

BENEFIT	IN-NETWORK
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FINANCIAL

Deductible: Single	\$2,000
Family	\$4,000
Coinsurance	None
Maximum Out-Of-Pocket: Single	\$2,000
Family	\$4,000
Maximum Lifetime Benefit Per Member	Unlimited

PREVENTIVE CARE

Adult Preventive Care	No charge
Pediatric Preventive Care	No charge
Infant Preventive Care	No charge
Immunizations	No charge

OUTPATIENT CARE

Primary Care Physician office visits	No Charge after the Deductible
Specialist office visits	No Charge after the Deductible
Surgery**	No Charge after the Deductible
Laboratory services**	No Charge
Radiology services**	No Charge after the Deductible

ALLERGY CARE

Initial visit, and all subsequent referral visits	No Charge after the Deductible
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HOSPITAL CARE

Physician's and surgeon's services **	No Charge after the Deductible
Semi-private room and board **	No Charge after the Deductible
All drugs and medication**	No Charge after the Deductible

EMERGENCY CARE

Ambulance Service	No Charge
At hospital Emergency Room (If member is admitted to the Hospital, notification is required)	No Charge after the Deductible
Emergency Care in Urgi-Center**	No Charge after the Deductible

MATERNITY CARE

Prenatal and Post-natal care**	No Charge after the Deductible
Hospital services for mother and child **	No Charge after the Deductible

SHORT TERM REHABILITATION

60 consec. Inpatient days per condition per lifetime**	No Charge after the Deductible
60 Outpatient visits per condition per lifetime**	No Charge after the Deductible

HOME HEALTH CARE

40 Home care visits per Calendar Year**	No Charge after the Deductible
Physician house calls	No Charge after the Deductible

SKILLED NURSING FACILITY

200 days per Calendar Year **	No Charge after the Deductible
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SUBSTANCE ABUSE

7 days of Inpatient detox. per Calendar Year **	No Charge after the Deductible
30 days of Inpatient rehab. per Calendar Year **	No Charge after the Deductible
60 Outpt rehab. visits per Calendar Year ** (combined w/office visits)	No Charge
60 office visits per Calendar Year **(combined w/outpatient visits)	No Charge

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MENTAL HEALTH CARE

30 days of Inpatient care per Calendar Year **	No Charge after the Deductible
30 Outpatient visits per Calendar Year** (combined w/office visits)	No Charge after the Deductible
30 office visits per Calendar Year** (combined w/outpatient visits)	No Charge after the Deductible

PRESCRIPTION DRUGS Subject to Plan Deductible

(Includes Oral Contraceptives) Generic Drugs****	\$15 copayment
Brand Name Drugs****	50% coinsurance

ALTERNATIVE MEDICINE

Chiropractic care	No Charge after the Deductible
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HOSPICE CARE (210 DAYS)

Inpatient care**	No Charge after the Deductible
Outpatient care**	No Charge after the Deductible

OTHER COVERAGE

Medical Supplies**	No Charge after the Deductible
Durable Medical Equipment** \$1,500 limit per Calendar Year Precertification for items \$500 or more.	No Charge after the Deductible
Exercise Facility Subscriber	\$200 reimbursement per 6 month period
Spouse	\$100 reimbursement per 6 month period

DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 19, or age 23 if a full time student. Benefits discontinue at the end of the Calendar Year.

Domestic Partners are covered with proper documentation.

** These services require **precertification** through Oxford. You must call Oxford at 800-444-6222 at least 14 days in advance of request.

Mental health and substance abuse services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

****Prescription medication ordered through the Mail Order Drug Program are subject to 2 retail pharmacy copays for Generic and 50% copayment for Brand Name Drugs.

The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles and/or maximum limits.

Please Note: This sample summary of coverage is provided for informational purposes only. The applicable Summary of Benefits will be issued to eligible enrolled members as part of the Certificate of Coverage. Coverage is subject to the terms and conditions of the Certificate.

Refer to your Certificate of Coverage for a more complete listing of all benefits, limitations, and exclusions which include, among other services not authorized by Oxford, cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorders, Worker's Compensation, military service-related conditions, hearing aids, or, unless otherwise stated, dental services, and vision correction services and supplies.

Please be advised this quote is for informational purposes only. The information contained herein is subject to both state regulatory and Oxford home office approval as appropriate.