

Enrollment information for groups with **3-50** employees



**CBIA**  
**HEALTH**  
**CONNECTIONS** **2**  
**THE POWER OF CHOICE**

*The doctors you want and the coverage you need.*



**OCTOBER 2010**

<b>Access</b>	Open Access
<b>Benefit Year</b>	Contract Year*
<b>Deductible</b>	\$2,500 individual/\$5,000 family
<b>Coinsurance</b>	N/A
<b>Maximum Out-of-Pocket Limit</b> —based on approved charges (including deductible)	N/A
<b>Coinsurance Limit</b> (not including deductible or in-network co-payments)	N/A
<b>Hospital Inpatient</b>	
Hospital Services: Semi-private room & board, medications, and related hospital services (includes inpatient services for mental/nervous and substance abuse)	Subject to plan deductible, then covered in full
<b>Outpatient Medical Services</b>	
Routine Physical Exams (adults and children based on schedule)	Covered in full
Medical Office Visits—includes office visits associated with mental/nervous and substance abuse	\$30 PCP/ \$45 specialist per visit
Routine OB/GYN Exam—1 visit annually	Covered in full
Routine Mammography (subject to age limitations)	Routine/preventive services covered in full; Deductible waived
Routine Colonoscopy (subject to age limitations)	Routine/preventive services covered in full; Deductible waived
Routine Vision Exam: 1 exam/24 mo.	\$45 per visit ; except Oxford covers to max of \$50 on a reimbursement basis only; CIGNA members must use VSP provider
Immunizations	Covered in full
Diagnostic X-ray	Subject to plan deductible, then covered in full.
Laboratory	Covered in full at participating labs
Outpatient Surgery (doctor's office or other facility)	\$30 PCP office/\$45 specialist office; Outpatient facility—covered in full after plan deductible.
<b>Other Services</b>	
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$45 per visit
Prescription Drugs (Retail) (MACA: 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. ConnectiCare & Oxford: Three-tier co-pay \$15/\$30/\$40 CIGNA: Two-tier co-pay \$15/\$35
Mail-order Pharmacy	Subject to \$100 pharmacy deductible, then 2X retail co-pays.
Urgent Care (includes walk-in centers)	\$75 per visit
Emergency Room Services	\$150 if not admitted to hospital
Ambulance Services	Subject to plan deductible, then covered in full.
<b>Lifetime Maximum</b>	Unlimited

\* For Oxford, only 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).

<b>Access</b>	CIGNA, Oxford: Gated; ConnectiCare: Open Access
<b>Benefit Year</b>	CIGNA, ConnectiCare: Contract Year; Oxford: Calendar Year
<b>Deductible</b>	N/A
<b>Coinsurance</b>	N/A
<b>Maximum Out-of-Pocket Limit</b> —based on approved charges (including deductible)	N/A
<b>Coinsurance Limit</b> (not including deductible or in-network co-payments)	N/A
<b>Hospital Inpatient</b>	
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 per day to a max. of \$2000 per year
<b>Outpatient Medical Services</b>	
Routine Physical Exams (adults and children based on schedule)	Covered in full
Medical Office Visits—includes office visits associated with mental/nervous and substance abuse	\$30 PCP/\$45 specialist per visit
Routine OB/GYN Exam—1 visit annually	Covered in full
Routine Mammography (subject to age limitations)	Routine/preventive services covered in full
Routine Colonoscopy (subject to age limitations)	Routine/preventive services covered in full
Routine Vision Exam: 1 exam/24 mo.	\$45 per visit; except Oxford covers to max of \$50 on a reimbursement basis only; CIGNA members must use VSP provider
Immunizations	Covered in full
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.
Laboratory	Covered in full at participating labs
Outpatient Surgery (doctor's office or other facility)	\$30 PCP office/\$45 specialist office; \$500 outpatient facility
<b>Other Services</b>	
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$45 per visit
Prescription Drugs (Retail) (MAC-A: Mandatory Generic*) See formularies for each health plan company. See explanation of benefits by carrier.	ConnectiCare & Oxford: Three-tier co-pay \$15/\$30/\$40 CIGNA: Two-tier co-pay \$15/\$35
Mail-order Pharmacy	2X retail co-pay for up to a 90-day supply.
Urgent Care (includes walk-in centers)	\$75 per visit
Emergency Room Services	\$150 if not admitted to hospital
Ambulance Services	Covered in full when medically necessary
<b>Lifetime Maximum</b>	Unlimited

\*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.

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).

