UnitedHealthcare® Oxford

OXFORD HEALTH INSURANCE, INC.
OXFORD EXCLUSIVE SELECT PLAN
SUMMARY OF COVERAGE
Liberty Network
Abel HR, Inc.

BENEFIT		IN-NETWORK
FINANCIAL		
Deductible:	Single	$1,000
	Family	$2,000
Coinsurance		None
Maximum Out-of-Pocket:	Single	$3,500
(Including Deductible)	Family	$7,000
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		$30 copay per visit
Specialist Office Visits		$50 copay per visit
Outpatient Surgery - Hospital Setting		No Charge after Deductible
Outpatient Surgery - Freestanding Facility		No Charge after Deductible
Laboratory Services Participating *(See your Certificate of Coverage for additional Lab details)*		No Charge
Radiology Services		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 *(If member is admitted to the hospital, notification is required)*		$100 copay; waived if admitted
Emergency Care in Urgi-Center		$50 copay per visit
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		$50 copay per visit
HOME HEALTH CARE		
Home Care Visits - 60 Visits per Calendar Year		$50 copay per visit
Physician House Calls		$50 copay per visit
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation		No Charge after Deductible
Office Visits or Outpatient Rehabilitation		$50 copay per visit
Outpatient Partial Hospitalization		No Charge
MENTAL HEALTH CARE		
Inpatient Care		No Charge after Deductible
Office Visits or Outpatient Care		$50 copay per visit
Outpatient Partial Hospitalization		No Charge
ALLERGY CARE		
Testing and Treatment		$50 copay per visit

BENEFIT	IN-NETWORK
CHIROPRACTIC CARE	
Chiropractic Care	$30 copay per visit
SHORT TERM REHAB & HABILITATIVE SERVICES	
60 Inpatient Days per Calendar Year	No Charge after Deductible
60 combined Outpatient Visits per Calendar Year	$50 copay per visit
DURABLE MEDICAL EQUIPMENT	
Unlimited *Precertification required for items over $500*	No Charge
HEARING AIDS	
Hearing Aids (Age 15 & under) - Limited to 1 hearing aid for each hearing impaired ear every 24 months.	No Charge
Hearing Aids (Age 16 & over) - Limited to $5,000 for each hearing impaired ear every 24 months.	No Charge
MEDICAL SUPPLIES	
Medical Supplies when Medically Necessary	No Charge after Deductible
EXERCISE FACILITY	
Subscriber	$200 reimbursement per 6 month period
Spouse	$100 reimbursement per 6 month period
INFERTILITY TREATMENT	
Specialist Office Visits	$50 copay per visit
Outpatient Facility Services	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	$100 Deductible (waived for Tier 1 Drugs)
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 Calendar Year.
Domestic Partners covered with proper documentation.

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.