OXFORD HEALTH INSURANCE, INC.
EPO PLAN
SUMMARY OF COVERAGE
Liberty Network
EOC of Suffolk, Inc
Mid Plan

BENEFIT		Designated Network/In-Network
FINANCIAL		
Deductible:	Single	$3,000
	Family	$6,000
Coinsurance		None
Maximum Out-of-Pocket:	Single	$7,900
(Including Deductible)	Family	$15,800
Financial Accumulation Period:		Policy Year

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.

BENEFIT	Designated Network	In-Network
PREVENTIVE CARE		
Adult Preventive Care	No Charge	No Charge
Infant and Pediatric Preventive Care	No Charge	No Charge
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 and then $350 copay per visit	Deductible and then $350 copay per visit
Outpatient Surgery - Freestanding Facility	No Charge after Deductible	No Charge after Deductible
Laboratory Services - Hospital Setting	No Charge after Deductible	No Charge after Deductible
Laboratory Services - Freestanding Facility	$25 copay per visit	$25 copay per visit
(See your Certificate of Coverage for additional Lab details)		
Radiology Services - Hospital Setting	No Charge after Deductible	No Charge after Deductible
Radiology Services - Freestanding Facility	$25 copay per visit	$25 copay per visit
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	No Charge after Deductible	No Charge after Deductible
Freestanding Radiology Facility	$75 copay per visit	$75 copay per visit
HOSPITAL CARE		
Physician's and Surgeon's Services	No Charge after Deductible	No Charge after Deductible
Semi-Private Room and Board	No Charge after Deductible	No Charge after Deductible
All Drugs and Medication	No Charge after Deductible	No Charge after Deductible
EMERGENCY CARE		
Ambulance Service when Medically Necessary	No Charge	No Charge
At Hospital Emergency Room	Deductible & 50% Coinsurance	Deductible & 50% Coinsurance
(If member is admitted to the hospital, notification is required)		
Emergency Care in Urgi-Center	$40 copay per visit	$40 copay per visit
MATERNITY CARE		
Routine Prenatal and Post-Natal Care	No Charge	No Charge
Hospital Services for Mother and Child	No Charge after Deductible	No Charge after Deductible
SKILLED NURSING FACILITY		
30 Days per Year	No Charge after Deductible	No Charge after Deductible
HOSPICE CARE		
Inpatient Care	No Charge after Deductible	No Charge after Deductible
Home Hospice Care Visits	$40 copay per visit	$40 copay per visit
HOME HEALTH CARE		
Home Care Visits - 40 Visits per Policy Year	$40 copay per visit	$40 copay per visit
Physician House Calls	$40 copay per visit	$80 copay per visit
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation	No Charge after Deductible	No Charge after Deductible
Office Visits or Outpatient Rehabilitation	$20 copay per visit	$20 copay per visit
Outpatient Partial Hospitalization	No Charge	No Charge
MENTAL HEALTH CARE		
Inpatient Care	No Charge after Deductible	No Charge after Deductible
Office Visits or Outpatient Care	$20 copay per visit	$20 copay per visit
Outpatient Partial Hospitalization	No Charge	No Charge

BENEFIT	Designated Network	In-Network
ALLERGY CARE		
Testing and Treatment	$40 copay per visit	$80 copay per visit
CHIROPRACTIC CARE		
Chiropractic Care	$40 copay per visit	$80 copay per visit
SHORT TERM REHAB OR HABILITATIVE SERVICES		
Inpatient limited to 60 Days per Year	No Charge after Deductible	No Charge after Deductible
Outpatient limited to 60 combined PT/OT/ST Visits per Year	$80 copay per visit	$80 copay per visit
DURABLE MEDICAL EQUIPMENT		
Unlimited *(Precert required for items over $500)*	No Charge after Deductible	No Charge after Deductible
HEARING AIDS		
Limited to a single purchase (including repair/replacement) every 3 Years.	No Charge after Deductible	No Charge after Deductible
MEDICAL SUPPLIES		
Medical Supplies when Medically Necessary	No Charge after Deductible	No Charge after Deductible
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
INFERTILITY		
(Covers all services in compliance with the NY Infertility Mandate)		
Specialist Office Visits	$40 copay per visit	$80 copay per visit
Inpatient Facility Services	No Charge after Deductible	No Charge after Deductible
Outpatient Surgery - Hospital Setting	Deductible and then $350 copay per visit	Deductible and then $350 copay per visit
Outpatient Surgery - Freestanding Facility	No Charge after Deductible	No Charge after Deductible
OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE	$100 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	$15 copay	$15 copay
Tier 2	$35 copay	$35 copay
Tier 3	$75 copay	$75 copay
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	$37.50 copay	$37.50 copay
Tier 2	$87.50 copay	$87.50 copay
Tier 3	$187.50 copay	$187.50 copay

DEPENDENT ELIGIBILITY:
Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.
Benefits discontinue at the end of the Month.

Domestic Partners covered with proper documentation.

Please be advised this sample summary of coverage is provided for informational purposes only. The information contained herein is subject to the approval of the New York Department of Insurance and Oxford home office approval as appropriate. 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, Workers' Compensation, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.