



Certificate of Coverage

PLAN 21: EPO



2018 | 2019



Oxford Health Insurance, Inc.
EPO Select Plan Summary of Benefits
Liberty Network
Abel HR, Inc

Primary Care and Preventive Care Covered Services

Out-of-Pocket Expenses

Preventive Care

Well-Baby and Well-Child Care

No Charge

Adult Periodic Physical Examinations

No Charge

**Well-Woman Examinations, Family
Planning and Breast Pumps**

No Charge

Screening for Prostate Cancer

No Charge

**Physician (Primary Care) Office and Home Visits -
Treatment of Illness or Injury**

\$50 per visit

Physician (Primary Care) Hospital Visits

Deductible and 50% Coinsurance

Diabetes Services (Primary Care)

Supplies, Education and Self-Management

Supplies - \$50 per 31-day supply of each item

Education and Self-Management - \$50 per visit

Diabetes Medications

Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.

Elective Termination of Pregnancy-

This benefit is limited to a maximum of one procedure per Calendar Year.

Office Visits - \$50

Inpatient Facility - Deductible and 50% Coinsurance

Outpatient Facility - Deductible and 50% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance, Inc.
EPO Select Plan Summary of Benefits

<u>Specialty Care Covered Services</u>	<u>Out-of-Pocket Expenses</u>
Physician (Specialist) Office and Home Visits	\$75 per visit
Physician (Specialist) Hospital Visits	Deductible and 50% Coinsurance
Diabetes Services (Specialty Care)	
Supplies, Education and Self-Management	Supplies - \$75 per 31-day supply of each item
	Education and Self-Management - \$75 per visit
Diabetes Medications	Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.
Allergy Testing & Treatment	\$75 per visit
Maternity and Newborn Care	Maternity Care - \$50 for initial visit
	Inpatient hospital services are Covered subject to: the inpatient facility Out-of-Pocket Expense.
	<i>Routine prenatal office visits, as well as certain lab tests and counseling services as described in the United States Preventive Services Task Force A and B recommendations and the Health Resources and Services Administration women's health coverage requirements are considered preventive care and are covered at No Charge.</i>
Rehabilitation and Habilitative Services (Physical, Speech and Occupational Therapies)	
Inpatient services are limited to 60 days per Calendar Year.	Inpatient - Deductible and 50% Coinsurance
Outpatient services are limited to 60 visits combined per Calendar Year.	Outpatient - \$50 per visit

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Oxford Health Insurance, Inc.
EPO Select Plan Summary of Benefits

Specialty Care Covered Services

Out-of-Pocket Expenses

For Autism Spectrum Disorder and other Developmental Disabilities –

Inpatient services are limited to 60 days per Calendar Year.

Inpatient - Deductible and 50% Coinsurance

Outpatient services are limited to 60 visits combined per Calendar Year.

Outpatient - \$50 per visit

Please note that limits do not apply to the treatment of Autism Spectrum Disorder.

Reconstructive and Corrective Surgery

Office Visits - \$75 per visit

Inpatient Facility - Deductible and 50% Coinsurance

Outpatient Hospital Services - Deductible and 50% Coinsurance

Outpatient Ambulatory Surgical Center - Deductible and 50% Coinsurance

Physician Fees for Surgical and Medical Services - Deductible and 50% Coinsurance

Gender Dysphoria Services

Office Visits - \$75 per visit

Inpatient Facility - Deductible and 50% Coinsurance

Outpatient Hospital Services - Deductible and 50% Coinsurance

Outpatient Ambulatory Surgical Center - Deductible and 50% Coinsurance

Physician Fees for Surgical and Medical Services - Deductible and 50% Coinsurance

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Oxford Health Insurance, Inc.
EPO Select Plan Summary of Benefits

Specialty Care Covered Services

Out-of-Pocket Expenses

Oral Surgery

Office Visits - \$75 per visit

Inpatient Facility - Deductible and 50% Coinsurance

Outpatient Hospital Services - Deductible and 50% Coinsurance

Outpatient Ambulatory Surgical Center - Deductible and 50% Coinsurance

Physician Fees for Surgical and Medical Services - Deductible and 50% Coinsurance

Outpatient Cardiac Rehabilitation–

This benefit is unlimited.

No Charge

Outpatient Pulmonary Rehabilitation

No Charge

**Orthoptic Exercises and Corneal Topographic
Procedures**

No Charge

Outpatient Diagnostic Services

Laboratory Services

Office Based Services - No Charge

Outpatient Facility - No Charge

Radiology Services

Major Diagnostic Procedures:

Office Based Services – \$75 per visit

Freestanding Radiology Center - Deductible and 50% Coinsurance

Hospital Facility Based Services – Deductible and 50% Coinsurance

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Oxford Health Insurance, Inc.
EPO Select Plan Summary of Benefits

Specialty Care Covered Services

Out-of-Pocket Expenses

Radiology Services

All other Radiology:

Office Based Services – \$75 per visit

Freestanding Radiology Center - Deductible and 50% Coinsurance

Hospital Facility Based Services – Deductible and 50% Coinsurance

Internal and External Prosthetic Devices

Internal- No Charge. Surgery is subject to either the inpatient or outpatient facility Out-of-Pocket Expense.

