MILLENNIUM MEDICAL SOLUTIONS
A Passion for Creative Benefits Solutions

Call (855) 667-4621

UnitedHealthcare Oxford

Benefit and Premium Details

Here are the number of contracts and total premiums per contract type.

HEALTHY NY For Small Businesses www.HealthyNY.com

Benefits	
Metallic Level	Gold
Product/Network/Gatekeeper	G HNY HMO Metro Gated OHP
In-Network Copayment	$25/$40
Out-of-Network Reimbursement	N/A
In-Network Coinsurance %	80%
In-Network Maximum Out of Pocket	$4000/$8000
In-Network Deductible	$600/$1200
Out-of-Network Coinsurance %	N/A
Out-of-Network Maximum Out of Pocket	N/A
Out-of-Network Deductible	N/A
Deductible Accumulation Period	Contract Year
Riders	
Pharmacy Rider	$10/$35/$70
Dependent Student Cutoff Age	26 Dependent – Standard
Domestic Partner	No

Premium Information

	Tier Rate
Single	$560.57
Couple	$1,121.13
Parent w/Children	$952.96
Family	$1,597.61

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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 welcometouhc.com/oxford or by calling 1-800-444-6222.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$600** Individual/**$1,200** Family Per Contract Year. Pharmacy drugs, and services listed below as "No Charge" do not apply to the **deductible.**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No, there are no other **deductibles**.	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.
Is there an out-of-pocket limit on my expenses?	Yes, Network: **$4,000** Individual/**$8,000** Family.	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.
What is not included in the out-of-pocket limit?	Premium, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No. This policy has no overall annual limit on the amount it will pay each year.	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. 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.	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**.
Do I need a referral to see a specialist?	Yes. Written approval is required to see a **specialist**.	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.
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.

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**, **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	$25 copay per visit after ded	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 after ded	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 after ded	Not covered	Cost share applies for only Manipulative (Chiropractic) Services.
	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)	$40 copay per service after ded	Not covered	Pre-Authorization required for Sleep Studies or benefit reduces to 50% of allowed
	Imaging (CT/PET scans, MRIs)	$40 copay per service after ded	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 oxfordhealth.com	Tier 1 - Your Lowest-Cost Option	Retail: $10 copay Mail Order: $25 copay	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. Tier 1 Contraceptives covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $35 copay Mail Order: $88 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.
	Tier 3 - Your Highest-Cost Option	Retail: $70 copay Mail Order: $175 copay	Not covered	---none---
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	Tier is Not Applicable for this Plan
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay per visit after ded	Not covered	---none---
	Physician/surgeon fees	$100 copay per visit after ded	Not covered	---none---
If you need immediate medical attention	Emergency room services	$150 copay per visit after ded*	$150 copay per visit after ded*	*Participating Deductible Applies
	Emergency medical transportation	$150 copay per transport after ded*	$150 copay per transport after ded*	*Participating Deductible Applies
	Urgent care	$60 copay per visit after ded	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)	$1,000 copay per admission after ded	Not covered	---none---
	Physician/surgeon fee	$100 copay per visit after ded	Not covered	---none---

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

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	$25 copay per visit after ded	Not covered	Other Network Outpatient Services: Deductible then 0% co-ins
	Mental/Behavioral health inpatient services	$1,000 copay per admission after ded	Not covered	---none---
	Substance use disorder outpatient services	$25 copay per visit after ded	Not covered	Other Network Outpatient Services: Deductible then 0% co-ins
	Substance use disorder inpatient services	$1,000 copay per admission after ded	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	$25 copay per visit after ded (per initial visit).	Not covered	Network routine prenatal care covered at No Charge. Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	$1,000 copay per admission after ded	Not covered	Inpatient Authorization may apply.
If you need help recovering or have other special health needs	Home health care	$25 copay per visit after ded	Not covered	Limited to 40 visits per calendar year.
	Rehabilitation services	$30 copay per outpatient visit after ded	Not covered	Depending on the type of therapy, there is a limit of 60 visits per calendar year.
	Habilitative services	$30 copay per outpatient visit after ded	Not covered	Depending on the type of therapy, there is a limit of 60 visits per calendar year.
	Skilled nursing care	$1,000 copay per admission after ded	Not covered	Limited to 200 days per calendar year.
	Durable medical equipment	20% co-ins after ded	Not covered	Pre-Authorization required for items over $500.
	Hospice service	$1,000 copay per admission after ded	Not covered	---none---

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

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 your child needs dental or eye care	Eye exam	$25 copay per visit after ded	Not Covered	Limited to 1 exam per calendar year. Covered for Individuals up to the age of 19.
	Glasses	20% co-ins after ded	Not Covered	Limited to 1 set of appliances per calendar year Covered for Individuals up to the age of 19.
	Dental check-up	$25 copay per visit after ded	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 Does NOT Cover (This isn't a complete list. 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 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 - limitations may apply
- Chiropractic care
- Hearing aids - limitations may apply
- Infertility treatment - limitations may apply

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 dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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 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.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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.
- Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 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:

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** $5,240
- **Patient pays** $2,300

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	$600
Copays	$1,500
Coinsurance	$0
Limits or exclusions	$200
Total	**$2,300**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,560
- **Patient pays** $1,840

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	$600
Copays	$1,200
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,840**

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 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 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.