OXFORD HEALTH INSURANCE, INC.
NY B LBTY NG 25/75/5750/70 EPO HSA 24 - Non-Gated
SUMMARY OF COVERAGE

Liberty Network

BENEFIT		IN-NETWORK
FINANCIAL		
Deductible:	Single*	$5,750
	Family	$11,500
Coinsurance:		30%
Maximum Out-Of-Pocket:	Single	$8,000
(Including Deductible)	Family	$16,000
Financial Accumulation Period:		Policy Year
Out-of-Network Reimbursement:		Not Applicable

Please Note: *All Copayments, Deductibles, and Coinsurance (medical and prescription) paid for In-Network Covered Services contribute to the In-Network, Out-of-Pocket Maximum.*

**If you have a family contract, the entire family Deductible must be satisfied before coverage under this Plan is available. A family contract is a Plan that covers you and one or more dependents.*

PREVENTIVE CARE	
Adult Preventive Care	No Charge
Infant and Pediatric Preventive Care	No Charge
Preventive Dental for Children (Up to age 19)	No Charge after Deductible
Pediatric Vision Exam (Up to age 19)	No Charge
Pediatric Vision Hardware (Up to age 19)	Deductible & 50% Coinsurance
OUTPATIENT CARE	
Primary Care Physician Office Visits	Deductible and then $25 copay per visit
Specialist Office Visits	Deductible and then $75 copay per visit
Virtual Visits	No Charge
Outpatient Surgery - Hospital Setting	Deductible & 30% Coinsurance
Outpatient Surgery - Freestanding Facility	Deductible & 30% Coinsurance
Laboratory Services	Deductible & 30% Coinsurance
Radiology Services	Deductible & 30% Coinsurance
DIABETIC SUPPLIES AND MEDICATIONS	
Diabetic Supplies	Deductible and then $25 copay
Diabetic Medications	Deductible and then $25 copay
MRIs, MRAs, CT SCANS, AND PET SCANS	
Outpatient Hospital Services	Deductible & 30% Coinsurance
Freestanding Radiology Facility	Deductible & 30% Coinsurance
HOSPITAL CARE	
Physician's and Surgeon's Services	Deductible & 30% Coinsurance
Semi-Private Room and Board	Deductible & 30% Coinsurance
All Drugs and Medication	Deductible & 30% Coinsurance
EMERGENCY CARE	
Ambulance Service When Medically Necessary	Deductible & 30% Coinsurance
At Hospital Emergency Room *(waived if admitted)*	Deductible & 50% Coinsurance
(If member is admitted to the hospital, notification is required.)	
Emergency Care in Urgi-Center	Deductible & 30% Coinsurance
MATERNITY CARE	
Prenatal and Post-Natal Care	No Charge
Hospital Services for Mother and Child	Deductible & 30% Coinsurance
SKILLED NURSING FACILITY	
200 days per Plan Year.	Deductible & 30% Coinsurance
HOSPICE CARE	
Inpatient Care	Deductible & 30% Coinsurance
Home Hospice - Unlimited.	Deductible and then $75 copay per visit
HOME HEALTH CARE	
Home Care Visits - 40 visits per Plan Year.	Deductible and then $75 copay per visit
Physician House Calls	Deductible and then $75 copay per visit
SUBSTANCE USE DISORDER SERVICES	
Inpatient Rehabilitation	Deductible & 30% Coinsurance
Outpatient Rehabilitation	Deductible and then $25 copay per visit
Outpatient Partial Hospitalization	No Charge after Deductible

BENEFIT	IN-NETWORK
MENTAL HEALTH CARE	
Inpatient Care	Deductible & 30% Coinsurance
Outpatient Visits	Deductible and then $25 copay per visit
Outpatient Partial Hospitalization	No Charge after Deductible
ALLERGY CARE	
Testing and Treatment	Deductible and then $75 copay per visit
ALTERNATIVE MEDICINE	
Chiropractic Care - Unlimited Visits	Deductible and then $75 copay per visit
SHORT TERM REHABILITATION	
Inpatient - Limited to 60 combined PT/OT/ST days per Plan Year.	Deductible & 30% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	Deductible and then $75 copay per visit
HABILITATIVE SERVICES	
Inpatient - Limited to 60 combined PT/OT/ST days per Plan Year.	Deductible & 30% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	Deductible and then $75 copay per visit
DURABLE MEDICAL EQUIPMENT	
Durable Medical Equipment - Unlimited. *Precertification required for items over $500*	Deductible & 30% Coinsurance
MEDICAL SUPPLIES	
Medical Supplies When Medically Necessary	Deductible & 30% Coinsurance
HEARING AIDS	
Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	Deductible & 30% Coinsurance
EXERCISE FACILITY	
Subscriber	$200 reimbursement per 6 month period
Spouse/Dependents over age 13	$100 reimbursement per 6 month period
OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE	Subject to Plan Deductible listed above
OUTPATIENT PRESCRIPTION DRUGS - RETAIL	
The Prescription Drug Benefit is based on a Per Calendar Year limit for any applicable deductibles and/or maximum limits.	
Tier 1	30% Coinsurance after Deductible
Tier 2	30% Coinsurance after Deductible
Tier 3	30% Coinsurance after Deductible
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER	
Tier 1	30% Coinsurance after Deductible
Tier 2	30% Coinsurance after Deductible
Tier 3	30% Coinsurance after Deductible

DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.

A Dependent who has attained the above limiting age can continue coverage until they reach age 30 subject to the eligibility requirements outlined in the Certificate.

Domestic Partners are covered with proper documentation.

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.

Benefits are subject to final approval by the Department of Insurance and therefore may be subject to change.