CBIA HEALTH CONNECTIONS 2
THE POWER OF CHOICE

Oxford USA $3500 F HSA-Compatible

3-50 EMPLOYEES

	In-Network	Out-of-Network
Access	Open Access	
Benefit Year	Contract Year*	
Plan Deductible	$3,500 individual plan deductible $7,000 family plan deductible	$10,000 individual plan deductible $20,000 family plan deductible
	Note: For Family coverage, this plan requires that the family plan deductible must be met completely prior to any member of the family becoming eligible for benefits after the deductible.	
Coinsurance	100% (Some services subject to co-pay)	50%
Coinsurance/Co-pay Limit (not including deductible)	Co-pay limit: $1,500 individual (2X family) (health services only)	$6,000 individual plan/$12,000 family plan (individual plan coinsurance limit is determined by member paying 50% of approved charges totaling $12,000)
Maximum Out-of-Pocket—based on approved charges	$5,750 individual (2X family); Includes plan deductible and copays for health services and pharmacy, to specified maximums	$16,000 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)	Subject to plan deductible then $100 copay per day ($500 copay max per year)	50% after plan deductible
Outpatient Medical Services		
Routine Physical Exams (including immunizations)	Covered in full	50% after plan deductible
Medical Office Visits—includes office visits associated with mental/nervous and substance abuse	Copay applies after plan deductible: $15 PCP; $30 specialist	50% after plan deductible
Routine OB/GYN Exam—1 visit annually	Covered in full	50% after plan deductible
Routine Mammography (subject to age limitations)	Routine/preventive services covered in full	50% after plan deductible
Routine Colonoscopy (subject to age limitations)	Routine/preventive services covered in full	50% after plan deductible
Routine Vision Exam	One exam every 24 months; $30 specialist copay applies after deductible	50% after plan deductible
Diagnostic X-ray	Co-pay applies after plan deductible: $45 non-advanced; $75 advanced imaging ($375 copay max per year)	50% after plan deductible
Laboratory	Covered in full after deductible	50% after plan deductible
Outpatient Surgery (doctor's office or other facility)	$100 copay after plan deductible	50% after plan deductible
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	$30 copay (per visit) after plan deductible	50% after plan deductible
Durable Medical Equipment	Subject to deductible, then covered in full	50% after plan deductible
Prescription Drugs (Retail) (MAC-C co-pay only. No differential paid between cost of brand and generic) See formularies for each health plan company.	Subject to plan deductible. Once deductible is met, then $15/$25/$40 (Tier 1/2/3) up to $750 co-pay max (2X family). Pharmacy max does not include plan deductible.	50% after plan deductible
Mail-order Pharmacy	Subject to plan deductible. Then 2X retail co-pay for up to a 90-day supply. Up to $750 co-pay max (2X family)	Not covered
Urgent Care (includes walk-in centers)	$75 copay after plan deductible	$75 copay after plan deductible
Emergency Room Services	$150 copay after plan deductible	$150 copay after plan deductible
Ambulance Services	100% after plan deductible	100% after plan deductible
Lifetime Maximum	Unlimited	Unlimited

*Oxford: 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.

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CBIA HEALTH CONNECTIONS 2
THE POWER OF CHOICE

Oxford USA POS $30/$45–$2,850/30%

3-50 EMPLOYEES

	In-Network	Out-of-Network
Access	Open Access	
Benefit Year	Contract Year*	
Plan Deductible	$2,850 individual/$5,700 family	$10,000 individual/$20,000 family
Coinsurance	70/30% after deductible	50% after deductible
Maximum Out-of-Pocket—based on approved charges	$5,850 individual/$11,700 family Includes plan deductible and coinsurance limit for health services only.	$20,000 individual/$40,000 family
Coinsurance Limit (not including deductible or in-network co-payments)	$3,000 individual/$6,000 family	$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)	Subject to deductible then 30% coinsurance	50% 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	50% after deductible
Routine OB/GYN Exam—1 visit annually	Routine/preventive services covered in full	50% after deductible
Routine Mammography (subject to age limitations)	Routine/preventive services covered in full	50% after deductible
Routine Colonoscopy (subject to age limitations)	Routine/preventive services covered in full	50% after deductible
Routine Vision Exam	One exam every 24 months; $45 specialist copay applies	50% after deductible
Diagnostic X-ray (includes advanced imaging)	Subject to deductible then 30% coinsurance	50% after deductible
Laboratory	Subject to deductible then 30% coinsurance	50% after deductible
Outpatient Surgery (doctor's office or other facility)	$30 PCP office / $45 specialist office; Outpatient facility: Subject to deductible then 30% coinsurance	50% after deductible
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	$45 specialist copay	50% after deductible
Durable Medical Equipment	Subject to deductible, then 30% coinsurance	50% 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)	Subject to deductible then 30% coinsurance	Subject to deductible then 30% coinsurance
Emergency Room Services	Subject to deductible then 30% coinsurance	Subject to deductible then 30% coinsurance
Ambulance Services	Subject to deductible then 30% coinsurance	Subject to deductible then 30% 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.

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CBIA HEALTH CONNECTIONS 2
THE POWER OF CHOICE

Oxford USA POS $30/$45–$2,500/20%

3-50 EMPLOYEES

	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

*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.

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CBIA HEALTH CONNECTIONS 2 THE POWER OF CHOICE

HSA-Compatible

Oxford USA PPO $2,000 D

3-50 EMPLOYEES

	In-Network	Out-of-Network
Access	Open Access	
Benefit Year	Contract Year*	
Plan 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 any 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) Includes plan deductible and pharmacy co-pays.	$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 (including immunizations)	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
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
Durable Medical Equipment	Subject to deductible then covered in full.	30% after deductible
Prescription Drugs (Retail) (MAC-C co-pay only. No differential paid between cost of brand and generic.) See formularies for each health plan company.	Subject to plan deductible. Once deductible is met, then $15/$25/$40 (Tier 1/2/3) to a pharmacy co-pay max of $3,000 individual (2X family) per contract year. Max does not include the plan deductible.	30% after plan deductible
Mail-order Pharmacy	Subject to plan deductible. Then 2X retail co-pay for up to a 90-day supply to pharmacy co-pay max.	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: 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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CBIA HEALTH CONNECTIONS 2
THE POWER OF CHOICE

Oxford USA POS $2,000

3-50 EMPLOYEES

	In-Network	Out-of-Network
Access	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
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 (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	Covered in full as part of routine physical exam. Otherwise 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	Subject to deductible, then covered in full.	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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CBIA HEALTH CONNECTIONS 2 THE POWER OF CHOICE

Oxford USA POS $30/$45–$3,000

3-50 EMPLOYEES

	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 (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	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)	$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
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
Lifetime Maximum	Unlimited	Unlimited

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** 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.

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CBIA HEALTH CONNECTIONS 2 THE POWER OF CHOICE

Oxford USA POS $20/$40—$1,500

3-50 EMPLOYEES

	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 (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
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	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

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**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.

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CBIA HEALTH CONNECTIONS 2 THE POWER OF CHOICE

Oxford USA $30

3-50 EMPLOYEES

	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 (including immunizations)	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 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
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
Durable Medical Equipment	Covered in full; no co-pay or coinsurance	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.
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).

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CBIA HEALTH CONNECTIONS 2 THE POWER OF CHOICE

Oxford USA $20

3-50 EMPLOYEES

	In-Network	Out-of-Network
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 (including immunizations)	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
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
Durable Medical Equipment	Covered in full; no co-pay or coinsurance	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.
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.

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