<b>Access</b>	CIGNA, Oxford: Gated; ConnectiCare: Open Access
<b>Benefit Year</b>	CIGNA, ConnectiCare: Contract Year; Oxford: Calendar Year
<b>Deductible</b>	N/A
<b>Coinsurance</b>	N/A
<b>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)	N/A
<b>Coinsurance Limit</b> (not including deductible or in-network co-payments)	N/A
<b>Hospital Inpatient</b>	
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 per admission co-pay
<b>Outpatient Medical Services</b>	
Routine Physical Exams (adults and children based on schedule)	Covered in full
Medical Office Visits—includes office visits associated with mental/nervous and substance abuse	\$20 per visit
Routine OB/GYN Exam—1 visit annually	Covered in full
Routine Mammography (subject to age limitations)	Routine/preventive services covered in full
Routine Colonoscopy (subject to age limitations)	Routine/preventive services 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	Covered in full
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.
Laboratory	Covered in full at participating labs
Outpatient Surgery (doctor's office or other facility)	\$20 doctor's office; \$100 outpatient facility
<b>Other Services</b>	
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$20 per visit
Prescription Drugs (Retail) (MAC-A: Mandatory Generic*) See formularies for each health plan company. See explanation of benefits by carrier.	ConnectiCare & Oxford: Three-tier co-pay \$15/\$30/\$40 CIGNA: Two-tier co-pay \$15/\$35
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	\$100 if not admitted to hospital
Ambulance Services	Covered in full when medically necessary
<b>Lifetime Maximum</b>	Unlimited

\*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.

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	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Access</b>	CIGNA, Oxford: Gated; ConnectiCare: Open Access	
<b>Benefit Year</b>	CIGNA, ConnectiCare: Contract Year; Oxford: Calendar Year	
<b>Deductible</b>	N/A	\$2,500 individual/\$5,000 family
<b>Coinsurance</b>	N/A	70/30% after deductible
<b>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)	N/A	\$7,500 individual/\$15,000 family
<b>Coinsurance Limit</b> (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)
<b>Hospital Inpatient</b>		
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 per day to a max. of \$2000 per year	70/30% after deductible
<b>Outpatient Medical Services</b>		
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; CIGNA members must use VSP provider	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 \$500 outpatient facility	70/30% after deductible
<b>Other Services</b>		
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.	ConnectiCare & Oxford: Three-tier co-pay \$15/\$30/\$40 CIGNA: Two-tier co-pay \$15/\$35	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
<b>Lifetime Maximum</b>	Unlimited	Unlimited

\*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.

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	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Access</b>	All Carriers Open Access	
<b>Benefit Year</b>	Contract Year*	
<b>Deductible</b>	N/A	\$5,000 individual/\$10,000 family
<b>Coinsurance</b>	N/A	70/30% after deductible
<b>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)	N/A	\$10,000 individual/\$20,000 family
<b>Coinsurance Limit</b> (not including deductible or in-network co-payment)	N/A	\$5,000 individual; \$10,000 family
<b>Hospital Inpatient</b>		
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
<b>Outpatient Medical Services</b>		
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; CIGNA members must use VSP provider	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 indiv./\$10,000 family	70/30% after deductible
<b>Other Services</b>		
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. ConnectiCare & Oxford: Three-tier co-pay \$15/\$30/\$40 CIGNA: Two-tier co-pay \$15/\$35	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
<b>Lifetime Maximum</b>	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.

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	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Access</b>	All Carriers Open Access	
<b>Benefit Year</b>	Contract Year*	
<b>Deductible</b>	N/A	\$5,000 individual/\$10,000 family
<b>Coinsurance</b>	N/A	70/30% after deductible
<b>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)	N/A	\$10,000 individual/\$20,000 family
<b>Coinsurance Limit</b> (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)
<b>Hospital Inpatient</b>		
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
<b>Outpatient Medical Services</b>		
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; CIGNA members must use VSP provider	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 \$3,000 indiv./\$6,000 family	70/30% after deductible
<b>Other Services</b>		
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.	ConnectiCare & Oxford: Three-tier co-pay \$15/\$30/\$40 CIGNA: Two-tier co-pay \$15/\$35	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
<b>Lifetime Maximum</b>	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.

