UnitedHealthcare Oxford

**OXFORD HEALTH INSURANCE, INC.**
**EPO PLAN**
**SUMMARY OF COVERAGE**
**Liberty Network**
**Parkshore Home Health Care, LLC**
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| BENEFIT | | In-Network |
|---|---|---|
| **FINANCIAL** | | |
| Deductible: | Single | $2,000 |
| | Family | $4,000 |
| Coinsurance | | 20% |
| Maximum Out-of-Pocket: | Single | $5,500 |
| (Including Deductible) | Family | $11,000 |
| Financial Accumulation Period: | | Calendar Year |

*Please Note: All Copayments, Deductibles, and Coinsurance (medical and prescription) paid for In-Network Covered Services contribute to the In-Network, Out-of-Pocket Maximum.*

| | |
|---|---|
| **PREVENTIVE CARE** | |
| Adult Preventive Care | No Charge |
| Infant and Pediatric Preventive Care | No Charge |
| **OUTPATIENT CARE** | |
| Primary Care Physician Office Visits | $25 copay per visit |
| Specialist Office Visits | $40 copay per visit |
| Outpatient Surgery - Hospital Setting | Deductible and 20% Coinsurance |
| Outpatient Surgery - Freestanding Facility | Deductible and 20% Coinsurance |
| Laboratory Services Participating | No Charge |
| *(See your Certificate of Coverage for additional Lab details)* | |
| Radiology Services | Deductible and 20% Coinsurance |
| **MRIs, MRAs, CT SCANS, AND PET SCANS** | |
| Outpatient Hospital Services | Deductible and 20% Coinsurance |
| Freestanding Radiology Facility | Deductible and 20% Coinsurance |
| **HOSPITAL CARE** | |
| Physician's and Surgeon's Services | Deductible and 20% Coinsurance |
| Semi-Private Room and Board | Deductible and 20% Coinsurance |
| All Drugs and Medication | Deductible and 20% Coinsurance |
| **EMERGENCY CARE** | |
| Ambulance Service when Medically Necessary | No Charge |
| At Hospital Emergency Room | $400 copay per visit; waived if admitted |
| *(If member is admitted to the hospital, notification is required)* | |
| Emergency Care in Urgi-Center | $40 copay per visit |
| **MATERNITY CARE** | |
| Routine Prenatal and Post-Natal Care | No Charge |
| Hospital Services for Mother and Child | Deductible and 20% Coinsurance |
| **SKILLED NURSING FACILITY** | |
| 30 Days per Calendar Year | Deductible and 20% Coinsurance |
| **HOSPICE CARE** | |
| Inpatient Care | Deductible and 20% Coinsurance |
| Home Hospice Care Visits | $40 copay per visit |
| **HOME HEALTH CARE** | |
| Home Care Visits - 60 Visits per Calendar Year | $40 copay per visit |
| Physician House Calls | $40 copay per visit |
| **SUBSTANCE USE DISORDER SERVICES** | |
| Inpatient Rehabilitation | Deductible and 20% Coinsurance |
| Office Visits or Outpatient Rehabilitation | $40 copay per visit |
| Outpatient Partial Hospitalization | No Charge after Deductible |
| **MENTAL HEALTH CARE** | |
| Inpatient Care | Deductible and 20% Coinsurance |
| Office Visits or Outpatient Care | $40 copay per visit |
| Outpatient Partial Hospitalization | No Charge after Deductible |
| **ALLERGY CARE** | |
| Testing and Treatment | $40 copay per visit |
| **CHIROPRACTIC CARE** | |
| Chiropractic Care | $40 copay per visit |

| BENEFIT | In-Network |
|---|---|
| **SHORT TERM REHAB OR HABILITATIVE SERVICES** | |
| Inpatient limited to 60 Days per Calendar Year | Deductible and 20% Coinsurance |
| Outpatient limited to 60 combined PT/OT/ST Visits per Calendar Year | $40 copay per visit |
| **DURABLE MEDICAL EQUIPMENT** | |
| Unlimited<br>*(Precert required for items over $500)* | Deductible and 20% Coinsurance |
| **HEARING AIDS** | |
| Limited to a single purchase (including repair/replacement) every 3 Years. | Deductible and 20% Coinsurance |
| **MEDICAL SUPPLIES** | |
| Medical Supplies when Medically Necessary | Deductible and 20% Coinsurance |
| **EXERCISE FACILITY** | |
| Subscriber | $200 reimbursement per 6 month period |
| Spouse | $100 reimbursement per 6 month period |
| **OUTPATIENT PRESCRIPTION DRUGS - RETAIL** | |
| *The Prescription Drug Benefit is based on a per Calendar Year limit for any applicable deductibles and/or maximum limits.* | |
| Tier 1 | $15 copay |
| Tier 2 | $35 copay |
| Tier 3 | $75 copay |
| **OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER** | |
| Tier 1 | $37.50 copay |
| Tier 2 | $87.50 copay |
| Tier 3 | $187.50 copay |

**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

**Please be advised this sample summary of coverage is provided for informational purposes only. The information contained herein is subject to the approval of the New York Department of Insurance and Oxford home office approval as appropriate. 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, Workers' Compensation, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.

