

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
FINANCIAL		70% HIAA
Deductible: Single	None	\$3,000
Deductible: Family	None	\$9,000
Coinsurance	None	30%
Maximum Out-Of-Pocket: Single	Not applicable	\$6,000 (Including Deductible)
Maximum Out-Of-Pocket: Family	Not applicable	\$18,000 (Including Deductible)
Maximum Lifetime Benefit Per Member	Unlimited	Unlimited
PREVENTIVE CARE		
Adult Physical Examination	No Charge	INN only
Routine pediatric care	No Charge	No Charge for preventive care for children through age 19. \$500 annual max payable.
Immunizations	No Charge	No Charge for immunizations for children through age 19. Adults covered INN only.
OUTPATIENT CARE		
Primary Care Physician office visits	\$30 copay per visit	Subject to Deductible & Coinsurance
Specialist Office Visits	\$50 copay per visit	Subject to Deductible & Coinsurance
Surgery **	\$500 copay	Subject to Deductible & Coinsurance
Laboratory services	At Participating Laboratories Only; No Charge	Subject to Deductible & Coinsurance
Magnetic Resonance Imaging (MRI) **	No Charge	Subject to Deductible & Coinsurance
ALLERGY CARE		
Initial visit, and all subsequent referral visits	\$50 copay per visit	Subject to Deductible & Coinsurance
HOSPITAL CARE		
Physician's & surgeon's services	No Charge	Subject to Deductible & Coinsurance**
Semi-private room and board **	\$500 per admission	Subject to Deductible & Coinsurance**
All drugs and medication	No Charge	Subject to Deductible & Coinsurance
EMERGENCY CARE		
Ambulance service when Medically Necessary	No Charge	No Charge
At hospital emergency room (If member is admitted to the Hospital, notification is required)	\$150 copay, waived if admitted	\$150 copay, waived if admitted
Emergency Care in Urgi-Center	\$50 copay per visit	Subject to Deductible & Coinsurance**
MATERNITY CARE		
Prenatal and post-natal care **	\$30 copay per initial visit	Subject to Deductible & Coinsurance**
Hospital services for mother and child**	\$500 per admission	Subject to Deductible & Coinsurance**
SHORT TERM REHABILITATION		
60 consec. inpatient days per condition / lifetime**	\$500 per admission	Subject to Deductible & Coinsurance**
60 outpatient visits per condition/lifetime	\$50 copay per visit	Subject to Deductible & Coinsurance
HOME HEALTH CARE		
40 home care visits**	\$50 copay per visit	Subject to 20% Coinsurance.
Physician house calls	\$50 copay per visit	Subject to Deductible & Coinsurance
SKILLED NURSING FACILITY**		
200 days per calendar year**	\$500 per admission	Subject to Deductible & Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
CHIROPRACTIC CARE		
Chiropractic Care-Unlimited visits	\$50 copay per visit	Subject to Deductible & Coinsurance
SUBSTANCE ABUSE		
7 days of inpatient detoxification per calendar year**	\$500 per admission	Subject to Deductible & 50% coinsurance**
30 days of inpatient rehab. per calendar year**	\$500 per admission	Subject to Deductible & 50% coinsurance**
60 outpatient rehab. visits per calendar year**	No Charge	Subject to Deductible & Coinsurance**
MENTAL HEALTH CARE		
30 days of Inpatient care per Calendar Year**	\$500 per admission	Subject to Deductible & Coinsurance
30 Outpatient visits per Calendar Year**	\$500 copay	Subject to Deductible & Coinsurance
30 Office visits (combined w/outpatient visits)**	\$50 copay per visit	Subject to Deductible & 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**	\$500 per admission	Subject to Deductible & Coinsurance
Outpatient Care**	\$500 copay	Subject to Deductible & Coinsurance
Office Visit**	\$50 copay per visit	Subject to Deductible & Coinsurance
PRESCRIPTION DRUGS		
(Includes Oral Contraceptives)	\$100 Deductible (waived for Tier 1 Drugs)	
Tier 1***	\$15 copayment	Covered at Participating Pharmacies Only
Tier 2***	\$30 copayment	Covered at Participating Pharmacies Only
Tier 3***	\$60 copayment	Covered at Participating Pharmacies Only
	\$3000 maximum per contract year	
HOSPICE CARE (210 days)**		
Inpatient Care	\$500 per admission	Subject to Deductible & Coinsurance
Outpatient Care	\$500 copay	Subject to Deductible & Coinsurance
EXERCISE FACILITY		
Subscriber		\$200 reimbursement per 6 month period
Spouse		\$100 reimbursement per 6 month period
OTHER COVERAGE		
DURABLE MEDICAL EQUIPMENT**	No Charge when ordered by an Oxford Participating Physician	Subject to Deductible & Coinsurance
(When Medically Necessary, this benefit is limited to \$1500 per calendar year. Pre-cert required for items over \$500.)		
Medical supplies, when medically necessary	OUT-OF-NETWORK BENEFIT ONLY	Subject to Deductible & Coinsurance



A UnitedHealthcare Company

OXFORD HEALTH PLANS, INC.
Metro Access
SUMMARY OF COVERAGE
Chamber Benefit Group
Freedom Network

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

*****\$3,000 Maximum**

We will pay a maximum of \$3,000 per Calendar Year for Covered Prescription Drugs.

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.