OXFORD HEALTH PLANS®
A UnitedHealthcare Company

OXFORD HEALTH PLANS, INC.
Liberty Plan Direct
SUMMARY OF COVERAGE
NEW YORK SOLE PROPRIETORS

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			**UCR: 70% of HIAA**
Deductible:	Single	$2,000	$2,000
	Family	$4,000	$4,000
Coinsurance		20%	40%
Maximum Out-Of-Pocket:	Single	$4,000	$6,000
(Including Deductible)	Family	$8,000	$12,000
Maximum Lifetime Benefit Per Member		Unlimited	$1,000,000
PREVENTIVE CARE			
Adult Preventive Care		No Charge	In-Network Benefit Only
Infant and Pediatric Preventive Care		No Charge	Deductible and 40% Coinsurance $300 annual maximum
Immunizations		No Charge	Deductible and 40% Coinsurance
OUTPATIENT CARE			
Primary Care Physician office visits		$30 copay per visit	Deductible and 40% Coinsurance
Specialist Office Visits		$50 copay per visit	Deductible and 40% Coinsurance
Surgery **		Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Laboratory services		At Participating Laboratories Covered at 100%	Deductible and 40% Coinsurance
Radiology services including PT, CT scans, Magnetic Resonance Imaging (MRI) **		Deductible and 20% Coinsurance	Deductible and 40% Coinsurance **Precertification is required for Out of Network PET scans, MRAs, surgical endoscopic prodedures, MRIs Nuclear Medicine, CT Scans, and Bone Density Studies.**
Screening Mammograms		Covered at 100%	Deductible and 40% Coinsurance
ALLERGY CARE			
Initial visit, and all subsequent referral visits		$50 copay per visit	Deductible and 40% Coinsurance
HOSPITAL CARE			
Physician's and surgeon's services **		Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Semi-private room and board **		Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
All drugs and medication		Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
EMERGENCY CARE			
Ambulance service when Medically Necessary		Deductible and 20% Coinsurance	Deductible and 20% Coinsurance
At hospital emergency room		$100 copay per visit	Deductible and 20% Coinsurance
(If member is admitted to the hospital through the ER, notification is required)			
Emergency Care in Urgi-Center		$50 copay per visit	Deductible and 40% Coinsurance
MATERNITY CARE			
Prenatal and post-natal care		$30 copay per visit	Deductible and 40% Coinsurance
Hospital services for mother and child **		Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
SHORT TERM REHABILITATION			
60 consec. inpatient days per condition / lifetime**		Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
60 outpatient visits per condition per lifetime		$50 copay per visit	Deductible and 40% Coinsurance
HOME HEALTH CARE			
40 home care visits **		Subject to 20% Coinsurance	Subject to 25% Coinsurance
Physician house calls		$50 copay per visit	Deductible and 40% Coinsurance
SKILLED NURSING FACILITY			
200 days per calendar year**		Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
SUBSTANCE ABUSE			
7 days of inpatient detox. per calendar year **		Deductible and 20% Coinsurance	In-Network Benefit Only
30 days of inpatient rehab. per calendar year **		Deductible and 20% Coinsurance	In-Network Benefit Only
60 outpatient rehab. visits per calendar year		$50 copay per visit	Deductible and 40% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
30 days of inpatient care per calendar year**	Deductible and 20% Coinsurance	In-Network Benefit Only
30 visits of outpatient care per calendar year	50% copay per visit	Deductible and 50% Coinsurance We pay a maximum of $25 per visit
PRESCRIPTION DRUGS	$100 Deductible (Waived for Generic Drugs)	
Generic	$15 copayment	Covered at Participating Pharmacies Only
Brand Name	50% coinsurance	
Includes Contraceptives		
HOSPICE CARE (210 days)		
Inpatient care **	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Outpatient care **	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
EXERCISE FACILITY		
Subscriber	$200 reimbursement per 6 month period	$200 reimbursement per 6 month period
Spouse	$100 reimbursement per 6 month period	$100 reimbursement per 6 month period
OTHER ITEMS		
Medical Supplies, when Medically Necessary	OUT-OF-NETWORK BENEFIT ONLY	Deductible and 40% Coinsurance
Durable Equipment, when Medically Necessary ****(precert required on items over $500)** (This benefit is limited to $1500 per calendar year.)	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 19, or age 23 if a full time student.
Benefits discontinue at the end of the Calendar Year.
Domestic Partners are covered with proper documentation.

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

****Prescription medications ordered through the Mail Order Drug Program are subject to 2 retail pharmacy copays for Generic Drugs and 50% coinsurance for Brand Name Drugs.

****The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles and/or maximum limits.

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 your 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, hearing aids, or, unless otherwise stated, dental services and vision correction services and supplies

IMPORTANT: If you live and work in a state other than New York, please check the back of your certificate for extraterritorial benefits rider Based on the state of your residence, additional coverage may be vailable to you.

Please be advised this quote is for informational purposes only. The information contained herein is subject to both state regulatory and Oxford home office approval as appropriate.