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

BENEFIT		In-Network
FINANCIAL		
Deductible:	Single	$2,500
	Family	$5,000*
Coinsurance		None
Maximum Out-of-Pocket:	Single	$6,900
(Including Deductible)	Family	$13,800
Financial Accumulation Period:		Calendar Year

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
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 - Hospital Setting	No Charge after Deductible
Laboratory Services - Freestanding Facility	No Charge after Deductible
(See your Certificate of Coverage for additional Lab details)	
Radiology Services - Hospital Setting	No Charge after Deductible
Radiology Services - Freestanding Facility	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	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	
Routine Prenatal and Post-Natal Care	No Charge
Hospital Services For Mother and Child	No Charge after Deductible
SKILLED NURSING FACILITY	
30 Days per Calendar Year	No Charge after Deductible
HOSPICE CARE (180 days per lifetime combined Inpatient & Home)	
Inpatient Care	No Charge after Deductible
Home Hospice Care Visits	No Charge after Deductible
HOME HEALTH CARE	
Home Care Visits - 60 Visits per Calendar Year	No Charge after Deductible
Physician House Calls	No Charge after Deductible
SUBSTANCE USE DISORDER SERVICES	
Inpatient Rehabilitation	No Charge after Deductible
Office Visits or Outpatient Rehabilitation	No Charge after Deductible
Intensive Behavioral Therapy	No Charge after Deductible
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment	No Charge after Deductible
MENTAL HEALTH CARE	
Inpatient Care	No Charge after Deductible
Office Visits or Outpatient Care	No Charge after Deductible
Intensive Behavioral Therapy	No Charge after Deductible
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment	No Charge after Deductible

BENEFIT	In-Network
ALLERGY CARE	
Testing and Treatment	No Charge after Deductible
CHIROPRACTIC CARE	
Chiropractic Care	No Charge after Deductible
SHORT TERM REHAB & HABILITATIVE SERVICES	
60 Inpatient Days per Calendar Year	No Charge after Deductible
60 combined Outpatient Visits per Calendar Year	No Charge after Deductible
DURABLE MEDICAL EQUIPMENT	
Unlimited *(Precertification required for items over $500)*	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	No Charge after Deductible
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	No Charge after Deductible
Outpatient Surgery - Hospital Setting	No Charge after Deductible
Outpatient Surgery - Freestanding Facility	No Charge after Deductible
Inpatient Facility Services	No Charge after Deductible
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	
The Prescription Drug Benefit is based on a Per Calendar Year Limit for any applicable deductible and/or maximum limits.	
Tier 1	$25 copay
Tier 2	$50 copay
Tier 3	$75 copay
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER	
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.