Please Note: Reimbursement for these items will be at the same rate as under the federal Medicare reimbursement schedule.

External- No Charge

Durable Medical Equipment, Orthotics and Braces

No Charge

Medical Supplies (Non-Diabetic)

Deductible and 50% Coinsurance

Treatment of Infertility –

Limited to four completed egg retrievals (and the procedures and treatments associated with such retrievals) while covered under this plan or any plan with the same employer.

Office Visits - \$75 per visit

Inpatient Facility - Deductible and 50% Coinsurance

Outpatient Hospital Services - Deductible and 50% Coinsurance

Outpatient Ambulatory Surgical Center - Deductible and 50% Coinsurance

Physician Fees for Surgical and Medical Services - Deductible and 50% Coinsurance

Prescription Medications - Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.

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Oxford Health Insurance, Inc.
EPO Select Plan Summary of Benefits

Specialty Care Covered Services

Out-of-Pocket Expenses

Transplants

Transplants performed at Our approved facilities are Covered: Subject to the Inpatient facility Out-of-Pocket Expense.
When performed at other Network facilities – the services are Not Covered.

Clinical Trials

Office Visits - \$75 per visit

Inpatient Facility - Deductible and 50% Coinsurance

Outpatient Hospital Services - Deductible and 50% Coinsurance

Outpatient Ambulatory Surgical Center - Deductible and 50% Coinsurance

Physician Fees for Surgical and Medical Services - Deductible and 50% Coinsurance

Home Health Care –

This benefit is limited to 60 visits per Calendar Year.

\$75 per visit

Chemotherapy

Deductible and 50% Coinsurance when performed in an outpatient facility

Chemotherapy performed in an office setting - No Charge

Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.

Hemodialysis

Office Visits - No Charge

Inpatient Facility - Deductible and 50% Coinsurance

Outpatient Facility - Deductible and 50% Coinsurance

Physician Fees for Surgical and Medical Services - Deductible and 50% Coinsurance

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Oxford Health Insurance, Inc.
EPO Select Plan Summary of Benefits

<u>Specialty Care Covered Services</u>	<u>Out-of-Pocket Expenses</u>
Second and Third Opinions	At Your Request - \$75 per visit At Our Request – No Charge
Chiropractic Services	\$30 per visit
Hearing Aids – For Members through age 15, coverage for hearing aids is limited to one hearing aid for each hearing-impaired ear every 24 months. For Members age 16 and older, coverage for hearing aids is limited to \$5,000 per hearing aid for each hearing-impaired ear every 24 months.	No Charge
New Jersey Early Intervention Family Cost Share Expense for Autism and other Developmental Disabilities	\$50 per monthly expense
Nutritional Counseling	\$75 per visit
Obesity Surgery - limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy. Obesity surgery must be received at a Designated Facility.	Office Visits - \$75 per visit Inpatient Facility - Deductible and 50% Coinsurance Outpatient Hospital Services - Deductible and 50% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 50% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 50% Coinsurance

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Oxford Health Insurance, Inc.
EPO Select Plan Summary of Benefits

<u>Hospital & Facility Based Covered Services</u>	<u>Out-of-Pocket Expenses</u>
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Hospital Services

Inpatient - Deductible and 50% Coinsurance

Outpatient - Deductible and 50% Coinsurance

Outpatient Ambulatory Surgical Center

Deductible and 50% Coinsurance

Skilled Nursing Facility Services -

This benefit is limited to 30 days per Calendar Year.

Deductible and 50% Coinsurance

Hospice Services - This benefit is limited to 180 days (inpatient and outpatient combined) per Lifetime. 5 sessions for bereavement counseling are available to the Member's family either before or after the Member's death.

Inpatient - Deductible and 50% Coinsurance

Outpatient - \$75 per visit

Home Health Care - \$75 per visit

Skilled Nursing Facility Services - Deductible and 50% Coinsurance

Physician Fees for Surgical and Medical Services - Deductible and 50% Coinsurance

Physician Fees for Surgical and Medical Services

Deductible and 50% Coinsurance

<u>Mental Health Services and Substance Use Disorder Services</u>	<u>Out-of-Pocket Expenses</u>
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Mental Health Services – This benefit is provided to the same extent as other surgical or medical benefits Covered under the Certificate.

Office Visits/Outpatient - \$75 per visit

Inpatient - Deductible and 50% Coinsurance

Partial Hospitalization/Intensive Outpatient Treatment - No Charge

Physician Fees for Surgical and Medical Services - Deductible and 50% Coinsurance

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Oxford Health Insurance, Inc.
EPO Select Plan Summary of Benefits

<u>Mental Health Services and Substance Use Disorder Services</u>	<u>Out-of-Pocket Expenses</u>
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Substance Use Disorder Services – This benefit is provided to the same extent as other surgical or medical benefits Covered under the Certificate.

