

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>FINANCIAL</b>		
Deductible: Single	\$2,000	\$2,000
Family	\$5,000	\$5,000
Coinsurance	20%	40%
Maximum Out-Of-Pocket: Single	\$4,000	\$6,000
(Including Deductible) Family	\$10,000	\$15,000
Maximum Lifetime Benefit Per Member	Unlimited	\$1,000,000
Financial Accumulation Period:	Calendar Year	Calendar Year
Out-of-Network Reimbursement	N/A	140% Medicare <sup>1</sup>
<b>PREVENTIVE CARE</b>		
Adult Preventive Care	No Charge	In-Network Benefit Only
Infant and Pediatric Preventive Care	No Charge	Deductible and 40% Coinsurance \$300 annual maximum
Immunizations	No Charge	Deductible and 40% Coinsurance
<b>OUTPATIENT CARE</b>		
Primary Care Physician office visits	\$30 copay per visit	Deductible and 40% Coinsurance
Specialist Office Visits	\$50 copay per visit	Deductible and 40% Coinsurance
Surgery **	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Laboratory services	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Radiology services including PT, CT scans, Magnetic Resonance Imaging (MRI) **	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance Precertification is required for Out of Network PET scans, MRAs, surgical endoscopic prodedures, MRIs Nuclear Medicine, CT Scans, and Bone Density Studies.
Screening Mammograms	Covered at 100%	Deductible and 40% Coinsurance
<b>ALLERGY CARE</b>		
Initial visit, and all subsequent referral visits	\$50 copay per visit	Deductible and 40% Coinsurance
<b>HOSPITAL CARE</b>		
Physician's and surgeon's services **	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Semi-private room and board **	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
All drugs and medication	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
<b>EMERGENCY CARE</b>		
Ambulance service when Medically Necessary At hospital emergency room (If member is admitted to the hospital through the ER, notification is required)	Deductible and 20% Coinsurance \$200 copay per visit	Deductible and 20% Coinsurance Deductible and 20% Coinsurance
Emergency Care in Urgi-Center	\$50 copay per visit	Deductible and 40% Coinsurance
<b>MATERNITY CARE</b>		
Prenatal and post-natal care	\$30 copay per visit	Deductible and 40% Coinsurance
Hospital services for mother and child **	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
<b>SHORT TERM REHABILITATION</b>		
60 consec. inpatient days per condition / lifetime**	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
60 outpatient visits per condition per lifetime	\$50 copay per visit	Deductible and 40% Coinsurance
<b>HOME HEALTH CARE</b>		
40 home care visits **	Subject to 20% Coinsurance	Subject to 25% Coinsurance
Physician house calls	\$50 copay per visit	Deductible and 40% Coinsurance
<b>SKILLED NURSING FACILITY</b>		
200 days per calendar year**	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>SUBSTANCE ABUSE</b>		
7 days of inpatient detox. per calendar year **	Deductible and 20% Coinsurance	In-Network Benefit Only
30 days of inpatient rehab. per calendar year **	Deductible and 20% Coinsurance	In-Network Benefit Only
60 outpatient rehab. visits per calendar year	\$50 copay per visit	Deductible and 40% Coinsurance
<b>MENTAL HEALTH CARE</b>		
30 days of Inpatient care per calendar year**	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
30 visits of Outpatient care per calendar year**	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Office visits (visits combined with Outpatient care)**	\$50 copay per visit	Deductible and 40% Coinsurance
<b>PRESCRIPTION DRUGS      \$100 Deductible (Waived for Generic Drugs)</b>		
Generic Drugs****	\$15 copayment	Covered at Participating Pharmacies Only
Brand Name Drugs****	50% coinsurance	Covered at Participating Pharmacies Only
Includes Contraceptives		
<b>HOSPICE CARE (210 DAYS)</b>		
Inpatient care**	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Outpatient care**	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
<b>EXERCISE FACILITY</b>		
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
<b>HEARING AIDS</b>		
Coverage is limited to \$1,500. Limited to a single purchase (including repair/replacement) every 3 years.	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
<b>OTHER ITEMS</b>		
Medical supplies, when medically necessary	OUT-OF-NETWORK BENEFIT ONLY	Deductible and 40% Coinsurance
Durable Equipment, when Medically Necessary	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
** (precert required on items over \$500) (This benefit is limited to \$1500 per calendar year.)		

**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 retail pharmacy copays for Generic Drugs and 50% coinsurance for Brand Name Drugs.

\*\*\*\*The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles.

**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.

**IMPORTANT:** If you live and work in a state other than New York, please check the back of your certificate for extraterritorial benefits rider. Based on the state of your residence, additional coverage may be available to you.

<sup>1</sup> 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.**