

BENEFIT IN-NETWORK

FINANCIAL

Deductible: Single	None
Deductible: Family	None
Coinsurance	None
Maximum Out-Of-Pocket: Single	None
Maximum Out-Of-Pocket: Family	None
Maximum Lifetime Benefit Per Member	Unlimited

PREVENTIVE CARE

Physical Examination	No charge
Routine pediatric care	No charge
Immunizations	No charge

OUTPATIENT CARE

Primary Care Physician office visits	\$20 copay per visit
Specialist Office Visits	\$40 copay per visit
Ambulatory surgery **	\$200 per continuous confinement
Laboratory services	No Charge
Radiology Services	No Charge

ALLERGY CARE

Initial visit, and all subsequent visits	\$40 copay per visit
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HOSPITAL CARE

Physician's and surgeon's services **	No Charge
Semi-private room and board **	\$200 per continuous confinement
All drugs and medication	No Charge

EMERGENCY CARE

Ambulance Services	No Charge
Emergency Room Services (If a member is admitted to the hospital, notification is required)	\$75 Copay - Waived if admitted
Emergency Care in Urgi-Center	\$40 copay per visit

MATERNITY CARE

Prenatal and post-natal care	\$20 copay per visit
Hospital services for mother and child **	\$200 per continuous confinement

SHORT TERM REHABILITATION

60 consec. inpatient days per condition / lifetime**	\$200 per continuous confinement
60 outpatient visits per condition/lifetime**	\$40 copay per visit

HOME HEALTH CARE

40 home care visits per calendar year**	\$40 copay per visit
Physician house calls	\$40 copay per visit

SKILLED NURSING FACILITY

200 days per calendar year **	\$200 per continuous confinement
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SUBSTANCE ABUSE

7 days of inpatient detox. per calendar year **	\$200 per continuous confinement
30 days of inpatient rehab. per calendar year **	\$200 per continuous confinement
60 outpt rehab. visits per cal year ** (combined w/office visits)	No Charge
60 office visits per calendar year ** (combined w/outpt visits)	No Charge

BENEFIT **IN-NETWORK**

MENTAL HEALTH CARE

30 days of Inpatient care per Calendar Year **	\$200 per continuous confinement
30 Outpatient visits per Calendar Year** (combined w/office visits)	\$40 copay per visit
30 office visits per Calendar Year** (combined w/outpatient visits)	\$40 copay per visit
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**	\$200 per continuous confinement
Outpatient Care**	\$40 copay per visit
Office visits**	\$40 copay per visit

PRESCRIPTION DRUGS

(Includes Oral Contraceptives)	\$50 Deductible (waived for Tier 1 Drugs)
Tier 1***	\$10 copayment
Tier 2***	\$25 copayment
Tier 3***	\$50 copayment

ALTERNATIVE MEDICINE

Chiropractic care	\$40 copay per visit
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HOSPICE CARE

Inpatient care**	\$200 per continuous confinement
Outpatient care**	\$200 per continuous confinement
210 days per calendar year (combined in/outpatient days)	

EXERCISE FACILITY

Subscriber	\$200 reimbursement per 6 month period
Spouse	\$100 reimbursement per 6 month period

OTHER COVERAGE

DURABLE MEDICAL EQUIPMENT (Items over \$500)** (\$1500 per calendar year combined with Medical Supplies)	No Charge
Medical Supplies (\$1500 per calendar year combined with DME)	No Charge



A UnitedHealthcare Company

OXFORD HEALTH PLANS, INC.
OXFORD EXCLUSIVE PLAN METRO
SUMMARY OF COVERAGE
Freedom
TEIGIT EPO

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 of the same or opposite sex 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 applicable retail pharmacy copays.

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.