

Access	CIGNA, Oxford: Gated; ConnectiCare: Open Access
Benefit Year	CIGNA: Contract Year; ConnectiCare, Oxford: Calendar Year
Deductible	N/A
Coinsurance	N/A
Maximum Out-of-Pocket Limit —based on approved charges (including deductible)	N/A
Coinsurance Limit (applies to out-of-network only, not including deductible or in-network co-payments)	N/A
Hospital Inpatient	
Hospital Services: Semi-private room & board, medications, and related hospital services (includes inpatient services for mental/nervous and substance abuse)	Covered in full after \$500 copay
Outpatient Medical Services	
Routine Physical Exams (adults and children based on schedule)	\$20 per visit
Medical Office Visits—includes office visits associated with mental/nervous and substance abuse	\$20 per visit
Routine OB/GYN Exam— 1 visit annually	\$20 per visit
Routine Mammography (subject to age limitations)	Covered in full
Routine Vision Exam: 1 exam/24 mo.	\$20 per visit; except Oxford covers to max. of \$50 on a reimbursement basis only; CIGNA members must use VSP provider
Immunizations	\$20 per visit
Diagnostic X-ray & Lab	Covered in full.
Outpatient Surgery (doctor's office or other facility)	\$20 doctor's office; \$100 outpatient facility
Other Services	
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$20 per visit
Prescription Drugs (Retail) (MAC-C is co-pay only) See formularies for each health plan company.	Three-tier co-pay: Generic/Preferred Brand*/Non-Preferred Brand \$10/\$20/\$40
Mail-order Pharmacy	2X retail co-pay for up to a 90-day supply.
Urgent Care (includes walk-in centers)	\$50 per visit
Emergency Room Services	\$50 if not admitted to hospital
Ambulance Services	Covered in full when medically necessary.
Lifetime Maximum	Unlimited

*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 in this brochure are only an overview of the entire benefit package. For a more detailed plan description prior to enrolling, please contact the health plan company that interests you. Health plan company phone numbers can be obtained from your employer. 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).