Employee Benefits Enrollment Guide

Plan Year: July 1, 2023-June 30, 2024




PAYCHEX

Payroll | Benefits | HR | Insurance

The Power of Simplicity

2023 – 2024 Benefits Enrollment Guide

Kulanu Academy recognizes the importance of being able to provide our employees and their families with quality benefits as part of their overall compensation package. Therefore, Kulanu Academy . has developed a comprehensive benefits package that delivers quality and value while satisfying the diverse needs of our workforce. This summary highlights the benefit options offered by Kulanu Academy .

Open Enrollment

For newly hired employees or for those who become newly eligible during the plan year, you must enroll n o later than 30 days after your eligibility date or the date of your change in eligibility status. All other eligi ble employees must enroll during open enrollment, which this year is from May 30, 2023-June 09,2023.

Eligibility

If you are an employee working at least 30 hours a week, you are eligible for the benefits outlined in this guide. Eligible employees may elect to cover their spouse or children to age 26. Benefits are effective on the first of the month following the date of hire.

Qualifying Event

Employee contributions for medical benefits are payroll deducted on a pre-tax basis under IRC Section 125. Outside of open enrollment you are not permitted to make changes to your benefit elections unless you experience a qualifying event defined as: marriage, divorce or legal separation, birth or adoption of a child, a change in your or your spouse's employment or insurance status, a dependent ceasing to meet eligibility requirements, or a change in residence that affects coverage. If you experience a qualifying event, HR must notify the insurance company within 30 days of the qualifying event or you will not be able to make changes to your current election until the next open enrollment period. Please contact HR as soon as possible upon a qualifying event.

Please Note: This is a brief summary, actual policy provisions govern all benefits and costs.

2023 – 2024 Additional Employee Benefits

BalanceCare®

As part of your benefits package, you are eligible to take advantage of Balance*Care* – a confidential and complimentary health advocacy service designed to help you understand and maximize your health care benefits. Available 24/7, Balance*Care* will connect you to a health care professional ready to assist you in managing and resolving a variety of health care issues including: claims assistance, ordering ID cards, referrals, care coordination, specialty care, eldercare, Medicare, transportation, clinical trials, home health care services, hospital planning, assisted living and finances, and rehabilitation services. Access to Balance*Care* is easy, with two convenient options: call 877-598-8617 toll free or e-mail balancecare@eniweb.com.

Paychex Flex

Kulanu Academy employees have access to Paychex Flex. Members can log into PaychexFlex.com or download the Flex Mobile Application to view current elections, plan summaries, and additional plan documents.

Please Note: This is a brief summary, actual policy provisions govern all benefits and costs.

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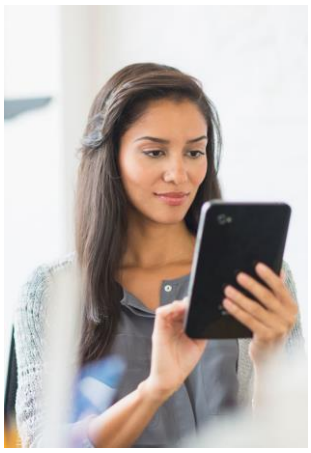
Enrolling Online with Paychex Flex



Follow these easy steps to elect your benefits for the next plan year:

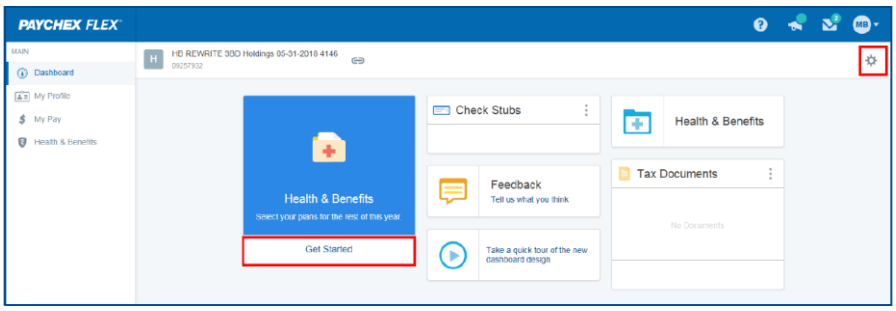
1. Create a Paychex Flex Account and Download the Paychex Flex Mobile Application.

2. Log into Paychex Flex from your Computer, Tablet or Smart Phone.

3. Access Health & Benefits From your Dashboard.

4. Choose Benefits!

Below you will find a tutorial if you have any further questions:
http://training.paychex.com/pia_health_benefits/employee/electing_benefits.html



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NAME: _____

OPT IN SECTION:

YES! I **would like to enroll for medical coverage.** I elect the following: (PLEASE CICRLE YOUR OPTION)
PLEASE NOTE: RATES ARE **PER PAYCHECK**

OXFORD Gold Freedom PPO	**TIER 1**	**TIER 2**	**TIER 3**	**TIER 4**
Employee	$250.00	$292.00	$335.00	$446.00
Employee + Spouse	$487.00	$590.00	$688.00	$842.00
Employee + Child(ren)	$335.00	$385.00	$440.00	$710.00
Family	$688.00	$710.00	$732.00	$1,185.00

OXFORD Silver LIBERTY EPO	**TIER 1**	**TIER 2**	**TIER 3**	**TIER 4**
Empoyee	$140.00	$186.00	$228.00	$330.00
Employee + Spouse	$275.00	$363.00	$450.00	$633.00
Employee + Child(ren)	$230.00	$235.00	$242.00	$538.00
Family	$395.00	$415.00	$435.00	$860.00

OXFORD LIBERTY BRONZE EPO HSA	**TIER 1**	**TIER 2**	**TIER 3**	**TIER 4**
Employee	$178.00	$158.00	$140.00	$121.00
Employee + Spouse	$367.00	$367.00	$367.00	$367.00
Employee + Child(ren)	$315.00	$315.00	$315.00	$315.00
Family	$660.00	$660.00	$660.00	$660.00

New York Health Benefits Waiver of Coverage

UnitedHealthcare® Oxford

Mailing Address: Oxford Enrollment Dept. ■ P.O. Box 29142 ■ Hot Springs, AR 71903 ■ 1-800-444-6222 ■ www.oxfordhealth.com

Group Name: Kulanu Academy

Group Policy Number (if known): _____

Employee Name: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Employment: _____

Date of Birth: _____

I am employed by and working at least 20 hours per week for the group shown above. I was given the opportunity to enroll in the Oxford* group health benefits plan(s) offered by my employer and I refuse coverage.

Reason for Refusal (please check all appropriate boxes)

☐ I have other coverage from:

- ☐ My spouse's employer
- ☐ Medicare
- ☐ Medicaid
- ☐ Veteran's Administration
- ☐ Union health plan
- ☐ Parental Waiver
- ☐ Another carrier's group health plan sponsored by this employer
- ☐ Another source of coverage (please specify): _____

REQUIRED INFORMATION: _____
Name of carrier Policy Number

☐ Other reason (please explain): _____

I certify that all information provided in this form is true and complete. By refusing group health benefits, I acknowledge that I and/or my dependent(s) may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Signature of Employee Date

Signature of Benefits Administrator Date

* Oxford insurance products are underwritten by Oxford Health Insurance, Inc.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myuhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-444-6222 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $1,500 Individual /$3,000 Family Out-of-Network: $4,000 Individual /$8,000 Family Per policy year. Previously 3k/6k	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, Prescription drugs -- $150 per person, does not apply to Tier 1 drugs. There are no other deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: $7,050 Individual /$14,100 Family Out-of-Network: $10,000 Individual /$20,000 Family Previously 6800/13600 and 8k/16k	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-800-444-6222 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

