

CVT PACIFICARE HEALTH PLANS
2008/2009

| BENEFIT | PacifiCare 1 | PacifiCare 2 | PacifiCare 3 | PacifiCare 4 | PacifiCare 5 | PacifiCare 6 |
|---|---|--|--|--|--|--|
| MAJOR MEDICAL* | No Deductible Copay Out-of-Pocket Max: \$800 individual / \$2400 family | No Deductible Copay Out-of-Pocket Max: \$1,000 individual / \$3,000 family | No Deductible Copay Out-of-Pocket Max: \$1,000 individual / \$3,000 family | No Deductible Copay Out-of-Pocket Max: \$1,000 individual / \$3,000 family | No Deductible Copay Out-of-Pocket Max: \$3,000 individual / \$9,000 family | No Deductible Copay Out-of-Pocket Max: \$4,500 individual / \$9,000 family (2 in Family) |
| DOCTOR VISITS | Covered, No Charge | \$5 Copay, Then 100% | \$10 Copay, Then 100% | \$20 Copay, Then 100% | \$15 Copay, Then 100% | \$20 Copay, Then 100% |
| ANNUAL PHYSICAL | Covered, No Charge | \$5 Copay, Then 100% | \$10 Copay, Then 100% | \$20 Copay, Then 100% | \$15 Copay – PCP \$30 Copay - Specialist | \$20 Copay – PCP \$40 Copay - Specialist |
| IMMUNIZATIONS | Covered, No Charge | \$5 Copay, Then 100% | \$10 Copay, Then 100% | \$20 Copay, Then 100% | Covered, No Charge – Under 2 \$15 Copay – PCP \$30 Copay – Specialist | Covered, No Charge – Under 2 \$20 Copay – PCP \$40 Copay – Specialist |
| PREVENTIVE CARE FOR CHILDREN | Covered, No Charge | Covered, No Charge – Under 2 \$5 Copay Over 2 | Covered, No Charge – Under 2 \$10 Copay Over 2 | Covered, No Charge – Under 2 \$20 Copay Over 2 | Covered, No Charge – Under 2 \$15 Copay Over 2 | Covered, No Charge – Under 2 \$20 Copay Over 2 |
| WELL WOMAN: PAP SMEAR/ MAMMOGRAM | Covered, No Charge | \$5 Copay, Then 100% | \$10 Copay, Then 100% | \$20 Copay, Then 100% | \$15 Copay, Then 100% | \$20 Copay, Then 100% |
| OUTPATIENT X-RAY & LAB | Covered, No Charge | Covered, No Charge | Covered, No Charge | Covered, No Charge | Lab - Covered, No Charge Std. X-Ray - Covered, No Charge Specialized - \$200 | Lab - Covered, No Charge Std. X-Ray - Covered, No Charge Specialized - \$200 |
| PHYSICAL THERAPY | Covered, No Charge | \$5 Copay, Then 100% | \$10 Copay, Then 100% | \$20 Copay, Then 100% | \$30 Copay, Then 100% | \$40 Copay, Then 100% |
| CHIROPRACTIC | Not Covered | Not Covered | Not Covered | Not Covered | Not Covered | Not Covered |
| ACUPUNCTURE | Not Covered | Not Covered | Not Covered | Not Covered | Not Covered | Not Covered |
| HOSPITAL INPATIENT | Covered, No Charge | Covered, No Charge | Covered, No Charge | Covered, No Charge | \$400 Copay | \$250 / Daily |

| Page Two | PacifiCare 1 | PacifiCare 2 | PacifiCare 3 | PacifiCare 4 | PacifiCare 5 | PacifiCare 6 |
|---|--|--|--|--|--|--|
| HOSPITAL OUTPATIENT | Covered, No Charge / \$35 Copay ER | Covered, No Charge / \$50 Copay ER | Covered, No Charge / \$50 Copay ER | Covered, No Charge / \$50 Copay ER | \$200 Copay Outpatient \$100 Copay ER | \$125 Copay Outpatient \$100 Copay ER |
| RADIATION THERAPY, CHEMOTHERAPY & SURGERY | Covered, No Charge | Covered, No Charge | Covered, No Charge | Covered, No Charge | Covered, No Charge | Covered, No Charge |
| HOME HEALTH CARE | Covered, No Charge | Covered, No Charge | Covered, No Charge | Covered, No Charge | Covered, No Charge 100 Visits Per Year | Covered, No Charge 100 Visits Per Year |
| HOSPICE | Covered, No Charge (prognosis of life expectancy of one year or less) | Covered, No Charge (prognosis of life expectancy of one year or less) | Covered, No Charge (prognosis of life expectancy of one year or less) | Covered, No Charge (prognosis of life expectancy of one year or less) | Covered, No Charge (prognosis of life expectancy of one year or less) | Covered, No Charge (prognosis of life expectancy of one year or less) |
| DURABLE MEDICAL EQUIPMENT | Covered, No Charge | Covered, No Charge | Covered, No Charge | Covered, No Charge | Covered, No Charge \$5,000 Annual Max | Covered, No Charge \$5,000 Annual Max |
| AMBULANCE- GROUND/AIR | No charge, if medically necessary | No charge, if medically necessary | No charge, if medically necessary | No charge, if medically necessary | No charge, if medically necessary | No charge, if medically necessary |
| MENTAL HEALTH INPATIENT | 30 days per calendar year; substance abuse limited to hospital detox plus residential treatment (limits) | 30 days per calendar year; substance abuse limited to hospital detox plus residential treatment (limits) | 30 days per calendar year; substance abuse limited to hospital detox plus residential treatment (limits) | 30 days per calendar year; substance abuse limited to hospital detox plus residential treatment (limits) | 30 days per calendar year; substance abuse limited to hospital detox plus residential treatment (limits) | \$250/Daily 30 visits per calendar year |
| MENTAL HEALTH- PROFESSIONAL CHARGES (INPATIENT & OUTPATIENT) | 30 visits per calendar year | \$5 Copay 30 visits per calendar year | \$10 Copay 30 visits per calendar year | \$20 Copay 30 visits per calendar year | \$30 Copay 30 visits per calendar year | \$40 Copay 30 visits per calendar year |
| LIFETIME MAX PER PERSON | N/A | N/A | N/A | N/A | N/A | N/A |

THIS SUMMARY IS FOR COMPARISON PURPOSES ONLY. PLEASE REFER TO THE ACTUAL SUMMARY PLAN DESCRIPTION FOR COMPLETE BENEFITS.