



**OXFORD HEALTH INSURANCE, INC.**  
**NY S MTRO GT 35/50/4000/70 EPO HSA 23 - Gated**  
**SUMMARY OF COVERAGE**  
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**Metro Network**

BENEFIT	IN-NETWORK
<b>FINANCIAL</b>	
Deductible:	
Single*	\$4,000
Family	\$8,000
Coinsurance:	30%
Maximum Out-Of-Pocket:	
Single	\$7,200
(Including Deductible) Family	\$14,400
Financial Accumulation Period:	Policy Year
Out-of-Network Reimbursement:	Not Applicable
<p><i>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.</i></p> <p><i>*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.</i></p>	
<b>PREVENTIVE CARE</b>	
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
<b>OUTPATIENT CARE</b>	
Primary Care Physician Office Visits	Deductible and then \$35 copay per visit
Specialist Office Visits*	Deductible and then \$50 copay per visit
Virtual Visits	No Charge after Deductible
Outpatient Surgery - Hospital Setting	Deductible and then \$750 copay per visit
Outpatient Surgery - Freestanding Facility	Deductible and then \$300 copay per visit
Laboratory Services	Deductible and then \$15 copay per service
Radiology Services	Deductible and then \$50 copay per service
<b>DIABETIC SUPPLIES AND MEDICATIONS</b>	
Diabetic Supplies	Deductible and then \$35 copay
Diabetic Medications	Deductible and then \$35 copay
<b>MRIs, MRAs, CT SCANS, AND PET SCANS</b>	
Outpatient Hospital Services	Deductible and then \$150 copay per service
Freestanding Radiology Facility	Deductible and then \$150 copay per service
<b>HOSPITAL CARE</b>	
Physician's and Surgeon's Services	Deductible & 30% Coinsurance
Semi-Private Room and Board	Deductible & 30% Coinsurance
All Drugs and Medication	Deductible & 30% Coinsurance
<b>EMERGENCY CARE</b>	
Ambulance Service When Medically Necessary	Deductible & 30% Coinsurance
At Hospital Emergency Room ( <i>waived if admitted</i> )	Deductible and then \$500 copay per visit
( <i>If member is admitted to the hospital, notification is required.</i> )	
Emergency Care in Urgi-Center	Deductible and then \$80 copay per visit
<b>MATERNITY CARE</b>	
Prenatal and Post-Natal Care	No Charge
Hospital Services for Mother and Child	Deductible & 30% Coinsurance
<b>SKILLED NURSING FACILITY</b>	
200 days per Plan Year.	Deductible & 30% Coinsurance
<b>HOSPICE CARE</b>	
Inpatient Care	Deductible & 30% Coinsurance
Home Hospice - Unlimited.	Deductible and then \$50 copay per visit
<b>HOME HEALTH CARE</b>	
Home Care Visits - 40 visits per Plan Year.	Deductible and then \$50 copay per visit
Physician House Calls	Deductible and then \$50 copay per visit
<b>SUBSTANCE USE DISORDER SERVICES</b>	
Inpatient Rehabilitation	Deductible & 30% Coinsurance
Outpatient Rehabilitation	Deductible and then \$35 copay per visit
Outpatient Partial Hospitalization	No Charge after Deductible

BENEFIT	IN-NETWORK
<b>MENTAL HEALTH CARE</b>	
Inpatient Care	Deductible & 30% Coinsurance
Outpatient Visits	Deductible and then \$35 copay per visit
Outpatient Partial Hospitalization	No Charge after Deductible
<b>ALLERGY CARE</b>	
Testing and Treatment	Deductible and then \$50 copay per visit
<b>ALTERNATIVE MEDICINE</b>	
Chiropractic Care - Unlimited Visits	Deductible and then \$50 copay per visit
<b>SHORT TERM REHABILITATION</b>	
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 \$50 copay per visit
<b>HABILITATIVE SERVICES</b>	
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 \$50 copay per visit
<b>DURABLE MEDICAL EQUIPMENT</b>	
Durable Medical Equipment - Unlimited. <i>Precertification required for items over \$500</i>	Deductible & 30% Coinsurance
<b>MEDICAL SUPPLIES</b>	
Medical Supplies When Medically Necessary	Deductible & 30% Coinsurance
<b>HEARING AIDS</b>	
Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	Deductible & 30% Coinsurance
<b>EXERCISE FACILITY</b>	
Subscriber	\$200 reimbursement per 6 month period
Spouse/Dependents over age 13	\$100 reimbursement per 6 month period
<b>OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE</b>	
	Subject to Plan Deductible listed above
<b>OUTPATIENT PRESCRIPTION DRUGS - RETAIL</b>	
<i>The Prescription Drug Benefit is based on a Per Policy Year limit for any applicable deductibles and/or maximum limits.</i>	
Tier 1	\$10 copay
Tier 2	\$65 copay
Tier 3	50% Coinsurance max \$800 per script
<b>OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER</b>	
Tier 1	\$25 copay
Tier 2	\$162.50 copay
Tier 3	50% Coinsurance max \$2,000 per script

**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.

\*Visits to an Oxford participating Specialist require an authorized referral from the member's Primary Care Physician.

**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.*