



Access	Oxford: Gated; ConnectiCare: Open Access
Benefit Year	ConnectiCare: Contract Year; Oxford: Calendar Year
Deductible	N/A
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)	Covered in full after \$500 per day to a max. of \$2000 per year
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	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
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.
Laboratory	Covered in full at participating labs
Outpatient Surgery (doctor's office or other facility)	\$30 PCP office/\$45 specialist office; \$500 outpatient facility
Other Services	
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable visits varies by carrier.)	\$45 per visit
Durable Medical Equipment	ConnectiCare: Covered subject to 50% coinsurance Oxford: Covered in full; no co-pay or coinsurance
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
Mail-order Pharmacy	2X retail co-pay for up to a 90-day supply.
Urgent Care (includes walk-in centers)	\$75 per visit
Emergency Room Services	\$150 if not admitted to hospital
Ambulance Services	Covered in full when medically necessary
Lifetime Maximum	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.

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).