

Access	Open Access
Benefit Year	Contract Year*
Deductible	\$2,500 individual/\$5,000 family
Coinsurance	N/A
Maximum Out-of-Pocket Limit —based on approved charges (including deductible)	N/A
Coinsurance Limit (not including deductible or in-network co-payments)	N/A
Hospital Inpatient	
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
Outpatient Medical Services	
Routine Physical Exams (including immunizations)	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	Routine/preventive services 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
Diagnostic X-ray (includes advanced imaging)	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.
Other Services	
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$45 per visit
Durable Medical Equipment	ConnectiCare: Subject to deductible, then 50% coinsurance. Oxford: Covered in full; no deductible or coinsurance.
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
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.
Lifetime Maximum	Unlimited

* Oxford: Contract year 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).

Access	Oxford: Gated; ConnectiCare: Open Access
Benefit Year	ConnectiCare: Contract Year; Oxford: Calendar Year
Deductible	N/A
Coinsurance	N/A
Maximum Out-of-Pocket Limit —based on approved charges (including deductible)	N/A
Coinsurance Limit (not including deductible or in-network co-payments)	N/A
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 \$500 per day to a max. of \$2000 per year
Outpatient Medical Services	
Routine Physical Exams (including immunizations)	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
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
Other Services	
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$45 per visit
Durable Medical Equipment	ConnectiCare: Covered subject to 50% coinsurance Oxford: Covered in full; no co-pay or coinsurance
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
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
Lifetime Maximum	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).

Access	Oxford: Gated; ConnectiCare: Open Access
Benefit Year	ConnectiCare: Contract Year; Oxford: Calendar Year
Deductible	N/A
Coinsurance	N/A
Maximum Out-of-Pocket —based on approved charges (including deductible)	N/A
Coinsurance Limit (not including deductible or in-network co-payments)	N/A
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 \$500 per admission co-pay
Outpatient Medical Services	
Routine Physical Exams (including immunizations)	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
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
Other Services	
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$20 per visit
Durable Medical Equipment	ConnectiCare: Covered subject to 50% coinsurance Oxford: Covered in full; no co-pay or coinsurance
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
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
Lifetime Maximum	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).

	In-Network	Out-of-Network
Access	Oxford: Gated; ConnectiCare: Open Access	
Benefit Year	ConnectiCare: Contract Year; Oxford: Calendar Year	
Deductible	N/A	\$2,500 individual/\$5,000 family
Coinsurance	N/A	70/30% after deductible
Maximum Out-of-Pocket —based on approved charges (including deductible)	N/A	\$7,500 individual/\$15,000 family
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)
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 \$500 per day to a max. of \$2000 per year	70/30% after deductible
Outpatient Medical Services		
Routine Physical Exams (including immunizations)	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
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
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$45 per visit	70/30% after deductible
Durable Medical Equipment	ConnectiCare: Covered subject to 50% coinsurance; Oxford: Covered in full; no co-pay or coinsurance.	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

*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).

	In-Network	Out-of-Network
Access		Open Access
Benefit Year		Contract Year*
Plan Deductible	\$2,500 individual/\$5,000 family	\$5,000 individual/\$10,000 family
Coinsurance	80/20% after deductible	60/40% after deductible
Maximum Out-of-Pocket —based on approved charges	\$5,000 individual/\$10,000 family Includes plan deductible and coinsurance limit for health services only.	\$10,000 individual/\$20,000 family
Coinsurance Limit (not including deductible or in-network co-payments)	\$2,500 individual/\$5,000 family	\$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 20% coinsurance	60/40% after deductible
Outpatient Medical Services		
Routine Physical Exams (including immunizations)	Covered in full	Only for members under 6 years old; Subject to deductible and coinsurance
Medical Office Visits—includes office visits associated with mental/nervous and substance abuse	\$30 PCP/\$45 specialist per visit	60/40% after deductible
Routine OB/GYN Exam—1 visit annually	Routine/preventive services covered in full	60/40% after deductible
Routine Mammography (subject to age limitations)	Routine/preventive services covered in full	60/40% after deductible
Routine Colonoscopy (subject to age limitations)	Routine/preventive services covered in full	60/40% after deductible
Routine Vision Exam	One exam every 24 months; \$45 specialist copay applies	60/40% after deductible
Diagnostic X-ray (includes advanced imaging)	Subject to deductible then 20% coinsurance	60/40% after deductible
Laboratory	Covered in full	60/40% after deductible
Outpatient Surgery (doctor's office or other facility)	\$30 PCP office / \$45 specialist office; Outpatient facility: Subject to deductible then 20% coinsurance	60/40% after deductible
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$45 specialist copay	60/40% after deductible
Durable Medical Equipment	Subject to deductible then 20% coinsurance	60/40% after deductible
Prescription Drugs (Retail) (MAC-A: Mandatory Generic**) See formularies for each health plan company. See explanation of benefits by carrier.	\$200 deductible on tiers 2 and 3 only, then co-pays apply. 3X deductible max per family. Three-tier co-pay \$10/\$30/\$40	Not covered. Members must use participating pharmacy
Mail-order Pharmacy	Subject to \$200 pharmacy deductible, then 2X retail co-pays	Not covered
Urgent Care (includes walk-in centers)	\$75 copay	\$75 copay
Emergency Room Services	\$150 copay; waived if admitted	\$150 copay; waived if admitted
Ambulance Services	Subject to deductible then 20% coinsurance	Subject to deductible then 20% coinsurance
Lifetime Maximum	Unlimited	Unlimited

