OXFORD HEALTH INSURANCE, INC.
Oxford Exclusive Plan
SUMMARY OF COVERAGE
Liberty Network
ABEL HR, INC.
PLAN 6

BENEFIT		In-Network
FINANCIAL		
Deductible:	Single	$1,000
	Family	$2,000
Coinsurance		10%
Maximum Out-of-Pocket:	Single	$4,000
(Including Deductible)	Family	$8,000
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	No Charge
Outpatient Surgery - Hospital Setting	Deductible & 10% Coinsurance
Outpatient Surgery - Freestanding Facility	Deductible & 10% Coinsurance
Preferred Laboratory Services	No Charge
Non-Preferred Laboratory Services - Hospital Setting	Deductible & 50% Coinsurance
Non-Preferred Laboratory Services - Freestanding Facility	Deductible & 50% Coinsurance
(See your Certificate of Coverage for additional Lab details)	
Radiology Services - Hospital Setting	Deductible & 10% Coinsurance
Radiology Services - Freestanding Facility	Deductible & 10% Coinsurance
MRIs, MRAs, CT SCANS, AND PET SCANS	
Outpatient Hospital Services	Deductible & 10% Coinsurance
Freestanding Radiology Facility	Deductible & 10% Coinsurance
HOSPITAL CARE	
Physician's and Surgeon's Services	Deductible & 10% Coinsurance
Semi-Private Room and Board	Deductible & 10% Coinsurance
All Drugs and Medication	Deductible & 10% Coinsurance
EMERGENCY CARE	
Ambulance Service When Medically Necessary	Deductible & 10% Coinsurance
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	Deductible & 10% Coinsurance
SKILLED NURSING FACILITY	
30 Days per Calendar Year	Deductible & 10% Coinsurance
HOSPICE CARE (180 days per lifetime combined Inpatient & Home)	
Inpatient Care	Deductible & 10% Coinsurance
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	Deductible & 10% Coinsurance
Office Visits or Outpatient Rehabilitation	$50 copay per visit
Intensive Behavioral Therapy	10% Coinsurance
Outpatient Partial Hospitalization	Deductible & 10% Coinsurance
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment	

BENEFIT	In-Network
MENTAL HEALTH CARE	
Inpatient Care	Deductible & 10% Coinsurance
Office Visits or Outpatient Care	$50 copay per visit
Intensive Behavioral Therapy	10% Coinsurance
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment	Deductible & 10% Coinsurance
ALLERGY CARE	
Testing and Treatment	$50 copay per visit
CHIROPRACTIC CARE	
Chiropractic Care	$50 copay per visit
SHORT TERM REHAB & HABILITATIVE SERVICES	
60 Inpatient Days per Calendar Year	Deductible & 10% Coinsurance
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 - Limited to 1 hearing aid for each hearing impaired ear every 24 months.	No Charge
MEDICAL SUPPLIES	
Medical Supplies when Medically Necessary	Deductible & 10% Coinsurance
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	Deductible & 10% Coinsurance
Inpatient Facility Services	Deductible & 10% Coinsurance
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
SPECIALTY DRUG PRODUCTS	
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.