UnitedHealthcare Oxford

OXFORD HEALTH INSURANCE, INC.
DIRECT PLAN
SUMMARY OF COVERAGE
Freedom Network
Jewish Theological Seminary

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	$500	$2,000
	Family	$1,000	$4,000
Coinsurance		10%	30%
Maximum Out-of-Pocket:	Single	$2,000	$4,500
(Including Deductible)	Family	$4,000	$9,000
Financial Accumulation Period:		Calendar Year	Calendar Year
Out-of-Network Reimbursement:		Not Applicable	High UCR[1]

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	In-Network Benefit Only***
Infant and Pediatric Preventive Care	No Charge	Deductible & 30% Coinsurance
OUTPATIENT CARE		
Primary Care Physician Office Visits	$25 copay per visit	Deductible & 30% Coinsurance
Specialist Office Visits	$40 copay per visit	Deductible & 30% Coinsurance
Outpatient Surgery - Hospital Setting**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Outpatient Surgery - Freestanding Facility**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Laboratory Services Participating**	No Charge	Deductible & 30% Coinsurance
(See your Certificate of Coverage for additional Lab details)		
Radiology Services**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
DIABETIC SUPPLIES AND MEDICATIONS		
Diabetic Supplies**	$25 copay per visit	Deductible & 30% Coinsurance
Diabetic Medications**	$25 copay per visit	Deductible & 30% Coinsurance
MRIs, MRAs, CT SCANS, AND PET SCANS		
Outpatient Hospital Services**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Freestanding Radiology Facility**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
HOSPITAL CARE		
Physician's and Surgeon's Services**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Semi-Private Room and Board**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
All Drugs and Medication	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
EMERGENCY CARE		
Ambulance Service when Medically Necessary**	Deductible & 10% Coinsurance	Deductible & 10% Coinsurance
At Hospital Emergency Room	$100 copay, waived if admitted	$100 copay, waived if admitted
(If member is admitted to the hospital, notification is required)		
Emergency Care in Urgi-Center	$40 copay per visit	Deductible & 30% Coinsurance
MATERNITY CARE		
Routine Prenatal and Post-Natal Care**	No Charge	Deductible & 30% Coinsurance
Hospital Services for Mother and Child**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
SKILLED NURSING FACILITY		
30 Days per Calendar Year**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
HOSPICE CARE		
Inpatient Care**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Home Hospice Care Visits**	Subject to 10% Coinsurance	Subject to 25% Coinsurance
HOME HEALTH CARE		
Home Care Visits - 40 Visits per Calendar Year**	Subject to 10% Coinsurance	Subject to 25% Coinsurance
Physician House Calls**	$40 copay per visit	Deductible & 30% Coinsurance
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Office Visits or Outpatient Rehabilitation	$40 copay per visit	Deductible & 30% Coinsurance
Outpatient Partial Hospitalization	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
MENTAL HEALTH CARE		
Inpatient Care**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Office Visits or Outpatient Care	$40 copay per visit	Deductible & 30% Coinsurance
Outpatient Partial Hospitalization**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
ALLERGY CARE		
Testing and Treatment**	$40 copay per visit	Deductible & 30% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
CHIROPRACTIC CARE		
Chiropractic Care**	$40 copay per visit	Deductible & 30% Coinsurance
SHORT TERM REHAB OR HABILITATIVE SERVICES		
Inpatient limited to 60 Days per Calendar Year**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Outpatient limited to 60 combined PT/OT/ST Visits per Calendar Year**	$40 copay per visit	Deductible & 30% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Unlimited** *(Precert required for items over $500)*	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
HEARING AIDS		
Limited to a single purchase (including repair/replacement) every 3 Years.	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
MEDICAL SUPPLIES		
Medical Supplies when Medically Necessary**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
EXERCISE FACILITY		
Subscriber	$200 reimbursement per 6 month period	$200 reimbursement per 6 month period
Spouse	$100 reimbursement per 6 month period	$100 reimbursement per 6 month period
OUTPATIENT PRESCRIPTION DRUGS - RETAIL		
The Prescription Drug Benefit is based on a per Calendar Year limit for any applicable deductibles and/or maximum limits.		
Tier 1	$10 copay	Only Covered at Participating Pharmacies
Tier 2	$25 copay	Only Covered at Participating Pharmacies
Tier 3	$50 copay	Only Covered at Participating Pharmacies
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	$25.00 copay	Only Covered at Participating Pharmacies
Tier 2	$62.50 copay	Only Covered at Participating Pharmacies
Tier 3	$125.00 copay	Only Covered at Participating Pharmacies

DEPENDENT ELIGIBILITY:
Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.
Benefits discontinue at the end of the Calendar Year

These services require **precertification through Oxford. Members must call Oxford at 1-800-444-6222 at least 14 days in advance of treatment to request precertification.
**Mental health and substance use disorder services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

***Adult Out of Network Preventive Care coverage is limited to Well Woman Routine Gynecology Exams, Bone Density Testing and Screening for Prostate Cancer.

Please be advised this sample summary of coverage is provided for informational purposes only. The information contained herein is subject to approval of the New York Department of Insurance and Oxford home office approval as appropriate. 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, Workers' Compensation, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.

'The High UCR fee schedule contains the maximum allowable fees and is set using data from the FH Benchmarks database, from FAIR Health, Inc., and the Centers for Medicare and Medicaid Services (CMS) and sources recognized by the federal government and insurance industry as a basis for evaluating and establishing fees. Physician fees are generally set using 80th percentile data from the FH Benchmarks database, from FAIR Health, Inc. The fee schedule for physician-administered pharmaceutical products is based upon a percentage of Average Wholesale Price. If a data source is no longer available, we will use a comparable data source to establish fees. Additional information about how we set the UCR fee schedule and reimburse Out-of-Network Covered Services is available in the Certificate of Coverage and Member Handbook.