<table>
<thead>
<tr>
<th>Benefit</th>
<th>Network</th>
<th>NonNetwork</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$500 single/$1,000 family</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Plan 90%, Member 10%</td>
<td>100% above plan allowable</td>
</tr>
<tr>
<td>Office Visit Exam</td>
<td>$0 visits 1-3, then $20 copay visits 4+</td>
<td>All billed amounts exceeding the max. allowed.</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Limit (OOP)</td>
<td>$1,000 single/ $3,000 family</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Deductible included in OOP Limit</td>
<td>YES</td>
<td>N/A</td>
</tr>
<tr>
<td>Lifetime Plan Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Preventive Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Child Care (through age 6)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine Physical Exam/immunizations</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Immunizations through age 6</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Well Woman Exams</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Mammograms</td>
<td>No charge, if part of WWE</td>
<td>Not covered</td>
</tr>
<tr>
<td>Adult Periodic Exams w/ Preventive</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic X-Ray and Lab Tests</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Pregnancy and Maternity Pre-Natal</td>
<td>$0 visits 1-3, then $20 copay visits 4+</td>
<td>All billed amounts exceeding the max. allowed.</td>
</tr>
<tr>
<td>Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Authorization of Services Required</td>
<td>10% coinsurance</td>
<td>All billed amounts exceeding the max. allowed. Not to exceed $600/day</td>
</tr>
<tr>
<td>Semi-Private Room and Board,Services and Supplies</td>
<td>10% coinsurance</td>
<td>All billed amounts exceeding the max. allowed. Not to exceed $600/day</td>
</tr>
<tr>
<td>Out-Patient Facility Charge (Ambulatory Surgical Centers)</td>
<td>10% coinsurance, some services have benefit limit</td>
<td>All billed amounts exceeding the max. allowed.</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$100 copay (Waived if admitted), then 10% coinsurance</td>
<td>Covered at in-network level of benefits</td>
</tr>
<tr>
<td>Non-Emergency</td>
<td>$100 copay (Waived if admitted), then 10% coinsurance</td>
<td>Covered at in-network level of benefits</td>
</tr>
<tr>
<td>Ambulance (Air and Ground)</td>
<td>$100 copay/trip, then 10% coinsurance</td>
<td>Covered at in-network level of benefits</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At Retail:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Generic copay</td>
<td>$5 network; $0 Costco</td>
<td>Not covered</td>
</tr>
<tr>
<td>- Brand copay</td>
<td>$20</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Number of days supply</td>
<td>30 days</td>
<td>Not Covered</td>
</tr>
<tr>
<td>From Mail Order</td>
<td>Costco Mail</td>
<td>N/A</td>
</tr>
<tr>
<td>- Generic copay</td>
<td>$50 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>- Brand copay</td>
<td>$20/30-day and $50/90-day</td>
<td>Not covered</td>
</tr>
<tr>
<td>Number of days supply</td>
<td>30 or 90 days</td>
<td>Not Covered</td>
</tr>
<tr>
<td>DME and Prosthetics (limits apply)</td>
<td>10% coinsurance</td>
<td>No covered</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>10% coinsurance</td>
<td>All billed amounts exceeding the max. allowed.</td>
</tr>
<tr>
<td>Skilled Nursing or Extended Care</td>
<td>10% coinsurance</td>
<td>All billed amounts exceeding the max. allowed.</td>
</tr>
<tr>
<td>Facility (100 days/year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>No charge</td>
<td>All billed amounts exceeding the max. allowed.</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>(subject to review by ASH)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>10% coinsurance</td>
<td>50% of max. allowed amount</td>
</tr>
<tr>
<td>(limit to 12 visits per year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility Diagnosis</td>
<td>10% coinsurance</td>
<td>All billed amounts exceeding the max. allowed.</td>
</tr>
<tr>
<td>Infertility Treatment</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Rehabilitation Services - Physical,</td>
<td>Member pays 10%, after deductible</td>
<td>All billed amounts exceeding the max. allowed.</td>
</tr>
<tr>
<td>Occupational, Speech</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Mental/Nervous &amp; Substance Abuse</td>
<td>10% coinsurance</td>
<td>All billed amounts exceeding the max. allowed. Not to exceed $600/day</td>
</tr>
<tr>
<td>Outpatient Mental/Nervous &amp; Substance Abuse</td>
<td>$20 copay per visit</td>
<td>All billed amounts exceeding the max. allowed.</td>
</tr>
</tbody>
</table>

The EOC will supersede information in this summary if different