

	In-Network	Out-of-Network
<b>Access</b>		Open Access
<b>Benefit Year</b>		Calendar Year
<b>Deductible</b>	N/A	\$1,000 individual/\$2,500 family
<b>Coinsurance</b> (deductible or in-network co-payments)	N/A	70% after deductible, up to \$10K. Indiv. max equal to 30% of the first \$10K of eligible charges after deductible
<b>Coinsurance Limit</b> (applies to out-of-network only, not including deductible or in-network co-payments)	N/A	\$3,000 individual; \$7,500 family
<b>Hospital Inpatient</b>		
Hospital Services: Semi-private room & board, medications, and related hospital services	Covered in full after \$500 per admission co-pay	70/30% after deductible
<b>Outpatient Medical Services</b>		
Routine Physical Exams (adults and children based on schedules)	Covered in full through age 19 only	Covered in full for children
Medical Office Visits	\$20 per visit	70/30% after deductible
Routine OB/GYN Exam — 1 visit annually	Covered in full	70/30% after deductible
Routine Mammography (subject to age limitations)	Covered in full	70/30% after deductible
Vision Exam	Not available	Not available
Immunizations	Covered in full	70/30% after deductible
Diagnostic X-ray & Lab	Covered in full	70/30% after deductible
Outpatient Surgery	Covered in full in hospital, facility, or ambulatory surgical center. Office visit copay applies in doctor's office	70/30% after deductible
<b>Other Services</b>		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required.	\$20 per visit	70/30% after deductible
Prescription Drugs (MAC C) See formulary to determine what tier your Rx falls in.	Three-tier formulary: Generic/ Preferred Brand**/Non-Preferred Brand \$10/\$20/\$35	Not covered
Mail-order Pharmacy (MAC C)	2x retail copay for up to 90-day supply \$20/\$40/\$70	Not available
Emergency Room Services	\$50 if not admitted to hospital	True medical emergency covered same as in-network
Ambulance Services	Covered in full when medically necessary	All covered ambulance services covered same as in-network
<b>Mental/Nervous and Substance Abuse</b>		
Outpatient	\$20 per visit	70/30% after deductible
Inpatient	Covered in full after \$500 per admission copay	70/30% after deductible
<b>Lifetime Maximum</b>	Unlimited	Unlimited

\*Oxford USA is our "out-of-area" option and is available in most states EXCLUDING: ID, ME, MS, MT, OK, SD, WY. Greater metro NY, NJ, DE and some parts of PA are considered in-area. See the Enrollment Brochure for plan designs.

\*\*Information relative to "Preferred Brand" drugs may be found on each health plan's Web site or by contacting each health plan's Member Services Department.

The services described above are only an overview of the entire benefit package. Services provided by the health plan company under the benefit plan you select will be fully described in the proof of coverage document you'll receive once you are enrolled in the program. The benefits are subject to various limitations, exclusions and conditions as fully described in each health plan company's Certificate of Coverage. The services identified are covered as described only when they are provided based on the guidelines of the program; in other words, when they are provided, prescribed or directed by the health plan company you have selected (except in cases of emergencies).