UnitedHealthcare/Oxford[1]: EXCLUSIVE PLAN FREEDOM OXF-FRE EPO 6B-NY

Coverage Period: 06/01/2015-05/31/2016

Coverage for: Employee + Family | **Plan Type:** EPO

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com/oxford or by calling the Member Service number listed on the back of your ID card.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,000** Individual/**$2,000** Family Per Calendar year. Prescription drugs, and services listed below with Copays and "No Charge" do not apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	Yes, Prescription drugs -- **$100** per person. 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.
Is there an out-of-pocket limit on my expenses?	Yes, Network: **$2,500** Individual/**$5,000** Family	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of–pocket limit?	Premium, balance-billed 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**. So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No, this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses **network providers**. If you use a non-network **provider** your cost may be more. For a list of **network providers**, see welcometouhc.com/oxford or call 1-800-444-6222.	If you use an **in-network** doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Plans use the terms **in-network**, preferred, or participating to refer to **providers** in their network.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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

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

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles, copayments and coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use a Participating Provider	Your Cost if You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$50 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$50 copay per visit	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Pre-Authorization required for Sleep Studies or benefit reduces to 50% of allowed. Radiology Covered at Deductible then 0% co-ins.
	Imaging (CT/PET scans, MRIs)	0% co-ins after ded	Not Covered	------none-------

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Common Medical Event	Services You May Need	Your Cost if You Use a Participating Provider	Your Cost if You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at oxfordhealth.com.**	Tier 1 - Your Lowest-Cost Option	Retail: $15 copay Mail-Order: $37.50 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-authorization requirement or may result in a higher cost. Tier 1 Contraceptives covered at No Charge. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Pharmacy Deductible does not apply to Tier 1.
	Tier 2 - Your Mid-Range Cost Option	Retail: $30 copay Mail-Order: $75 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail: $60 copay Mail-Order: $180 copay	Not Covered	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins after ded	Not Covered	---none---
	Physician/surgeon fees	0% co-ins after ded	Not Covered	---none---
If you need immediate medical attention	Emergency room services	$200 copay per visit	$200 copay per visit	---none---
	Emergency medical transportation	No Charge	Not Covered	---none---
	Urgent care	$50 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins after ded	Not Covered	---none---
	Physician/surgeon fee	0% co-ins after ded	Not Covered	---none---

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Common Medical Event	Services You May Need	Your Cost if You Use a Participating Provider	Your Cost if You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay per visit	Not Covered	---none---
	Mental/Behavioral health inpatient services	0% co-ins after ded	Not Covered	---none---
	Substance use disorder outpatient services	$50 copay per visit	Not Covered	---none---
	Substance use disorder inpatient services	0% co-ins after ded	Not Covered	---none---
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	0% co-ins after ded	Not Covered	---none---
If you need help recovering or have other special health needs	Home health care	$50 copay per visit	Not Covered	Limited to 60 visits per Calendar Year.
	Rehabilitation services	$50 copay per outpatient visit	Not Covered	Depending on the type of therapy, there is a limit of 90 visits per Calendar Year, combined with Habilitative.
	Habilitative services	$50 copay per outpatient visit	Not Covered	Services provided under and limits are combined with Rehabilitation Services above.
	Skilled nursing care	0% co-ins after ded	Not Covered	Limited to 30 days per Calendar Year.
	Durable medical equipment	0% co-ins after ded	Not Covered	Pre-Authorization required for items over $500.
	Hospice service	0% co-ins after ded	Not Covered	---none---

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Common Medical Event	Services you may need	Your Cost if You Use a Participating Provider	Your Cost if You Use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No Coverage for Eye Exam.
	Glasses	Not Covered	Not Covered	No Coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No Coverage for Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

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

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Chiropractic Care
- Hearing aids
- Infertility treatment

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance.**
For questions about your rights, this notice, or assistance, you can contact: your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or dfs.ny.gov/index.html.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

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

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- ☐ **Amount owed to providers:** $7,540
- ☐ **Plan pays** $6,320
- ☐ **Patient pays** $1,220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,220**

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

- ☐ **Amount owed to providers**: $5,400
- ☐ **Plan pays** $3,860
- ☐ **Patient pays** $1,540

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$1,400
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,540**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the examples.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

