This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.oxhp.com or by calling 1-800-444-6222.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes, **$100** for Pharmacy expenses. There are no other deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no out-of-pocket limit.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the insurer pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.oxhp.com or call 1-800-444-6222 for a list of participating providers.	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. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	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**.

[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. Administrative services provided by Oxford Health Plans LLC.

- **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**, **co-payments** and **co-insurance amounts**.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not covered.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$40 copay per visit	Not covered.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$40 copay per visit for Manipulative (Chiropractic) Services .	Not covered.	Pre-Authorization required or benefit reduces to 50% of allowed
	Preventive care/screening/immunization	No Charge	Not covered.	Includes preventive health services specified in the health care reform law. No Coverage Non-Network
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not covered.	X-rays: 50% up to a max of $100 Participating Lab network providers.
	Imaging (CT/PET scans, MRIs)	50% up to a max of $100	Not covered.	---none---

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.oxhp.com	Generic drugs	Retail: $10 copay Mail Order: $$25.00 copay	Not covered.	Retail: Up to a 31-day supply Mail Order: Up to a 90-day supply Oral Contraceptives Tier 1 covered at No Charge Deductible waived for Tier 1 drugs. Not all drugs are covered.
	Preferred brand drugs	Retail: $30 copay Mail Order: $$75.00 copay	Not covered.	Retail: Up to a 31-day supply Mail Order: Up to a 90-day supply Oral Contraceptives Tier 1 covered at No Charge Deductible waived for Tier 1 drugs. Not all drugs are covered.
	Non-preferred brand drugs	Retail: $60 copay Mail Order: $$150.00 copay	Not covered.	Retail: Up to a 31-day supply Mail Order: Up to a 90-day supply Oral Contraceptives Tier 1 covered at No Charge Deductible waived for Tier 1 drugs. Not all drugs are covered.
	Specialty drugs	Not Applicable	Not Applicable	Tier is Not Applicable for this Plan
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay per visit	Not covered.	Pre-Authorization required or benefit reduces to 50% of allowed
	Physician/surgeon fees	No Charge	Not covered.	---none---
If you need immediate medical attention	Emergency room services	$200 copay per visit	Not covered.	---none---
	Emergency medical transportation	No Charge	No Charge	---none---
	Urgent care	$40 copay per visit	Not covered.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay per day up to 5 days.	Not covered.	Pre-Authorization required or benefit reduces to 50% of allowed
	Physician/surgeon fee	No Charge	Not covered.	---none---

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay per visit	Not covered.	Limited to 30 visits per calendar year. Biological Outpatient is Unlimited. Pre-Authorization required or benefit reduces to 50% of allowed
	Mental/Behavioral health inpatient services	$200 copay per day up to 5 days.	Not covered.	Limited to 30 visits per calendar year. Biological Inpatient is Unlimited. Pre-Authorization required or benefit reduces to 50% of allowed
	Substance use disorder outpatient services	$40 copay per visit	Not covered.	Limited to 60 visits per calendar year Pre-Authorization required or benefit reduces to 50% of allowed
	Substance use disorder inpatient services	$200 copay per day up to 5 days.	Not covered.	Limited to 30 days per calendar year Pre-Authorization required or benefit reduces to 50% of allowed
If you are pregnant	Prenatal and postnatal care	$20 copay per visit (per initial visit).	Not covered.	Routine Prenatal care covered at No Charge Additional copays, deductibles, coins and Notification may apply.
	Delivery and all inpatient services	$200 copay per day up to 5 days.	Not covered.	Pre-Authorization required or benefit reduces to 50% of allowed
If you need help recovering or have other special health needs	Home health care	$40 copay per visit	Not covered.	Limited to 40 visits per calendar year
	Rehabilitation services	$40 copay per visit	Not covered.	Depending on the type of therapy, there is a limit of 60 visits per condition per lifetime. Pre-Authorization required or benefit reduces to 50% of allowed
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services
	Skilled nursing care	$200 copay per day up to 5 days.	Not covered.	Limited to 200 days per calendar year. Pre-Authorization required or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Durable medical equipment	0% co-ins	Not covered.	Limited to $1,500 maximum per calendar year if the benefit/device is determined to be non-essential. Pre-Authorization required for items over $500.
	Hospice service	$200 copay per day up to 5 days.	Not covered.	Limited to 210 days per calendar year Inpatient Pre-Authorization required or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for Eye exam
	Glasses	Not Covered	Not Covered	No coverage for Glasses
	Dental check-up	No Charge	No Charge	For Children (through age 11) limited to 1 visit per calendar year

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
- Long-term care
- Routine eye care (Adult)
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Dental care (Adult)
- Private-duty nursing
- 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 - may be covered with limitations
- Infertility treatment - may be covered with limitations
- Chiropractic care
- Hearing aids - may be covered with limitations

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-444-6222. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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: your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit http://www.dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or visit http://www.dfs.ny.gov/index.htm. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http:///ciio.cms.gov/prgrams/consumer/capgrants/index.html

- Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.
- **若需要中文协助，请拨打您会员卡上的电话号码**
- **Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih**
- **Para sa tulong sa Tagalog, tawagan ang numero sa iyong ID card.**

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

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.

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.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,060
- **Patient pays** $480

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	$20
Copays	$220
Coinsurance	$90
Limits or exclusions	$150
Total	**$480**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,620
- **Patient pays** $780

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	$100
Copays	$600
Coinsurance	$0
Limits or exclusions	$80
Total	**$780**

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 to the U.S.Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same policy 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?

✗ **No.** Treatments shown are just examples.The care you would receive for these conditions 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?

✗ **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 your 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 Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for 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 also should 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.