MAX RESTAURANT GROUP

Connecticut Employees

Effective January 1, 2011

BENEFIT FEATURE	Max Group Current Core Plan POS $20/$40 $2,500	Max Group Core Plan	Max Group Buy Up Plan
	IN-NETWORK	IN-NETWORK	IN-NETWORK
Individual Calendar Year Plan Deductible -	N/A	$1,000	N/A
Family Calendar Year Plan Deductible -	N/A	$2,000	N/A
Individual Annual Out-of-Pocket Maximum -	N/A	$3,000 including deductible	N/A
Family Annual Out-of-Pocket Maximum -	N/A	$6,000 including deductible	N/A
Coinsurance -	100%	50%	100%
Lifetime Maximum (per member) -	Unlimited	Unlimited	Unlimited
Referral Required -	No	No	No
Preventative Services -	$20 Copay	No Charge	No Charge
Child Preventive Care	$20 Copay	No Charge	No Charge
Adult Preventive Care			
Routine Well Woman Exam	$40 Copay	No Charge	No Charge
Routine Mammography	No charge	No Charge	No Charge
Routine Eye Exam (one per year)	$40 Copay	50% deductible waived	$10 Copay
Primary Care Office Visit (sickness/injury)	$20 Copay	$30 Copay	$30 Copay
Specialist Office Services -	$40 Copay	50% after plan deductible	$45 Copay
Outpatient Surgical Facility Services -	$2,500 / $5,000 deductible	50% after plan deductible	$2,500 / $5,000 deductible
Non-Advanced Radiology -	No Charge	50% after plan deductible	$10 Copay
Laboratory Services -	No charge	50% after plan deductible	No Charge
High Diagnostic- MRI, PET, etc. (prior authorization required)	$75 Copay	50% after plan deductible	$75 Copay
Hospitalization for Maternity, Illness or Injury - *Semi-Private Room & Board*	$2,500 / $5,000	50% after plan deductible	$2,500 / $5,000 deductible
Emergency Room -	$150 Copay	50% after plan deductible	$150 Copay
Urgent Care Centers -	$75 Copay	50% after plan deductible	75 Copay
Emergency Ambulance Services -	No charge	50% after plan deductible	No Charge
Retail Prescription Drugs (34-day supply) - Generic Tier 1 Drugs Listed Brand Tier 2 Drugs Non-Listed Brand Tier 3 Drugs	$15/30/40	$15/$30/$40	$15/30/40
Mail Order Prescription Drugs (90-day supply) - Generic Tier 1 Drugs Listed Brand Tier 2 Drugs Non-Listed Brand Tier 3 Drugs	$30/60/80	$30/60/80	$30/60/80
	OUT-OF-NETWORK	OUT-OF-NETWORK	OUT-OF-NETWORK
Individual Calendar Year Plan Deductible -	$5,000	$5,000	$3,500
Family Calendar Year Plan Deductible -	$10,000	$10,000	$10,500
Individual Annual Out-of-Pocket Maximum -	$10,000 including deductible	$15,000 including deductible	$5,500 including deductible
Family Annual Out-of-Pocket Maximum -	$20,000 including deductible	$30,000 including deductible	$16,500 including deductible
Coinsurance -	30%	50%	30%
Lifetime Maximum (per member) -	$1,000,000	Unlimited	Unlimited