UnitedHealthcare Oxford

OXFORD HEALTH INSURANCE, INC.
DIRECT PLAN
SUMMARY OF COVERAGE
Liberty Network
ABEL HR, INC.
PLAN 7

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	$500	$2,000
	Family	$1,000	$4,000
Coinsurance		10%	30%
Maximum Out-of-Pocket:	Single	$5,000	$10,000
(Including Deductible)	Family	$10,000	$20,000
Financial Accumulation Period:		Calendar Year	Calendar Year
Out-of-Network Reimbursement:		Not Applicable	140% of Medicare

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	Deductible & 30% Coinsurance
Infant and Pediatric Preventive Care	No Charge	Deductible & 30% Coinsurance
OUTPATIENT CARE		
Primary Care Physician Office Visits	$25 copay per visit	Deductible & 30% Coinsurance
Specialist Office Visits	$40 copay per visit	Deductible & 30% Coinsurance
Virtual Visits	$10 copay per visit	In-Network Benefit Only
Outpatient Surgery - Hospital Setting**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Outpatient Surgery - Freestanding Facility**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Laboratory Services - Hospital Setting**	No Charge	Deductible & 30% Coinsurance
Laboratory Services - Freestanding Facility**	No Charge	Deductible & 30% Coinsurance
(See your Certificate of Coverage for additional Lab details)		
Radiology Services - Hospital Setting**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Radiology Services - Freestanding Facility**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
MRIs, MRAs, CT SCANS, AND PET SCANS		
Outpatient Hospital Services**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Freestanding Radiology Facility**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
HOSPITAL CARE		
Physician's and Surgeon's Services **	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Semi-Private Room and Board **	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
All Drugs and Medication	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
EMERGENCY CARE		
Ambulance Service When Medically Necessary**	Deductible & 10% Coinsurance	Deductible & 10% Coinsurance
At Hospital Emergency Room	$100 per visit, waived if admitted	$100 per visit, waived if admitted
(If member is admitted to the hospital, notification is required)		
Emergency Care in Urgi-Center	$40 copay per visit	Deductible & 30% Coinsurance
MATERNITY CARE		
Routine Prenatal and Post-Natal Care **	No Charge	Deductible & 30% Coinsurance
Hospital Services for Mother and Child **	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
SKILLED NURSING FACILITY		
30 Days per Calendar Year**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
HOSPICE CARE (180 days per lifetime combined Inpatient & Home)		
Inpatient Care**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Home Hospice Care Visits**	$40 copay per visit	Deductible & 30% Coinsurance
HOME HEALTH CARE		
Home Care Visits - 60 Visits per Calendar Year**	$40 copay per visit	Deductible & 30% Coinsurance
Physician House Calls**	$40 copay per visit	Deductible & 30% Coinsurance
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Office Visits or Outpatient Rehabilitation	$30 copay per visit	Deductible & 30% Coinsurance
Outpatient Partial Hospitalization	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
MENTAL HEALTH CARE		
Inpatient Care**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Office Visits or Outpatient Care	$30 copay per visit	Deductible & 30% Coinsurance
Outpatient Partial Hospitalization**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
ALLERGY CARE		
Testing and Treatment**	$40 copay per visit	Deductible & 30% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
CHIROPRACTIC CARE		
Chiropractic Care** *Out-of-Network coverage limited to $500 per Calendar Year per Member*	$30 copay per visit	Deductible & 50% Coinsurance
SHORT TERM REHAB & HABILITATIVE SERVICES		
60 Inpatient Days per Calendar Year**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
60 combined Outpatient Visits per Calendar Year**	$40 copay per visit	Deductible & 30% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Unlimited** *(Precertification required for items over $500)*	No Charge	Deductible & 30% Coinsurance
HEARING AIDS		
Hearing Aids (Age 15 & under) - Limited to 1 hearing aid for each hearing impaired ear every 24 months.	No Charge	Deductible & 30% Coinsurance
Hearing Aids (Age 16 & over) - Limited to $5,000 for each hearing impaired ear every 24 months.	No Charge	Deductible & 30% Coinsurance
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
EXERCISE FACILITY		
Subscriber	$200 reimbursement per 6 month period	$200 reimbursement per 6 month period
Spouse/Dependents over age 13	$100 reimbursement per 6 month period	$100 reimbursement per 6 month period
INFERTILITY TREATMENT		
Specialist Office Visits**	$40 copay per visit	Deductible & 30% Coinsurance
Outpatient Facility Services**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
Inpatient Facility Services**	Deductible & 10% Coinsurance	Deductible & 30% Coinsurance
INFERTILITY MEDICATIONS		
Infertility Medications**	Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.	Deductible & 30% Coinsurance
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 deductibles and/or maximum limits.		
Tier 1	$25 copay	Covered at Participating Pharmacies Only
Tier 2	$50 copay	Covered at Participating Pharmacies Only
Tier 3	$75 copay	Covered at Participating Pharmacies Only
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	$50 copay	Covered at Participating Pharmacies Only
Tier 2	$100 copay	Covered at Participating Pharmacies Only
Tier 3	$150 copay	Covered at Participating Pharmacies Only

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.

** These services require **precertification** through Oxford. Members must call Oxford at 1-800-444-6222 at least 14 days in advance of request of treatment to request precertification.
**Mental health and substance use disorder services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

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, Worker's Compensation, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.