[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.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit, deductible does not apply	40% coinsurance	Virtual visits (Telehealth) - No Charge per visit by a Designated Virtual Network Provider. No Virtual Visit coverage out-of-network. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	$40 copay per visit, deductible does not apply	40% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No coverage Out-of-Network, however, certain services are covered when using an Out-of-Network provider.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: 50% coinsurance Previously no charge Xray: $25 copay per service	Lab: Not Covered 40% coinsurance	Designated Network Lab: No Charge Preauthorization required for certain services or benefit reduces to the lesser of 50% or $500.
	Imaging (CT/PET scans, MRIs)	$100 copay per service	40% coinsurance	Preauthorization required for certain services or benefit reduces to the lesser of 50% or $500.
	Tier 1	Retail: $10 copay, deductible does not apply Mail-Order: $25 copay, deductible does not apply	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30-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 preauthorization requirement or may result in a higher cost. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required
	Tier 2	Retail: $40 copay Mail-Order: $100 copay	Not Covered	
	Tier 3	Retail: $80 copay Mail-Order: $200 copay	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myuhc.com				to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 4	Not Applicable	Not Applicable	Tier not applicable for this plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Ctr /Office: $150 copay per service Hospital: $250 copay per service	40% coinsurance	Preauthorization required for certain services or benefit reduces to the lesser of 50% or $500.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization required for certain services or benefit reduces to the lesser of 50% or $500.
If you need immediate medical attention	Emergency room care	$500 copay per visit, deductible does not apply	$500 copay per visit, deductible does not apply	None
	Emergency medical transportation	20% coinsurance*	20% coinsurance*	*Network Deductible Applies.
	Urgent care	$75 copay per visit, deductible does not apply	40% coinsurance	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required for certain services or benefit reduces to the lesser of 50% or $500.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization required for certain services or benefit reduces to the lesser of 50% or $500.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Previously $40 $25 copay per visit, deductible does not apply	40% coinsurance	Network partial hospitalization/intensive outpatient treatment: 0% coinsurance. Preauthorization required for certain services or benefit reduces to the lesser of 50% or $500.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required for certain services or benefit reduces to the lesser of 50% or $500.
If you are pregnant	Office visits	No Charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Inpatient preauthorization may apply or benefit reduces to 50% of allowed.
If you need help recovering or have other special health needs	Home health care	$40 copay per visit, deductible does not apply	40% coinsurance	Limited to 40 visits per policy year. Preauthorization required for certain services or benefit reduces to the lesser of 50% or $500.
	Rehabilitation services	$40 copay per outpatient visit, deductible does not apply	40% coinsurance	Limits per policy year: Physical, speech and occupational therapy combined limit 60 visits. Preauthorization required for certain services or benefit reduces to the lesser of 50% or $500.
	Habilitation services	$40 copay per outpatient visit, deductible does not apply	40% coinsurance	Limits per policy year: Physical, speech and occupational therapy combined limit 60 visits. Preauthorization required for certain services or benefit reduces to the lesser of 50% or $500.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 200 days per policy year. Preauthorization required for certain services or benefit reduces to the lesser of 50% or $500.
	Durable medical equipment	20% coinsurance	Not Covered	Preauthorization required for DME over $500 or there is no coverage.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization required before admission for an Inpatient Stay in a hospice facility or benefit reduces to the lesser of 50% or $500.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$25 copay per visit, deductible does not apply	50% coinsurance	Limited to 1 exam every 12 months. Covered for individuals up to the age of 19.
	Children's glasses	50% coinsurance, deductible does not apply	50% coinsurance	One pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Covered for individuals up to the age of 19.
	Children's dental check-up	0% coinsurance	50% coinsurance	Cleanings are covered 2 times per 12 months. Additional limitations may apply. Covered for individuals up to the age of 19.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic (Manipulative) care
- Hearing Aids
- Infertility Treatment – Cycle limits may apply.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: www.dfs.ny.gov/index.htm Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance,

contact: your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov/index.htm.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist copay	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,170**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copay	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,300**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copay	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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).

OXFORD HEALTH INSURANCE, INC.
NY G FRDM NG 25/40/1500/80 PPO 23 - Non-Gated
SUMMARY OF COVERAGE

Freedom Network

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	$1,500	$4,000
	Family	$3,000	$8,000
Coinsurance:		20%	40%
Maximum Out-Of-Pocket:	Single	$7,050	$10,000
(Including Deductible)	Family	$14,100	$20,000
Financial Accumulation Period:		Policy Year	Policy Year
Out-of-Network Reimbursement:		Not Applicable	140% of Medicare

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 ****Please see your Certificate for a complete list of Preventive Care benefits covered Out-of-Network*	No Charge	Limited Coverage***
Infant and Pediatric Preventive Care	No Charge	Deductible & 40% Coinsurance
Preventive Dental for Children (Up to age 19)****	No Charge after Deductible	Deductible & 50% Coinsurance
Pediatric Vision Exam (Up to age 19)	$25 copay per visit	Deductible & 50% Coinsurance
Pediatric Vision Hardware (Up to age 19)	50% Coinsurance	Deductible & 50% Coinsurance
Additional Coverage Adult and Pediatric Vision Exam *Please see your Certificate for more information about the Additional Vision coverage*	$10 copay	$40 Allowance
OUTPATIENT CARE		
Primary Care Physician Office Visits	$25 copay per visit	Deductible & 40% Coinsurance
Specialist Office Visits	$40 copay per visit	Deductible & 40% Coinsurance
Virtual Visits	No Charge	Not Covered
Outpatient Surgery - Hospital Setting**	Deductible and then $250 copay per visit	Deductible & 40% Coinsurance
Outpatient Surgery - Hospital Setting Deductible**	Not Applicable	Not Applicable
Outpatient Surgery - Freestanding Facility**	Deductible and then $150 copay per visit	Deductible & 40% Coinsurance
Designated Diagnostic Provider Laboratory Services**	No Charge	Not Covered
Non-Designated Diagnostic Provider Laboratory Services**	Deductible & 50% Coinsurance	Not Covered
Radiology Services**	Deductible and then $25 copay per service	Deductible & 40% Coinsurance
DIABETIC SUPPLIES AND MEDICATIONS		
Diabetic Supplies**	$25 copay	Deductible & 40% Coinsurance
Diabetic Medications**	$25 copay	Deductible & 40% Coinsurance
MRIs, MRAs, CT SCANS, AND PET SCANS		
Outpatient Hospital Services**	Deductible and then $100 copay per service	Deductible & 40% Coinsurance
Freestanding Radiology Facility**	Deductible and then $100 copay per service	Deductible & 40% Coinsurance
HOSPITAL CARE		
Physician's and Surgeon's Services**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Semi-Private Room and Board**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
All Drugs and Medication	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
EMERGENCY CARE		
Ambulance Service When Medically Necessary	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
At Hospital Emergency Room *(waived if admitted)* *(If member is admitted to the hospital, notification is required.)*	$500 copay per visit	$500 copay per visit
Emergency Care in Urgi-Center	$75 copay per visit	Deductible & 40% Coinsurance
MATERNITY CARE		
Prenatal and Post-Natal Care	No Charge	Deductible & 40% Coinsurance
Hospital Services for Mother and Child**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
SKILLED NURSING FACILITY		
200 days per Plan Year.**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
HOSPICE CARE		
Inpatient Care**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Home Hospice - Unlimited.**	$40 copay per visit	Deductible & 40% Coinsurance
HOME HEALTH CARE		
Home Healthcare Visits - 40 visits per Plan Year.**	$40 copay per visit	Deductible & 40% Coinsurance
Physician House Calls**	$40 copay per visit	Deductible & 40% Coinsurance
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Outpatient Rehabilitation	$25 copay per visit	Deductible & 40% Coinsurance
Outpatient Partial Hospitalization**	No Charge after Deductible	Deductible & 40% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
Inpatient Care**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Outpatient Visits	$25 copay per visit	Deductible & 40% Coinsurance
Outpatient Partial Hospitalization**	No Charge after Deductible	Deductible & 40% Coinsurance
ALLERGY CARE		
Testing and Treatment**	$40 copay per visit	Deductible & 40% Coinsurance
ALTERNATIVE MEDICINE		
Chiropractic Care - Unlimited Visits **	$40 copay per visit	Deductible & 40% Coinsurance
SHORT TERM REHABILITATION		
Inpatient - Limited to 60 combined PT/OT/ST days per Plan Year.**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.**	$40 copay per visit	Deductible & 40% Coinsurance
HABILITATIVE SERVICES		
Inpatient - Limited to 60 combined PT/OT/ST days per Plan Year.**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.**	$40 copay per visit	Deductible & 40% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment - Unlimited.**	Deductible & 20% Coinsurance	Not Covered
Precertification required for items over $500		
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
HEARING AIDS		
Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
EXERCISE FACILITY		
Subscriber	$200 reimbursement per 6 month period	$200 reimbursement per 6 month period
Spouse/Dependents over age 13	$100 reimbursement per 6 month period	$100 reimbursement per 6 month period
OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE	$150 Deductible (Waived for Tier 1 drugs)	
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	$10 copay	Not Covered
Tier 2	$40 copay	Not Covered
Tier 3	$80 copay	Not Covered
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	$25 copay	Not Covered
Tier 2	$100 copay	Not Covered
Tier 3	$200 copay	Not Covered

