UnitedHealthcare Oxford

OXFORD HEALTH INSURANCE, INC.
Oxford Exclusive Select Plan
SUMMARY OF COVERAGE
Liberty Network
ABEL HR, Inc.
PLAN 23

BENEFIT		In-Network
FINANCIAL		
Deductible:	Single	None
	Family	None
Coinsurance		None
Maximum Out-of-Pocket:	Single	$4,500
(Including Deductible)	Family	$9,000
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
Virtual Visits	$15 copay per visit
Outpatient Surgery - Hospital Setting	$50 copay per visit
Outpatient Surgery - Freestanding Facility	$50 copay per visit
Laboratory Services - Hospital Setting	No Charge
Laboratory Services - Freestanding Facility	No Charge
(See your Certificate of Coverage for additional Lab details)	
Radiology Services - Hospital Setting	No Charge
Radiology Services - Freestanding Facility	No Charge
MRIs, MRAs, CT SCANS, AND PET SCANS	
Outpatient Hospital Services	No Charge
Freestanding Radiology Facility	No Charge
HOSPITAL CARE	
Physician's and Surgeon's Services	No Charge
Semi-Private Room and Board	$500 copay per day up to $2,500, $5,000 max per Calendar Year
All Drugs and Medication	No Charge
EMERGENCY CARE	
Ambulance Service When Medically Necessary	No Charge
At Hospital Emergency Room	$100 copay; waived if admitted
(If member is admitted to the hospital, notification is required)	
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	$500 copay per day up to $2,500, $5,000 max per Calendar Year
SKILLED NURSING FACILITY	
30 Days per Calendar Year	$500 copay per day up to $2,500, $5,000 max per Calendar Year
HOSPICE CARE (180 days per lifetime combined Inpatient & Home)	
Inpatient Care	$500 copay per day up to $2,500, $5,000 max per Calendar Year
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
Office Visits or Outpatient Rehabilitation	$30 copay per visit
Outpatient Partial Hospitalization	No Charge
MENTAL HEALTH CARE	
Inpatient Care	No Charge
Office Visits or Outpatient Care	$30 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	$500 copay per day up to $2,500, $5,000 max per Calendar Year
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
EXERCISE FACILITY	
Subscriber	$200 reimbursement per 6 month period
Spouse/Dependents over age 13	$100 reimbursement per 6 month period
INFERTILITY TREATMENT	
Specialist Office Visits	$50 copay per visit
Outpatient Facility Services	$50 copay per visit
Inpatient Facility Services	$500 copay per day up to $2,500, $5,000 max per Calendar Year
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.