

| | 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).