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.

**These services require precertification through Oxford. Members must call Oxford at 1-800-444-6222 at least 14 days in advance of request 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.

****Precertification is required for Pediatric Orthodontia services only

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.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myuhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-444-6222 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,250 Individual /$6,500 Family Per policy year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, Prescription drugs -- $200 per person, does not apply to Tier 1 drugs. There are no other deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: $9,100 Individual /$18,200 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-800-444-6222 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

[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.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay per visit, deductible does not apply	Not Covered	Virtual visits (Telehealth) - No Charge per visit by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	$80 copay per visit, deductible does not apply	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: 50% coinsurance Xray: 40% coinsurance	Not Covered	Designated Network Lab: No Charge
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not Covered	none
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myuhc.com	Tier 1	Retail: $10 copay, deductible does not apply Mail-Order: $25 copay, deductible does not apply	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30-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 preauthorization requirement or may result in a higher cost. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2	Retail: $50 copay Mail-Order: $125 copay	Not Covered	
	Tier 3	Retail: $90 copay Mail-Order: $225 copay	Not Covered	
	Tier 4	Not Applicable	Not Applicable	Tier not applicable for this plan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not Covered	$500 Hospital per occurrence deductible applies prior to the overall deductible.
	Physician/surgeon fees	40% coinsurance	Not Covered	none
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance*	*Network Deductible Applies.
	Emergency medical transportation	No Charge	No Charge	none
	Urgent care	$75 copay per visit, deductible does not apply	Not Covered	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not Covered	none
	Physician/surgeon fees	40% coinsurance	Not Covered	none
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay per visit, deductible does not apply	Not Covered	Network partial hospitalization/intensive outpatient treatment: 0% coinsurance
	Inpatient services	40% coinsurance	Not Covered	none
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% coinsurance	Not Covered	
	Childbirth/delivery facility services	40% coinsurance	Not Covered	none
If you need help recovering or have other special health needs	Home health care	$80 copay per visit, deductible does not apply	Not Covered	Limited to 40 visits per policy year.
	Rehabilitation services	$80 copay per outpatient visit, deductible does not apply	Not Covered	Limits per policy year: Physical, speech and occupational therapy combined limit 60 visits per condition per policy year.
	Habilitation services	$80 copay per outpatient visit, deductible does not apply	Not Covered	Limits per policy year: Physical, speech and occupational therapy combined limit 60 visits per condition per policy year.
	Skilled nursing care	40% coinsurance	Not Covered	Limited to 200 days per policy year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	40% coinsurance	Not Covered	Preauthorization required for DME over $500 or there is no coverage.
	Hospice services	40% coinsurance	Not Covered	none
If your child needs dental or eye care	Children's eye exam	$30 copay per visit, deductible does not apply	Not Covered	Limited to 1 exam per 12-month period. Covered for individuals up to the age of 19.
	Children's glasses	50% coinsurance, deductible does not apply	Not Covered	Limited to 1 pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Covered for individuals up to the age of 19.
	Children's dental check-up	0% coinsurance	Not Covered	Limited to 2 times per 12 months. Additional limitations may apply. Covered for individuals up to the age of 19.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment – Cycle limits may apply.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: www.dfs.ny.gov/index.htm Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565

or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov/index.htm.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-866-633-2446.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,250
Specialist copay	$80
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,200
Copayments	$10
Coinsurance	$2,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,870**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,250
Specialist copay	$80
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,250
Specialist copay	$80
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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).

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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

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OXFORD HEALTH INSURANCE, INC.
NY S LBTY NG 40/80/3250/60 EPO 23 - Non-Gated
SUMMARY OF COVERAGE
0
Liberty Network

BENEFIT		IN-NETWORK
FINANCIAL		
Deductible:	Single	$3,250
	Family	$6,500
Coinsurance:		40%
Maximum Out-Of-Pocket:	Single	$9,100
(Including Deductible)	Family	$18,200
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.*

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)	$30 copay per visit
Pediatric Vision Hardware (Up to age 19)	50% Coinsurance

OUTPATIENT CARE	
Primary Care Physician Office Visits	$40 copay per visit
Pediatric Office Visits (Up to age 19)	Not Applicable
Specialist Office Visits	$80 copay per visit
Virtual Visits	No Charge
Outpatient Surgery - Hospital Setting	Deductible & 40% Coinsurance
Outpatient Surgery - Hospital Setting Per Occurrence Deductible	$500 Deductible
Outpatient Surgery - Freestanding Facility	Deductible & 40% Coinsurance
Designated Diagnostic Provider Laboratory Services	No Charge
Non-Designated Diagnostic Provider Laboratory Services	Deductible & 50% Coinsurance
Radiology Services	Deductible & 40% Coinsurance

DIABETIC SUPPLIES AND MEDICATIONS	
Diabetic Supplies	$40 copay
Diabetic Medications	$40 copay

MRIs, MRAs, CT SCANS, AND PET SCANS	
Outpatient Hospital Services	Deductible & 40% Coinsurance
Freestanding Radiology Facility	Deductible & 40% Coinsurance

HOSPITAL CARE	
Physician's and Surgeon's Services	Deductible & 40% Coinsurance
Semi-Private Room and Board	Deductible & 40% Coinsurance
All Drugs and Medication	Deductible & 40% Coinsurance

EMERGENCY CARE	
Ambulance Service When Medically Necessary	No Charge
At Hospital Emergency Room *(waived if admitted)*	Deductible & 50% Coinsurance
(If member is admitted to the hospital, notification is required.)	
Emergency Care in Urgi-Center	$75 copay per visit

MATERNITY CARE	
Prenatal and Post-Natal Care	No Charge
Hospital Services for Mother and Child	Deductible & 40% Coinsurance

SKILLED NURSING FACILITY	
Limited to 200 days per Plan Year.	Deductible & 40% Coinsurance

HOSPICE CARE	
Inpatient Care	Deductible & 40% Coinsurance
Home Hospice - Unlimited.	$80 copay per visit

HOME HEALTH CARE	
Limited to 40 visits per Plan Year.	$80 copay per visit
Physician House Calls	$80 copay per visit

SUBSTANCE USE DISORDER SERVICES	
Inpatient Rehabilitation	Deductible & 40% Coinsurance
Outpatient Rehabilitation	$40 copay per visit
Outpatient Partial Hospitalization	No Charge after Deductible

BENEFIT	IN-NETWORK
MENTAL HEALTH CARE	
Inpatient Care	Deductible & 40% Coinsurance
Outpatient Visits	$40 copay per visit
Outpatient Partial Hospitalization	No Charge after Deductible
ALLERGY CARE	
Testing and Treatment	$80 copay per visit
ALTERNATIVE MEDICINE	
Chiropractic Care - Unlimited	$80 copay per visit
SHORT TERM REHABILITATION	
Inpatient - Limited to 60 combined days per Plan Year.	Deductible & 40% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	$80 copay per visit
HABILITATIVE SERVICES	
Inpatient - Limited to 60 combined days per Plan Year.	Deductible & 40% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	$80 copay per visit
DURABLE MEDICAL EQUIPMENT	
Durable Medical Equipment - Unlimited. *Precertification required for items over $500*	Deductible & 40% Coinsurance
MEDICAL SUPPLIES	
Medical Supplies When Medically Necessary	Deductible & 40% Coinsurance
HEARING AIDS	
Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	Deductible & 40% Coinsurance
EXERCISE FACILITY	
Subscriber	$200 reimbursement per 6 month period
Spouse/Dependents over age 13	$100 reimbursement per 6 month period
OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE	$200 Deductible (Waived for Tier 1 drugs)
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	$10 copay
Tier 2	$50 copay
Tier 3	$90 copay
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER	
Tier 1	$25 copay
Tier 2	$125 copay
Tier 3	$225 copay

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.

