# Summary of Benefits and Coverage: What This Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the chart starting on page 2 for your other costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No, there are no other deductibles.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes, Network: $2,000 Individual/$4,000 Family</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premium, balance-billed charges and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No, this policy has no overall annual limit on the amount it will pay each year.</td>
<td>The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see welcometouhc.com/oxford or call 1-800-444-6222.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>Yes. Written approval is required to see a specialist.</td>
<td>This plan will pay some or all of the costs to see a specialist but only if you have the plan’s permission before you see the specialist for covered services.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

Notes:

- 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. Administrative services provided by Oxford Health Plans LLC.

Questions: Call 1-800-444-6222 or oxfordhealth.com. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at dol.gov/ebisa/healthreform or cciio.cms.gov, or call the telephone numbers above to request a copy. **This is only a summary.** It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents for complete terms of this plan.
### Summary of Benefits and Coverage: What This Plan Covers & What it Costs

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if You Use a Participating Provider</th>
<th>Your Cost if You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
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<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copay per visit</td>
<td>Not Covered</td>
<td>If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$35 copay per visit</td>
<td>Not Covered</td>
<td>If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$35 copay per visit</td>
<td>Not Covered</td>
<td>Cost Share applies for only Manipulative (Chiropractic) Services.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Includes preventive health services specified in the health care reform law.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$35 copay per service</td>
<td>Not Covered</td>
<td>Pre-Authorization required for Sleep Studies or benefit reduces to 50% of allowed.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$35 copay per service</td>
<td>Not Covered</td>
<td>---none---</td>
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<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Your Lowest-Cost Option</td>
<td>Retail: $10 copay Mail-Order: $25 copay</td>
<td>Not Covered</td>
<td>Provider means pharmacy for purposes of this section. Retail: Up to a 31 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 pre-authorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 Contraceptives covered at No Charge.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at oxfordhealth.com.</td>
<td>Tier 2 - Your Mid-Range Cost Option</td>
<td>Retail: $30 copay Mail-Order: $75 copay</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Your Highest-Cost Option</td>
<td>Retail: $60 copay Mail-Order: $150 copay</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Additional High-Cost Options</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100 copay per visit</td>
<td>Not Covered</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>---none---</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$100 copay per visit</td>
<td>$100 copay per visit</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$100 copay per transport</td>
<td>$100 copay per transport</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$55 copay per visit</td>
<td>Not Covered</td>
<td>If you receive services in addition to urgent care, additional copays, deductibles or co-ins may apply.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$500 copay per admission</td>
<td>Not Covered</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No Charge</td>
<td>Not Covered</td>
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<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>$15 copay per visit</td>
<td>Not Covered</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$500 copay per admission</td>
<td>Not Covered</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$15 copay per visit</td>
<td>Not Covered</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$500 copay per admission</td>
<td>Not Covered</td>
<td>---none---</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Additional copays, deductibles, or co-ins may apply depending on services rendered.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$500 copay per admission</td>
<td>Not Covered</td>
<td>---none---</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>$15 copay per visit</td>
<td>Not Covered</td>
<td>Limited to 40 days per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$25 copay per outpatient visit</td>
<td>Not Covered</td>
<td>Depending on the type of therapy, there is a limit of 60 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Habilitative services</td>
<td>$25 copay per visit</td>
<td>Not Covered</td>
<td>Depending on the type of therapy, there is a limit of 60 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$500 copay per admission</td>
<td>Not Covered</td>
<td>Limited to 200 days per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% co-ins</td>
<td>Not Covered</td>
<td>Pre-Authorization required for items over $500.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>$500 copay per admission</td>
<td>Not Covered</td>
<td>Limited to 210 days (combined inpatient, and home hospice) per calendar year.</td>
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</thead>
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<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>$15 copay per visit</td>
<td>Not Covered</td>
<td>Limited to one exam per calendar year. Covered for Individuals up to the age of 19.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>10% co-ins</td>
<td>Not Covered</td>
<td>Limited to one set of appliances per calendar year. Covered for Individuals up to the age of 19.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>$15 copay per visit</td>
<td>Not Covered</td>
<td>Limited to one exam per 6-month period. Covered for Individuals up to the age of 19.</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)
- Acupuncture
- Cosmetic surgery
- Dental check-up (adult)
- Glasses (adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

#### Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)
- Bariatric surgery
- Chiropractic Care
- Hearing aids
- Infertility treatment
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Your Rights to Continue Coverage:
Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-444-6222. You may also contact your state insurance department, New York Department of Financial Services at 1-800-342-3736 or dfs.ny.gov/index.html.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

- New York Department of Financial Services at 1-800-342-3736 or dfs.ny.gov/index.html.
- Additionally, a consumer assistance program can help you file your appeal. Contact communityhealthadvocates.org or 1-888-614-5400.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage”. This plan or policy does provide minimum essential coverage.

Language Access Services:
Para obtener asistencia en Español, llame al 1-866-633-2446.
如果需要中文的帮助，请拨打这个号码 1-866-633-2446.
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 page
### Coverage Examples

#### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

#### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan Pays:** $6,440
- **Patient Pays:** $1,100

**Sample care costs:**
- Hospital charges (mother): $2,700
- Routine obstetric care: $2,100
- Hospital charges (baby): $900
- Anesthesia: $900
- Laboratory tests: $500
- Prescriptions: $200
- Radiology: $200
- Vaccines, other preventive: $40

**Total:** $7,540

**Patient pays:**
- Deductibles: $0
- Copays: $900
- Coinsurance: $0
- Limits or exclusions: $200

**Total:** $1,100

#### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan Pays:** $4,160
- **Patient Pays:** $1,240

**Sample care costs:**
- Prescriptions: $2,900
- Medical Equipment and Supplies: $1,300
- Office Visits and Procedures: $700
- Education: $300
- Laboratory tests: $100
- Vaccines, other preventive: $100

**Total:** $5,400

**Patient pays:**
- Deductibles: $0
- Copays: $1,200
- Coinsurance: $0
- Limits or exclusions: $40

**Total:** $1,240

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This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.
Coverage Examples

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the examples.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

X No. Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

X No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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