



BENEFIT		In-Network
<b>FINANCIAL</b>		
Deductible:	Single	\$2,500
	Family	\$5,000*
Coinsurance		50%
Maximum Out-of-Pocket:	Single	\$6,450
(Including Deductible)	Family	\$12,900
Financial Accumulation Period:		Calendar Year
<i>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.</i>		
<b>PREVENTIVE CARE</b>		
Adult Preventive Care		No Charge
Infant and Pediatric Preventive Care		No Charge
<b>OUTPATIENT CARE</b>		
Primary Care Physician Office Visits		Deductible & 50% Coinsurance
Specialist Office Visits		Deductible & 50% Coinsurance
Virtual Visits		No Charge after Deductible
Outpatient Surgery - Hospital Setting		Deductible & 50% Coinsurance
Outpatient Surgery - Freestanding Facility		Deductible & 50% Coinsurance
Laboratory Services - Hospital Setting		Deductible & 50% Coinsurance
Laboratory Services - Freestanding Facility		Deductible & 50% Coinsurance
<i>(See your Certificate of Coverage for additional Lab details)</i>		
Radiology Services - Hospital Setting		Deductible & 50% Coinsurance
Radiology Services - Freestanding Facility		Deductible & 50% Coinsurance
<b>MRIs, MRAs, CT SCANS, AND PET SCANS</b>		
Outpatient Hospital Services		Deductible & 50% Coinsurance
Freestanding Radiology Facility		Deductible & 50% Coinsurance
<b>HOSPITAL CARE</b>		
Physician's and Surgeon's Services		Deductible & 50% Coinsurance
Semi-Private Room and Board		Deductible & 50% Coinsurance
All Drugs and Medication		Deductible & 50% Coinsurance
<b>EMERGENCY CARE</b>		
Ambulance Service When Medically Necessary		Deductible & 50% Coinsurance
At Hospital Emergency Room		Deductible & 50% Coinsurance
<i>(If member is admitted to the hospital, notification is required)</i>		
Emergency Care in Urgi-Center		Deductible & 50% Coinsurance
<b>MATERNITY CARE</b>		
Routine Prenatal and Post-Natal Care		No Charge
Hospital Services For Mother and Child		Deductible & 50% Coinsurance
<b>SKILLED NURSING FACILITY</b>		
30 Days per Calendar Year		Deductible & 50% Coinsurance
<b>HOSPICE CARE (180 days per lifetime combined Inpatient &amp; Home)</b>		
Inpatient Care		Deductible & 50% Coinsurance
Home Hospice Care Visits		Deductible & 50% Coinsurance
<b>HOME HEALTH CARE</b>		
Home Care Visits - 60 Visits per Calendar Year		Deductible & 50% Coinsurance
Physician House Calls		Deductible & 50% Coinsurance
<b>SUBSTANCE USE DISORDER SERVICES</b>		
Inpatient Rehabilitation		Deductible & 50% Coinsurance
Office Visits or Outpatient Rehabilitation		Deductible & 50% Coinsurance
Outpatient Partial Hospitalization		Deductible & 50% Coinsurance
<b>MENTAL HEALTH CARE</b>		
Inpatient Care		Deductible & 50% Coinsurance
Office Visits or Outpatient Care		Deductible & 50% Coinsurance
Outpatient Partial Hospitalization		Deductible & 50% Coinsurance
<b>ALLERGY CARE</b>		
Testing and Treatment		Deductible & 50% Coinsurance

<b>BENEFIT</b>	<b>In-Network</b>
<b>CHIROPRACTIC CARE</b>	
Chiropractic Care	Deductible & 50% Coinsurance
<b>SHORT TERM REHAB &amp; HABILITATIVE SERVICES</b>	
60 Inpatient Days per Calendar Year	Deductible & 50% Coinsurance
60 combined Outpatient Visits per Calendar Year	Deductible & 50% Coinsurance
<b>DURABLE MEDICAL EQUIPMENT</b>	
Unlimited <i>(Precertification required for items over \$500)</i>	No Charge after Deductible
<b>HEARING AIDS</b>	
Hearing Aids - Limited to 1 hearing aid for each hearing impaired ear every 24 months.	No Charge after Deductible
<b>MEDICAL SUPPLIES</b>	
Medical Supplies when Medically Necessary	Deductible & 50% Coinsurance
<b>EXERCISE FACILITY</b>	
Subscriber	\$200 reimbursement per 6 month period
Spouse/Dependents over age 13	\$100 reimbursement per 6 month period
<b>INFERTILITY TREATMENT</b>	
Specialist Office Visits	Deductible & 50% Coinsurance
Outpatient Freestanding Facility Services	Deductible & 50% Coinsurance
Outpatient Hospital Facility Services	Deductible & 50% Coinsurance
Inpatient Facility Services	Deductible & 50% Coinsurance
<b>INFERTILITY MEDICATIONS</b>	
Infertility Medications	Covered Subject to the applicable Prescription Drug Out-of-Pocket Expense.
<b>OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE</b>	
	Subject to Plan Deductible then applicable Prescription Drug Copay
<b>OUTPATIENT PRESCRIPTION DRUGS - RETAIL</b>	
<i>The Prescription Drug Benefit is based on a Per Calendar Year Limit for any applicable deductible and/or maximum limits.</i>	
Tier 1	\$25 copay
Tier 2	\$50 copay
Tier 3	\$75 copay
<b>OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER</b>	
Tier 1	\$50 copay
Tier 2	\$100 copay
Tier 3	\$150 copay

**DEPENDENT ELIGIBILITY:**

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.  
Benefits discontinue at the end of the Month.  
Domestic Partners covered with proper documentation.

\*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.

**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, Workers' Compensation, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.