

<b>BENEFIT</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>FINANCIAL</b>		
Deductible: Single	None	\$2,000
Deductible: Family	None	\$6,000
Coinsurance	None	30%
Maximum Out-Of-Pocket: Single	Not applicable	\$5,000 (Including Deductible)
Maximum Out-Of-Pocket: Family	Not applicable	\$15,000 (Including Deductible)
Maximum Lifetime Benefit Per Member	Unlimited	Unlimited
Out-of-Network Reimbursement	N/A	140% of Medicare*
<b>PREVENTIVE CARE</b>		
Adult Preventive Care	No Charge	IN-NETWORK BENEFIT ONLY
Pediatric Preventive Care	No Charge	No Charge
Immunizations	No Charge	No Charge
<b>OUTPATIENT CARE</b>		
Primary Care Physician office visits	\$25 copay per visit	Subject to Deductible & Coinsurance
Specialist Office Visits	\$40 copay per visit	Subject to Deductible & Coinsurance
Surgery **	\$250 copay	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
<b>ALLERGY CARE</b>		
Initial visit, and all subsequent visits	\$40 copay per visit	Subject to Deductible & Coinsurance
<b>HOSPITAL CARE</b>		
Physician's & surgeon's services	No Charge	Subject to Deductible & Coinsurance
Semi-private room and board **	\$250 copay per day (\$1250 Calendar year max.)	Subject to Deductible & Coinsurance
All drugs and medication	No Charge	Subject to Deductible & Coinsurance
<b>EMERGENCY CARE</b>		
Ambulance Service	No Charge	No Charge
At hospital emergency room (If member is admitted to the Hospital, notification is required)	\$75 copay, waived if admitted	\$75 copay, waived if admitted
Emergency Care in Urgi-Center	\$40 copay per visit	Subject to Deductible & Coinsurance
<b>MATERNITY CARE</b>		
Prenatal and post-natal care **	\$25 copay per initial visit	Subject to Deductible & Coinsurance
Hospital services for mother and child**	\$250 copay per day (\$1250 Calendar year max.)	Subject to Deductible & Coinsurance
<b>SHORT TERM REHABILITATION</b>		
60 consec. Inpatient days per condition per lifetime**	\$250 copay per day (\$1250 Calendar year max.)	Subject to Deductible & Coinsurance
60 outpatient visits per condition/lifetime	\$40 copay per visit	Subject to Deductible & Coinsurance
<b>HOME HEALTH CARE</b>		
40 home care visits**	\$40 copay per visit	Subject to 20% Coinsurance.
Physician house calls	\$40 copay per visit	Subject to Deductible & Coinsurance
<b>SKILLED NURSING FACILITY</b>		
200 days per calendar year**	\$250 copay per day (\$1250 Calendar year max.)	Subject to Deductible & Coinsurance
<b>CHIROPRACTIC CARE</b>		
Chiropractic care	\$40 copay per visit	Subject to Deductible & Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>SUBSTANCE ABUSE</b>		
7 days of Inpatient detox. per Calendar Year**	\$250 copay per day (\$1250 Calendar year max.)	Subject to Deductible & 50% Coinsurance
30 days of Inpatient rehab. per Calendar Year**	\$250 copay per day (\$1250 Calendar year max.)	Subject to Deductible & 50% Coinsurance
60 Outpatient rehab. visits per Calendar Year**	No Charge	Subject to Deductible & Coinsurance
<b>MENTAL HEALTH CARE</b>		
30 days of Inpatient care per Calendar Year**	\$250 copay per day (\$1250 Calendar year max.)	Subject to Deductible & Coinsurance
30 Outpatient visits per Calendar Year**	\$40 copay per visit	Subject to Deductible & Coinsurance
30 Office visits (combined w/outpatient visits)**	\$40 copay per visit	Subject to Deductible & Coinsurance
<b>HOSPICE CARE (210 days)</b>		
Inpatient Care	\$250 copay per day (\$1250 Calendar year max.)	Subject to Deductible & Coinsurance
Outpatient Care	\$250 copay	Subject to Deductible & Coinsurance
<b>EXERCISE FACILITY</b>		
Subscriber		\$200 reimbursement per 6 month period
Spouse		\$100 reimbursement per 6 month period
<b>OTHER COVERAGE</b>		
Medical Supplies**	OUT-OF-NETWORK BENEFIT ONLY	Subject to Deductible & Coinsurance
Durable Medical Equipment** \$1500 limit per Calendar Year Precertification for items \$500 or more.	No Charge	Subject to Deductible & Coinsurance

**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.

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, 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.**

\*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.