OXFORD HEALTH PLANS, INC.
OXFORD EXCLUSIVE PLAN METRO
SUMMARY OF COVERAGE
LIBERTY NETWORK
NEW YORK SOLE PROPRIETORS

BENEFIT		IN-NETWORK
FINANCIAL		
Deductible:	Single	$2,000
	Family	$4,000
Coinsurance		10%
Maximum Out-of-Pocket:	Single	$3,000
	Family	$6,000
Maximum Lifetime Benefit Per Member		Unlimited
PREVENTIVE CARE		
Adult Preventive Care		No Charge
Pediatric Preventive Care		No Charge
Infant Preventive Care		No Charge
Immunizations		No Charge
OUTPATIENT CARE		
Primary Care Physician office visits		$25 copay per visit
Specialist office visits		$50 copay per visit
Surgery**		Deductible and 10% Coinsurance
Laboratory services**		No Charge
Radiology services**		Deductible and 10% Coinsurance
ALLERGY CARE		
Initial visit, and all subsequent visits		$50 copay per visit
HOSPITAL CARE		
Physician's and surgeon's services**		Deductible and 10% Coinsurance
Semi-private room and board**		Deductible and 10% Coinsurance
All drugs and medication**		Deductible and 10% Coinsurance
EMERGENCY CARE		
Ambulance Service		No Charge
At hospital Emergency Room		$75 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		
Prenatal and Post-natal care**		$25 copay per initial visit
Hospital services for mother and child **		Deductible and 10% Coinsurance
SHORT TERM REHABILITATION		
60 consec. Inpatient days per condition per lifetime**		Deductible and 10% Coinsurance
60 Outpatient visits per condition per lifetime**		$50 copay per visit
HOME HEALTH CARE		
40 Home care visits per Calendar Year**		10% Coinsurance
Physician house calls		$50 copay per visit
SKILLED NURSING FACILITY		
200 days per Calendar Year **		Deductible and 10% Coinsurance
SUBSTANCE ABUSE		
7 days of Inpatient detox. per Calendar Year **		Deductible and 10% Coinsurance
30 days of Inpatient rehab. per Calendar Year **		Deductible and 10% Coinsurance
60 Outpt rehab. visits per Calendar Year **		No Charge
(combined w/office visits)		
60 office visits per Calendar Year **		No Charge
(combined w/outpatient visits)		

BENEFIT		IN-NETWORK
MENTAL HEALTH CARE		
30 days of Inpatient care per Calendar Year **		Deductible and 10% Coinsurance
30 Outpatient visits per Calendar Year		Deductible and 50% Coinsurance
(combined w/office visits)		
30 office visits per Calendar Year		Deductible and 50% Coinsurance
(combined w/outpatient visits)		

PRESCRIPTION DRUGS	
(Includes Oral Contraceptives)	$100 Deductible (waived for Generic Drugs)
Generic Drugs****	$15 copayment
Brand Name Drugs****	50% copayment

ALTERNATIVE MEDICINE	
Chiropractic care	$50 copay per visit

HOSPICE CARE (210 days)	
Inpatient care**	Deductible and 10% Coinsurance
Outpatient care**	Deductible and 10% Coinsurance

OTHER COVERAGE	
Medical Supplies**	Deductible and 10% Coinsurance
Durable Medical Equipment** $1500 limit per Calendar Year Precertification for items $500 or more.	Deductible and 10% Coinsurance
Exercise Facility	
Subscriber	$200 reimbursement per 6 month period
Spouse	$100 reimbursement per 6 month period

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 of the same or opposite sex 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.
Mental health and substance abuse services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.
****Prescription medication ordered through the Mail Order Drug Program are subject to 2 retail pharmacy copays for Generic and 50% copayment 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.
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.