# SUMMARY OF COVERAGE

**Liberty Network**

## FINANCIAL

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>In-Network Deductible</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$5,750</td>
<td>70%</td>
</tr>
<tr>
<td>Family</td>
<td>$11,500</td>
<td></td>
</tr>
</tbody>
</table>

**Coinsurance:**
- Single: 70%
- Family: Not Applicable

**Maximum Out-Of-Pocket:**
- Single: $7,000
- Family: $14,000

**Financial Accumulation Period:** Calendar 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.

### PREVENTIVE CARE
- Adult Preventive Care: No Charge
- Infant and Pediatric Preventive Care: No Charge
- Preventive Dental for Children (Up to age 19): No Charge
- Pediatric Vision Exam (Up to age 19): No Charge
- Pediatric Vision Hardware (Up to age 19): Deductible and 50% Coinsurance

### OUTPATIENT CARE
- Primary Care Physician Office Visits: Deductible and then $25 copay per visit
- Specialist Office Visits: No Charge after Deductible
- Virtual Visits: Deductible & 30% Coinsurance
- 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 per visit
- Diabetic Medications: Deductible and then $25 copay per visit

### MRI, 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.): Deductible & 30% Coinsurance
- 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 Calendar 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 Calendar 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 $75 copay per visit
- Outpatient Partial Hospitalization: Deductible and then $75 copay per visit

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**Please Note:**
- 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.

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**Benefit:**
- In-Network

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**Oxford Health Insurance, Inc.**

**NY B LBTY NG 25/75/5750/70 EPO HSA 21 - Non-Gated**

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### BENEFIT

#### MENTAL HEALTH CARE
Inpatient Care
- Deductible & 30% Coinsurance
Outpatient Visits
- Deductible and then $75 copay per visit
Outpatient Partial Hospitalization
- Deductible and then $75 copay per visit

#### ALLEGY 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 visits per calendar year
- Deductible & 30% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per calendar year
- Deductible and then $75 copay per visit

#### HABILITATIVE SERVICES
Inpatient - Limited to 60 combined PT/OT/ST days per calendar year
- Deductible & 30% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per calendar year
- Deductible and then $75 copay per visit

#### DURABLE MEDICAL EQUIPMENT
Durable Medical Equipment - Unlimited
- Pre-certification 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 - 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.

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*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.*