



**OXFORD HEALTH INSURANCE, INC.**  
**Oxford Exclusive Select Plan**  
**SUMMARY OF COVERAGE**  
**Liberty Network**  
**ABEL HR, INC.**  
**PLAN 21**

BENEFIT		In-Network
<b>FINANCIAL</b>		
Deductible:	Single	\$2,500
	Family	\$5,000
Coinsurance		50%
Maximum Out-of-Pocket:	Single	\$6,350
(Including Deductible)	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		\$50 copay per visit
Specialist Office Visits		\$75 copay per visit
Outpatient Surgery - Hospital Setting		Deductible & 50% Coinsurance
Outpatient Surgery - Freestanding Facility		Deductible & 50% Coinsurance
Laboratory Services Participating		No Charge
<i>(See your Certificate of Coverage for additional Lab details)</i>		
Radiology Services		Deductible & 50% Coinsurance
<b>MRIs, MRAs, CT SCANS, AND PET SCANS</b>		
Outpatient Hospital Services		Deductible & 50% Coinsurance
Freestanding Radiology Facility		Deductible & 50% Coinsurance
<b>HOSPITAL CARE</b>		
Physician's and Surgeon's Services		Deductible & 50% Coinsurance
Semi-Private Room and Board		Deductible & 50% Coinsurance
All Drugs and Medication		Deductible & 50% Coinsurance
<b>EMERGENCY CARE</b>		
Ambulance Service When Medically Necessary		Deductible & 50% Coinsurance
At Hospital Emergency Room		\$100 copay then 50% Coinsurance
<i>(If member is admitted to the hospital, notification is required)</i>		
Emergency Care in Urgi-Center		\$75 copay per visit
<b>MATERNITY CARE</b>		
Routine Prenatal and Post-Natal Care		No Charge
Hospital Services For Mother and Child		Deductible & 50% Coinsurance
<b>SKILLED NURSING FACILITY</b>		
30 Days per Calendar Year		Deductible & 50% Coinsurance
<b>HOSPICE CARE (180 days per lifetime combined Inpatient &amp; Home)</b>		
Inpatient Care		Deductible & 50% Coinsurance
Home Hospice Care Visits		\$75 copay per visit
<b>HOME HEALTH CARE</b>		
Home Care Visits - 60 Visits per Calendar Year		\$75 copay per visit
Physician House Calls		\$75 copay per visit
<b>SUBSTANCE USE DISORDER SERVICES</b>		
Inpatient Rehabilitation		Deductible & 50% Coinsurance
Office Visits or Outpatient Rehabilitation		\$30 copay per visit
Outpatient Partial Hospitalization		No Charge
<b>MENTAL HEALTH CARE</b>		
Inpatient Care		Deductible & 50% Coinsurance
Office Visits or Outpatient Care		\$30 copay per visit
Outpatient Partial Hospitalization		No Charge
<b>ALLERGY CARE</b>		
Testing and Treatment		\$75 copay per visit

BENEFIT	In-Network
<b>CHIROPRACTIC CARE</b>	
Chiropractic Care	\$30 copay per visit
<b>SHORT TERM REHAB &amp; HABILITATIVE SERVICES</b>	
60 Inpatient Days per Calendar Year	Deductible & 50% Coinsurance
60 combined Outpatient Visits per Calendar Year	\$50 copay per visit
<b>DURABLE MEDICAL EQUIPMENT</b>	
Unlimited <i>(Recertification required for items over \$500)</i>	No Charge
<b>HEARING AIDS</b>	
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
<b>MEDICAL SUPPLIES</b>	
Medical Supplies when Medically Necessary	Deductible & 50% Coinsurance
<b>EXERCISE FACILITY</b>	
Subscriber	\$200 reimbursement per 6 month period
Spouse	\$100 reimbursement per 6 month period
<b>INFERTILITY TREATMENT</b>	
Specialist Office Visits	\$75 copay per visit
Outpatient Facility Services	Deductible & 50% Coinsurance
Inpatient Facility Services	Deductible & 50% Coinsurance
<b>INFERTILITY MEDICATIONS</b>	
Infertility Medications	Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.
<b>OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE</b>	
	\$100 Deductible (waived for Tier 1 Drugs)
<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 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.