



OXFORD HEALTH INSURANCE, INC.
 NY B LBTY NG 25/75/5750/70 EPO HSA 2 - Non-Gated
 SUMMARY OF COVERAGE

Liberty Network

BENEFIT	IN-NETWORK
FINANCIAL	
Deductible: Single*	\$5,750
Family	\$11,500
Coinsurance:	30%
Maximum Out-Of-Pocket: Single	\$
(Including Deductible) Family	\$
Financial Accumulation Period:	3 R O L F \ 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.	
*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.	
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)	No Charge
Pediatric Vision Hardware (Up to age 19)	Deductible & 50% Coinsurance
OUTPATIENT CARE	
Primary Care Physician Office Visits	Deductible and then \$25 copay per visit
Specialist Office Visits	Deductible and then \$75 copay per visit
Virtual Visits	No Charge
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
Diabetic Medications	Deductible and then \$25 copay
MRIs, 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
	Deductible & 30% Coinsurance
200 days per Plan Year.	Deductible & 30% Coinsurance
	Deductible & 30% Coinsurance
Home Hospice - Unlimited.	
	Deductible & 30% Coinsurance

