

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
FINANCIAL		
Deductible: Single	None	\$300
Deductible: Family	None	\$750
Coinsurance	None	20%
Maximum Out-Of-Pocket: Single	Not Applicable	\$1,300 (Including Deductible)
Maximum Out-Of-Pocket: Family	Not Applicable	\$3,250 (Including Deductible)
Maximum Lifetime Benefit Per Member	Unlimited	Unlimited
Out-of-Network Fee Schedule:	N/A	140% Medicare ¹
PREVENTIVE CARE		
Adult Preventive Care	No Charge	IN-NETWORK BENEFIT ONLY
Pediatric Preventive Care	No Charge	Subject to Deductible and Coinsurance (through age 19)
Immunizations	No Charge	No Charge
Preventive dental for children (Under age 12)	No Charge	No charge
Preventive dental for children (Through age 11)	No Charge	No Charge
OUTPATIENT CARE		
Primary Care Physician office visits	\$20 copay per visit	Subject to Deductible & Coinsurance
Specialist Office Visits*	\$20 copay per visit	Subject to Deductible & Coinsurance
Surgery **	No Charge	Subject to Deductible & Coinsurance
Laboratory services	No Charge for UHC Lab Network Providers	Subject to Deductible & Coinsurance
Magnetic Resonance Imaging (MRI) **	No Charge	Subject to Deductible & Coinsurance
ALLERGY CARE		
Initial visit, and all subsequent referral visits*	\$20 copay per visit	Subject to Deductible & Coinsurance
HOSPITAL CARE		
Physician's and surgeon's services **	No Charge	Subject to Deductible & Coinsurance
Semi-private room and board **	\$100 copay per continuous confinement	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 a member is admitted to the hospital, notification is required)	\$50 copay; waived if admitted	\$50 copay; waived if admitted
Emergency Care in Urgi-Center**	\$20 copay per visit	Subject to Deductible & Coinsurance
MATERNITY CARE		
Prenatal and post-natal care **	\$20 copay per initial visit	Subject to Deductible & Coinsurance
Hospital services for mother and child **	\$100 copay per continuous confinement	Subject to Deductible & Coinsurance
SHORT TERM REHABILITATION		
60 consec. inpatient days per condition / lifetime**	\$100 copay per continuous confinement	Subject to Deductible & Coinsurance
90 outpatient visits per condition / lifetime*	\$20 copay per visit	Subject to Deductible & Coinsurance
HOME HEALTH CARE		
60 home care visits **	\$20 copay per visit	Subject to a 20% Coinsurance.
Physician house calls	\$20 copay per visit	Subject to Deductible & Coinsurance
SKILLED NURSING FACILITY		
Unlimited days**	\$100 copay per continuous confinement in a Skilled Nursing Facility	Subject to Deductible & Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
SUBSTANCE ABUSE		
7 days of inpatient detox. per calendar year **	\$100 copay per continuous confinement	IN-NETWORK BENEFIT ONLY
30 days of inpatient rehab. per calendar year **	\$100 copay per continuous confinement	IN-NETWORK BENEFIT ONLY
60 outpatient rehab. visits per calendar year **	No Charge	Subject to Deductible & Coinsurance
MENTAL HEALTH CARE		
30 days of Inpatient care per Calendar Year**	\$100 copay per continuous confinement	Subject to Deductible & Coinsurance
30 Outpatient visits per Calendar Year**	\$20 copay per visit	Subject to Deductible & Coinsurance
30 Office visits (combined w/outpatient visits)**	\$20 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**	\$100 copay per continuous confinement	Subject to Deductible & Coinsurance
Outpatient Care**	\$20 copay per visit	Subject to Deductible & Coinsurance
Office Visit**	\$20 copay per visit	Subject to Deductible & Coinsurance
PRESCRIPTION DRUGS		
(Includes Oral Contraceptives)	\$100 Deductible (Waived for Tier 1 Drugs)	
Tier 1****	\$10 Copayment	Covered at Participating Pharmacies only
Tier 2****	\$30 copayment	
Tier 3****	\$60 copayment	
ALTERNATIVE MEDICINE		
Chiropractic care	\$20 copay per visit	Subject to Deductible and Coinsurance
Acupuncturist care	\$20 copay per visit	IN-NETWORK BENEFIT ONLY
HOSPICE CARE (210 days per Calendar year)		
Inpatient Care**	\$100 copay per continuous confinement	Subject to Deductible & Coinsurance
Outpatient care**	No Charge	Subject to Deductible & Coinsurance
HEARING AIDS		
Coverage is limited to \$1,500. Limited to a single purchase (including repair/replacement) every 3 years.	No Charge	Subject to Deductible & 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		
Durable Medical Equipment ** ** precert required for items over \$500 (This benefit is limited to \$1,500 per calendar year)	No Charge when ordered by a Oxford Participating Physician	Subject to Deductible & Coinsurance
Medical Supplies**	OUT-OF-NETWORK BENEFIT ONLY	Subject to Deductible & Coinsurance

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 of the same sex are covered with proper documentation.

*Visits to an Oxford participating specialist require an authorized referral from your Primary Care Physician.

** 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 2.5 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 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.

¹When 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.