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.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myuhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-444-6222 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $7,000 Individual /$14,000 Family Per policy year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	previously 7050/14100 Network: $7,000 Individual /$14,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-800-444-6222 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

[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.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	Not Covered	Virtual visits (Telehealth) - 0% coinsurance per visit by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	0% coinsurance	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: 0% coinsurance Xray: 0% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myuhc.com	Tier 1	Retail: 0% coinsurance Mail-Order: 0% coinsurance	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30-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 preauthorization requirement or may result in a higher cost. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2	Retail: 0% coinsurance Mail-Order: 0% coinsurance	Not Covered	
	Tier 3	Retail: 0% coinsurance Mail-Order: 0% coinsurance	Not Covered	
	Tier 4	Not Applicable	Not Applicable	Tier not applicable for this plan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not Covered	None
	Physician/surgeon fees	0% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	0% coinsurance*	0% coinsurance*	*Network Deductible Applies.
	Emergency medical transportation	0% coinsurance*	0% coinsurance*	*Network Deductible Applies.
	Urgent care	0% coinsurance	Not Covered	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not Covered	None
	Physician/surgeon fees	0% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	Not Covered	Network partial hospitalization/intensive outpatient treatment: 0% coinsurance
	Inpatient services	0% coinsurance	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	Not Covered	
	Childbirth/delivery facility services	0% coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	Limited to 40 visits per policy year.
	Rehabilitation services	0% coinsurance	Not Covered	Limits per policy year: Physical, speech and occupational therapy combined limit 60 visits.
	Habilitation services	0% coinsurance	Not Covered	Limits per policy year: Physical, speech and occupational therapy combined limit 60 visits.
	Skilled nursing care	0% coinsurance	Not Covered	Limited to 200 days per policy year.
	Durable medical equipment	0% coinsurance	Not Covered	Preauthorization required for DME over $500 or there is no coverage.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	0% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 exam every 12 months. Covered for individuals up to the age of 19.
	Children's glasses	50% coinsurance	Not Covered	One pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Covered for individuals up to the age of 19.
	Children's dental check-up	0% coinsurance	Not Covered	Cleanings are covered 2 times per 12 months. Additional limitations may apply. Covered for individuals up to the age of 19.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic (Manipulative) care
- Hearing Aids
- Infertility Treatment – Cycle limits may apply.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: www.dfs.ny.gov/index.htm Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565

or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov/index.htm.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-866-633-2446.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$7,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$7,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$7,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$5,300**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$7,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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).

OXFORD HEALTH INSURANCE, INC.
NY B LBTY NG 7000/100 EPO HSA 23 - Non-Gated
SUMMARY OF COVERAGE
0
Liberty 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. *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.

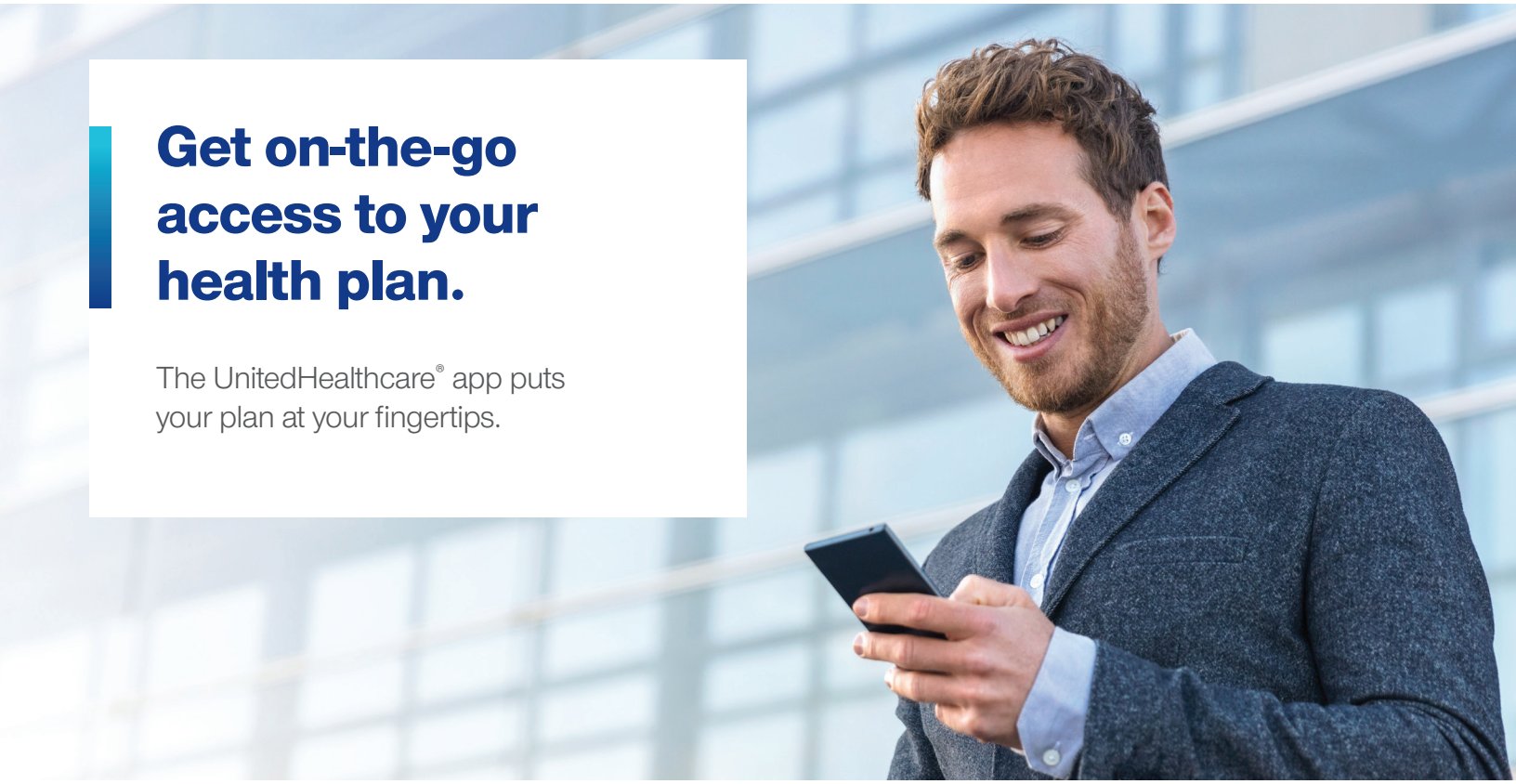
A Dependent who has attained the above limiting age can continue coverage until they reach age 30 subject to the eligibility requirements outlined in the Certificate.

Domestic Partners are covered with proper documentation.

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.