Office Visits/Outpatient - \$75 per visit

Inpatient - Deductible and 50% Coinsurance

Partial Hospitalization/Intensive Outpatient Treatment - No Charge

Physician Fees for Surgical and Medical Services - Deductible and 50% Coinsurance

<u>Medical Emergency Covered Services</u>	<u>Out-of-Pocket Expenses</u>
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Hospital Emergency Room Visits

\$100 per visit (waived if Member is admitted to the Hospital), in addition to 50% Coinsurance
Please note that the Emergency Room Copayment applies for each Hospital Emergency Room Visit and does not apply to the Plan Deductible. You will be responsible for the Emergency Room Copayment in addition to the Plan Deductible and/or Coinsurance.

Ambulance Services

Deductible and 50% Coinsurance

<u>Urgent Care Covered Services</u>	<u>Out-of-Pocket Expenses</u>
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Urgent Care

\$75 per visit

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

EPO Select Plan Summary of Benefits

Additional Coverage

Out-of-Pocket Expenses

Outpatient Prescription Drugs

Retail Benefit – The Out-of-Pocket Expenses are applied to each 31-day supply of a Prescription Drug to a maximum of a 90-day supply.

Triple Tier

Tier 1 Prescription Drug Products- \$25 Copayment

Tier 2 Prescription Drug Products- \$50 Copayment after the Deductible has been met

Tier 3 Prescription Drug Products- \$75 Copayment after the Deductible has been met

Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.

You are not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

Mail Order Benefit – up to a 90-day supply of Prescription Drugs will be provided.

You will be responsible for 2 retail Copayments for Prescription Drugs after the Deductible has been met.

Exercise Facility Reimbursement

Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.

We will reimburse a Subscriber \$200 per six-months. We will reimburse a Subscriber's spouse, civil union partner or domestic partner (if the Group has purchased this coverage) \$100 per six-months. The Member must complete 50 visits within the six-month period.

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EPO Select Plan Summary of Benefits

Precertification List

Breast Pumps, Insulin Pumps, Inpatient admissions for obstetrical services, Allergy Testing and Treatment performed outside a physician's office, Inpatient Rehabilitation Services, Inpatient Admission for Reconstructive and Corrective Surgery, Outpatient Cardiac Rehabilitation, Outpatient Pulmonary Rehabilitation, Orthoptic Exercises and Corneal Topographic Procedures, Inpatient Admission for Oral Surgery, Laboratory Procedures (Precertification is not required for routine blood work and screening tests), Major Diagnostic Procedures, Infertility Services, Chemotherapy, Internal Prosthetic Devices, Durable Medical Equipment (Precertification required before purchase of \$500 or more), Transplants, Clinical Trials, Home Health Care, Medical Supplies, Services Delivered in the Home, Hemodialysis, Home Treatment of Hemophilia, Chiropractic Services, Inpatient Hospital Services, Outpatient Hospital Services, Ambulatory Surgical Center Services, Inpatient or In-Home Hospice Services, Skilled Nursing Facility Services, Inpatient and Intermediate Care Substance Use Disorder Services, Inpatient and Intermediate Care Mental Health Services, Obesity Surgery, Non-Urgent Ambulance Services, and Gender Dysphoria Services.

Additional Plan Information

Plan Deductible

Individual: \$2,500 per Calendar Year

Family: \$5,000 per Calendar Year

Please note that the Emergency Room Copayment applies for each Hospital Emergency Room Visit and does not apply to the Plan Deductible.

Deductible for Prescription Drugs

\$100 per Member per Calendar Year. The Deductible is waived for Tier 1 Drugs.

The Deductible is waived for PPACA Zero Cost Share Preventive Care Medications.

Plan Out-of-Pocket Maximum

Individual: \$6,350 per Calendar Year

Family: \$12,700 per Calendar Year

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EPO Select Plan Summary of Benefits

Eligibility & Effective Dates of Coverage

Eligibility Limits

The limiting age for Dependents (as defined in the Certificate) is 26. Coverage ends at the end of the Calendar Year in which the child reaches the limiting age.

Please note, extended coverage is available up to the age of 31 for Dependents who meet the definition of an Over-Age Dependent, as defined in the Certificate.

Effective Dates of Coverage

Initial Enrollment (During initial Group Open Enrollment Period)

Coverage is effective on the effective date of the Agreement.

Newly Eligible Employee (Application within 31 days of becoming eligible)

Coverage is effective as of the date the employee became eligible.

Newly Eligible Dependent(s) (Application within 31 days of becoming eligible)

Coverage is effective as of the date the dependent became eligible.

Coverage is effective at birth for newborns and newly born adopted children subject to the enrollment requirements as described by the Certificate.

Group Open Enrollment Period

Coverage is effective on the renewal date of the Agreement.

IMPORTANT: This document is not a contract. It is only a summary of your coverage. Please read your Certificate of Coverage and Member Handbook for a full description of your Covered Services, exclusions and other terms and conditions of coverage.

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