

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
FINANCIAL		
Deductible: Single	\$2,850	\$2,850
Family	\$5,700	\$5,700
Coinsurance	10%	30%
Medical Maximum Out-Of-Pocket: Single	\$3,850	\$5,850
(Including Deductible) Family	\$7,700	\$11,700
Maximum Lifetime Benefit Per Member	Unlimited	Unlimited
Financial Accumulation Period:	Calendar Year	Calendar Year
Out-of-Network Reimbursement	N/A	140% Medicare ¹
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	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Specialist Office Visits	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Surgery **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Laboratory services	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Radiology services including PT, CT scans, Magnetic Resonance Imaging (MRI) **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Preventive Mammograms	No Charge	Deductible and 30% Coinsurance
ALLERGY CARE		
Initial visit, and all subsequent referral visits	Deductible and 10% Coinsurance	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	Deductible and 10% Coinsurance	Deductible and 10% Coinsurance
At hospital emergency room	Deductible and 10% Coinsurance	Deductible and 10% Coinsurance
Emergency Care in Urgi-Center**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
MATERNITY CARE		
Prenatal and post-natal care	Deductible and 10% Coinsurance	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	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
HOME HEALTH CARE		
40 home care visits per calendar year**	Deductible and 10% Coinsurance	Subject to 25% Coinsurance
Physician house calls	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
SKILLED NURSING FACILITY		
200 days per calendar year**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

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 outpt rehab. visits per cal yr (combined w/office visits)	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
60 office visits per cal year (combined w/outpatient visits)	Deductible and 10% Coinsurance	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 (combined w/office visits)**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
30 office visits per Calendar Year (combined w/outpatient visits)**	Deductible and 10% Coinsurance	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**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
PRESCRIPTION DRUGS		
Includes Contraceptives	Subject to plan Deductible listed above, then	
Tier 1****	\$10 Copayment	Covered Only at Participating Pharmacies
Tier 2****	\$30 copayment	
Tier 3****	\$60 copayment	
HOSPICE CARE (210 days combined with inpatient and outpatient)		
Inpatient care **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Outpatient care **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
HEARING AIDS		
Coverage is limited to \$1,500. Limited to a single purchase (including repair/replacement) every 3 years.	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
OTHER COVERAGE		
Medical Supplies- non-diabetic**	OUT-OF-NETWORK BENEFIT ONLY	Deductible and 30% Coinsurance
DURABLE MEDICAL EQUIPMENT ** precert required for items over \$500 \$1500 maximum per calendar year.	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Exercise Reimbursement:		
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

DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26. 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 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 2.5 times the applicable retail pharmacy copays for a 90 day supply.

Pharmacy claims are subject to the in-network deductible. Once the deductible has been satisfied, the applicable prescription drug copay will apply based on the option selected at plan inception.

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 the 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, or, unless otherwise stated, dental services, and vision correction services and supplies.

¹ When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.

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.