

	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Access</b>		Open Access
<b>Benefit Year</b>		Contract Year*
<b>Deductible</b>	\$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*
<b>Coinsurance</b>	100%	70/30%
<b>Coinsurance Limit</b> (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)
<b>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)	\$5,000 individual (2X family)	\$5,000 individual (2X 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)	100% after plan deductible	70/30% after plan deductible
<b>Outpatient Medical Services</b>		
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 Colonoscopy (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
<b>Other Services</b>		
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
<b>Lifetime Maximum</b>	Unlimited	Unlimited

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<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>Coinsurance Limit</b> (not including deductible or in-network co-payments)	N/A	\$2,000 individual/\$4,000 family
<b>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)	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)	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	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
<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. 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.
<b>Lifetime Maximum</b>	Unlimited	Unlimited

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<b>Access</b>		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>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>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)	N/A	\$10,000 individual/\$20,000 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 \$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	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
<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.	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
<b>Lifetime Maximum</b>	Unlimited	Unlimited

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<b>Access</b>		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>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>Maximum Out-of-Pocket</b> —based on approved charges (including deductible)	N/A	\$7,500 individual/\$15,000 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 \$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	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
<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.	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
<b>Lifetime Maximum</b>	Unlimited	Unlimited

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<b>Access</b>		Open Access
<b>Benefit Year</b>		Calendar Year
<b>Deductible</b>	N/A	\$2,500 individual/\$7,500 family
<b>Coinsurance</b> (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.
<b>Coinsurance Limit</b> (applies to out-of-network only, not including deductible or in-network co-payments)	N/A	\$6,000 individual/\$18,000 family
<b>Hospital Inpatient</b>		
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
<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	\$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
<b>Other Services</b>		
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.
<b>Mental/Nervous and Substance Abuse</b>		
Outpatient	\$30 per visit	70/30% after deductible
Inpatient	\$500/day up to \$2,000 max. per calendar year	70/30% after deductible
<b>Lifetime Maximum</b>	Unlimited	Unlimited

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<b>Access</b>		Open Access
<b>Benefit Year</b>		Calendar Year
<b>Deductible</b>	N/A	\$1,000 individual/\$2,500 family
<b>Coinsurance</b> (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.
<b>Coinsurance Limit</b> (applies to out-of-network only, not including deductible or in-network co-payments)	N/A	\$3,000 individual/\$7,500 family
<b>Hospital Inpatient</b>		
Hospital Services: Semi-private room & board, medications, and related hospital services	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	\$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
<b>Other Services</b>		
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.
<b>Mental/Nervous and Substance Abuse</b>		
Outpatient	\$20 per visit	70/30% after deductible
Inpatient	Covered in full after \$500 per admission co-pay	70/30% after deductible
<b>Lifetime Maximum</b>	Unlimited	Unlimited

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