MAX RESTAURANT GROUP

Massachusetts Employees

Effective January 1, 2011

BENEFIT FEATURE	Max Group Current Core Plan POS $20/$40 $2,500	Max Group Core Plan H.S.A.	Max Group Buy Up Plan
	IN-NETWORK	**IN-NETWORK**	**IN-NETWORK**
Individual Calendar Year Plan Deductible -	N/A	$2,500	N/A
Family Calendar Year Plan Deductible -	N/A	$5,000	N/A
Individual Annual Out-of-Pocket Maximum -	N/A	N/A	N/A
Family Annual Out-of-Pocket Maximum -	N/A	N/A	N/A
Coinsurance -	100%	100%	100%
Lifetime Maximum (per member) -	Unlimited	Unlimited	Unlimited
Referral Required -	No	No	No
Preventative Services -			
Child Preventive Care	$20 Copay	No Charge	No Charge
Adult Preventive Care	$20 Copay	No Charge	No Charge
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	No Charge	$10 Copay
Primary Care Office Visit (sickness/injury)	$20 Copay	100% after deductible	$30 Copay
Specialist Office Services -	$40 Copay	100% after deductible	$45 Copay
Outpatient Surgical Facility Services -	$2,500 / $5,000 deductible	100% after deductible	$500 Copay
Non-Advanced Radiology -	No Charge	100% after deductible	$10 Copay
Laboratory Services -	No charge	100% after deductible	100%
High Diagnostic- MRI, PET, etc. (prior authorization required)	$75 Copay	100% after deductible	$75 Copay
Hospitalization for Maternity, Illness or Injury -	$2,500 / $5,000	100% after deductible	$500/day up to $2,000 per year
Semi-Private Room & Board			
Emergency Room -	$150 Copay	100% after deductible	$150 Copay
Urgent Care Centers -	$75 Copay	100% after deductible	75 Copay
Emergency Ambulance Services -	No charge	100% after deductible	No Charge
Retail Prescription Drugs (34-day supply) -			
Generic Tier 1 Drugs	$15/30/40	Rx subject to deductible, then $15/25/40 to maximum of $750/$1,500	$15/30/40
Listed Brand Tier 2 Drugs			
Non-Listed Brand Tier 3 Drugs			
Mail Order Prescription Drugs (90-day supply) -			
Generic Tier 1 Drugs	$30/60/80	Rx subject to deductible, then $30/50/80 to maximum of $750/$1,500	$30/60/80
Listed Brand Tier 2 Drugs			
Non-Listed Brand Tier 3 Drugs			
	OUT-OF-NETWORK	**OUT-OF-NETWORK**	**OUT-OF-NETWORK**
Individual Calendar Year Plan Deductible -	$5,000	N/A	$2,000
Family Calendar Year Plan Deductible -	$10,000	N/A	$6,000
Individual Annual Out-of-Pocket Maximum -	$10,000 including deductible	N/A	$5,000 including deductible
Family Annual Out-of-Pocket Maximum -	$20,000 including deductible	N/A	$15,000 including deductible
Coinsurance -	30%	N/A	50%
Lifetime Maximum (per member) -	$1,000,000	N/A	Unlimited