The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.welcometouhc.com/oxford. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-444-6222 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,000 Individual / $6,000 Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $7,900 Individual / $15,800 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://www.oxfordhealth.com/shopny or call 1-800-444-6222 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. A written approval is required to see a specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

[1]Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc., Oxford Health Plans (NJ), Inc., and Oxford Health Plans (CT), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc.

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All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit, deductible does not apply	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	$70 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No coverage Non-Network.
If you have a test	Diagnostic test (x-ray, blood work)	$15 copay per service	Not Covered	none
	Imaging (CT/PET scans, MRIs)	$115 copay per service	Not Covered	none
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.oxfordhealth.com/shopny	Tier 1	Retail: $5 copay, deductible does not apply Mail-Order: $12.50 copay, deductible does not apply	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30-day supply Mail Order: Up to a 90-day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. Certain preventive medications (including certain contraceptives) are covered at No Charge. Prescription drug costs are subject to the annual deductible. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2	Retail: $65 copay Mail-Order: $162.50 copay	Not Covered	
	Tier 3	Retail: $90 copay Mail-Order: $225 copay	Not Covered	
	Tier 4	Not Applicable	Not Applicable	Tier not applicable for this plan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Ctr /Office: $250 copay per visit Hospital: $500 copay per visit	Not Covered	none
	Physician/surgeon fees	30% coinsurance	Not Covered	none
If you need immediate medical attention	Emergency room care	50% coinsurance*	50% coinsurance*	*Network Deductible Applies.
	Emergency medical transportation	No Charge	No Charge	none
	Urgent care	$70 copay per visit, deductible does not apply	Not Covered	none
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 copay per day up to a maximum of $1,600 max per admission	Not Covered	none
	Physician/surgeon fees	30% coinsurance	Not Covered	none
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$70 copay per visit, deductible does not apply	Not Covered	Network partial hospitalization/intensive outpatient treatment: $70 copay per visit, deductible does not apply.
	Inpatient services	$400 copay per day up to a maximum of $1,600 max per admission	Not Covered	none
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	Not Covered	
	Childbirth/delivery facility services	$400 copay per day up to a maximum of $1,600 max per admission	Not Covered	Inpatient preauthorization may apply.
If you need help	Home health care	$70 copay per visit,	Not Covered	Limited to 40 visits per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
recovering or have other special health needs		deductible does not apply		
	Rehabilitation services	$70 copay per outpatient visit	Not Covered	Limits per calendar year: Physical, speech and occupational therapy combined limit 60 visits.
	Habilitation services	$70 copay per outpatient visit	Not Covered	Limits per calendar year: Physical, speech and occupational therapy combined limit 60 visits.
	Skilled nursing care	$400 copay per day up to a maximum of $1,600 max per admission	Not Covered	Limited to Limited to 200 days per calendar year.
	Durable medical equipment	30% coinsurance	Not Covered	Preauthorization required for DME over $500 or there is no coverage.
	Hospice services	$400 copay per day up to a maximum of $1,600 max per admission	Not Covered	none
If your child needs dental or eye care	Children's eye exam	$15 copay per visit, deductible does not apply	Not Covered	Limited to 1 exam per 12-month period. Covered for individuals up to the age of 19.
	Children's glasses	50% coinsurance, deductible does not apply	Not Covered	Limited to 1 set of appliances in a 12-month period. Covered for individuals up to the age of 19.
	Children's dental check-up	0% coinsurance	Not Covered	Limited to 1 exam per 6-month period. Covered for individuals up to the age of 19.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment – Cycle limits may apply.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov/index.htm.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-633-2446.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,000
Specialist copay	$70
Hospital (facility) copay	$400
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$800
Coinsurance	$60
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,920

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist copay	$70
Hospital (facility) copay	$400
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$3,630

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist copay	$70
Hospital (facility) copay	$400
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,270

The plan would be responsible for the other costs of these EXAMPLE covered services.