Care</b> <ul style="list-style-type: none"> <li>Up to 1 visit per day/100 visits per Plan Year Maximum</li> </ul>  | 100% Covered – No Deductible   | 50% after deductible                               | 20% after deductible                               | 50% after deductible                               |
| <b>Transplants</b>  | 20% after deductible – Up to Out-of-Pocket Maximum                                     | Not Covered  | 20% after deductible – Up to Out-of-Pocket Maximum | Not Covered  |



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| MENTAL HEALTH AND<br>CHEMICAL<br>DEPENDENCY<br>SERVICE  | STANDARD PLAN  |  | BASIC PLAN  |  |
|---|--|--|---|--|
|   | NETWORK<br>SERVICES                                      | NON-NETWORK<br>SERVICES                                  | NETWORK<br>SERVICES                                   | NON-NETWORK<br>SERVICES                                  |
| <b>Mental Health Inpatient:<br/>Requires pre-<br/>certification</b>                                       | 20% after deductible<br>– Up to Out-of-Pocket<br>Maximum | 50% after deductible –<br>Up to Out-of-Pocket<br>Maximum | 20% after deductible – Up<br>to Out-of-Pocket Maximum | 50% after deductible –<br>Up to Out-of-Pocket<br>Maximum |
| <b>Mental Health<br/>Outpatient:</b>  | 20% after deductible<br>– Up to Out-of-Pocket<br>Maximum | 50% after deductible –<br>Up to Out-of-Pocket<br>Maximum | 20% after deductible – Up to<br>Out-of-Pocket Maximum | 50% after deductible –<br>Up to Out-of-Pocket<br>Maximum |
| <b>Chemical Dependency<br/>Inpatient:<br/>Requires pre-<br/>certification</b>                             | 20% after deductible<br>– Up to Out-of-Pocket<br>Maximum | 50% after deductible –<br>Up to Out-of-Pocket<br>Maximum | 20% after deductible – Up<br>to Out-of-Pocket Maximum | 50% after deductible –<br>Up to Out-of-Pocket<br>Maximum |
| <b>Chemical Dependency<br/>Outpatient:</b>  | 20% after deductible<br>– Up to Out-of-Pocket<br>Maximum | 50% after deductible –<br>Up to Out-of-Pocket<br>Maximum | 20% after deductible – Up<br>to Out-of-Pocket Maximum | 50% after deductible –<br>Up to Out-of-Pocket<br>Maximum |
| THERAPY SERVICES  |  |  |   |  |
| <b>Outpatient Physical<br/>Therapy</b><br>• 60 visit Maximum per<br>Plan Year                             | \$50 Copay   | 50% after deductible<br>– Up to Out-of-Pocket<br>Maximum | 20% after deductible – Up<br>to Out-of-Pocket Maximum | 50% after deductible –<br>Up to Out-of-Pocket<br>Maximum |
| <b>Outpatient Speech,<br/>Hearing and<br/>Occupational Therapy</b><br>• 60 visit Maximum per<br>Plan Year | \$50 Copay   | 50% after deductible<br>– Up to Out-of-Pocket<br>Maximum | 20% after deductible – Up<br>to Out-of-Pocket Maximum | 50% after deductible –<br>Up to Out-of-Pocket<br>Maximum |



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More highlights of your Great-West Healthcare Health Plan are listed below. This list is not all inclusive; the Summary Plan Description will give detailed information about your plan, exclusions, and coverage limitations.

### COMPLEMENTARY ALTERNATIVE MEDICINE DISCOUNT PROGRAM

- Receive 20% savings for services received from an ACN Group Inc., network acupuncturist, massage therapist, dietitian, nutritionist, or naturopathic doctor.
- Access [www.mycignaforhealth.com](http://www.mycignaforhealth.com) for an overview of the program, examples of services provided by Alternative Care practitioners and information on how to look up a provider.
- ACN Group Inc., and its alternative care providers are solely responsible for the services and products they provide.

### ONLINE HEALTH AND WELLNESS TOOLS

- All enrolled members have access to a personalized wellness focused website with information regarding nutrition, lifestyle and fitness.
- Health articles are available and updated daily for many different conditions.
- Pharmaceutical information, including drug interactions and supplement information is available online.
- Through the CareCompare tool, you can compare facilities based on many different criteria including cost, number of treatments provided by category, average length of stay and others.
- Through the secure website, you can also check the status of your claims, find in-network providers, view your benefit specifics and find claim forms.

### AWARD WINNING DISEASE MANAGEMENT PROGRAM

- Great-West Healthcare nurses work directly with enrolled members to help manage chronic conditions such as Asthma, Diabetes, Heart Failure, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Pain Management, End Stage Renal Disease and Maternity Management.
- You may take online assessments to receive information about chronic diseases and send specific questions to a nurse through the Web site.

### PRESCRIPTION DRUG COVERAGE

- Express Scripts, Inc. is your Pharmacy Benefit Manager. For prescription drug related questions, please contact 877-531-4918.
- The home delivery program provides a 90 day supply vs. a retail supply of 30 days for a reduced cost.

### PRE-CERTIFICATION PENALTY

Pre-authorization is required on all inpatient admissions and outpatient surgery not performed in the doctors office. See the below list for services requiring pre-authorization. Network providers are contractually obligated to perform pre-authorization on behalf of their clients; the member must verify that a non-network provider performs the pre-authorization procedures. If a non-network provider does not obtain pre-treatment authorization or if a Member does not follow the recommended care plan, a \$250 penalty will be applied.

- |   |  |
|---|--|
| * Outpatient Surgery  | * Skilled Nursing                      |
| * Home Health Care  | * Renal Dialysis                       |
| * Air Ambulance   | * Durable Medical Equipment over \$500 |
| * High Cost Drug  | * Genetic Testing                      |
| * Transplant Evaluations  |  |
| * Hospital Admissions (including partial hospitalization programs for mental nervous) |  |
| * High Tech Radiology (examples include CAT scans, PET scans and MRI's)               |  |



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### SPECIAL ENROLLMENT RIGHTS NOTICE

- If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health Plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for the other coverage or if the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 31 days after your or your dependents' other coverage ends or after the employer stops contributing toward the other coverage.
- In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days of the marriage, birth, adoption or placement for adoption.
- To request special enrollment or obtain more information, contact your HR/Benefits Director.

### WHAT'S NOT COVERED (THIS IS NOT ALL INCLUSIVE)

- \* services that aren't medically necessary
- \* experimental or investigational treatments
- \* infertility treatment
- \* accidental injury or sickness for which benefits are paid or payable under any Worker's Compensation or similar law
- \* services provided by government health plans
- \* cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption.
- \* weight loss treatment, including but not limited to Bariatric surgery, Gastroplasty or any residual treatment from gastro surgery.
- \* Massage, except when it is part of a covered course of physical therapy and is provided by or under the direct supervision of a physical therapist.
- \* custodial care
- \* sex transformation
- \* surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses.
- \* vision therapy or orthoptic treatment
- \* reversal of sterilization procedures
- \* nonprescription drugs or anti-obesity drugs
- \* gene manipulation therapy
- \* smoking cessation programs
- \* treatment of temporomandibular disorders and craniofacial muscle disorders (TMJ).
- \* Hearing aids or the fitting of hearing aids.

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