Certificate of Coverage

PLAN 6: EPO

UnitedHealthcare®
Oxford

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	$30 per visit
Physician (Primary Care) Hospital Visits	Deductible and 10% Coinsurance
Diabetes Services (Primary Care)	
Supplies, Education and Self-Management	Supplies - $30 per 31-day supply of each item Education and Self-Management - $30 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 - $30 Inpatient Facility - Deductible and 10% Coinsurance Outpatient Facility - Deductible and 10% Coinsurance

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EPO Select Plan Summary of Benefits

Specialty Care Covered Services	Out-of-Pocket Expenses
Physician (Specialist) Office and Home Visits	$50 per visit
Physician (Specialist) Hospital Visits	Deductible and 10% Coinsurance
Diabetes Services (Specialty 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.
Allergy Testing & Treatment	$50 per visit
Maternity and Newborn Care	Maternity Care - $30 for initial visit Inpatient hospital services are Covered subject to: the inpatient facility Out-of-Pocket Expense. *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.***
Rehabilitation and Habilitative Services (Physical, Speech and Occupational Therapies) Inpatient services are limited to 60 days per Calendar Year. Outpatient services are limited to 60 visits combined per Calendar Year.	Inpatient - Deductible and 10% Coinsurance Outpatient - $50 per visit

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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. Outpatient services are limited to 60 visits combined per Calendar Year. Please note that limits do not apply to the treatment of Autism Spectrum Disorder.	Inpatient - Deductible and 10% Coinsurance Outpatient - $50 per visit
Reconstructive and Corrective Surgery	Office Visits - $50 per visit Inpatient Facility - Deductible and 10% Coinsurance Outpatient Hospital Services - Deductible and 10% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance
Gender Dysphoria Services	Office Visits - $50 per visit Inpatient Facility - Deductible and 10% Coinsurance Outpatient Hospital Services - Deductible and 10% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance

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Specialty Care Covered Services	Out-of-Pocket Expenses
Oral Surgery	Office Visits - $50 per visit Inpatient Facility - Deductible and 10% Coinsurance Outpatient Hospital Services - Deductible and 10% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% 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 – $50 per visit Freestanding Radiology Center - Deductible and 10% Coinsurance Hospital Facility Based Services – Deductible and 10% Coinsurance

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Specialty Care Covered Services	Out-of-Pocket Expenses
Radiology Services	***All other Radiology:*** Office Based Services – $50 per visit Freestanding Radiology Center - Deductible and 10% Coinsurance Hospital Facility Based Services – Deductible and 10% Coinsurance
Internal and External Prosthetic Devices **Please Note:** Reimbursement for these items will be at the same rate as under the federal Medicare reimbursement schedule.	Internal- No Charge. Surgery is subject to either the inpatient or outpatient facility Out-of-Pocket Expense. External- No Charge
Durable Medical Equipment, Orthotics and Braces	No Charge
Medical Supplies (Non-Diabetic)	Deductible and 10% 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 - $50 per visit Inpatient Facility - Deductible and 10% Coinsurance Outpatient Hospital Services - Deductible and 10% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance Prescription Medications - Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.

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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 - $50 per visit Inpatient Facility - Deductible and 10% Coinsurance Outpatient Hospital Services - Deductible and 10% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance
Home Health Care – This benefit is limited to 60 visits per Calendar Year.	$50 per visit
Chemotherapy	Deductible and 10% 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 10% Coinsurance Outpatient Facility - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance

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Specialty Care Covered Services	Out-of-Pocket Expenses
Second and Third Opinions	At Your Request - $50 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	$30 per monthly expense
Nutritional Counseling	$50 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 - $50 per visit Inpatient Facility - Deductible and 10% Coinsurance Outpatient Hospital Services - Deductible and 10% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance

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Hospital & Facility Based Covered Services	Out-of-Pocket Expenses
Hospital Services	Inpatient - Deductible and 10% Coinsurance Outpatient - Deductible and 10% Coinsurance
Outpatient Ambulatory Surgical Center	Deductible and 10% Coinsurance
Skilled Nursing Facility Services - This benefit is limited to 30 days per Calendar Year.	Deductible and 10% 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 10% Coinsurance Outpatient - $50 per visit Home Health Care - $50 per visit Skilled Nursing Facility Services - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance
Physician Fees for Surgical and Medical Services	Deductible and 10% Coinsurance

Mental Health Services and Substance Use Disorder Services	Out-of-Pocket Expenses
Mental Health Services – This benefit is provided to the same extent as other surgical or medical benefits Covered under the Certificate.	Office Visits/Outpatient - $50 per visit Inpatient - Deductible and 10% Coinsurance Partial Hospitalization/Intensive Outpatient Treatment - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance

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Mental Health Services and Substance Use Disorder Services	**Out-of-Pocket Expenses**
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 - $50 per visit Inpatient - Deductible and 10% Coinsurance Partial Hospitalization/Intensive Outpatient Treatment - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance

Medical Emergency Covered Services	**Out-of-Pocket Expenses**
Hospital Emergency Room Visits	$100 per visit (waived if Member is admitted to the Hospital)
Ambulance Services	Deductible and 10% Coinsurance

Urgent Care Covered Services	**Out-of-Pocket Expenses**
Urgent Care	$50 per visit

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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. Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.
Exercise Facility Reimbursement	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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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: $1,000 per Calendar Year Family: $2,000 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: $4,000 per Calendar Year Family: $8,000 per Calendar Year

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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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