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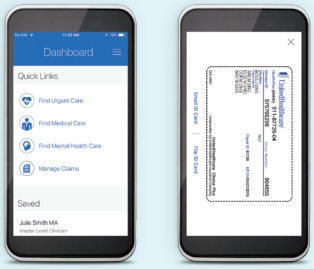

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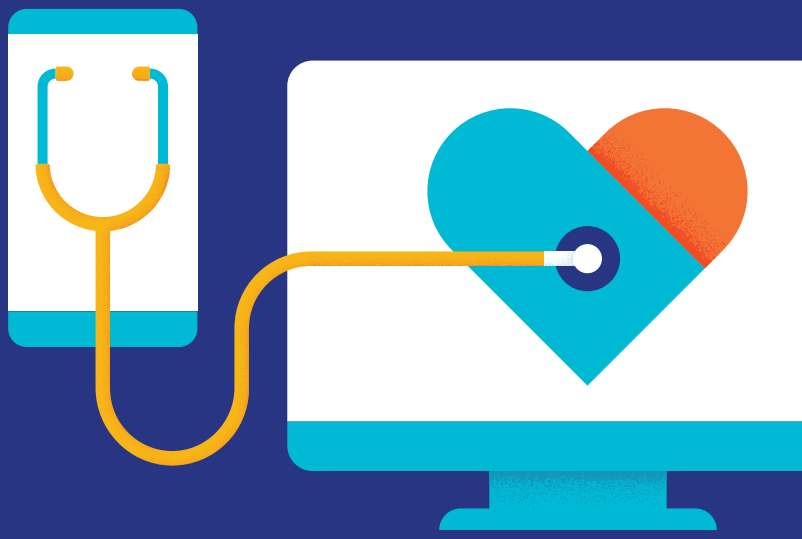

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Put your health plan at your fingertips

Get the most out of your benefits

Your personalized website, **myuhc.com®**, features tools designed to help you:

- **Find, price and save on care—**you can save with Virtual Visits* and other tools. You can save an average of 36%[1] when you compare costs for providers and services
- **Get care from anywhere** with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7
- **Understand your benefits** and the financial impact of care decisions
- **Find tailored recommendations** regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status
- **Access claim details,** plan balances and your health plan ID card quickly
- **Follow through on clinical recommendations** and access wellness programs
- **Order prescription refills,** get estimates and compare medication pricing**
- **Check your plan balances,** access financial accounts and more

Download the UnitedHealthcare® app

It's perfect for on-the-go access, help finding a nearby doctor and more.

*Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

**Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

continued

United Healthcare

Activation is quick

1. Go to **myuhc.com > Register Now**
2. Fill out the required fields and create your username/password
3. Enter your contact information and security questions
4. Agree to the website's policies and be sure to opt-in for email updates. We promise you'll only see our name in your inbox with relevant news and wellness updates

Get started at myuhc.com

United Healthcare

[1] UnitedHealthcare Internal Claims Analysis, 2019.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Get rewarded for exercising

With the Oxford® Sweat Equity™ program, you may earn up to $200 in 6 months for meeting the program exercise requirements.

What it is

It's our goal to help people live healthier lives. Making exercise a part of your routine may be one of the most important steps you take toward being the healthiest "you." To help you on your way, we've created the Sweat Equity physical fitness reimbursement program.

The program offers a variety of exercises to choose from and the option to combine your fitness facility visits with your physical fitness classes and events to help you reach the required 50 workouts in a 6-month period.

Spouses/domestic partners and dependents, ages 13 and older,[1] covered by the Oxford health plan may participate in the Sweat Equity program and may get rewarded—up to $100 in a 6-month period.[2]

How it works

Eligible Oxford members* may get reimbursed up to $200 in a 6-month period.[1] You can apply for reimbursement under the program as long as you:

- Are an active member of an eligible Oxford plan
- Have gone to the gym and/or exercise classes, as described below, 50 times in 6 months

Your reimbursement period begins on the date of your first fitness facility visit, class or event and ends 6 months later. You can start a new reimbursement period 1 day after your previous reimbursement period ends.

So many ways to help you get fit and rewarded

Complete 50 visits, 50 classes, 50 fitness events or a mix of these options that add up to 50 in 6 months.

Examples of qualifying fitness facilities and classes:

- Boxing/kickboxing
- CrossFit
- Indoor rock climbing
- Marathons
- Martial arts
- Personal training
- Pilates
- Standard gym, including YMCAs and community centers where fitness services are offered

Examples of cardiovascular equipment:

- Yoga
- Elliptical trainer/ cross-trainer
- Rowing machine
- Stair climber
- Stationary bicycle
- Treadmill

* In this document, the term "member" refers to the Oxford plan subscriber of a fully insured Oxford medical plan or the plan participant of a self-funded plan administered by Oxford, as well as the subscriber's or plan participant's covered spouse or domestic partner and covered dependents ages 13 and older. For the spouse, domestic partner or dependent(s) to be eligible for this benefit, they must also be enrolled in the Oxford product.

continued

How to get started

Decide on a cardio (aerobic) workout that you'll enjoy and find a facility with the equipment or classes that promote cardiovascular wellness.[3] For you to be reimbursed, the facility, classes or fitness events you choose must be open to the general public. Then, you just need to start moving to start earning.

What we need from you

After you've completed a total of 50 workouts—either gym visits, classes, fitness events or any mix of these options—in a 6-month period, send us:

1. **Your completed Sweat Equity Program Reimbursement form**
2. **Proof of your payment** (e.g., receipt, automatic bank withdrawal statement) for the gym fee, as well as any money you paid for qualifying fitness classes and organized group fitness events (e.g., marathon) during the 6-month period
3. **A copy of the brochure or flier or printout of the website page** that describes the cardio (aerobic) machines at the gym you used, the cardio benefits of the class you took or organized group fitness event in which you participated

Mail these documents to: Oxford Sweat Equity Program, P.O. Box 31386, Salt Lake City, UT 84131

- These documents must be mailed to us (postmarked) no later than 180 days from the end of the 6-month period for which you are requesting reimbursement. Requests postmarked after this date will not be reimbursed.
- We cannot accept requests for reimbursement before your 6-month program end date, even if you have completed the required number of qualifying workouts before this date

Electronic reimbursement request

You have the option to make your Sweat Equity reimbursement request online if you do not wish to make the request by mail. To make the request online:

- Sign in to **myuhc.com®**
- Click **Claims & Accounts**
- Click **Submit a Claim**
- On the **Medical** tile, click **Start a claim** and fill in the required information

If you are unable to meet the reimbursement requirements of this program, you might be able to earn the same reward in a different way. Call us at the toll-free phone number on your health plan ID card and we will work with you and, if necessary, your doctor, to find another way for you to earn the same reward.

Learn more

Call the phone number on your health plan ID card

United Healthcare Oxford

[1] Eligible covered dependents' participation effective beginning with the 2020 policy renewal date.

[2] Reimbursement is generally limited to the lesser of $200 (subscriber)/$100 (covered spouse/domestic partner and eligible dependents ages 13 and older) or the actual amount of the qualifying fitness costs per 6-month period, but the reimbursement may vary by plan. For the subscriber's spouse/domestic partner and dependents to be eligible for this benefit, they must also be enrolled in an Oxford product. Refer to your Oxford benefits documents or check with your company benefits administrator to confirm eligibility and find out how much you may be reimbursed. You may submit a request for reimbursement under the program once every 6 months. Requests for reimbursement will not be accepted before your 6-month program end date, even if you have completed the required number of qualifying workouts before this date. Rewards may be taxable. Consult with an appropriate tax professional to determine if you have any tax obligations from receiving reimbursement under this program.

[3] To be eligible for reimbursement under the program, the qualifying facility, class or organized group fitness event (e.g., marathon) that you choose must be available to the general public and promote cardiovascular wellness, as determined by us, and have staff supervision. Memberships in tennis clubs, country clubs, social clubs, sports teams, weight-loss clinics or spas or any other similar organizations, leagues or facilities will not be reimbursed. You will not be reimbursed for lessons, equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages). Reimbursement is limited to actual workout visits. Physical and rehabilitative therapies do not apply.

