

	In-Network	Out-of-Network
Access		Open Access
Benefit Year		Contract Year*
Deductible	\$2,000 individual plan deductible \$4,000 family plan deductible Note: For Family coverage, the Oxford plan requires that the family plan deductible must be met completely prior to any member of the family eligible for benefits after the deductible.	\$2,000 individual plan deductible \$4,000 family plan deductible*
Coinsurance	100%	70/30%
Coinsurance Limit (not including deductible or in-network co-payments)	N/A	\$3,000 individual/\$6,000 family (individual coinsurance limit is determined by member paying 30% of approved charges totaling \$10,000)
Maximum Out-of-Pocket —based on approved charges (including deductible)	\$5,000 individual (2X family)	\$5,000 individual (2X family)
Hospital Inpatient Hospital Services: Semi-private room & board, medications, and related hospital services (includes inpatient services for mental/nervous and substance abuse)	100% after plan deductible	70/30% after plan deductible
Outpatient Medical Services		
Routine Physical Exams (adults and children based on schedules)	Covered in full	70/30% after plan deductible
Medical Office Visits—includes office visits associated with mental/nervous and substance abuse	100% after plan deductible	70/30% after plan deductible
Routine OB/GYN Exam—1 visit annually	Covered in full	70/30% after plan deductible
Routine Mammography (subject to age limitations)	Covered in full	70/30% after plan deductible
Routine Vision Exam	Not covered unless provided by PCP at time of routine exam	Not covered
Immunizations	Covered in full (based on schedules)	70/30% after plan deductible
Diagnostic X-ray	100% after plan deductible	70/30% after plan deductible
Laboratory	Covered in full as part of routine physical exam; Otherwise subject to deductible	70/30% after plan deductible
Outpatient Surgery (doctor's office or other facility)	100% after plan deductible	70/30% after plan deductible
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	100% after plan deductible	70/30% after plan deductible
Prescription Drugs (Retail) See formularies for each health plan company.	Subject to plan deductible. Once deductible is met, then \$15/\$25/\$40 (Tier 1/2/3)	70/30% after plan deductible
Mail-order Pharmacy	Subject to plan deductible. Then 2X retail co-pay for up to a 90-day supply.	30% after plan deductible
Urgent Care (includes walk-in centers)	100% after plan deductible	70/30% after plan deductible
Emergency Room Services	100% after plan deductible	100% after in-network plan deductible
Ambulance Services	100% after plan deductible	100% after in-network plan deductible
Lifetime Maximum	Unlimited	Unlimited

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Benefit Year		Contract Year*
Deductible	\$2,000 individual/\$4,000 family	\$3,000 individual/\$6,000 family
Coinsurance	100%	70/30% after deductible
Coinsurance Limit (not including deductible or in-network co-payments)	N/A	\$2,000 individual/\$4,000 family
Maximum Out-of-Pocket —based on approved charges (including deductible)	N/A	\$5,000 individual/\$10,000 family
Hospital Inpatient		
Hospital Services: Semi-private room & board, medications, and related hospital services (includes inpatient services for mental/nervous and substance abuse)	Subject to deductible, then covered in full.	70/30% after deductible
Outpatient Medical Services		
Routine Physical Exams (adults and children based on schedules)	Covered in full	No coverage, except for well-child care through age 6
Medical Office Visits—includes office visits associated with mental/nervous and substance abuse	Routine/preventive services covered in full.	70/30% after deductible
Routine OB/GYN Exam—1 visit annually	Routine/preventive services covered in full.	Not covered
Routine Mammography (subject to age limitations)	Routine/preventive services covered in full.	Not covered
Routine Vision Exam	Covered in full as part of routine physical exam. Otherwise not covered.	Not covered
Immunizations	Covered in full if routine/preventive. Otherwise subject to deductible.	Not covered
Diagnostic X-ray	Subject to deductible, then covered in full.	70/30% after deductible
Laboratory	Covered in full as part of routine physical exam. Otherwise subject to deductible.	70/30% after deductible
Outpatient Surgery (doctor's office or other facility)	Subject to deductible, then covered in full.	70/30% after deductible
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	Subject to deductible, then covered in full.	70/30% after deductible
Prescription Drugs (Retail) (MAC-A: Mandatory Generic**) See formularies for each health plan company. See explanation of benefits by carrier.	\$100 deductible on tiers 2 and 3 only, then co-pays apply. 3X deductible max. per family. Three-tier co-pay \$15/\$30/\$40	Not covered. Members must use participating pharmacy.
Mail-order Pharmacy	Subject to \$100 pharmacy deductible, then 2X retail co-pays.	Not available unless member uses in-network vendor.
Urgent Care (includes walk-in centers)	Subject to deductible, then covered in full.	70/30% after deductible
Emergency Room Services	Subject to in-network deductible, then covered in full.	Subject to in-network deductible, then covered in full.
Ambulance Services	Subject to in-network deductible, then covered in full.	Subject to in-network deductible, then covered in full.
Lifetime Maximum	Unlimited	\$1,000,000

