Comparison of Health Care Plans for Part-Time Faculty

This is intended to provide a general overview of benefits. Please refer to each plan's Summary of Plan Benefits for more details and information on other types of services.

Oxford Plans	EPO Plan	Open Access 1000 Plan	
PLAN FEATURES	**In-Network Only**	**In-Network**	**Out-of-Network**
Annual Deductible - the amount of covered expenses that you must pay each calendar year before the plan will make a payment for eligible benefits.			
Individual	None	None	$1,000
Family	None	None	$2,000
Coinsurance[1]	None	None	30%
Individual Out-of-Pocket Maximum[2]	None	None	$4,000
Family Out-of-Pocket Maximum[2]	None	None	$8,000
Lifetime Maximum Plan Benefit	Unlimited	Unlimited	Unlimited
Primary Care Physician Selection	Not required	Not required	Not applicable
Specialist Referral Requirement	Not required	Not required	Not applicable
Precertification Requirements	Not required	Not required	Member responsible for hospital admissions and certain other services
Type of Service			
Physician Services Performed in an Office Setting (Includes Mental Health Practitioners)	$25 Copayment per Primary Care Physician Office Visit $40 Copayment per Specialist Office Visit	$30 Copayment per Office Visit	30% after deductible is met
Preventive Care (includes annual adult physical, well child care, gynecological exams)[3]	Covered 100%	Covered 100%	30% after deductible is met
Inpatient Hospitalization	Covered 100%	Covered 100% after payment of $100 copayment[4]	30% after deductible is met
Outpatient Hospital Care	Covered 100%	Covered 100% after payment of $50 copayment	30% after deductible is met
Maternity	$25 Copayment for initial office visit only; thereafter covered 100%	$30 Copayment for initial office visit only; thereafter covered 100%	30% after deductible is met
Routine Vision Exam	Maximum reimbursement of $50 every 12 months	Maximum reimbursement of $50 every 12 months	Maximum reimbursement of $50 every 12 months
Vision Eyewear	Maximum Reimbursement of $200 every 24 months	Maximum Reimbursement of $200 every 24 months	
Emergency Room Care	$100 Copayment; waived if admitted	$100 Copayment; waived if admitted	$100 Copayment; waived if admitted
Retail Pharmacy Benefit (up to a 30-day or 1 month supply)	$15 Copayment for Generic Drugs $25 Copayment for Formulary Brand-Name Drugs $50 Copayment for Non-Formulary Brand-Name Drugs	$15 Copayment for Generic Drugs $25 Copayment for Formulary Brand-Name Drugs $50 Copayment for Non-Formulary Brand-Name Drugs	Not applicable
Mail Order Pharmacy Benefit (up to a 90-day or 3 months supply)	2x Retail Pharmacy Copayment	2x Retail Pharmacy Copayment	Not applicable

[1]The Coinsurance amount is a percentage of the Usual and Customary Rate (UCR). You are also responsible for amounts charged in excess of the UCR Rate.
[2]Includes Annual Deductible [3]Subject to age and gender guidelines [4] Waived if readmitted within 90 days

9/2011