SUMMARY OF COVERAGE
AMERISOFT PROSYSTEMS LLC

NJ, NY, CT

PPO Plan C
LIBERTY NETWORK

BENEFIT	IN-NETWORK	OUT-OF-NETWORK [1]
FINANCIAL		
Deductible: Single	None	$3,000
Deductible: Family	None	$6,000
Coinsurance	None	30%
Coinsurance Maximum Limit:	N/A	$10,000
Maximum Lifetime Benefit Per Member	Unlimited	Unlimited
PREVENTIVE SERVICES		
Preventive care (under 1 year old)	$40 copay per visit	$750 per covered person
Preventive care (1 year and over)	$40 copay per visit	$500 per covered person through the end of the calendar year
Immunizations and lead poisoning screening and treatments for children	No Charge	Subject to 30% Coinsurance
OUTPATIENT CARE		
Physician office visits	$40 copay per visit	Subject to Deductible & 30% Coinsurance
Ambulatory Surgery**	$40 copay per visit	Subject to Deductible & 30% Coinsurance**
Second Surgical Opinions**	$40 copay per visit	Subject to Deductible & 30% Coinsurance**
Pre-admission testing**	$40 copay per visit	Subject to Deductible & 30% Coinsurance**
Allergy care visits	$40 copay per visit	Subject to Deductible & 30% Coinsurance
Podiatric care visits	$40 copay per visit	Subject to Deductible & 30% Coinsurance
Alcoholism care visits**	$40 copay per visit	Subject to Deductible & 30% Coinsurance**
Physical/Occupational Therapy Combined maximum 30 visits per calendar year	$40 copay per visit	Subject to Deductible & 30% Coinsurance
Speech/Cognitive Therapy Combined maximum 30 visits per calendar year	$40 copay per visit	Subject to Deductible & 30% Coinsurance
Physician house calls	$40 copay per visit	Subject to Deductible & 30% Coinsurance
Laboratory services	At Participating Labs; No Charge	Subject to Deductible & 30% Coinsurance
Magnetic Resonance Imaging (MRI)	No Charge	Subject to Deductible & 30% Coinsurance
Therapeutic Manipulation 30 visits per calendar year	$40 copay per visit	Subject to Deductible & 30% Coinsurance
SPECIAL SERVICES		
Home Health Care**	No Charge	Subject to Deductible & 30% Coinsurance**
Skilled Nursing Care**	$400 per day , up to $2000 per confinement, to a maximum of $4000 per Calendar Year	Subject to Deductible & 30% Coinsurance**
Hospice Care**	$400 per day , up to $2000 per confinement, to a maximum of $4000 per Calendar Year	Subject to Deductible & 30% Coinsurance**
HOSPITAL CARE		
Physician's and surgeon's services **	No Charge	Subject to Deductible & 30% Coinsurance**
Semi-private room and board **	$400 per day , up to $2000 per confinement, to a maximum of $4000 per Calendar Year	Subject to Deductible & 30% Coinsurance**
All drugs and medication	No Charge	Subject to Deductible & 30% Coinsurance
Inpatient Surgery **	No Charge	Subject to Deductible & 30% Coinsurance**
EMERGENCY CARE *(Oxford must be contacted within 48 hours)*		
Ambulance service when Medically Necessary	No Charge	Subject to Deductible & 30% Coinsurance
At hospital emergency room	$100 copay; waived if admitted	$100 copay; waived if admitted
Emergency Care in Urgi-Center	$40 copay per visit	Subject to Deductible & 30% Coinsurance
MATERNITY CARE		
Prenatal 1st visit	$40 copay per initial visit	Subject to Deductible & 30% Coinsurance
Prenatal and post-natal care	No Charge	Subject to Deductible & 30% Coinsurance
Birthing centers	$40 copay per visit	Subject to Deductible & 30% Coinsurance
Hospital services for mother and child **	No Charge	Subject to Deductible & 30% Coinsurance**

1 Usual and Customary Rates will apply to Out-of-Network services.

*** 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. For Mental Health Services, this applies if you choose to exchange one inpatient day for two outpatient visits.*

BENEFIT	IN-NETWORK	OUT-OF-NETWORK [1]
MENTAL HEALTH/SUBSTANCE ABUSE		
Outpatient visits (Non-Bio 20 per calendar year) (Bio Unlimited)	(Unused Inpatient days may be exchanged, on a two-for-one basis, for additional Outpatient visits.)	
Inpatient Care (Non-Bio 30 days per calendar year)** (Bio Unlimited)	(Unused Inpatient days may be exchanged, on a two-for-one basis, for additional Outpatient visits.)	
SUBSTANCE ABUSE	At approved facilities only	
Outpatient visits	$40 copay per visit	Subject to Deductible & 30% Coinsurance
Inpatient care **	$400 per day , up to $2000 per confinement, to a maximum of $4000 per Calendar Year	Subject to Deductible & 30% Coinsurance**
MENTAL HEALTH CARE		
Inpatient Care ** Biologically Based Conditions	$400 per day , up to $2000 per confinement, to a maximum of $4000 per Calendar Year	Subject to Deductible & 30% Coinsurance**
Inpatient Care ** Non-Biologically Based Conditions	$400 per day , up to $2000 per confinement, to a maximum of $4000 per Calendar Year	Subject to Deductible & 30% Coinsurance**
Outpatient Visits** Biologically Based Conditions	$40 copay per visit	Subject to Deductible & 30% Coinsurance**
Outpatient Visits** Non-Biologically Based Conditions	$40 copay per visit	Subject to Deductible & 30% Coinsurance**
PRESCRIPTION DRUGS		
(Includes Oral Contraceptives)		
Tier 1	$10 copayment	Covered at Participating Pharmacies Only
Tier 2	$25 copayment	
Tier 3	$50 copayment	
OTHER ITEMS		
Medical Supplies, when Medically Necessary**	OUT-OF-NETWORK BENEFIT ONLY	Subject to Deductible & 30% Coinsurance**
Durable Equipment, when Medically Necessary **	No Charge if pre-certified by Oxford in advance and ordered by an Oxford Participating Physician	Subject to Deductible & 30% 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.

Please note: This sample summary of coverage is provided for informational purposes only. 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, including limitations and exclusions.

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OXFORD HEALTH PLANS®
A UnitedHealthcare Company

SUMMARY OF COVERAGE
AMERISOFT PROSYSTEMS LLC

USA

PPO Plan C
United Healthcare Choice Plus Network
Oxford USA

BENEFIT	IN-NETWORK	OUT-OF-NETWORK [1]
FINANCIAL		
Deductible: Single	None	$1,000
Deductible: Family	None	$2,000
Coinsurance	None	30%
Coinsurance Maximum Limit:	N/A	$10,000
Maximum Lifetime Benefit Per Member	Unlimited	Unlimited
PREVENTIVE SERVICES		
Preventive care (under 1 year old)	$30 copay per visit	$750 per covered person
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