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**Generic substitution required when available. If member purchases brand drug when a generic is available, member pays the co-pay plus the difference in cost between brand and generic. 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.

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Access		Open Access
Benefit Year		Contract Year*
Deductible	N/A	\$5,000 individual/\$10,000 family
Coinsurance	N/A	70/30% after deductible
Coinsurance Limit (not including deductible or in-network co-payments)	N/A	\$5,000 individual/\$10,000 family (individual coinsurance limit is determined by member paying 30% of approved charges totaling \$16,667)
Maximum Out-of-Pocket —based on approved charges (including deductible)	N/A	\$10,000 individual/\$20,000 family
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 Hospital & Facility-based Services deductible of \$3,000 individual/\$6,000 family	70/30% after deductible
Outpatient Medical Services		
Routine Physical Exams (adults and children based on schedules)	\$30 per visit	No coverage, except for well-child care through age 6
Medical Office Visits —includes office visits associated with mental/nervous and substance abuse	\$30 PCP/\$45 specialist per visit	70/30% after deductible
Routine OB/GYN Exam — 1 visit annually	\$45 per visit	70/30% after deductible
Routine Mammography (subject to age limitations)	Covered in full	70/30% after deductible
Routine Vision Exam	Covered up to \$50 on a reimbursement basis only	Same as in-network
Immunizations	\$30 per visit	70/30% after deductible
Diagnostic X-ray (Advanced imaging services may vary by carrier and are defined in an employee's certificate of coverage)	Advanced imaging: \$75 co-pay per service to a co-pay max. of \$375 per year. All other services covered in full.	70/30% after deductible
Laboratory	Covered in full at participating labs.	70/30% after deductible
Outpatient Surgery (doctor's office or other facility)	\$30 PCP office/\$45 specialist office; Outpatient facility: Subject to Hospital & Facility-based Services deductible of \$3,000 individual/\$6,000 family	70/30% after deductible
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$45 per visit	70/30% after deductible
Prescription Drugs (Retail) (MAC-A: Mandatory Generic**) See formularies for each health plan company. See explanation of benefits by carrier.	Three-tier co-pay \$15/\$30/\$40	Not covered. Members must use participating pharmacy.
Mail-order Pharmacy	2X retail co-pay for up to a 90-day supply	Not covered
Urgent Care (includes walk-in centers)	\$75 per visit	70/30% after deductible
Emergency Room Services	\$150 if not admitted to hospital	\$150 if not admitted to hospital
Ambulance Services	Covered in full when medically necessary	Covered in full when medically necessary
Lifetime Maximum	Unlimited	\$1,000,000