X **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

X **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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2015/2016

Plan Description: Guardian PPO XS Northeast
Product: PPO
Network: DentalGuard Preferred
Provider: Guardian Dental
Member Services Phone #: 1-800-541-7846
Plan Website Address: http://www.guardiananytime.com

Benefit	In-Network	Out-of-Network
Deductibles & Maximum Amounts		
Calendar Year Benefit Maximum	• $1,200	• $1,200
Calendar Year Deductible - Individual	• None	• $50
Calendar Year Deductible - Family	• None	• $150
Preventive & Diagnostic Services		
Preventive & Diagnostic Services	• 100%	• Deductible then 100% of UCR
Basic / Restorative Services		
Basic / Restorative Services	• 90%	• Deductible then 75% of UCR
Major Services		
Major Services	• 60%	• Deductible then 50% of UCR
Orthodontic Services		
Orthodontic Lifetime Maximum	• $1,200 lifetime maximum for child(ren) under age 19. Adult ortho not covered	• $1,200 lifetime maximum for child(ren) under age 19. Adult ortho not covered
Orthodontic Deductible	• None	• None
Orthodontic Coinsurance	• 50%	• 50%
Diagnosis	• 50%	• 50%
Initial Placement of Orthodontic Appliance	• Covered as part of Active and Retention Treatments	• Covered as part of Active and Retention Treatments
Active and Retention Treatments	• 50%	• 50%
Services		
Oral Examination Copay / Coinsurance	• 100%	• Deductible then 100% of UCR
Dental X-Rays	• 100%	• Deductible then 100% of UCR
Prophylaxis - Adult	• 100%	• Deductible then 100% of UCR
Prophylaxis - Child	• 100%	• Deductible then 100% of UCR
Topical Application of Fluoride	• 100%	• Deductible then 100% of UCR
Topical Application of Sealants	• 100%	• Deductible then 100% of UCR
Fillings	• 90%	• Deductible then 75% of UCR
Periodontic Services	• 60%	• Deductible then 50% of UCR
Extractions	• Simple Extractions: 90%, Surgical Extractions: 60%	• Simple Extractions: Deductible then 75% of UCR, Surgical Extractions: Deductible then 50% of UCR
Endodontics	• 60%	• Deductible then 50% of UCR
Oral Surgery	• 60%	• Deductible then 50% of UCR
Inlays	• 60%	• Deductible then 50% of UCR
Crowns	• 60%	• Deductible then 50% of UCR
Dentures	• 60%	• Deductible then 50% of UCR
Bridges	• 60%	• Deductible then 50% of UCR

Get the best in eyecare and eyewear with ADP TOTAL SOURCE and VSP® Vision Care.

Why enroll in VSP? We invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness first.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP provider including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Register at vsp.com.**
  Once your plan is effective, review your benefit information.
- **Find an eyecare provider who's right for you.**
  To find a VSP provider, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a VSP provider who carries these brands.

Enroll in VSP today. You'll be glad you did.

Contact us. **800.877.7195**
vsp.com

Your VSP Vision Benefits Summary

ADP TOTAL SOURCE and VSP provide you with an affordable eyecare plan.

VSP Coverage Effective Date: 06/01/2015
VSP Provider Network: VSP Choice

Visit **vsp.com** for more details on your vision benefit and for exclusive savings and promotions for VSP members.

Benefit	Description	Copay	Frequency
	Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$5	Every plan year*
Prescription Glasses		$10	See frame and lenses
Frame	• $180 allowance for a wide selection of frames • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every plan year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every plan year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every plan year
Contacts (instead of glasses)	• $150 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every plan year
Laser VisionCare Preferred Program	• $150 allowance both eyes for LASIK, Custom LASIK, and PRK. • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities. • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.	$0	Every plan year
Extra Savings	**Glasses and Sunglasses** • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		

Your Coverage with Out-of-Network Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

Exam.....up to $45	Single Vision Lenses.....up to $45	Lined Trifocal Lenses.....up to $85	Contacts.....up to $150
Frame.....up to $70	Lined Bifocal Lenses.....up to $65	Progressive Lenses.....up to $65	

* Plan year begins in June
VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Enroll in VSP today. You'll be glad you did.
Contact us. **800.877.7195**
vsp.com

[1] Brands/Promotion subject to change.