Sweat Equity is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you.

If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program.

The total annual reward amount for your participation in incentive-based programs cannot generally exceed 30% of the cost of coverage.

Oxford does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability in health programs and activities. We provide free services to help you communicate with us. Such as, letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free phone number listed on your Oxford health plan ID card, Monday through Friday, 8 a.m. to 6 p.m. ET. TTY users dial 711.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Oxford HMO products are underwritten by Oxford Health Plans (CT), Inc. and Oxford Health Plans (NJ), Inc. Administrative services provided by Oxford Health Plans LLC.

Visit with a doctor 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a doctor by phone or video[1] through **myuhc.com**® or the UnitedHealthcare® app.

A convenient and faster way to get care

Doctors can treat a wide range of health conditions—including many of the same conditions as an emergency room (ER) or urgent care—and may even prescribe medications,[2] if needed. **With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is usually $49 or less.[3]**

Consider 24/7 Virtual Visits for these common conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- and more

$49 cost

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit — bringing a potential $2,000[4] cost down to $49.

Get started

Sign in at **myuhc.com/virtualvisits** | Call **1-855-615-8335**
Download the UnitedHealthcare app

United Healthcare

[1] Data rates may apply.

[2] Certain prescriptions may not be available, and other restrictions may apply.

[3] The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

[4] Average allowed amounts charged by UnitedHealthcare Network Providers are not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. Estimated Urgent Care savings are based on $131 difference between average Urgent Care visit cost of $180 and Virtual Visit cost of $49; $2,000.00 difference between the average Emergency Room visit and the average urgent care visit. The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

A wellness program built to inspire healthier habits

Welcome to UnitedHealthcare Rewards, where healthy choices may result in healthy savings.

It all starts with a few small steps

Members track daily activities designed to help them move more and take healthy actions, with the potential of getting rewarded up to $1,000—depending on their plan.

What makes Rewards different?

Combining the best practices from our existing health and wellness incentive programs, Rewards goes a step further by:

- Offering a registration incentive for completing onboarding questions and pairing a device
- Adding wellness activities built for better sleep, regular exercise and taking other rewardable actions
- Integrating the member's digital experience with the UnitedHealthcare® app, making it available at their fingertips

Getting rewards

With daily participation, there's a potential to earn up to:

- **$300*** with Rewards Core,[1] including a $25 registration incentive
- **$1,000*** with Rewards Premium,[1] including a $65 registration incentive

Redeeming rewards

Earnings can be deposited directly into health savings accounts or used toward:

- A Visa® gift card[2]
- Electronic devices and more

*Per member, per year.

continued

United Healthcare Oxford

Important reminder about Medicare Estimation

Medicare Estimation is a process for determining the secondary payment when Medicare Part B is primary, and the member has not enrolled in Medicare Part B. Medicare Estimation reduces the payment by the amount the primary Medicare Part B would have paid if the eligible member was enrolled. This amount is not covered by the fully insured plan. Remind your impacted members to consider enrolling in Medicare Part B.

Applicability

Medicare Estimation applies in any of the following scenarios:

- Member has Part A and no Part B, and Medicare is primary.
- Member has both Parts A and B (primary), but provider does not bill or participate in Medicare or has specifically opted out of Medicare.
- Member has Part B only (primary), but provider does not bill or participate in Medicare or has specifically opted out of Medicare.

Medicare Estimation **does not** apply in these scenarios:

- Member has Part B, and provider is participating with Medicare. If the member has Part B, we pay secondary based on the actual amount Medicare paid.
- Medicare (any part) is the member's secondary payer.
- Member is not eligible for Medicare.

The reduction is permissible under NY rule 11 NYCRR 52.23(l).

The process is described in the member's certificate of coverage. For your reference, the New York plan exclusions state:

- **Medicare or other governmental programs:** "We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). **When You are eligible for Medicare, we will reduce our benefits by the amount Medicare would have paid for the Covered Services.** Except as otherwise required by law, **this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare Premium.** Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not eligible for premium-free Medicare Part A."

Our process applies to Medicare-eligible members who have Medicare Part A, but not Medicare Part B, and Medicare is primary.

- Medicare is primary in these scenarios:
  - Medicare due to age, and group size is 19 or less.
  - Medicare due to disability, and group size is 99 or less.
  - Medicare due to end-stage renal disease (ESRD), and Medicare is primary depending on what stage of dialysis treatment member is in.
  - Medicare primary (regardless of reason or group size) and a member not actively working (COBRA, state continuation, retiree).

Learn more

Contact your broker or UnitedHealthcare sales representative for more information

UnitedHealthcare Vision benefit now included with small group Freedom network plans

All Oxford New York small group (1–100) Freedom Network medical plans now include a UnitedHealthcare vision benefit.[1] This new vision rider is available along with the current Essential Health Benefits (EHB) vision benefits for children, providing both subscribers and their dependent children the ability to access the same network and plan design for their vision needs.

With our large, national eye care network, UnitedHealthcare Vision Network, members can take advantage of personalized care at a private practice or convenient evening and weekend hours at their favorite retail chain.

Network retailer examples

LensCrafters
1800contacts
myeyedr.
EyeGlass World
Costco Optical
Visionworks
For Eyes by GrandVision
Walmart Save money. Live better.
Sam's Club
America's Best Contacts & Eyeglasses
Warby Parker

Search for providers

Search for vision providers by following these steps:

- Visit **myuhcvision.com**
- Click **Provider Quick Search** and enter criteria

What's included with the new vision benefit

Eye exam

One exam once every 12 months, with a $10 copayment, when accessing the national UnitedHealthcare Vision Network doctors and retail providers.

Frame allowance[2]

A $130 frame allowance to help cover the costs of any frame a UnitedHealthcare Vision Network eye doctor offers; a 30% discount is applied to any cost over the allowance amount.

continued

UnitedHealthcare Oxford

Contact lens benefit[2]

An allowance of $125 is provided for use toward the purchase of contact lenses and a $40 allowance to use toward contact lens fitting and evaluation fees.

Lens options[2]

Popular lens options like UV protection or anti-reflective coating are available at price-protected amounts. Plus, standard scratch coating and polycarbonate lenses for dependent children are available at no cost.

Additional pairs of glasses

A 20% discount on additional pairs of eyeglasses, including prescription sunglasses.

[1] Beginning with January 1, 2023 policy effective dates, pending final New York Department of Financial Services approval.

[2] Plans may vary. Check coverage at **myuhc.com** to verify benefits. Discount on additional pair may not be available from all providers. Not all providers participate in all plans. Members should check with their provider before using benefits.

Learn more

Contact your broker or Oxford sales representative.

United Healthcare Oxford

IMPORTANT NOTICE

CHANGES TO YOUR 2023 NEW YORK SMALL GROUP PLAN

Your New York small group health coverage is coming up for renewal. Below is a summary of the main changes that will become effective when your plan renews in 2023. Please feel free to share this information with your employees as part of the Open Enrollment period. As always, employees should refer to their Certificate of Coverage (COC) during the plan year for details about their benefits and processes that apply to their coverage.

