

| | 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 <u>any</u> 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) | Routine/preventive services covered in full | 70/30% after plan deductible |
| Routine Mammography (subject to age limitations) | Routine/preventive services 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/preventive services; 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 |

*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 will run on a contract year. All other benefits will operate on a calendar year.

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.

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).

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|---|---|---|
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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. 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 | 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/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 |
| 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 | Unlimited |

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Oxford USA POS \$30/\$45—\$3,000



| | In-Network | Out-of-Network |
|---|--|--|
| 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) | 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 | 70/30% after deductible |
| Routine Mammography (subject to age limitations) | Routine/preventive services covered in full | 70/30% after deductible |
| Routine Colonoscopy (subject to age limitations) | Routine/preventive services covered in full | 70/30% after deductible |
| Routine Vision Exam | Covered up to \$50 on a reimbursement basis only | Same as in-network |
| Immunizations | Covered in full | 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 | Unlimited |

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Oxford USA POS

\$20/\$40—\$1,500



| | In-Network | Out-of-Network |
|---|--|---|
| 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) | 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 | 70/30% after deductible |
| Routine Mammography (subject to age limitations) | Routine/preventive services covered in full | 70/30% after deductible |
| Routine Colonoscopy (subject to age limitations) | Routine/preventive services covered in full | 70/30% after deductible |
| Routine Vision Exam | Covered up to \$50 on a reimbursement basis only | Same as in-network |
| Immunizations | Covered in full | 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 | Unlimited |

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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 | No coverage except for well-child care through age 6 |
| 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) | Routine/preventive services covered in full | 70/30% after deductible |
| Routine Colonoscopy (subject to age limitations) | Routine/preventive services 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 |

*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 | | 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 | No coverage except for well-child care through age 6 |
| 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) | Routine/preventive services covered in full | 70%/30% after deductible |
| Routine Colonoscopy (subject to age limitations) | Routine/preventive services 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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