CBIA HEALTH CONNECTIONS 2
THE POWER OF CHOICE

51 plus

ConnectiCare, Oxford

POS $30/$45—$5,000

51-100 EMPLOYEES

	In-Network	Out-of-Network
Access	All Carriers Open Access	
Benefit Year	Contract Year*	
Deductible	N/A	$5,000 individual/$10,000 family
Coinsurance	N/A	70/30% after deductible
Maximum Out-of-Pocket—based on approved charges (including deductible)	N/A	$10,000 individual/$20,000 family
Coinsurance Limit (not including deductible or in-network co-payment)	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)	Covered in full after Hospital & Facility-based Services deductible of $5,000 individual/$10,000 family	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	$30 PCP/$45 specialist per visit	70/30% after deductible
Routine OB/GYN Exam—1 visit annually	Covered in full	Not covered
Routine Mammography (subject to age limitations)	Routine/preventive services covered in full	Not covered
Routine Colonoscopy (subject to age limitations)	Routine/preventive services covered in full	Not covered
Routine Vision Exam: 1 exam/24 mo.	$45/visit; except Oxford covers to max. of $50 on a reimbursement basis only	Not covered; except Oxford offers coverage same as in-network
Immunizations	Covered in full	Not covered
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 $5,000 individual/$10,000 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.	$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 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	Unlimited

*Oxford: Contract year effective July 1, 2009 for new business. In-force groups may be contract year or calendar year, determined at a group's renewal. NOTE: For Oxford, deductibles run on a contract year. All other benefits operate on a calendar year.

**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.

The services described 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).