- **$0 RX (Vital Medications):** Certain prescription drug products which are on the list of zero cost share medications located at myuhc.com are available at no cost share as permitted under state and federal law if obtained from any retail network pharmacy. These prescription drug products may also be available from a mail order network pharmacy. The list currently includes certain prescription drug products under the following drug classes or categories: insulins, epinephrine, glucagon, naloxone, albuterol inhalers and nebulized solutions.
- **Additional Payments for Out-of-Network Benefits:** The following provision has been removed: When you receive covered services from non-participating provider, we will calculate the allowed amount based on the location of the non-participating provider's office. This will apply even if the covered service was received in a different location.
- **Assignment of Benefits:** You cannot assign any benefits or legal claims based on a denial of benefits or request for plan documents to any person, corporation, or other organization and any such assignment will be void and unenforceable. You cannot assign any monies due to any person, corporation, or other organization. Assignment means the transfer to another person, corporation or other organization of your right to the services provided under this Certificate or your right to collect money from us for those services or your right to sue based on a denial of benefits or request for plan documents. Nothing in this paragraph shall affect your right to appoint a designee or representative as otherwise permitted by applicable law.
- **Care Cash:** Care Cash, a new program designed to help members pay for cost sharing for certain services through a prefunded debit card, is included in the following plans: NY P LBTY NG (5/35/500/100 EPO 23), NY G LBTY NG (20/40/2000/80 EPO 23), or NY S LBTY NG (25/45/5000/50 EPO 23).
- **Cost-Share:** Any cost-sharing changes, including whether the plan is a different metallic level from the previous plan, are described in the REVIEW section of your renewal package.
- **Defined Term - Designated Virtual Network Provider:** The Designated Virtual Network Provider definition no longer includes “a designated virtual network provider may be a local provider, who offers health care services to a patient population within a fixed or defined geography, or a national care provider, who offers health care services to a patient population within the entirety of the United States, including United States territories”.
- **Definition of Formulary:** The definition of formulary has been revised to: The list that identifies those prescription drugs for which coverage may be available. To determine which tier a particular prescription drug has been assigned, visit our website at www.myuhc.com or call the number on your ID card.
- **Definitions Added:** A definition may have been added to your plan for the following: "in-network cost-sharing", "out-of-network cost-sharing", "per occurrence deductible", and "premium".
- **Designated Pharmacies:** We will provide benefits that apply to prescription drugs dispensed by a designated pharmacy to prescription drugs that are purchased from a retail pharmacy when that retail pharmacy is a participating pharmacy and agrees to the same reimbursement amount as the designated pharmacy.
- **Early Intervention Program Services:** Medically necessary early intervention services are reimbursed through an early intervention program (“EIP”) services pool.
- **Formulary Changes:** We will not add utilization management restrictions to a prescription drug on our formulary during a plan year unless the requirements are added pursuant to FDA safety concerns.
- **Independent Dispute Resolution Process:** Either we or a provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.
- **Insulin Drugs:** For insulin drugs, the cost sharing will not exceed $100 (including before the deductible) for a 30-day supply for each insulin prescription.

- **Laboratory Procedures:** For preferred provider benefits, laboratory services must be received by a preferred provider. Lab services received from a participating provider that is not a preferred provider will be covered at a lower benefit level.
- **Mail Order Drugs:** We will provide benefits that apply to prescription drugs dispensed by a mail order pharmacy to prescription drugs that are purchased from a retail pharmacy when that retail pharmacy is a participating pharmacy and agrees to the same reimbursement amount as a participating mail order pharmacy.
- **My ScriptRewards Program:** My ScriptRewards program is no longer available.
- **Nutritional Counseling:** Mental health outpatient services includes nutritional counseling to treat a mental health condition.
- **Participating Provider:** If a covered person receives a covered health care service from an non-participating provider and was informed incorrectly by us prior to receipt of the covered health care service that the provider was a participating provider, either through our database, our provider directory, or in our response to a request for such information (via telephone, electronic, web-based or internet-based means), the covered person may be eligible for cost sharing that would be no greater than if the service had been provided from a participating provider. In these situations, if a provider bills you for more than your in-network cost-sharing and you pay the bill, you are entitled to a refund from the provider, plus interest.
- **Payments for Air Ambulance Services:** We will pay a participating provider the amount we have negotiated with the participating provider for the air ambulance service. We will pay a non-participating provider the amount we have negotiated with the non-participating provider for the air ambulance service or an amount We have determined is reasonable for the air ambulance service. However, the negotiated amount or the amount we determine is reasonable will not exceed the non-participating provider's charge. If a dispute involving a payment for air ambulance services is submitted to an independent dispute resolution entity (IDRE), we will pay the amount, if any, determined by the IDRE for the air ambulance services. You are responsible for any cost-sharing for air ambulance services. The non-participating provider may only bill you for your cost-sharing. If you receive a bill from a non-participating provider that is more than your cost-sharing, you should contact us.
- **Payments Relating to Emergency Services:** We will pay a participating provider the amount we have negotiated with the participating provider for the emergency services. We will pay a non-participating provider the amount we have negotiated with the non-participating provider for the emergency service or an amount we have determined is reasonable for the emergency service. However, the negotiated amount the amount we determine is reasonable will not exceed the non-participating provider's charge. The non-participating provider may only bill you for your cost-sharing. If you receive a bill from a non-participating provider that is more than your cost-sharing, you should contact us.
- **Prescription Drug Formulary Changes:** Our formulary is subject to our periodic review and modification. However, a prescription drug will not be removed from our formulary during the plan year, except when the FDA determines that such prescription drug should be removed from the market. Before we remove a prescription drug from our formulary at the beginning of the upcoming plan year, we will provide at least 90 days' notice prior to the start of the plan year. We will also post such notice on our website at www.myuhc.com. We will not add utilization management restrictions (e.g., step therapy or preauthorization requirements) to a prescription drug on our formulary during a plan year unless the requirements are added pursuant to FDA safety concerns.
- **Prescription Drug Preauthorization:** We will not add preauthorization requirements to a prescription drug on our formulary during a plan year unless the requirements are added pursuant to FDA safety concerns.
- **Prescription Drug Step Therapy:** We will not add step therapy requirements to a prescription drug on our formulary during a plan year unless the requirements are added pursuant to FDA safety concerns.
- **Prescription Drug Tier Status:** A prescription drug will not be moved to a tier with a higher cost-sharing during the plan year, except a brand-name drug may be moved to a tier with higher cost-sharing if an AB-rated generic equivalent or interchangeable biological product for that prescription drug is added to the formulary at the same time. Additionally, a prescription drug may be moved to a tier with a higher copayment during the plan year, although the change will not apply to you if you are already taking the prescription drug or you have been diagnosed or presented with a condition on or prior to the start of the plan year which is treated by such prescription drug or for which the prescription drug is or would be part of your treatment regimen. Before we move a prescription drug to a different tier, we will provide at least 90 days' notice prior to the start of the plan year. We will also post such notice on our website at www.myuhc.com. If a prescription drug is moved to a different tier during the plan year for one of reasons described above, we will provide at least 30 days' notice before the change is effective.

