

	In-Network	Out-of-Network
Access		Open Access
Benefit Year		Contract Year
Deductible	\$2,000 individual/\$4,000 family	\$10,000 individual/\$20,000 family
Coinsurance	70/30% after deductible	50% after deductible
Maximum Out-of-Pocket —based on approved charges (excludes pharmacy deductible)	\$4,250 individual/\$8,500 family	\$20,000 individual/\$40,000 family
Coinsurance Limit (not including deductible or in-network co-payments)	\$2,250 individual/\$4,500 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)	30% after deductible	50% 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; Specialist 30% after deductible	50% 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. One exam per contract year	Not covered
Diagnostic X-ray	30% after deductible	50% after deductible
Laboratory	Covered in full as part of routine/preventive services. Otherwise 30% after deductible.	50% after deductible
Outpatient Surgery (doctor's office or other facility)	30% after deductible	50% after deductible
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable visits varies by carrier.)	30% after deductible	50% after deductible
Durable Medical Equipment	30% after deductible	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)	30% after deductible	50% after deductible
Emergency Room Services	30% after deductible	30% after in-network deductible
Ambulance Services	30% after deductible	30% after in-network deductible
Lifetime Maximum	Unlimited	Unlimited

*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).