UnitedHealthcare Oxford

OXFORD HEALTH INSURANCE, INC.
Gold EPO 15/30 Metro - Gated
SUMMARY OF COVERAGE
Group Name
Metro Network

G EPO 15/30 Metro Gated OHI
Single Rate Cost:
month
$649.78

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	$750	Not Covered
	Family	$1,500	Not Covered
Coinsurance		20%	Not Covered
Maximum Out-Of-Pocket:	Single	$3,500	Not Covered
(Including Deductible)	Family	$7,000	Not Covered
Financial Accumulation Period:		Contract Year	Not Applicable
Out-of-Network Reimbursement:		Not Applicable	Not Applicable
PREVENTIVE CARE			
Adult Preventive Care		No Charge	Not Covered
Infant and Pediatric Preventive Care		No Charge	Not Covered
Preventive Dental for Children (Up to age 19)		No Charge after Deductible	Not Covered
Pediatric Vision Exam (Up to age 19)		$15 copay per visit	Not Covered
Pediatric Vision Hardware (Up to age 19)		50% Coinsurance	Not Covered
OUTPATIENT CARE			
Primary Care Physician Office Visits		$15 copay per visit	Not Covered
Specialist Office Visits*		$30 copay per visit	Not Covered
Outpatient Surgery - Hospital Setting		Deductible then $500 copay	Not Covered
Outpatient Surgery - Freestanding Facility		Deductible then $200 copay	Not Covered
Laboratory Services		No Charge	Not Covered
Radiology Services		$35 copay per service.	Not Covered
MRIs, MRAs, CT SCANS, AND PET SCANS			
Outpatient Hospital Services		Deductible then $250 copay	Not Covered
Freestanding Radiology Facility		Deductible then $50 copay	Not Covered
HOSPITAL CARE			
Physician's and Surgeon's Services		Deductible & 20% Coinsurance	Not Covered
Semi-Private Room and Board		Deductible & 20% Coinsurance	Not Covered
All Drugs and Medication		Deductible & 20% Coinsurance	Not Covered
EMERGENCY CARE			
Ambulance Service When Medically Necessary		Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
At Hospital Emergency Room *(waived if admitted)*		$400 copay per visit	$400 copay per visit
(If member is admitted to the hospital, notification is required.)			
Emergency Care in Urgi-Center		$65 copay per visit	Not Covered
MATERNITY CARE			
Prenatal and Post-Natal Care		No Charge	Not Covered
Hospital Services for Mother and Child		Deductible & 20% Coinsurance	Not Covered
SKILLED NURSING FACILITY			
200 days per Calendar Year.		Deductible & 20% Coinsurance	Not Covered
HOSPICE CARE			
Inpatient Care		Deductible & 20% Coinsurance	Not Covered
Home Hospice - Unlimited.		$30 copay per visit	Not Covered
HOME HEALTH CARE			
Home Care Visits - 40 visits per Calendar Year.		$30 copay per visit	Not Covered
Physician House Calls		$30 copay per visit	Not Covered
SUBSTANCE USE DISORDER SERVICES			
Inpatient Rehabilitation		Deductible & 20% Coinsurance	Not Covered
Outpatient Rehabilitation		$30 copay per visit	Not Covered
Outpatient Partial Hospitalization		No Charge after Deductible	Not Covered

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.*

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
Inpatient Care	Deductible & 20% Coinsurance	Not Covered
Outpatient Visits	$30 copay per visit	Not Covered
Outpatient Partial Hospitalization	No Charge after Deductible	Not Covered
ALLERGY CARE		
Testing and Treatment	$30 copay per visit	Not Covered
ALTERNATIVE MEDICINE		
Chiropractic Care - Unlimited Visits	$30 copay per visit	Not Covered
SHORT TERM REHAB & HABILITATIVE SERVICES		
Inpatient limited to 60 days per Calendar Year.	Deductible & 20% Coinsurance	Not Covered
Outpatient limited to 60 visits per Calendar Year.	$30 copay per visit	Not Covered
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment - Unlimited. *Precertification required for items over $500*	Deductible & 20% Coinsurance	Not Covered
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary	Deductible & 20% Coinsurance	Not Covered
HEARING AIDS		
Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	Deductible & 20% Coinsurance	Not Covered
EXERCISE FACILITY		
Subscriber	$200 reimbursement per 6 month period	Not Covered
Spouse	$100 reimbursement per 6 month period	Not Covered
OUTPATIENT PRESCRIPTION DRUGS - RETAIL		
The Prescription Drug Benefit is based on a Per Contract Year limit for any applicable deductibles and/or maximum limits.		
Tier 1	$5 copay	Not Covered
Tier 2	$65 copay	Not Covered
Tier 3	50% Coinsurance max $800	Not Covered
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	$12.50 copay	Not Covered
Tier 2	$162.50 copay	Not Covered
Tier 3	50% Coinsurance max $2,000	Not Covered

DEPENDENT ELIGIBILITY:
Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.

*Visits to an Oxford participating Specialist require an authorized referral from the member's Primary Care Physician.

Please Note: This sample summary of coverage is provided for informational purposes only. 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, Worker's Compensation, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.

Benefits are subject to final approval by the Department of Insurance and therefore may be subject to change.