*Oxford: Contract year 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).

	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 (including immunizations)	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
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
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$45 per visit	70/30% after deductible
Durable Medical Equipment	ConnectiCare: Covered subject to 50% coinsurance; Oxford: Covered in full; no co-pay or coinsurance.	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).

	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-payments)	N/A	\$5,000 individual; \$10,000 family (individual coinsurance limit is determined by member paying 30% of approved charges totaling \$16,667)
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 (including immunizations)	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
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
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$45 per visit	70/30% after deductible
Durable Medical Equipment	ConnectiCare: Covered subject to 50% coinsurance; Oxford: Covered in full; no co-pay or coinsurance.	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

*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).

	In-Network	Out-of-Network
Access	All Carriers Open Access	
Benefit Year	Contract Year*	
Deductible	N/A	\$2,500 individual/\$5,000 family
Coinsurance	N/A	70/30% after deductible
Maximum Out-of-Pocket —based on approved charges (including deductible)	N/A	\$7,500 individual/\$15,000 family
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)
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 (including immunizations)	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;	Not covered; except Oxford offers coverage same as in-network
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
Durable Medical Equipment	ConnectiCare: Covered subject to 50% coinsurance; Oxford: Covered in full; no co-pay or coinsurance.	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

*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).

	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-payments)	N/A	\$5,000 individual; \$10,000 family (individual coinsurance limit is determined by member paying 30% of approved charges totaling \$16,667)
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 \$2,500 individual/\$5,000 family	70/30% after deductible
Outpatient Medical Services		
Routine Physical Exams (including immunizations)	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;	Not covered; except Oxford offers coverage same as in-network
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
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$40 per visit	70/30% after deductible
Durable Medical Equipment	ConnectiCare: Covered subject to 50% coinsurance; Oxford: Covered in full; no co-pay or coinsurance.	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

*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).

	In-Network	Out-of-Network
Access	Available as Gated or Open Access	
Benefit Year	ConnectiCare: Contract Year; Oxford: Calendar Year	
Deductible	N/A	\$750 individual/\$2,250 family
Coinsurance	N/A	70/30% after deductible
Maximum Out-of-Pocket —based on approved charges (including deductible)	N/A	\$3,750 individual/\$11,250 family
Coinsurance Limit (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)
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 \$500 per admission co-pay	70/30% after deductible
Outpatient Medical Services		
Routine Physical Exams (including immunizations)	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;	Not covered; except Oxford offers coverage same as in-network
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
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$20 per visit	70/30% after deductible
Durable Medical Equipment	ConnectiCare: Covered subject to 50% coinsurance; Oxford: Covered in full; no co-pay or coinsurance.	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 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
Lifetime Maximum	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.

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).

	In-Network	Out-of-Network
Access	All Carriers Open Access	
Benefit Year	Contract Year*	
Deductible	\$2,000 individual/\$4,000 family	\$3,000 individual/\$6,000 family
Coinsurance	100%	70/30% after deductible
Maximum Out-of-Pocket —based on approved charges (including deductible)	N/A	\$5,000 individual/\$10,000 family
Coinsurance Limit (not including deductible or in-network co-payments)	N/A	\$2,000 individual; \$4,000 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 (including immunizations)	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; Oxford not covered	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
Durable Medical Equipment	ConnectiCare: Subject to deductible then 50% coinsurance. Oxford: 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 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.
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).