- **Renewal Date:** Your plan will automatically renew each year on the renewal date, unless otherwise terminated by us or you as permitted by this plan.
- **Surprise Bill Certification Forms:** Surprise bill certification forms should be submitted to the address on your ID card.
- **Surprise Bills:** You will be held harmless for any non-participating provider charges for the surprise bill that exceed your cost-sharing. The non-participating provider may only bill you for your cost-sharing. You can sign a form to notify us and the non-participating provider that you received a surprise bill. The form for surprise bills is available at www.dfs.ny.gov or you can visit our website at www.myuhc.com for a copy of the form. You need to mail a copy of the form to us at the address on your ID card and to your provider.
- **Sweat Equity Fitness Reimbursement**: Exercise activity fees include costs the subscriber pays for exercise facility fees, or exercise facility and class membership fees, outdoor bike rentals, organized group in-person exercise classes, individual fitness in-person instruction, or organized group in-person physical events, such as a marathon but only if such fees are paid to facilities or organizations which maintain equipment and/or offer programs that promote cardiovascular wellness and are available to the general public.
- **Termination of Coverage:** Coverage will terminate at the end of the month following the 30th day after the group's provision of written notice of termination of coverage to us; or such later termination date requested by the group's notice.
- **Travel and Lodging:** We will reimburse certain travel and lodging expenses for you to travel at least 50 miles from your residence to another state to access covered services when access to covered services is not available to you due to a law or regulation in the state where you reside unless such reimbursement is prohibited by law. This program provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the covered person. Lodging expenses are limited to $50 per night for you, or $100 per night if you are traveling with a companion.
- **UnitedHealthcare Rewards Program:** UHC Rewards is included. UHC Rewards is a digital wellness and rewards program that provides the opportunity for eligible members to receive rewards for achieving certain goals. Some examples of goals include completing 30 minutes of activity or steps per day, completing a biometric screening, participating in programs like Real Appeal, signing up for a flu shot, or taking a health risk assessment. If you have Motion and/or Simply Engaged programs, they are no longer available.
- **Variable Copay Program:**
    - The variable copay program has been removed.
    - The following provision has been removed: The amount of the coupon will not count toward any applicable deductible or out-of-pocket limits.
- **Vision Care Rider:** For Freedom Plans only, a comprehensive vision benefit has been added.
- **Wellness Program:** The wellness program has been removed as other programs to encourage you to manage your health and well-being are included.
- **When a Brand-Name Drug Becomes Available as a Generic Drug:** The provision when a brand-name drug becomes available as a generic drug has been removed in its entirety.
- **When Your Provider Leaves the Network:** If you are pregnant, you may continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. You will be responsible only for any applicable cost-sharing.
- **Who Receives Payment under this Contract/Certificate:** Payments for services provided by a participating provider will be made directly by us to the provider. If you receive services from a non-participating provider, we reserve the right to pay either you or the provider. However, we will directly pay a provider instead of you for emergency services, including inpatient services following emergency department care, pre-hospital emergency medical services, air ambulance services, and surprise bills.
- **Your Right to an External Appeal:** In some cases, you have a right to an external appeal of a denial of coverage. If we have denied coverage on the basis that a service is not medically necessary (including appropriateness, health care setting, level of care or effectiveness of a covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment; or is an emergency service or a surprise bill (including whether the correct cost-sharing was applied), you or your representative may appeal that decision to an external appeal agent, an independent third party certified by the state to conduct these appeals.

New York Member Enrollment Form – OHI

MAILING ADDRESS: P. O. Box 29142, Hot Springs, AR 71903 • 1-800-444-6222

UnitedHealthcare Oxford

THANK YOU FOR CHOOSING AN OXFORD PRODUCT
FOR YOU AND YOUR FAMILY.

IMPORTANT:

PLEASE PRINT AND PRESS DOWN FIRMLY WHEN COMPLETING THIS FORM.

IN ORDER TO PROCESS THE ATTACHED FORM AND BEGIN COVERAGE, ALL FIELDS MUST BE COMPLETED ACCURATELY AND IN ITS ENTIRETY.

BE SURE TO:

- @ Use only blue or black ballpoint pen
- @ Enter all dates using the MM/DD/YYYY format
- @ Employer and employee signatures are required
- @ List any coordinating coverage (coverage in addition to this coverage)
- @ List any coverage you had prior to this coverage
- @ Attach disability paperwork, if applicable
- @ Check “young adult” in the child column if the child is under the age of 30, eligible, and enrolling onto the young adult option. The young adult will also need to list their qualifying event, address and signature.
- @ Submit this form within 31 days of the requested effective date or within 60 days of the qualifying event for COBRA or State Continuation

IF YOU HAVE ANY QUESTIONS,
PLEASE FEEL FREE TO CALL CUSTOMER SERVICE AT
1-800-444-6222

New York Member Enrollment Form – OHI

UnitedHealthcare Oxford

MAILING ADDRESS: P. O. Box 29142, Hot Springs, AR 71903 • 1-800-444-6222

A. Group Information (To be completed by the employer)

Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY

Group Number	Group Name	Plan CSP/Plan ID	Billing Group	Date of Hire	Effective Date	Occupation
1299345	Kulanu Academy			/ /	/ /	

☐ On Leave of Absence ☐ Retired ☐ Union Employee

COBRA/Young Adult/SC Qualifying Event — Event Date / /

Employer Signature X — Date / /

B. Applicant Details (To be completed by the employee)

	Employee/Subscriber	Spouse	Child	Child
Social Security Number:				
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender: (Check appropriate boxes.)	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:		☐ Domestic Partner	☐ Young Adult	☐ Young Adult

C. Coordination of Benefits

	Employee/Subscriber	Spouse	Child	Child
Medicare Coverage — Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all — Policy Number: Carrier: Policy Holder: Effective Date: / / Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all — Policy Number: Carrier: Policy Holder: Effective Date:	/ /	/ /	/ /	/ /

I understand that my enrollments and benefits are in accordance with those described in the Oxford Health Insurance Certificate. I understand that, in order to receive in-network benefits, I and any enrolled dependents must seek care through our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. I further understand that if I do not adhere to these requirements, I will be eligible only for out-of-network health insurance coverage under the terms of the Certificate. **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.** I authorize any health provider or insurer to furnish Oxford any records concerning me or any enrolled member of my family for whom information is requested.

Employee's/Young Adult's Address	(Apt #)	Preferred Phone: ☐ Home ☐ Cell ☐ Work _____
City / State / ZIP Code		Alternate Phone: ☐ Home ☐ Cell ☐ Work _____
Email Address:		Employee's/Young Adult's Signature X — Date / /

UnitedHealthcare Oxford

Addition/Termination Change Form

P. O. Box 29142, Hot Springs, AR 71903 ▪ 1-800-444-6222

Please print neatly using black or blue ballpoint pen

ALL DATES MUST BE: MM/DD/YYYY

A. Employer/Employee Information (To be completed by the employer)

Group ID Number: 1299345	Group Name: Kulanu Academy
Employee Insurance ID Number:	Employer Signature X / Date / /
Employee Name:	

B. Transaction	Effective Date	Required Information
☐ **Termination**	/ /	**Who:** ☐ Employee ☐ Spouse/Partner ☐ Dependent(s) ☐ NY Young Adult **Reason:** ☐ Left Employer ☐ Discontinue COBRA ☐ Switched Plans ☐ Discontinue NY Young Adult ☐ Other:
☐ **Change** Address changes can be done online or by calling Oxford.	/ /	**Who:** Last Name: First Name: Effective Date: / / Date of Birth: / / Other: SS#: Middle Intial: Gender: ☐ M ☐ F
☐ **COBRA or State Continuation**	/ /	**Who:** ☐ Employee ☐ Spouse/Partner* ☐ Dependent(s)* **Reason:** ☐ Left Employer ☐ Hours Reduction ☐ Other: Date of Event: / / *A **New Member Enrollment Form** is required for: Loss of Dependent Status, Divorce/Separation, or Death of Subscriber.
☐ **Transfer** Complete entire section	/ /	New Plan CSP/Plan ID: New Billing Group: Reason: Retiree Drug Subsidy: ☐ Yes ☐ No Actively Working: ☐ Yes ☐ No Enrolled in Medicare Part: ☐ A ☐ B ☐ D
☐ **Addition** Complete WHO, REASON and SECTION C below	/ /	**Who:** ☐ Spouse ☐ Civil Union ☐ Domestic Partner ☐ Dependent(s) **Reason:** ☐ Open Enrollment ☐ Loss of Coverage ☐ Birth/Adoption ☐ Other: ☐ Date of Marriage ☐ Date of Civil Union ☐ Date of Partnership

C. Additional Information	Spouse	Dependent	Dependent
Social Security Number:			
Last Name:			
First Name, Middle Initial:			
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /
Gender and Disability Status:	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient, check "Yes".)	☐ Yes	☐ Yes	☐ Yes
Check all that apply:	☐ Actively employed ☐ Not actively employed	☐ Full-time Student (Age 19 - 23)	☐ Full-time Student (Age 19 - 23)
Prior Carrier What coverage you had prior to this. Policy Number: Carrier: From Date: Through Date:	/ / / /	/ / / /	/ / / /

D. Coordination of Benefits		Spouse	Dependent	Dependent
Medicare	Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all Effective Date: / /	Policy Number: Carrier: Policy Holder: Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: Carrier: Policy Holder: Effective Date:	/ /	/ /	/ /

ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR INSURANCE IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES

Employee Signature X _____ Date / /

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