

A UnitedHealthcare Company

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
FINANCIAL		UCR: 70% of HIAA
Deductible: Single	\$500	\$1,000
Deductible: Family	\$1,000	\$2,000
Coinsurance	10%	30%
Maximum Out-Of-Pocket: Single (Including Deductible)	\$1,500	\$4,000
Maximum Out-Of-Pocket: Family (Including Deductible)	\$3,000	\$8,000
Maximum Lifetime Benefit Per Member	Unlimited	\$1,000,000
PREVENTIVE CARE		
Adult Preventive Care	No charge	In-Network Benefit Only
Infant and Pediatric Preventive Care	No charge	Deductible and 30% Coinsurance \$300 annual maximum
Immunizations	No charge	Deductible and 30% Coinsurance
OUTPATIENT CARE		
Primary Care Physician office visits	\$15 copay per visit	Deductible and 30% Coinsurance
Specialist Office Visits	\$25 copay per visit	Deductible and 30% Coinsurance
Surgery **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Laboratory services	At Participating Laboratories No Charge	Deductible and 30% Coinsurance
Radiology services including PT, CT scans, Magnetic Resonance Imaging (MRI) **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance Precertification is required for Out of Network PET scans, MRAs, surgical endoscopic procedures, MRIs Nuclear. Medicine, CT Scans, and Bone Density Studies.
Screening Mammograms	No charge	Deductible and 30% Coinsurance
ALLERGY CARE		
Initial visit, and all subsequent referral visits	\$25 copay per visit	Deductible and 30% Coinsurance
HOSPITAL CARE		
Physician's and surgeon's services **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Semi-private room and board **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
All drugs and medication	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
EMERGENCY CARE		
Ambulance service when Medically Necessary	Deductible and 10% Coinsurance	Deductible and 10% Coinsurance
At hospital emergency room (If member is admitted to the hospital through the ER, notification is required)	\$100 copay per visit	Deductible and 10% Coinsurance
Emergency Care in Urgi-Center	\$25 copay per visit	Deductible and 30% Coinsurance
MATERNITY CARE		
Prenatal and post-natal care**	\$15 copay per initial visit	Deductible and 30% Coinsurance
Hospital services for mother and child**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
SHORT TERM REHABILITATION		
60 consec. inpatient days per condition / lifetime**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
60 outpatient visits per condition per lifetime	\$25 copay per visit	Deductible and 30% Coinsurance
HOME HEALTH CARE		
40 home care visits**	Subject to 10% Coinsurance	Subject to 25% Coinsurance
Physician house calls	\$25 copay per visit	Deductible and 30% Coinsurance
SKILLED NURSING FACILITY		
200 days per calendar year**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

A UnitedHealthcare Company

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
SUBSTANCE ABUSE		
7 days of inpatient detox. per calendar year **	Deductible and 10% Coinsurance	In-Network Benefit Only
30 days of inpatient rehab. per calendar year **	Deductible and 10% Coinsurance	In-Network Benefit Only
60 outpatient rehab. visits per calendar year **	\$25 copay per visit	Deductible and 30% Coinsurance
MENTAL HEALTH CARE		
30 days of Inpatient care per calendar year**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
30 visits of Outpatient care per calendar year**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Office visits (visits combined with Outpatient care)**	\$25 copay per visit	Deductible and 30% Coinsurance
Biologically Based Mental Health Services & Services for Children with Serious Emotional Disorders (Visits for Biologically based services will count toward Non-Biologically based service limits.)		
Inpatient Care**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Outpatient Care**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Office Visit**	\$25 copay per visit	Deductible and 30% Coinsurance
PRESCRIPTION DRUGS		
	\$50 Deductible (waived for Tier 1 Drugs)	
Tier 1****	\$10 copayment	Covered at Participating Pharmacies Only
Tier 2****	\$25 copayment	Covered at Participating Pharmacies Only
Tier 3****	\$50 copayment	Covered at Participating Pharmacies Only
Includes Contraceptives		
HOSPICE CARE (210 days)		
Inpatient Care**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Outpatient care**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
EXERCISE FACILITY		
Subscriber	\$200 reimbursement per 6 month period	\$200 reimbursement per 6 month period
Spouse	\$100 reimbursement per 6 month period	\$100 reimbursement per 6 month period
OTHER COVERAGE		
Medical supplies, when medically necessary	OUT-OF-NETWORK BENEFIT ONLY	Deductible and 30% Coinsurance
Durable Equipment, when medically necessary **(precert required on items over \$500) (This benefit is limited to \$1500 per calendar year)	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

A UnitedHealthcare Company

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.

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

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

****Prescription medications ordered through the Mail Order Drug Program are subject to two times the applicable retail pharmacy copays for a 90 day supply.

****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.

IMPORTANT: If you live and work in a state other than New York, please check the back of your certificate for extraterritorial benefits rider. Based on the state of your residence, additional coverage may be available to you.

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.