**OXFORD HEALTH INSURANCE, INC.**
**ACCESS PLAN**
**SUMMARY OF COVERAGE**
**Liberty Network**
**ABEL HR, INC.**
**Plan 10**

| BENEFIT | | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|---|
| **FINANCIAL** | | | |
| Deductible: | Single | None | $2,000 |
| | Family | None | $4,000 |
| Coinsurance: | | None | 30% |
| Maximum Out-of-Pocket: | Single | $2,500 | $5,000 |
| (Including Deductible) | Family | $5,000 | $10,000 |
| 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 | $30 copay per visit | Deductible & 30% Coinsurance |
| Specialist Office Visits | $30 copay per visit | Deductible & 30% Coinsurance |
| Virtual Visits | No Charge | In-Network Benefit Only |
| Outpatient Surgery - Hospital Setting** | $100 copay per visit | Deductible & 30% Coinsurance |
| Outpatient Surgery - Freestanding Facility** | $100 copay per visit | 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** | No Charge | Deductible & 30% Coinsurance |
| Radiology Services - Freestanding Facility** | No Charge | Deductible & 30% Coinsurance |
| **MRIs, MRAs, CT SCANS, AND PET SCANS** | | |
| Outpatient Hospital Services** | No Charge | Deductible & 30% Coinsurance |
| Freestanding Radiology Facility** | No Charge | Deductible & 30% Coinsurance |
| **HOSPITAL CARE** | | |
| Physician's and Surgeon's Services** | No Charge | Deductible & 30% Coinsurance |
| Semi-Private Room and Board** | $250 copay per admission | Deductible & 30% Coinsurance |
| All Drugs and Medication | No Charge | Deductible & 30% Coinsurance |
| **EMERGENCY CARE** | | |
| Ambulance Service When Medically Necessary** | No Charge | No Charge |
| At Hospital Emergency Room | $100 copay; waived if admitted | $100 copay; waived if admitted |
| *(If member is admitted to the hospital, notification is required)* | | |
| Emergency Care in Urgi-Center | $30 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** | $250 copay per admission | Deductible & 30% Coinsurance |
| **SKILLED NURSING FACILITY** | | |
| 30 Days per Calendar Year** | $250 copay per admission | Deductible & 30% Coinsurance |
| **HOSPICE CARE (180 days per lifetime combined Inpatient & Home)** | | |
| Inpatient Care** | $250 copay per admission | Deductible & 30% Coinsurance |
| Home Hospice Care Visits** | $30 copay per visit | Deductible & 30% Coinsurance |
| **HOME HEALTH CARE** | | |
| Home Care Visits - 60 Visits per Calendar Year | $30 copay per visit | Deductible & 30% Coinsurance |
| Physician House Calls** | $30 copay per visit | Deductible & 30% Coinsurance |
| **SUBSTANCE USE DISORDER SERVICES** | | |
| Inpatient Rehabilitation** | $250 copay per admission | Deductible & 30% Coinsurance |
| Office Visits or Outpatient Rehabilitation | $30 copay per visit | Deductible & 30% Coinsurance |
| Outpatient Partial Hospitalization | No Charge | Deductible & 30% Coinsurance |
| **MENTAL HEALTH CARE** | | |
| Inpatient Care** | $250 copay per admission | Deductible & 30% Coinsurance |
| Office Visits or Outpatient Care | $30 copay per visit | Deductible & 30% Coinsurance |
| Outpatient Partial Hospitalization | No Charge | Deductible & 30% Coinsurance |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **ALLERGY CARE** | | |
| Testing and Treatment** | $30 copay per visit | Deductible & 30% Coinsurance |
| **CHIROPRACTIC CARE** | | |
| Chiropractic Care**<br>*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** | $250 copay per admission | Deductible & 30% Coinsurance |
| 60 combined Outpatient Visits per Calendar Year** | $30 copay per visit | Deductible & 30% Coinsurance |
| **DURABLE MEDICAL EQUIPMENT** | | |
| Unlimited<br>*(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** | No Charge | 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** | $30 copay per visit | Deductible & 30% Coinsurance |
| Outpatient Facility Services** | $100 copay per visit | Deductible & 30% Coinsurance |
| Inpatient Facility Services** | $250 copay per admission | Deductible & 30% Coinsurance |
| **INFERTILITY MEDICATIONS** | | |
| Infertility Medications** | Covered subject to the applicable Prescription Drug Out-of-Pocket Expense. | Deductible & 30% Coinsurance |
| **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 Month.
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.