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	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Access</b>	All Carriers Open Access	
<b>Benefit Year</b>	Contract Year*	
<b>Deductible</b>	N/A	\$2,500 individual/\$5,000 family
<b>Coinsurance</b>	N/A	70/30% after deductible
<b>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)	N/A	\$7,500 individual/\$15,000 family
<b>Coinsurance Limit</b> (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)
<b>Hospital Inpatient</b>		
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
<b>Outpatient Medical Services</b>		
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	\$20 PCP/\$40 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.	\$40/visit; except Oxford covers to max. of \$50 on a reimbursement basis only; CIGNA members must use VSP provider	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)	\$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
<b>Other Services</b>		
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.	ConnectiCare & Oxford: Three-tier co-pay \$15/\$30/\$40 CIGNA: Two-tier co-pay \$15/\$35	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
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<b>Access</b>	All Carriers Open Access	
<b>Benefit Year</b>	Contract Year*	
<b>Deductible</b>	N/A	\$5,000 individual/\$10,000 family
<b>Coinsurance</b>	N/A	70/30% after deductible
<b>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)	N/A	\$10,000 individual/\$20,000 family
<b>Coinsurance Limit</b> (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)
<b>Hospital Inpatient</b>		
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 \$2,500 individual/\$5,000 family	70/30% after deductible
<b>Outpatient Medical Services</b>		
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	\$20 PCP/\$40 specialist per visit	70/30% after deductible
Routine OB/GYN Exam — 1 visit annually	Covered in full	Not covered
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Routine Colonoscopy (subject to age limitations)	Routine/preventive services covered in full	Not covered
Routine Vision Exam: 1 exam/24 mo.	\$40/visit; except Oxford covers to max. of \$50 on a reimbursement basis only; CIGNA members must use VSP provider	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)	\$20 PCP office/\$40 specialist office; Outpatient facility: Subject to Hospital & Facility-based services deductible of \$2,500 individual/\$5,000 family	70/30% after deductible
<b>Other Services</b>		
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.	ConnectiCare & Oxford: Three-tier co-pay \$15/\$30/\$40 CIGNA: Two-tier co-pay \$15/\$35	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
<b>Lifetime Maximum</b>	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.

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	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Access</b>	Available as Gated or Open Access	
<b>Benefit Year</b>	CIGNA, ConnectiCare: Contract Year; Oxford: Calendar Year	
<b>Deductible</b>	N/A	\$750 individual/\$2,250 family
<b>Coinsurance</b>	N/A	70/30% after deductible
<b>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)	N/A	\$3,750 individual/\$11,250 family
<b>Coinsurance Limit</b> (not including deductible or in-network co-payments)	N/A	\$3,000 individual; \$9,000 family (individual coinsurance limit is determined by member paying 30% of approved charges totaling \$10,000)
<b>Hospital Inpatient</b>		
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 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	No coverage, except for well-child care through age 6
Medical Office Visits — includes office visits associated with mental/nervous and substance abuse	\$20 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.	\$20/visit; except Oxford covers to max. of \$50 on a reimbursement basis only; CIGNA members must use VSP provider	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)	\$20 doctor's office; \$100 outpatient facility	70/30% after deductible
<b>Other Services</b>		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$20 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.	ConnectiCare & Oxford: Three-tier co-pay \$15/\$30/\$40 CIGNA: Two-tier co-pay \$15/\$35	Not covered. Members must use participating pharmacy.
Mail-order Pharmacy	2X retail co-pay for up to a 90-day supply.	Not available unless member uses in-network vendor
Urgent Care (includes walk-in centers)	\$50 per visit	70/30% after deductible
Emergency Room Services	\$100 if not admitted to hospital	\$100 if not admitted to hospital
Ambulance Services	Covered in full when medically necessary	Covered in full when medically necessary
<b>Lifetime Maximum</b>	Unlimited	Unlimited

\*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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	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Access</b>	All Carriers Open Access	
<b>Benefit Year</b>	Contract Year*	
<b>Deductible</b>	\$2,000 individual/\$4,000 family	\$3,000 individual/\$6,000 family
<b>Coinsurance</b>	100%	70/30% after deductible
<b>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)	N/A	\$5,000 individual/\$10,000 family
<b>Coinsurance Limit</b> (not including deductible or in-network co-payments)	N/A	\$2,000 individual; \$4,000 family
<b>Hospital Inpatient</b>		
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
<b>Outpatient Medical Services</b>		
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. All other services subject to deductible, then 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 Colonoscopy (subject to age limitations)	Routine/preventive services covered in full	Not covered
Routine Vision Exam	ConnectiCare: Covered in full, one exam per Contract Year; CIGNA and Oxford 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/preventive services. 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
<b>Other Services</b>		
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. ConnectiCare & Oxford: Three-tier co-pay \$15/\$30/\$40 CIGNA: Two-tier co-pay \$15/\$35	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)	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.
<b>Lifetime Maximum</b>	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.

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