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?	Network:**$1,000** Individual/**$2,000** Family Per Calendar Year. Does not apply to copays, pharmacy drugs, and services listed below as "No Charge".	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?	Yes, Prescription drugs -- **$100 Individual / $200 Family**. 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?	**$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, health care this plan doesn't cover, penalties for failure to obtain pre-authorization for services.	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 insurer 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 www.oxhp.com 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. 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?	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 6. 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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit	Not covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$60 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	$60 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	Radiology: $35 copay per service. $500 max per calendar year. Pre-Authorization required for Sleep Studies or benefit reduces to 50% of allowed
	Imaging (CT/PET scans, MRIs)	$100 copay per service. $500 max per calendar year.	Not covered	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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.oxhp.com	Tier 1 - Your Lowest-Cost Option	Retail: $15 copay Mail Order: $38 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. Pharmacy Deductible does not apply to Tier 1.
	Tier 2 - Your Midrange-Cost Option	Retail: $35 copay Mail Order: $88 copay	Not covered	You may need to obtain certain drugs, including certain speciality 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: $75 copay Mail Order: $188 copay	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 - 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)	$250 copay per visit after ded	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	0% co-ins after ded	---none---
	Urgent care	$75 copay per visit	Not covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.

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 a hospital stay	Facility fee (e.g., hospital room)	$500 copay per day. $2,000 max per admission after ded.	Not covered	Pre-Authorization required or benefit reduces to 50% of allowed
	Physician/surgeon fee	No Charge	Not covered	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60 copay per visit	Not covered	---none---
	Mental/Behavioral health inpatient services	$500 copay per day. $2,000 max per admission after ded.	Not covered	Pre-Authorization required or benefit reduces to 50% of allowed
	Substance use disorder outpatient services	$60 copay per visit	Not covered	---none---
	Substance use disorder inpatient services	$500 copay per day. $2,000 max per admission after ded.	Not covered	Pre-Authorization required or benefit reduces to 50% of allowed
If you are pregnant	Prenatal and postnatal care	$30 copay per visit (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	$500 copay per day. $2,000 max per admission after ded.	Not covered	Inpatient Authorization may apply.
If you need help recovering or have other special health needs	Home health care	$60 copay per visit	Not covered	Limited to 40 visits per calendar year. Pre-Authorization required or benefit reduces to 50% of allowed
	Rehabilitation services	$60 copay per outpatient visit	Not covered	Depending on the type of therapy, there is a limit of 60 visits per calendar year (combined with Habilitative Service). 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
	Habilitative services	$60 copay per outpatient visit	Not covered	Pre-Authorization required for certain services or benefit reduces to 50% of allowed. Services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	$500 copay per day. $2,000 max per admission after ded.	Not covered	Limited to 200 days per calendar year. Pre-Authorization required or benefit reduces to 50% of allowed.
	Durable medical equipment	No Charge	Not covered	Pre-Authorization required for items over $500
	Hospice service	$500 copay per day. $2,000 max per admission after ded.	Not covered	Limited to 210 days combined (Inpatient & Home) per lifetime. Inpatient Pre-Authorization required or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Eye exam	$30 copay per visit	Not covered	Limited to 1 exam per calendar year.. Covered for Individuals up to the age of 19.
	Glasses	50% co-ins	Not covered	Covered for Individuals up to the age of 19.
	Dental check-up	No Charge	No Charge	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 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

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 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** $5,840
- **Patient pays** $1,700

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	$1,020
Copays	$530
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,700**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,230
- **Patient pays** $2,170

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	$1,100
Copays	$990
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,170**

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.