



BENEFIT		In-Network
FINANCIAL		
Deductible:	Single	\$2,500
	Family	\$5,000*
Coinsurance		50%
Maximum Out-of-Pocket:	Single	\$6,350
(Including Deductible)	Family	\$12,700
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>		
PREVENTIVE CARE		
Adult Preventive Care		No Charge
Infant and Pediatric Preventive Care		No Charge
OUTPATIENT CARE		
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 & 40% 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
MRIs, MRAs, CT SCANS, AND PET SCANS		
Outpatient Hospital Services		Deductible & 50% Coinsurance
Freestanding Radiology Facility		Deductible & 40% Coinsurance
HOSPITAL CARE		
Physician's and Surgeon's Services		Deductible & 50% Coinsurance
Semi-Private Room and Board		Deductible & 50% Coinsurance
All Drugs and Medication		Deductible & 50% Coinsurance
EMERGENCY CARE		
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
MATERNITY CARE		
Routine Prenatal and Post-Natal Care		No Charge
Hospital Services For Mother and Child		Deductible & 50% Coinsurance
SKILLED NURSING FACILITY		
30 Days per Calendar Year		Deductible & 50% Coinsurance
HOSPICE CARE (180 days per lifetime combined Inpatient & Home)		
Inpatient Care		Deductible & 50% Coinsurance
Home Hospice Care Visits		Deductible & 50% Coinsurance
HOME HEALTH CARE		
Home Care Visits - 60 Visits per Calendar Year		Deductible & 50% Coinsurance
Physician House Calls		Deductible & 50% Coinsurance
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation		Deductible & 50% Coinsurance
Office Visits or Outpatient Rehabilitation		Deductible & 50% Coinsurance
Outpatient Partial Hospitalization		Deductible & 50% Coinsurance
MENTAL HEALTH CARE		
Inpatient Care		Deductible & 50% Coinsurance
Office Visits or Outpatient Care		Deductible & 50% Coinsurance
Outpatient Partial Hospitalization		Deductible & 50% Coinsurance
ALLERGY CARE		
Testing and Treatment		Deductible & 50% Coinsurance

BENEFIT	In-Network
CHIROPRACTIC CARE	
Chiropractic Care	Deductible & 50% Coinsurance
SHORT TERM REHAB & HABILITATIVE SERVICES	
60 Inpatient Days per Calendar Year	Deductible & 50% Coinsurance
60 combined Outpatient Visits per Calendar Year	Deductible & 50% Coinsurance
DURABLE MEDICAL EQUIPMENT	
Unlimited <i>(Precertification required for items over \$500)</i>	No Charge after Deductible
HEARING AIDS	
Hearing Aids - Limited to 1 hearing aid for each hearing impaired ear every 24 months.	No Charge after Deductible
MEDICAL SUPPLIES	
Medical Supplies when Medically Necessary	Deductible & 50% Coinsurance
EXERCISE FACILITY	
Subscriber	\$200 reimbursement per 6 month period
Spouse/Dependents over age 13	\$100 reimbursement per 6 month period
INFERTILITY TREATMENT	
Specialist Office Visits	Deductible & 50% Coinsurance
Outpatient Freestanding Facility Services	Deductible & 40% Coinsurance
Outpatient Hospital Facility Services	Deductible & 50% Coinsurance
Inpatient Facility Services	Deductible & 50% Coinsurance
INFERTILITY MEDICATIONS	
Infertility Medications	Covered Subject to the applicable Prescription Drug Out-of-Pocket Expense.
OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE	
	Subject to Plan Deductible then applicable Prescription Drug Copay
OUTPATIENT PRESCRIPTION DRUGS - RETAIL	
<i>The Prescription Drug Benefit is based on a Per Calendar Year Limit for any applicable deductible and/or maximum limits.</i>	
Tier 1	\$15 copay
Tier 2	50% Coinsurance to max of \$250 per script
Tier 3	50% Coinsurance to max of \$250 per script
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER	
Tier 1	\$30 copay
Tier 2	50% Coinsurance to max of \$500 per script
Tier 3	50% Coinsurance to max of \$500 per script

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.