**OXFORD HEALTH INSURANCE, INC.**
**NY B MTRO GT 7000/100 EPO HSA 23 - Gated**
**SUMMARY OF COVERAGE**
**0**
**Metro Network**

| BENEFIT | | IN-NETWORK |
|---|---|---|
| **FINANCIAL** | | |
| Deductible: | Single* | $7,000 |
| | Family | $14,000 |
| Coinsurance: | | None |
| Maximum Out-Of-Pocket: | Single | $7,000 |
| (Including Deductible) | Family | $14,000 |
| Financial Accumulation Period: | | Policy Year |
| Out-of-Network Reimbursement: | | 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.*

**If you have a family contract, the entire family Deductible must be satisfied before coverage under this Plan is available. A family contract is a Plan that covers you and one or more dependents.*

| | |
|---|---|
| **PREVENTIVE CARE** | |
| Adult Preventive Care | No Charge |
| Infant and Pediatric Preventive Care | No Charge |
| Preventive Dental for Children (Up to age 19) | No Charge after Deductible |
| Pediatric Vision Exam (Up to age 19) | No Charge |
| Pediatric Vision Hardware (Up to age 19) | Deductible & 50% Coinsurance |
| **OUTPATIENT CARE** | |
| Primary Care Physician Office Visits | No Charge after Deductible |
| Specialist Office Visits* | No Charge after Deductible |
| Virtual Visits | No Charge after Deductible |
| Outpatient Surgery - Hospital Setting | No Charge after Deductible |
| Outpatient Surgery - Freestanding Facility | No Charge after Deductible |
| Laboratory Services | No Charge after Deductible |
| Radiology Services | No Charge after Deductible |
| **DIABETIC SUPPLIES AND MEDICATIONS** | |
| Diabetic Supplies | No Charge after Deductible |
| Diabetic Medications | No Charge after Deductible |
| **MRIs, MRAs, CT SCANS, AND PET SCANS** | |
| Outpatient Hospital Services | No Charge after Deductible |
| Freestanding Radiology Facility | No Charge after Deductible |
| **HOSPITAL CARE** | |
| Physician's and Surgeon's Services | No Charge after Deductible |
| Semi-Private Room and Board | No Charge after Deductible |
| All Drugs and Medication | No Charge after Deductible |
| **EMERGENCY CARE** | |
| Ambulance Service When Medically Necessary | No Charge after Deductible |
| At Hospital Emergency Room *(waived if admitted)* | No Charge after Deductible |
| *(If member is admitted to the hospital, notification is required.)* | |
| Emergency Care in Urgi-Center | No Charge after Deductible |
| **MATERNITY CARE** | |
| Prenatal and Post-Natal Care | No Charge |
| Hospital Services for Mother and Child | No Charge after Deductible |
| **SKILLED NURSING FACILITY** | |
| 200 days per Plan Year. | No Charge after Deductible |
| **HOSPICE CARE** | |
| Inpatient Care | No Charge after Deductible |
| Home Hospice - Unlimited. | No Charge after Deductible |
| **HOME HEALTH CARE** | |
| Home Care Visits - 40 visits per Plan Year. | No Charge after Deductible |
| Physician House Calls | No Charge after Deductible |
| **SUBSTANCE USE DISORDER SERVICES** | |
| Inpatient Rehabilitation | No Charge after Deductible |
| Outpatient Rehabilitation | No Charge after Deductible |
| Outpatient Partial Hospitalization | No Charge after Deductible |

| BENEFIT | IN-NETWORK |
|---|---|
| **MENTAL HEALTH CARE** | |
| Inpatient Care | No Charge after Deductible |
| Outpatient Visits | No Charge after Deductible |
| Outpatient Partial Hospitalization | No Charge after Deductible |
| **ALLERGY CARE** | |
| Testing and Treatment | No Charge after Deductible |
| **ALTERNATIVE MEDICINE** | |
| Chiropractic Care - Unlimited Visits | No Charge after Deductible |
| **SHORT TERM REHABILITATION** | |
| Inpatient - Limited to 60 combined PT/OT/ST days per Plan Year. | No Charge after Deductible |
| Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year. | No Charge after Deductible |
| **HABILITATIVE SERVICES** | |
| Inpatient - Limited to 60 combined PT/OT/ST days per Plan Year. | No Charge after Deductible |
| Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year. | No Charge after Deductible |
| **DURABLE MEDICAL EQUIPMENT** | |
| Durable Medical Equipment - Unlimited.<br>*Precertification required for items over $500* | No Charge after Deductible |
| **MEDICAL SUPPLIES** | |
| Medical Supplies When Medically Necessary | No Charge after Deductible |
| **HEARING AIDS** | |
| Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years. | No Charge after Deductible |
| **EXERCISE FACILITY** | |
| Subscriber | $200 reimbursement per 6 month period |
| Spouse/Dependents over age 13 | $100 reimbursement per 6 month period |
| **OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE** | Subject to Plan Deductible listed above |
| **OUTPATIENT PRESCRIPTION DRUGS - RETAIL** | |
| *The Prescription Drug Benefit is based on a Per Policy Year limit for any applicable deductibles and/or maximum limits.* | |
| Tier 1 | No Charge after Deductible |
| Tier 2 | No Charge after Deductible |
| Tier 3 | No Charge after Deductible |
| **OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER** | |
| Tier 1 | No Charge after Deductible |
| Tier 2 | No Charge after Deductible |
| Tier 3 | No Charge after Deductible |

**DEPENDENT ELIGIBILITY:**

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

A Dependent who has attained the above limiting age can continue coverage until they reach age 30 subject to the eligibility requirements outlined in the Certificate.

Domestic Partners are covered with proper documentation.

*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.***