

	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.

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 above are only an overview of the entire benefit package. 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).