UnitedHealthcare Oxford

OXFORD HEALTH INSURANCE, INC.
EPO HSA Plan
SUMMARY OF COVERAGE
Liberty Network
ABEL HR, INC.
PLAN 26

BENEFIT		In-Network
FINANCIAL		
Deductible:	Single	$2,500
	Family	$5,000*
Coinsurance		50%
Maximum Out-of-Pocket:	Single	$6,450
(Including Deductible)	Family	$12,900
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	Deductible & 50% Coinsurance
Specialist Office Visits	Deductible & 50% Coinsurance
Outpatient Surgery - Hospital Setting	Deductible & 50% Coinsurance
Outpatient Surgery - Freestanding Facility	Deductible & 50% Coinsurance
Laboratory Services Participating	Deductible & 50% Coinsurance
(See your Certificate of Coverage for additional Lab details)	
Radiology Services	Deductible & 50% Coinsurance
MRIs, MRAs, CT SCANS, AND PET SCANS	
Outpatient Hospital Services	Deductible & 50% Coinsurance
Freestanding Radiology Facility	Deductible & 50% Coinsurance
HOSPITAL CARE	
Physician's and Surgeon's Services	Deductible & 50% Coinsurance
Semi-Private Room and Board	Deductible & 50% Coinsurance
All Drugs and Medication	Deductible & 50% Coinsurance
EMERGENCY CARE	
Ambulance Service When Medically Necessary	Deductible & 50% Coinsurance
At Hospital Emergency Room	Deductible & 50% Coinsurance
(If member is admitted to the hospital, notification is required)	
Emergency Care in Urgi-Center	Deductible & 50% Coinsurance
MATERNITY CARE	
Routine Prenatal and Post-Natal Care	No Charge
Hospital Services For Mother and Child	Deductible & 50% Coinsurance
SKILLED NURSING FACILITY	
30 Days per Calendar Year	Deductible & 50% Coinsurance
HOSPICE CARE (180 days per lifetime combined Inpatient & Home)	
Inpatient Care	Deductible & 50% Coinsurance
Home Hospice Care Visits	Deductible & 50% Coinsurance
HOME HEALTH CARE	
Home Care Visits - 60 Visits per Calendar Year	Deductible & 50% Coinsurance
Physician House Calls	Deductible & 50% Coinsurance
SUBSTANCE USE DISORDER SERVICES	
Inpatient Rehabilitation	Deductible & 50% Coinsurance
Office Visits or Outpatient Rehabilitation	Deductible & 50% Coinsurance
Outpatient Partial Hospitalization	Deductible & 50% Coinsurance
MENTAL HEALTH CARE	
Inpatient Care	Deductible & 50% Coinsurance
Office Visits or Outpatient Care	Deductible & 50% Coinsurance
Outpatient Partial Hospitalization	Deductible & 50% Coinsurance
ALLERGY CARE	
Testing and Treatment	Deductible & 50% Coinsurance

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