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 http://www.dol.gov/ebsa/healthreform or http://www.cciio.cms.gov/ 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 Contract 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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 preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, Prescription drugs -- **$100** per person, does not apply to Tier 1 drugs. 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.
What is the out-of-pocket limit for this plan?	Network: **$6,850** Individual/**$13,700** 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?	Premium 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 www.welcometouhc.com/oxford 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?	No.	You can see the specialist you choose without a referral.

[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.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating 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	$30 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	$75 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.
	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.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: No Charge X-ray: 40% coinsurance	Not covered	none
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	none
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at oxfordhealth.com	Tier 1	Retail: $15 copay Mail Order: $37.50 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. Certain preventive medications (including certain contraceptives) are covered at No Charge.
	Tier 2	Retail: $65 copay Mail Order: $162.50 copay	Not covered	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Tier 3	Retail: 50% coinsurance with a $800 maximum Mail Order: 50% coinsurance with a $2,000 maximum	Not covered	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 4	Not Applicable	Not Applicable	Tier is Not Applicable for this Plan
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	none
	Physician/surgeon fees	40% coinsurance	Not covered	none
If you need immediate medical attention	Emergency room care	$500 copay per visit*	$500 copay per visit*	*Participating Deductible Applies.
	Emergency medical transportation	No Charge	No Charge	none
	Urgent care	$80 copay per visit, deductible does not apply	Not covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	none
	Physician/surgeon fee	40% coinsurance	Not covered	none
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$75 copay per visit, deductible does not apply	Not covered	none
	Inpatient services	40% coinsurance	Not covered	none
If you are pregnant				

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Office visits	No Charge	Not covered	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.).
	Childbirth/delivery professional services	40% coinsurance	Not covered	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.).
	Childbirth/delivery facility services	40% coinsurance	Not covered	Inpatient preauthorization may apply.
If you need help recovering or have other special health needs	Home health care	$75 copay per visit, deductible does not apply	Not covered	Limited to 40 visits per calendar year.
	Rehabilitation services	$75 copay per outpatient visit, deductible does not apply	Not covered	Any combination of outpatient rehabilitation services is limited to 60 visits per calendar year.
	Habilitative services	$75 copay per outpatient visit, deductible does not apply	Not covered	Limits per calendar year: Physical/Occupational/Speech: combined limit 60 visits.
	Skilled nursing care	40% coinsurance	Not covered	200 days per calendar year.
	Durable medical equipment	40% coinsurance	Not covered	Preauthorization required for items over $500.
	Hospice service	40% coinsurance	Not covered	none
If your child needs dental or eye care	Children's eye exam	$30 copay per visit, deductible does not apply	Not Covered	1 exam per 12-month period. Covered for Individuals up to the age of 19.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Children's glasses	50% coinsurance, deductible does not apply	Not Covered	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	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 other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Infertility treatment - Cycle limits may apply
- Bariatric surgery - limitations may apply
- Chiropractic (Manipulative) care
- Hearing aids

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: dfs.ny.gov/index.htm, 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 options to continue coverage are 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 dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or 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 page.

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**	$3000.00
■ **Specialist *copayment***	$75
■ **Hospital (facility) *coinsurance***	40%
■ **Other *coinsurance***	40%

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	$30
Coinsurance	$2,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,990**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	$3000.00
■ **Specialist *copayment***	$75
■ **Hospital (facility) *coinsurance***	40%
■ **Other *coinsurance***	40%

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	$300
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,130**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	$3000.00
■ **Specialist *copayment***	$75
■ **Hospital (facility) *coinsurance***	40%
■ **Other *coinsurance***	40%

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	$900
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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