UnitedHealthcare Oxford

**OXFORD HEALTH INSURANCE, INC.**
**EPO PLAN**
**SUMMARY OF COVERAGE**
**Metro Network**
**Parkshore Home Healthcare**

| BENEFIT | | In-Network |
|---|---|---|
| **FINANCIAL** | | |
| Deductible: | Single | $1,250 |
| | Family | $2,500* |
| Coinsurance | | 20% |
| Maximum Out-of-Pocket: | Single | $4,500 |
| (Including Deductible) | Family | $9,000 |
| Financial Accumulation Period: | | Calendar Year |

*Please Note: All Copayments, Deductibles, and Coinsurance (medical and prescription) paid for In-Network Covered Services contribute to the In-Network, Out-of-Pocket Maximum.*

| | |
|---|---|
| **PREVENTIVE CARE** | |
| Adult Preventive Care | No Charge |
| Infant and Pediatric Preventive Care | No Charge |
| **OUTPATIENT CARE** | |
| Primary Care Physician Office Visits | $25 copay per visit |
| Specialist Office Visits** | $40 copay per visit |
| Outpatient Surgery - Hospital Setting*** | Deductible then $500 copay per visit |
| Outpatient Surgery - Freestanding Facility*** | Deductible then $200 copay per visit |
| Laboratory Services Participating*** | No Charge |
| *(See your Certificate of Coverage for additional Lab details)* | |
| Radiology Services*** | $35 copay per visit |
| **MRIs, MRAs, PET SCAN & CT SCAN** | |
| Outpatient Hospital Services*** | Deductible then $250 copay per visit |
| Freestanding Radiology Facility*** | Deductible then $50 copay per visit |
| **HOSPITAL CARE** | |
| Physician's and Surgeon's Services *** | Deductible & 20% Coinsurance |
| Semi-Private Room and Board *** | Deductible & 20% Coinsurance |
| All Drugs and Medication | Deductible & 20% Coinsurance |
| **EMERGENCY CARE** | |
| Ambulance Service when Medically Necessary *** | No Charge |
| At Hospital Emergency Room | $400 copay per visit; waived if admitted |
| *(If member is admitted to the hospital, notification is required)* | |
| Emergency Care in Urgi-Center | $65 copay per visit |
| **MATERNITY CARE** | |
| Routine Prenatal and Post-Natal Care*** | No Charge |
| Hospital Services for Mother and Child*** | Deductible & 20% Coinsurance |
| **SKILLED NURSING FACILITY** | |
| 30 Days per Calendar Year** | Deductible & 20% Coinsurance |
| **HOSPICE CARE** | |
| Inpatient Care*** | Deductible & 20% Coinsurance |
| Home Hospice Care*** | $40 copay per visit |
| **HOME HEALTH CARE** | |
| Home Care Visits - 60 Visits per Calendar Year*** | $40 copay per visit |
| Physician House Calls*** | $40 copay per visit |
| **SUBSTANCE USE DISORDER SERVICES** | |
| Inpatient Rehabilitation*** | Deductible & 20% Coinsurance |
| Outpatient Rehabilitation | $40 copay per visit |
| Office Visits | $40 copay per visit |
| **MENTAL HEALTH CARE** | |
| Inpatient Care*** | Deductible & 20% Coinsurance |
| Outpatient Care | $40 copay per visit |
| Office Visits | $40 copay per visit |
| **ALLERGY CARE** | |
| Testing and Treatment*** | $40 copay per visit |
| **CHIROPRACTIC CARE** | |
| Chiropractic Care*** | $40 copay per visit |

| BENEFIT | In-Network |
|---|---|
| **SHORT TERM REHAB OR HABILITATIVE SERVICES** | |
| 60 Inpatient Days per Calendar Year*** | Deductible & 20% Coinsurance |
| Outpatient limited to 60 combined PT/OT/ST Visits per Calendar Year*** | $40 copay per visit |
| **DURABLE MEDICAL EQUIPMENT** | |
| Unlimited*** | Deductible & 20% Coinsurance |
| *(Precert required for items over $500)* | |
| **HEARING AIDS** | |
| Limited to a single purchase (including repair/replacement) every 3 Years. | Deductible & 20% Coinsurance |
| **MEDICAL SUPPLIES** | |
| Medical Supplies when Medically Necessary*** | Deductible & 20% Coinsurance |
| **EXERCISE FACILITY** | |
| Subscriber | $200 reimbursement per 6 month period |
| Spouse | $100 reimbursement per 6 month period |
| **OUTPATIENT PRESCRIPTION DRUGS - RETAIL** | |
| *The Prescription Drug Benefit is based on a per Calendar Year limit for any applicable deductibles and/or maximum limits.* | |
| Tier 1 | $5 copay |
| Tier 2 | $65 copay |
| Tier 3 | 50% up to $800 per script |
| **OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER** | |
| Tier 1 | $12.50 copay |
| Tier 2 | $162.50 copay |
| Tier 3 | 50% up to $2,000 per script |

**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

*If you have a family contract, the entire family Deductible must be satisfied before coverage under this Plan is available. A family contract is a Plan that covers you and one or more dependents.

**In-Network visits to an Oxford Participating Specialist require an authorized referral from the member's PCP.

***These services require **precertification** through Oxford. Members must call Oxford at 1-800-444-6222 at least 14 days in advance of treatment to request precertification.

***Mental health and substance use disorder services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

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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, Workers' Compensation, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.