

	In-Network	Out-of-Network
<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 (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	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
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
Durable Medical Equipment	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
<b>Lifetime Maximum</b>	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: Deductibles will run on a contract year. All other benefits will 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.

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).