



OXFORD USASM
New York Small Groups
SAMPLE SUMMARY OF COVERAGE
 Oxford Health Insurance, Inc.

<u>Plan Options</u>	<u>Copay</u>	<u>Deductible</u>	<u>Coinsurance Max.</u>
Plan 1:	\$10	\$250	\$1,500
Plan 2:	\$15	\$250	\$1,500
Plan 3:	\$15	\$500	\$1,500
Plan 4:	\$15	\$1,000	\$3,000
Plan 5:	\$20	\$500	\$3,000
Plan 6:	\$20	\$1,000	\$3,000

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
FINANCIAL		UCR: HIAA 70%
Deductible: Single	None	See plan options
Family	None	2.5X single deductible
Coinsurance	None	30%. See plan for coinsurance max.
<i>Coinsurance maximums shown above reflect the maximum coinsurance outlay by the Member. These numbers do not include the deductible.</i>		
<i>Family Coinsurance maximums are capped at 250% of the single maximum.</i>		
Maximum Lifetime Benefit Per Member	Unlimited	Unlimited
PREVENTIVE CARE		
Physical Examination	No Charge	Not Covered for adults
Well Woman Care	No Charge	
Routine pediatric care & Immunizations	No Charge	Subject to Deductible & Coinsurance for children through age 19.
Immunizations	No Charge	Not Covered for adults
Preventive dental for children (Under age 12)	No Charge	No Charge
OUTPATIENT CARE		
Physician Office Visit Copay	As chosen in plan design	Subject to Deductible & Coinsurance
Surgery	No Charge	Subject to Deductible & Coinsurance
Laboratory services	No Charge	Subject to Deductible & Coinsurance
Radiology Services, including MRI, CAT scans, and others	No Charge	Subject to Deductible & Coinsurance
HOSPITAL CARE		
Physician's and surgeon's services	No Charge	Subject to Deductible & Coinsurance
Semi-private room and board	No Charge	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	\$50 copay; waived if admitted	Unauthorized admissions are Subject to Deductible & 50% Coinsurance
Emergency Care in Urgi-Center	Office Visit copay	Subject to Deductible & Coinsurance
MATERNITY CARE		
Prenatal and post-natal care	Office Visit copay for initial visit	Subject to Deductible & Coinsurance
Hospital services for mother and child	No Charge	Subject to Deductible & Coinsurance
SHORT-TERM REHABILITATION		
60 consec. inpatient days per condition / lifetime	No Charge	Subject to Deductible & Coinsurance
90 outpatient visits per condition / lifetime	Office Visit copay	Subject to Deductible & Coinsurance

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BENEFIT	IN-NETWORK	OUT-OF-NETWORK
HOME HEALTH CARE		
60 home care visits	Office Visit copay	Subject to a 20% Coinsurance
Physician house calls	Office Visit copay	Subject to Deductible & Coinsurance
SKILLED NURSING FACILITY		
200 days per calendar year	No Charge	Subject to Deductible & Coinsurance
SUBSTANCE ABUSE		
7 days of inpatient detox. per calendar year	No Charge	IN-NETWORK BENEFIT ONLY
30 days of inpatient rehab. per calendar year	No Charge	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	No Charge	IN-NETWORK BENEFIT ONLY
30 outpatient visits per calendar year	50% copayment	After Deductible, \$25 max. benefit per visit.
PRESCRIPTION DRUGS (includes oral contraceptives)		
Generic/Preferred Brand/ Brand Copay options:	\$5/\$15/\$50 or \$7/\$20/\$50	Not Covered
Annual Deductible options: (Annual Deductibles are waived for Generics)	\$0, \$50, or \$100	Not Covered
CHIROPRACTIC CARE		
Chiropractic care	Office Visit copay	Subject to Deductible & Coinsurance
HOSPICE CARE (210 days)		
Inpatient care	No Charge	Subject to Deductible & Coinsurance
Outpatient care	No Charge	Subject to Deductible & Coinsurance
Home Health	Office Visit copay	Subject to Deductible & Coinsurance
INFERTILITY TREATMENT (\$10,000 per lifetime)		
Specialist office visits	Office Visit copay	IN-NETWORK BENEFIT ONLY
Outpatient facility services	No Charge	IN-NETWORK BENEFIT ONLY
EXERCISE FACILITY		
Subscriber	\$100 reimbursement per 6 month period	\$100 reimbursement per 6 month period
Spouse	\$50 reimbursement per 6 month period	\$50 reimbursement per 6 month period
OTHER COVERAGE		
Durable Equipment, when medically necessary	For items over \$500, pre-certified by Oxford in advance and ordered by an Oxford Participating Physician	Subject to Deductible & Coinsurance
Medical Supplies, when medically necessary	OUT-OF-NETWORK BENEFIT ONLY	Subject to Deductible & Coinsurance
Vision Care (must be purchased as a rider):	OUT-OF-NETWORK BENEFIT ONLY	\$50 per year for examination, \$70 every 24 months for appliances.

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.

Employees who live and work in a state other than New York, New Jersey or Connecticut should check the Extraterritorial Benefits rider at the back of their Certificate of coverage. Based on state of residence, additional Covered Services may be available.

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.