UnitedHealth care/Oxford: EPO Liberty
ALL ELIGIBLE EES

Coverage Period: 01/01/2013 - 12/31/2013
Coverage for: Employee + Family | Plan Type: EPO

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

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 www.oxhp.com or by calling the Member Service number listed on the back of your ID card.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart for your costs for services this plan covers.
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 Common Medical Events chart for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	No, there is no out-of-pocket limit on your expenses. Other limits apply - see chart that starts on page 2.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of–pocket limit?	The plan has no out-of-pocket limit.	Not applicable because there's no out-of-pocket limit on your expenses.
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 Common Medical Events chart describes any limit on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.oxhp.com or Call 1-800-444-6222 for a list of participating doctors and hospitals.	If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the Common Medical Events chart for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	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 under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-444-6222 or visit us at www.oxhp.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov, or call the telephone numbers above to request a copy. This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

- Co-payments (copays) are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance (co-ins) 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 co-insurance 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 a Non-Network Provider charges more than the allowed amount, you may have to pay the difference. For example, if a Non-Network Provider 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 deductible, 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	$15 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$15 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$15 copay per visit for Manipulative (Chiropractic) Services	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Pre-Authorization required or benefit reduces to 50% of allowed.
	Preventive care/screening/immunizations	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Pre-Authorization required or benefit reduces to 50% of allowed.

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 www.oxhp.com.	Tier 1 - Your Lowest-Cost Option	Retail: $5 copay Mail-Order: $12.50 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. 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 or may result in a higher cost. Tier 1 Contraceptives covered at No Charge.
	Tier 2 - Your Mid-Range Cost Option	Retail: $15 copay Mail-Order: $37.50 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail: $25 copay Mail-Order: $62.50 copay	Not Covered	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not covered	Pre-Authorization required or benefit reduces to 50% of allowed.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	$35 copay per visit	$35 copay per visit	None
	Emergency medical transportation	No Charge	Not Covered	None
	Urgent care	$15 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Pre-Authorization required or benefit reduces to 50% of allowed.
	Physician/ surgeon fee	No Charge	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
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay per visit	Not Covered	Pre-Authorization required or benefit reduces to 50% of allowed.
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Pre-Authorization required or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	$15 copay per visit	Not Covered	Pre-Authorization required or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	No Charge	Not Covered	Pre-Authorization required or benefit reduces to 50% of allowed.
If you become pregnant	Prenatal and postnatal care	$15 copay per initial visit	Not Covered	Additional copays, deductibles or co-ins may apply. Routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	No Charge	Not Covered	Pre-Authorization required or benefit reduces to 50% of allowed.
If you have a recovery or other special health need	Home health care	$15 copay per visit	Not Covered	Limited to 60 visits per Calendar Year. Pre-Authorization required or benefit reduces to 50% of allowed.
	Rehabilitation services	$15 copay per outpatient visit	Not Covered	Limited to 60 visits per condition, per lifetime. Pre-Authorization required or benefit reduces to 50% of allowed.
	Habilitation services	Not Covered	Not Covered	No coverage for habilitation services.
	Skilled nursing care	No Charge	Not Covered	Limited to 30 days per Calendar Year. Pre-Authorization required or benefit reduces to 50% of allowed.
	Durable medical equipment	No Charge	Not Covered	Max benefit of $1500 per Calendar Year combined with medical supplies. Pre-Authorization required for items over $500.
	Hospice service	No Charge	Not Covered	Limited to 210 days per calendar year (combined inpatient, outpatient and home hospice). At Approved Facilities Only. Inpatient Pre-Authorization required or benefit reduces to 50% of allowed.

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 your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for Eye exam.
	Glasses	Not Covered	Not Covered	No coverage for Glasses.
	Dental check-up	No Charge	Not Covered	For children through age 11. Limited to 1 visit per Calendar Year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- Acupuncture
- Cosmetic surgery
- Dental check-up (adult)
- Glasses
- Habilitation Services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult/child)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your cost for these services.)

- Bariatric surgery may be covered with limitations
- Hearing aids may be covered with limitations
- Infertility treatment may be covered with limitations

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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit www.cciio.cms.gov.

Questions: Call 1-800-444-6222 or visit us at www.oxhp.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov, or call the telephone numbers above to request a copy. This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

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 or the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or New York Department of Financial Services at 1-800-342-3736 or visit http://www.dfs.ny.gov/index.html.

Additionally, a consumer assistance program may help you file your appeal. Contact Community Service Society of New York, Community Health Advocates at 1-888-614-5400 or visit http://www.communityhealthadvocates.org/. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación
若需要中文协助，请拨打您会员卡上的电话号码。
Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih
Para sa tulong sa Tagalog, tawagan ang numero sa iyong ID card.

——————— *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 also will 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 $7,340
- Patient Pays $200

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	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$200
Total	$200

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

- Amount owed to providers: $5,400
- Plan Pays $4,820
- Patient Pays $580

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	$0
Co-pays	$500
Co-insurance	$0
Limits or exclusions	$80
Total	$580

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.