

	In-Network	Out-of-Network
Access		Open Access
Benefit Year		Contract Year*
Plan Deductible	\$3,500 individual plan deductible \$7,000 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.	\$10,000 individual plan deductible \$20,000 family plan 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.

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).