



OXFORD HEALTH INSURANCE, INC.  
Oxford EPO HSA Select Plan  
SUMMARY OF COVERAGE  
Liberty Network  
Abel HR

| BENEFIT                                                                                                                                                                               |        | In-Network                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------------------|
| <b>FINANCIAL</b>                                                                                                                                                                      |        |                              |
| Deductible:                                                                                                                                                                           | Single | \$2,000                      |
|                                                                                                                                                                                       | Family | \$4,000*                     |
| Coinsurance                                                                                                                                                                           |        | 40%                          |
| Maximum Out-of-Pocket:<br>(Including Deductible)                                                                                                                                      | Single | \$6,350                      |
|                                                                                                                                                                                       | 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> |        |                              |
| <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 & 40% Coinsurance |
| Specialist Office Visits                                                                                                                                                              |        | Deductible & 40% Coinsurance |
| Virtual Visits                                                                                                                                                                        |        | No Charge after Deductible   |
| Outpatient Surgery - Hospital Setting                                                                                                                                                 |        | Deductible & 40% Coinsurance |
| Outpatient Surgery - Freestanding Facility                                                                                                                                            |        | Deductible & 40% Coinsurance |
| Laboratory Services - Hospital Setting                                                                                                                                                |        | Deductible & 40% Coinsurance |
| Laboratory Services - Freestanding Facility                                                                                                                                           |        | Deductible & 40% Coinsurance |
| <i>(See your Certificate of Coverage for additional Lab details)</i>                                                                                                                  |        |                              |
| Radiology Services - Hospital Setting                                                                                                                                                 |        | Deductible & 40% Coinsurance |
| Radiology Services - Freestanding Facility                                                                                                                                            |        | Deductible & 40% Coinsurance |
| <b>MRIs, MRAs, CT SCANS, AND PET SCANS</b>                                                                                                                                            |        |                              |
| Outpatient Hospital Services                                                                                                                                                          |        | Deductible & 40% Coinsurance |
| Freestanding Radiology Facility                                                                                                                                                       |        | Deductible & 40% Coinsurance |
| <b>HOSPITAL CARE</b>                                                                                                                                                                  |        |                              |
| Physician's and Surgeon's Services                                                                                                                                                    |        | Deductible & 40% Coinsurance |
| Semi-Private Room and Board                                                                                                                                                           |        | Deductible & 40% Coinsurance |
| All Drugs and Medication                                                                                                                                                              |        | Deductible & 40% Coinsurance |
| <b>EMERGENCY CARE</b>                                                                                                                                                                 |        |                              |
| Ambulance Service When Medically Necessary                                                                                                                                            |        | Deductible & 40% Coinsurance |
| At Hospital Emergency Room                                                                                                                                                            |        | Deductible & 40% Coinsurance |
| <i>(If member is admitted to the hospital, notification is required)</i>                                                                                                              |        |                              |
| Emergency Care in Urgi-Center                                                                                                                                                         |        | Deductible & 40% Coinsurance |
| <b>MATERNITY CARE</b>                                                                                                                                                                 |        |                              |
| Routine Prenatal and Post-Natal Care                                                                                                                                                  |        | No Charge                    |
| Hospital Services For Mother and Child                                                                                                                                                |        | Deductible & 40% Coinsurance |
| <b>SKILLED NURSING FACILITY</b>                                                                                                                                                       |        |                              |
| 30 Days per Calendar Year                                                                                                                                                             |        | Deductible & 40% Coinsurance |
| <b>HOSPICE CARE (180 days per lifetime combined Inpatient &amp; Home)</b>                                                                                                             |        |                              |
| Inpatient Care                                                                                                                                                                        |        | Deductible & 40% Coinsurance |
| Home Hospice Care Visits                                                                                                                                                              |        | Deductible & 40% Coinsurance |
| <b>HOME HEALTH CARE</b>                                                                                                                                                               |        |                              |
| Home Care Visits - 60 Visits per Calendar Year                                                                                                                                        |        | Deductible & 40% Coinsurance |
| Physician House Calls                                                                                                                                                                 |        | Deductible & 40% Coinsurance |
| <b>SUBSTANCE USE DISORDER SERVICES</b>                                                                                                                                                |        |                              |
| Inpatient Rehabilitation                                                                                                                                                              |        | Deductible & 40% Coinsurance |
| Office Visits or Outpatient Rehabilitation                                                                                                                                            |        | Deductible & 40% Coinsurance |
| Intensive Behavioral Therapy                                                                                                                                                          |        | Deductible & 40% Coinsurance |
| Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment                                                   |        | Deductible & 40% Coinsurance |
| <b>MENTAL HEALTH CARE</b>                                                                                                                                                             |        |                              |
| Inpatient Care                                                                                                                                                                        |        | Deductible & 40% Coinsurance |
| Office Visits or Outpatient Care                                                                                                                                                      |        | Deductible & 40% Coinsurance |
| Intensive Behavioral Therapy                                                                                                                                                          |        | Deductible & 40% Coinsurance |
| Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment                                                   |        | Deductible & 40% Coinsurance |

| BENEFIT                                                                                                                         | In-Network                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <b>ALLERGY CARE</b>                                                                                                             |                                                                            |
| Testing and Treatment                                                                                                           | Deductible & 40% Coinsurance                                               |
| <b>CHIROPRACTIC CARE</b>                                                                                                        |                                                                            |
| Chiropractic Care                                                                                                               | Deductible & 40% Coinsurance                                               |
| <b>SHORT TERM REHAB &amp; HABILITATIVE SERVICES</b>                                                                             |                                                                            |
| 60 Inpatient Days per Calendar Year                                                                                             | Deductible & 40% Coinsurance                                               |
| 60 combined Outpatient Visits per Calendar Year                                                                                 | Deductible & 40% Coinsurance                                               |
| <b>DURABLE MEDICAL EQUIPMENT</b>                                                                                                |                                                                            |
| Unlimited<br><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 & 40% 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 & 40% Coinsurance                                               |
| Outpatient Surgery - Hospital Setting                                                                                           | Deductible & 40% Coinsurance                                               |
| Outpatient Surgery - Freestanding Facility                                                                                      | Deductible & 40% Coinsurance                                               |
| Inpatient Facility Services                                                                                                     | Deductible & 40% 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.