<table>
<thead>
<tr>
<th>Services</th>
<th>New Rates Effective January to December 31, 2020</th>
<th>Deductibles apply</th>
<th>Deductibles apply for out-of-network services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Monthly Premium</td>
<td>Individual $652.14, Family $1,696.50</td>
<td>Bi-Weekly Deduction</td>
<td>算是</td>
</tr>
<tr>
<td>Clark's Monthly Contribution</td>
<td>Individual $551.00, Family $1,269.50</td>
<td>Bi-Weekly Deduction</td>
<td>算是</td>
</tr>
<tr>
<td>Employee Monthly Contribution</td>
<td>Individual $101.14, Family $427.00</td>
<td>Bi-Weekly Deduction</td>
<td>算是</td>
</tr>
<tr>
<td>Bi-Weekly Deduction (24 Pays)</td>
<td>Individual $50.57, Family $213.50</td>
<td>Bi-Weekly Deduction</td>
<td>算是</td>
</tr>
</tbody>
</table>

### In-network Out-of-pocket maximum
- Individual $2500 Ind/$5000 Family
- Family $500 Ind/$10,000 Family
- Family $2500 Ind/$5000 Family

### Co-Insurance
- Individual $1000 Ind/$2000 Family
- Family $500 Ind/$1000 Family
- Family $2500 Ind/$5000 Family

### Preventive Care Office Visits (annual exams with PCP or gynecologist and well-child visits)
- Covered in full

### Preventive Dental Care (children up to age 13)
- Covered in full (2 visits per member per year)

### Vision Tests
- $25 copayment (once per year)

### Imaging: MRI, CAT, PET, etc.
- $75 co-pay per visit (only charged 2x per year maximum)

### Home health care and hospice services
- Subject to $500 per admission copayment or $250 per visit day surgery
- Covered in full; after deductible

### Oxygen and equipment for its administration
- Covered in full; after deductible

### Durable medical equipment / Prosthetics
- 20% cost sharing

### Surgery and related anesthesia
- Subject to $500 per admission copayment or $250 per visit day surgery
- Covered in full; after deductible

### Inpatient Care (including maternity care)
- Subject to $500 per admission copayment or $250 per visit day surgery
- 20% coinsurance after deductible

### Rehabilitation hospital care (60 days per calendar year)
- Covered in full; after deductible

### Skilled nursing facility care (100 days per calendar year)
- Covered in full; after deductible

### Effective 1/1/2020 enhancements to the Rx plan through OPTUMRx
- Will be implemented moving the OPTUMRx exclusive specialty prescription program to Briova.

### Blue Cross Blue Shield - www.bluecrossma.com - 1-800-358-2227

### Plan year 2020 Premium Rates
- Individual Monthly Premium $50.86, Family $134.76
- No Deductibles Maximum Calendar year coverage is $1,500 per person
- Bi-Weekly Deduction (24 Pays) $25.43, $67.38