OXFORD HEALTH INSURANCE, INC.
NY G LBTY NG 20/40/2000/80 EPO 23 - Non-Gated
SUMMARY OF COVERAGE
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Liberty Network
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BENEFIT		PREFERRED PROVIDER	IN-NETWORK
FINANCIAL			
Deductible:	Single	$2,000	$2,000
	Family	$4,000	$4,000
Coinsurance:		20%	20%
Maximum Out-Of-Pocket:	Single	$8,750	$8,750
(Including Deductible)	Family	$17,500	$17,500
Financial Accumulation Period:		Policy Year	Policy Year
Out-of-Network Reimbursement:		Not Applicable	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	No Charge
Infant and Pediatric Preventive Care	No Charge	No Charge
Preventive Dental for Children (Up to age 19)	No Charge after Deductible	No Charge after Deductible
Pediatric Vision Exam (Up to age 19)	$30 copay per visit	$30 copay per visit
Pediatric Vision Hardware (Up to age 19)	50% Coinsurance	50% Coinsurance
OUTPATIENT CARE		
Primary Care Physician Office Visits	$20 copay per visit	$40 copay per visit
Specialist Office Visits	$40 copay per visit	$80 copay per visit
Virtual Visits	No Charge	No Charge
Outpatient Surgery - Hospital Setting	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Outpatient Surgery - Freestanding Facility	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Laboratory Services	Deductible & 50% Coinsurance	Deductible & 50% Coinsurance
Radiology Services	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
DIABETIC SUPPLIES AND MEDICATIONS		
Diabetic Supplies	$20 copay	$40 copay
Diabetic Medications	$20 copay	$40 copay
MRIs, MRAs, CT SCANS, AND PET SCANS		
Outpatient Hospital Services	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Freestanding Radiology Facility	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
HOSPITAL CARE		
Physician's and Surgeon's Services	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Semi-Private Room and Board	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
All Drugs and Medication	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
EMERGENCY CARE		
Ambulance Service When Medically Necessary	No Charge	No Charge
At Hospital Emergency Room *(waived if admitted)*	$500 copay per visit	$500 copay per visit
(If member is admitted to the hospital, notification is required.)		
Emergency Care in Urgi-Center	$75 copay per visit	$75 copay per visit
MATERNITY CARE		
Prenatal and Post-Natal Care	No Charge	No Charge
Hospital Services for Mother and Child	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
SKILLED NURSING FACILITY		
Limited to 200 days per Plan Year.	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
HOSPICE CARE		
Inpatient Care	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Home Hospice - Unlimited.	$40 copay per visit	$40 copay per visit
HOME HEALTH CARE		
Limited to 40 visits per Plan Year.	$40 copay per visit	$40 copay per visit
Physician House Calls	$40 copay per visit	$40 copay per visit
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Outpatient Rehabilitation	$40 copay per visit	$40 copay per visit
Outpatient Partial Hospitalization	No Charge after Deductible	No Charge after Deductible

BENEFIT	PREFERRED PROVIDER	IN-NETWORK
MENTAL HEALTH CARE		
Inpatient Care	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Outpatient Visits	$40 copay per visit	$40 copay per visit
Outpatient Partial Hospitalization	No Charge after Deductible	No Charge after Deductible
ALLERGY CARE		
Testing and Treatment	$40 copay per visit	$80 copay per visit
ALTERNATIVE MEDICINE		
Chiropractic Care - Unlimited	$40 copay per visit	$40 copay per visit
SHORT TERM REHABILITATION		
Inpatient - Limited to 60 combined PT/OT/ST days per Plan Year.	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	$80 copay per visit	$80 copay per visit
HABILITATIVE SERVICES		
Inpatient - Limited to 60 combined PT/OT/ST days per Plan Year.	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	$80 copay per visit	$80 copay per visit
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment - Unlimited. *Precertification required for items over $500*	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
HEARING AIDS		
Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
EXERCISE FACILITY		
Subscriber	$200 reimbursement per 6 month period	$200 reimbursement per 6 month period
Spouse/Dependents over age 13	$100 reimbursement per 6 month period	$100 reimbursement per 6 month period
OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE	$200 Deductible (Waived for Tier 1 drugs)	
OUTPATIENT PRESCRIPTION DRUGS - RETAIL		
The Prescription Drug Benefit is based on a Per Policy Year limit for any applicable deductibles and/or maximum limits.		
Tier 1	$10 copay	
Tier 2	$50 copay	
Tier 3	$90 copay	
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	$25 copay	
Tier 2	$125 copay	
Tier 3	$225 copay	

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.