



**OXFORD HEALTH INSURANCE, INC.**  
**Oxford Exclusive Plan**  
**SUMMARY OF COVERAGE**  
**Freedom Network**  
**ABEL HR, INC.**  
**PLAN 8**

BENEFIT	In-Network	
<b>FINANCIAL</b>		
Deductible:	Single	None
	Family	None
Coinsurance		None
Maximum Out-of-Pocket:	Single	\$4,500
(Including Deductible)	Family	\$9,000
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		\$30 copay per visit
Specialist Office Visits		\$50 copay per visit
Virtual Visits		No Charge
Outpatient Surgery - Hospital Setting		\$250 copay per visit
Outpatient Surgery - Freestanding Facility		\$250 copay per visit
Preferred Laboratory Services		No Charge
Non-Preferred Laboratory Services - Hospital Setting		\$60 copay per visit
Non-Preferred Laboratory Services - Freestanding Facility		\$60 copay per visit
<i>(See your Certificate of Coverage for additional Lab details)</i>		
Radiology Services - Hospital Setting		No Charge
Radiology Services - Freestanding Facility		No Charge
<b>MRIs, MRAs, CT SCANS, AND PET SCANS</b>		
Outpatient Hospital Services		No Charge
Freestanding Radiology Facility		No Charge
<b>HOSPITAL CARE</b>		
Physician's and Surgeon's Services		\$500 copay per day up to a max of \$5,000, \$5,000 annual max
Semi-Private Room and Board		\$500 copay per admission
All Drugs and Medication		\$500 copay per day up to a max of \$5,000, \$5,000 annual max
<b>EMERGENCY CARE</b>		
Ambulance Service When Medically Necessary		No Charge
At Hospital Emergency Room		\$100 copay; waived if admitted
<i>(If member is admitted to the hospital, notification is required)</i>		
Emergency Care in Urgi-Center		\$50 copay per visit
<b>MATERNITY CARE</b>		
Routine Prenatal and Post-Natal Care		No Charge
Hospital Services For Mother and Child		\$500 copay per admission
<b>SKILLED NURSING FACILITY</b>		
30 Days per Calendar Year		\$500 copay per admission
<b>HOSPICE CARE (180 days per lifetime combined Inpatient &amp; Home)</b>		
Inpatient Care		\$500 copay per admission
Home Hospice Care Visits		\$50 copay per visit
<b>HOME HEALTH CARE</b>		
Home Care Visits - 60 Visits per Calendar Year		\$50 copay per visit
Physician House Calls		\$50 copay per visit
<b>SUBSTANCE USE DISORDER SERVICES</b>		
Inpatient Rehabilitation		\$500 copay per admission
Office Visits or Outpatient Rehabilitation		\$50 copay per visit
Intensive Behavioral Therapy		No Charge
Outpatient Partial Hospitalization		No Charge
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment		

<b>BENEFIT</b>	<b>In-Network</b>
<b>MENTAL HEALTH CARE</b>	
Inpatient Care	\$500 copay per admission
Office Visits or Outpatient Care	\$50 copay per visit
Intensive Behavioral Therapy	No Charge
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment	No Charge
<b>ALLERGY CARE</b>	
Testing and Treatment	\$50 copay per visit
<b>CHIROPRACTIC CARE</b>	
Chiropractic Care	\$50 copay per visit
<b>SHORT TERM REHAB &amp; HABILITATIVE SERVICES</b>	
60 Inpatient Days per Calendar Year	\$500 copay per admission
60 combined Outpatient Visits per Calendar Year	\$50 copay per visit
<b>DURABLE MEDICAL EQUIPMENT</b>	
Unlimited (Precertification required for items over \$500)	No Charge
<b>HEARING AIDS</b>	
Hearing Aids - Limited to 1 hearing aid for each hearing impaired ear every 24 months.	No Charge
<b>MEDICAL SUPPLIES</b>	
Medical Supplies when Medically Necessary	No Charge
<b>EXERCISE FACILITY</b>	
Subscriber	\$200 reimbursement per 6 month period
Spouse/Dependents over age 13	\$100 reimbursement per 6 month period
<b>INFERTILITY TREATMENT</b>	
Specialist Office Visits	\$50 copay per visit
Outpatient Facility Services	\$250 copay per visit
Inpatient Facility Services	\$500 copay per admission
<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
<b>SPECIALTY DRUG PRODUCTS</b>	
Tier 1	\$25 copay
Tier 2	20% Coinsurance up to \$150 max
Tier 3	50% Coinsurance up to \$500 max

**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.

**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.