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Access		Open Access
Benefit Year		Contract Year*
Deductible	N/A	\$2,500 individual/\$5,000 family
Coinsurance	N/A	70/30% after deductible
Coinsurance Limit (not including deductible or in-network co-payments)	N/A	\$5,000 individual/\$10,000 family (individual coinsurance limit is determined by member paying 30% of approved charges totaling \$16,667)
Maximum Out-of-Pocket —based on approved charges (including deductible)	N/A	\$7,500 individual/\$15,000 family
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 Hospital & Facility-based Services deductible of \$1,500 individual/\$3,000 family	70/30% after deductible
Outpatient Medical Services		
Routine Physical Exams (adults and children based on schedules)	\$20 per visit	No coverage, except for well-child care through age 6
Medical Office Visits —includes office visits associated with mental/nervous and substance abuse	\$20 PCP/\$40 specialist per visit	70/30% after deductible
Routine OB/GYN Exam — 1 visit annually	\$40 per visit	70/30% after deductible
Routine Mammography (subject to age limitations)	Covered in full	70/30% after deductible
Routine Vision Exam	Covered up to \$50 on a reimbursement basis only	Same as in-network
Immunizations	\$20 per visit	70/30% after deductible
Diagnostic X-ray (Advanced imaging services may vary by carrier and are defined in an employee's certificate of coverage)	Advanced imaging: \$75 co-pay per service to a co-pay max. of \$375 per year. All other services covered in full.	70/30% after deductible
Laboratory	Covered in full at participating labs.	70/30% after deductible
Outpatient Surgery (doctor's office or other facility)	\$20 PCP office/\$40 specialist office; Outpatient facility: Subject to Hospital & Facility-based Services deductible of \$1,500 individual/\$3,000 family	70/30% after deductible
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$40 per visit	70/30% after deductible
Prescription Drugs (Retail) (MAC-A: Mandatory Generic**) See formularies for each health plan company. See explanation of benefits by carrier.	Three-tier co-pay \$15/\$30/\$40	Not covered. Members must use participating pharmacy.
Mail-order Pharmacy	2X retail co-pay for up to a 90-day supply	Not covered
Urgent Care (includes walk-in centers)	\$75 per visit	70/30% after deductible
Emergency Room Services	\$150 if not admitted to hospital	\$150 if not admitted to hospital
Ambulance Services	Covered in full when medically necessary	Covered in full when medically necessary
Lifetime Maximum	Unlimited	\$1,000,000

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	In-Network	Out-of-Network
Access		Open Access
Benefit Year		Calendar Year
Deductible	N/A	\$2,500 individual/\$7,500 family
Coinsurance (deductible or in-network co-payments)	N/A	70% after deductible, up to \$20K. Individual max. equal to 30% of the first \$20K of eligible charges after deductible.
Coinsurance Limit (applies to out-of-network only, not including deductible or in-network co-payments)	N/A	\$6,000 individual/\$18,000 family
Hospital Inpatient		
Hospital Services: Semi-private room & board, medications, and related hospital services	\$500/day up to \$2,000 max. per calendar year	70/30% after deductible
Outpatient Medical Services		
Routine Physical Exams (adults and children based on schedules)	Covered in full through age 19 only	Covered in full for children
Medical Office Visits	\$30 per visit	70/30% after deductible
Specialist Office Visit	\$45	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	\$250 co-pay in hospital, facility, or ambulatory surgical center. Office visit co-pay applies in doctor's office.	70/30% after deductible
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required.	\$45 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/\$40	Not covered
Mail-order Pharmacy (MAC-C)	2X retail co-pay for up to a 90-day supply \$20/\$40/\$80	Not available
Emergency Room Services	\$150 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.
Mental/Nervous and Substance Abuse		
Outpatient	\$30 per visit	70/30% after deductible
Inpatient	\$500/day up to \$2,000 max. per calendar year	70/30% after deductible
Lifetime Maximum	Unlimited	Unlimited

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Access		Open Access
Benefit Year		Calendar Year
Deductible	N/A	\$1,000 individual/\$2,500 family
Coinsurance (deductible or in-network co-payments)	N/A	70% after deductible, up to \$10K. Individual max. equal to 30% of the first \$10K of eligible charges after deductible.
Coinsurance Limit (applies to out-of-network only, not including deductible or in-network co-payments)	N/A	\$3,000 individual/\$7,500 family
Hospital Inpatient		
Hospital Services: Semi-private room & board, medications, and related hospital services	Covered in full after \$500 per admission co-pay	70/30% after deductible
Outpatient Medical Services		
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 co-pay applies in doctor's office.	70/30% after deductible
Other Services		
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 co-pay for up to a 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.
Mental/Nervous and Substance Abuse		
Outpatient	\$20 per visit	70/30% after deductible
Inpatient	Covered in full after \$500 per admission co-pay	70/30% after deductible
Lifetime Maximum	Unlimited	Unlimited

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