OXFORD HEALTH INSURANCE, INC.
NY P LBTY GT 10/25/250/90 EPO LA 23 - Gated
SUMMARY OF COVERAGE
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Liberty Network

BENEFIT		IN-NETWORK
FINANCIAL		
Deductible:	Single	$250
	Family	$500
Coinsurance:		10%
Maximum Out-Of-Pocket:	Single	$2,500
(Including Deductible)	Family	$5,000
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.*

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)	$10 copay per visit
Pediatric Vision Hardware (Up to age 19)	50% Coinsurance
OUTPATIENT CARE	
Primary Care Physician Office Visits	$10 copay per visit
Pediatric Office Visits (Up to age 19)	Not Applicable
Specialist Office Visits*	$25 copay per visit
Virtual Visits	No Charge
Outpatient Surgery - Hospital Setting	Deductible & 10% Coinsurance
Outpatient Surgery - Hospital Setting Per Occurrence Deductible	Not Applicable
Outpatient Surgery - Freestanding Facility	Deductible & 10% Coinsurance
Designated Diagnostic Provider Laboratory Services	No Charge
Non-Designated Diagnostic Provider Laboratory Services	Deductible & 50% Coinsurance
Radiology Services	Deductible & 10% Coinsurance
DIABETIC SUPPLIES AND MEDICATIONS	
Diabetic Supplies	$10 copay
Diabetic Medications	$10 copay
MRIs, MRAs, CT SCANS, AND PET SCANS	
Outpatient Hospital Services	Deductible & 10% Coinsurance
Freestanding Radiology Facility	Deductible & 10% Coinsurance
HOSPITAL CARE	
Physician's and Surgeon's Services	Deductible & 10% Coinsurance
Semi-Private Room and Board	Deductible & 10% Coinsurance
All Drugs and Medication	Deductible & 10% Coinsurance
EMERGENCY CARE	
Ambulance Service When Medically Necessary	No Charge
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	$30 copay per visit
MATERNITY CARE	
Prenatal and Post-Natal Care	No Charge
Hospital Services for Mother and Child	Deductible & 10% Coinsurance
SKILLED NURSING FACILITY	
Limited to 200 days per Plan Year.	Deductible & 10% Coinsurance
HOSPICE CARE	
Inpatient Care	Deductible & 10% Coinsurance
Home Hospice - Unlimited.	$25 copay per visit
HOME HEALTH CARE	
Limited to 40 visits per Plan Year.	$25 copay per visit
Physician House Calls	$25 copay per visit
SUBSTANCE USE DISORDER SERVICES	
Inpatient Rehabilitation	Deductible & 10% Coinsurance
Outpatient Rehabilitation	$10 copay per visit
Outpatient Partial Hospitalization	No Charge after Deductible

BENEFIT	IN-NETWORK
MENTAL HEALTH CARE	
Inpatient Care	Deductible & 10% Coinsurance
Outpatient Visits	$10 copay per visit
Outpatient Partial Hospitalization	No Charge after Deductible
ALLERGY CARE	
Testing and Treatment	$25 copay per visit
ALTERNATIVE MEDICINE	
Chiropractic Care - Unlimited	$25 copay per visit
SHORT TERM REHABILITATION	
Inpatient - Limited to 60 combined days per Plan Year.	Deductible & 10% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	$25 copay per visit
HABILITATIVE SERVICES	
Inpatient - Limited to 60 combined days per Plan Year.	Deductible & 10% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	$25 copay per visit
DURABLE MEDICAL EQUIPMENT	
Durable Medical Equipment - Unlimited. *Precertification required for items over $500*	Deductible & 10% Coinsurance
MEDICAL SUPPLIES	
Medical Supplies When Medically Necessary	Deductible & 10% Coinsurance
HEARING AIDS	
Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	Deductible & 10% 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	$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.

*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.