UnitedHealthcare Oxford

**OXFORD HEALTH INSURANCE, INC.**
**Platinum EPO 10/20 Metro - Gated**
**SUMMARY OF COVERAGE**
**Group Name**
**Metro Network**

**PLATINUM**
**10/20 Metro Gated**
**OHI**
**Single Rate Cost:**
**$751.61**
/ month

| BENEFIT | | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|---|
| **FINANCIAL** | | | |
| Deductible: | Single | None | Not Covered |
| | Family | None | Not Covered |
| Coinsurance | | None | Not Covered |
| Maximum Out-Of-Pocket: | Single | $3,000 | Not Covered |
| (Including Deductible) | Family | $6,000 | Not Covered |
| Financial Accumulation Period: | | Contract Year | Not Applicable |
| Out-of-Network Reimbursement: | | Not Applicable | Not Applicable |

***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 | Not Covered |
| Infant and Pediatric Preventive Care | No Charge | Not Covered |
| Preventive Dental for Children (Up to age 19) | No Charge | Not Covered |
| Pediatric Vision Exam (Up to age 19) | $10 copay per visit | Not Covered |
| Pediatric Vision Hardware (Up to age 19) | 50% Coinsurance | Not Covered |
| **OUTPATIENT CARE** | | |
| Primary Care Physician Office Visits | $10 copay per visit | Not Covered |
| Specialist Office Visits* | $20 copay per visit | Not Covered |
| Outpatient Surgery - Hospital Setting | $500 copay per service | Not Covered |
| Outpatient Surgery - Freestanding Facility | $100 copay per service | Not Covered |
| Laboratory Services | No Charge | Not Covered |
| Radiology Services | $20 copay per service. | Not Covered |
| **MRIs, MRAs, CT SCANS, AND PET SCANS** | | |
| Outpatient Hospital Services | $150 copay per service | Not Covered |
| Freestanding Radiology Facility | No Charge | Not Covered |
| **HOSPITAL CARE** | | |
| Physician's and Surgeon's Services | No Charge | Not Covered |
| Semi-Private Room and Board | $200 copay per day. $800 max per admission | Not Covered |
| All Drugs and Medication | No Charge | Not Covered |
| **EMERGENCY CARE** | | |
| Ambulance Service When Medically Necessary | No Charge | No Charge |
| At Hospital Emergency Room *(waived if admitted)* | $200 copay per visit | $200 copay per visit |
| *(If member is admitted to the hospital, notification is required.)* | | |
| Emergency Care in Urgi-Center | $50 copay per visit | Not Covered |
| **MATERNITY CARE** | | |
| Prenatal and Post-Natal Care | No Charge | Not Covered |
| Hospital Services for Mother and Child | $200 copay per day. $800 max per admission | Not Covered |
| **SKILLED NURSING FACILITY** | | |
| 200 days per Calendar Year. | $200 copay per day. $800 max per admission | Not Covered |
| **HOSPICE CARE** | | |
| Inpatient Care | $200 copay per day. $800 max per admission | Not Covered |
| Home Hospice - Unlimited. | $20 copay per visit | Not Covered |
| **HOME HEALTH CARE** | | |
| Home Care Visits - 40 visits per Calendar Year. | $20 copay per visit | Not Covered |
| Physician House Calls | $20 copay per visit | Not Covered |
| **SUBSTANCE USE DISORDER SERVICES** | | |
| Inpatient Rehabilitation | $200 copay per day. $800 max per admission | Not Covered |
| Outpatient Rehabilitation | $20 copay per visit | Not Covered |
| Outpatient Partial Hospitalization | No Charge after Deductible | Not Covered |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **MENTAL HEALTH CARE** | | |
| Inpatient Care | $200 copay per day. $800 max per admission | Not Covered |
| Outpatient Visits | $20 copay per visit | Not Covered |
| Outpatient Partial Hospitalization | No Charge after Deductible | Not Covered |
| **ALLERGY CARE** | | |
| Testing and Treatment | $20 copay per visit | Not Covered |
| **ALTERNATIVE MEDICINE** | | |
| Chiropractic Care - Unlimited Visits | $20 copay per visit | Not Covered |
| **SHORT TERM REHAB & HABILITATIVE SERVICES** | | |
| Inpatient limited to 60 days per Calendar Year. | $200 copay per day. $800 max per admission | Not Covered |
| Outpatient limited to 60 visits per Calendar Year. | $20 copay per visit | Not Covered |
| **DURABLE MEDICAL EQUIPMENT** | | |
| Durable Medical Equipment - Unlimited.<br>*Precertification required for items over $500* | No Charge | Not Covered |
| **MEDICAL SUPPLIES** | | |
| Medical Supplies When Medically Necessary | No Charge | Not Covered |
| **HEARING AIDS** | | |
| Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years. | No Charge | 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.***