OXFORD HEALTH PLANS, INC.
HMO SELECT PLAN
SUMMARY OF COVERAGE
LIBERTY NETWORK
HMO $25/40 G

BENEFIT		IN-NETWORK
FINANCIAL		
Deductible:	Single	$1,000
	Family	$2,000
Coinsurance		20%
Maximum Out-of-Pocket:	Single	$3,000
(Including Deductibles)	Family	$6,000
Maximum Lifetime Benefits Per Member		Unlimited
Financial Accumulation Period:		Calendar Year
PREVENTIVE CARE		
Preventive Care (under 1 year old)		No Charge
Preventive Care (1 year and over)		No Charge
Immunizations		No Charge
Lead poisoning screening and treatments for children		No Charge
OUTPATIENT CARE		
Physician Office Visits		$25 PCP/$40 Specialist copay per visit
Ambulatory Surgery**		N/A
Second Surgical Opinions**		$25 PCP/$40 Specialist copay per visit
Pre-admission Testing**		$25 PCP/$40 Specialist copay per visit
Podiatric Care Visits		$25 PCP/$40 Specialist copay per visit
Physician House Calls		$25 PCP/$40 Specialist copay per visit
Laboratory Services		At Participating Labs; No Charge
Magnetic Resonance Imaging (MRI)**		Deductible & 20% Coinsurance
Therapeutic Manipulation		$25 PCP/$40 Specialist copay per visit
30 visits per Calendar Year		
HOSPITAL CARE		
Physician's and Surgeon's Services**		Deductible & 20% Coinsurance
Semi-private Room and Board**		Deductible and 20% Coinsurance
All Drugs and Medication		Deductible & 20% Coinsurance
Inpatient Surgery**		Deductible & 20% Coinsurance
EMERGENCY CARE		
(Oxford must be contacted within 48 hours)		
Ambulance service when Medically Necessary		Deductible & 20% Coinsurance
At Hospital Emergency Room		$100 copay; waived if admitted
Emergency Care in Urgi-Center		$25 PCP/$40 Specialist copay per visit
MATERNITY CARE		
Prenatal 1st Visit		$25 PCP/$40 Specialist copay per initial visit
Prenatal and post-natal Care**		No Charge
Birthing Centers		$25 PCP/$40 Specialist copay per visit
Hospital Services for Mother and Child**		Deductible and 20% Coinsurance
SKILLED NURSING FACILITY		
Skilled Nursing Care**		Deductible & 20% Coinsurance
HOSPICE CARE		
Hospice Care**		Deductible & 20% Coinsurance
HOME HEALTH CARE		

BENEFIT	IN-NETWORK
SUBSTANCE ABUSE At approved facilities only	
Outpatient Visits**	$25 PCP/$40 Specialist
Inpatient Care**	Deductible and 20% Coinsurance
MENTAL HEALTH CARE	
Inpatient Care**	
Biologically Based Conditions	Deductible and 20% Coinsurance
Inpatient Care**	
Non-Biologically Based Conditions	Deductible and 20% Coinsurance
Outpatient Visits**	
Biologically Based Conditions	$25 PCP/$40 Specialist
Outpatient Visits**	
Non-Biologically Based Conditions	$25 PCP/$40 Specialist
ALLERGY CARE	
Allergy Care Visits	$25 PCP/$40 Specialist copay per visit
SHORT TERM REHABILITATION	
Physical/Occupational Therapy**	$25 PCP/$40 Specialist copay per visit
Combined maximum 30 visits per Calendar Year	
Speech/Cognitive Therapy**	$25 PCP/$40 Specialist copay per visit
Combined maximum 30 visits per Calendar Year	
DURABLE MEDICAL EQUIPMENT	
Durable Equipment, when Medically Necessary**	No Charge, If pre-certified by Oxford in advance and ordered by an Oxford Participating Physician.
Prosthetics	No Charge
Orthotics	No Charge
HEARING AIDS	
Coverage is limited to $5,000 per hearing aid for each hearing impaired ear every 24 months. Accessories, fittings and repairs are not subject to the $5,000 limit.	No Charge
MEDICAL SUPPLIES	
Medical Supplies, when Medically Necessary**	NOT COVERED
PRESCRIPTION DRUGS (Includes Oral Contraceptives)	$50 Deductible (Waived for Tier 1 Drugs)
Tier 1	$10 copayment
Tier 2	$25 copayment
Tier 3	$50 copayment
OTHER COVERAGE	

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 Calendar Year.

These services require **pre-certification through Oxford. You must call Oxford at 800-444-6222 at least 14 days in advance of treatment to request pre-certification.

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 services not authorized

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