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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 visits 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).