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: **$1,250** Individual/**$2,500** Family Per Calendar 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: **$3,750** Individual/**$7,500** 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 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?	No.	You can see the **specialist** you choose without permission from this plan.
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 Network Provider	Your Cost if you use a Non-Network 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	Not covered	---none---
	Specialist visit	$40 copay per visit	Not covered	---none---
	Other practitioner office visit	$30 copay per visit	Not covered	Cost share applies for only Manipulative (Chiropractic) Services and is limited to 30 visits per calendar year
	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: Deductible then 20% co-ins. Pre-Authorization required for Sleep Studies or benefit reduces to 50% of allowed
	Imaging (CT/PET scans, MRIs)	Free Standing Provider /Physician's Office: $100 copay per service after ded Hospital-Based: 50% co-ins 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 Network Provider	Your Cost if you use a Non-Network 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: $25 copay Mail Order: $50 copay	Not covered	Provider means pharmacy for purposes of this section. Retail: Up to a 90-day supply. Copays shown are for 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: $50 copay Mail Order: $100 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.
	Tier 3 - Your Highest-Cost Option	Retail: $75 copay Mail Order: $150 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)	Free Standing Provider /Physician's Office: $40 copay per visit Hospital-Based: $150 copay per visit	Not covered	---none---
	Physician/surgeon fees	20% co-ins after ded	Not covered	---none---
If you need immediate medical attention	Emergency room services	$100 copay per visit then 20% co-ins	$100 copay per visit then 20% co-ins	Copay waived if admitted to the hospital.
	Emergency medical transportation	20% co-ins after ded*	20% co-ins after ded*	*Network Deductible Applies.
	Urgent care	$50 copay per visit	Not covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins after ded	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost if you use a Network Provider	Your Cost if you use a Non-Network Provider	Limitations & Exceptions
	Physician/surgeon fee	20% co-ins after ded	Not covered	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay per visit	Not covered	Other Network Outpatient Services: No Charge
	Mental/Behavioral health inpatient services	20% co-ins after ded	Not covered	---none---
	Substance use disorder outpatient services	$40 copay per visit	Not covered	Other Network Outpatient Services: No Charge
	Substance use disorder inpatient services	20% co-ins after ded	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	No Charge	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	20% co-ins after ded	Not covered	Inpatient Authorization may apply.
If you need help recovering or have other special health needs	Home health care	$40 copay per visit	Not covered	Limited to 60 visits per calendar year.
	Rehabilitation services	$40 copay per outpatient visit	Not covered	Depending on the type of therapy, there is a limit of 30 visits PT/OT combined per calendar year.
	Habilitative services	$40 copay per outpatient visit	Not covered	Limited to 30 visits PT/OT combined per calendar year. Limits do not apply to Autism.
	Skilled nursing care	20% co-ins after ded	Not covered	---none---
	Durable medical equipment	No Charge	Not covered	Pre-Authorization required for items over $500.
	Hospice service	20% co-ins after ded	Not covered	---none---
If your child needs dental or eye care	Eye exam	$25 copay per visit	Not Covered	Limited to one exam every 12 months. Covered for Individuals up to the age of 19.
	Glasses	50% co-ins	Not Covered	Limited to one pair every 12 months. Covered for Individuals up to the age of 19.

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 Network Provider	Your Cost if you use a Non-Network Provider	Limitations & Exceptions
	Dental check-up	0% co-ins after ded	Not Covered	Limited to one exam and cleaning 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.
- 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 (through age 15)
- Infertility treatment (Artificial Insemination only)
- Private-duty nursing for Home Health care

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 Jersey Department of Banking and Insurance at 1-800-446-7467 or state.nj.us/dobi/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 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** $5,120
- **Patient pays** $2,420

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	$1,300
Copays	$20
Coinsurance	$900
Limits or exclusions	$200
Total	**$2,420**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,160
- **Patient pays** $2,240

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	$200
Copays	$2,000
Coinsurance	$0
Limits or exclusions	$40
Total	**$2,240**

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.

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាបង់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).