OXFORD HEALTH INSURANCE, INC.
PRIMARY ADVANTAGE
SUMMARY OF COVERAGE
Plan 1
Liberty Network

BENEFIT		IN-NETWORK
FINANCIAL		
Deductible:	Single	$1,500
	Family	$3,750
Coinsurance		0%
Maximum Out-of-Pocket:[1]	Single	$7,500
	Family	$18,750
Maximum Lifetime Benefit Per Member		Unlimited
Financial Accumulation Period		Calendar
PREVENTIVE CARE		
Adult Preventive Care		No Charge
Infant and Pediatric Preventive Care		No Charge
Immunizations		No Charge
OUTPATIENT CARE		
Primary Care Physician Office Visits		$25 copay per visit
Specialist Office Visits		Deductible then $50 copay per visit
Surgery**		Deductible then $150 copay
Laboratory Services		Deductible then $50 copay per visit
Radiology services including		Deductible then 50%
PET, CT Scans, Magnetic Resonance Imaging (MRI)**		
HOSPITAL CARE		
Physician's and Surgeon's Services**		No Charge after Deductible
Semi-private Room and Board**		Deductible then $250 copay per day up to 5 days per admission
All Drugs and Medication		No Charge after Deductible
EMERGENCY CARE		
Ambulance service when medically necessary		Deductible then $100 copay
At hospital emergency room		Deductible then $250 copay; waived if admitted
(If member is admitted to the hospital through the ER, notification is required)		
Emergency Care in Urgi-Center		Deductible then $50 copay per visit
MATERNITY CARE		
Prenatal and post-natal care		$25 copay per initial visit
Hospital services for mother and child**		Deductible then $250 copay per day up to 5 days per admission
SHORT TERM REHABILITATION		
60 consec. Inpatient days per condition per lifetime**		Deductible then $250 copay per day up to 5 days per admission
60 Outpatient visits per condition per lifetime*		Deductible then $50 copay per visit
*(pre-cert upon initial visit)		
HOME HEALTH CARE		
40 visits per Calendar Year**		$50 copay per visit
Physician House Calls**		$50 copay per visit
SKILLED NURSING FACILITY		
30 days per Calendar Year**		Deductible then $250 copay per day up to 5 days per admission
SUBSTANCE ABUSE		
7 days of Inpatient Detox. per Calendar Year**		Deductible then $250 copay per day up to 5 days per admission
30 days of Inpatient rehab. per Calendar Year**		Deductible then $250 copay per day up to 5 days per admission
60 Outpatient rehab. visits per Calendar Year**		Deductible and $50 copay per visit

BENEFIT	IN-NETWORK
ALLERGY CARE	
Initial visit, and all subsequent referral visits	Deductible then $50 copay per visit
MENTAL HEALTH CARE	
30 days of Inpatient care per Calendar Year**	Deductible then $250 copay per day up to 5 days per admission
30 visits of Outpatient care per Calendar Year (combined with office visits)**	Deductible and $50 copay per visit
30 Office visits (combined with outpatient care)**	Deductible and $50 copay per visit
PRESCRIPTION DRUGS (Includes Oral Contraceptives)	
Tier 1***	$15 copay
Tier 2***	Plan Deductible then 50% up to $250 per script
Tier 3***	Plan Deductible then 50% up to $250 per script
HOSPICE CARE (210 days combined inpatient, outpatient and home)	
Inpatient Care**	Deductible then $250 copay per day up to 5 days per admission
Outpatient Care**	Deductible then $150 copay
Home Hospice**	$50 copay per visit
EXERCISE FACILITY	
Subscriber	$200 reimbursement per 6 month period
Spouse	$100 reimbursement per 6 month period
HEARING AIDS	
Coverage is limited to $1,500. Limited to a single purchase (including repair/replacement) every 3 years.	Deductible then $100 copay
OTHER COVERAGE	
Medical Supplies**	Deductible then $50 copay per item
Durable Medical Equipment includes Orthotics** $1,500 limit per Calendar Year Precertification for items $500 or more.	Deductible then $100 copay

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 **precertification through Oxford. You must call Oxford at 1-800-444-6222 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 medication ordered through the Mail Order Drug Program are subject to 2.5 applicable retail pharmacy copays.
***Tier 2 and Tier 3 Pharmacy claims are subject to the in-network deductible. Once the deductible has been satisfied, the applicable prescription drug copayment will apply and will no longer accumulate toward the Maximum Out-of-Pocket.
[1]Maximum Out-of-Pocket includes the shared medical and pharmacy deductible, medical copayments and medical coinsurance. It does not include prescription drug copayments or coinsurance incurred above the plan deductible.

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, Worker's Compensation, military service-related conditions 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 the certificate for extraterritorial benefits rider.
Based on the state of your residence, additional coverage may be available 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.

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