



OXFORD HEALTH INSURANCE, INC.
EPO PLAN
SUMMARY OF COVERAGE
Liberty Network
Jewish Theological Seminary

BENEFIT		In-Network
FINANCIAL		
Deductible:	Single	\$500
	Family	\$1,000
Coinsurance		10%
Maximum Out-of-Pocket:	Single	\$3,000
(Including Deductible)	Family	\$6,000
Financial Accumulation Period:		Calendar Year
<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>		
PREVENTIVE CARE		
Adult Preventive Care		No Charge
Infant and Pediatric Preventive Care		No Charge
OUTPATIENT CARE		
Primary Care Physician Office Visits		\$25 copay per visit
Specialist Office Visits		\$40 copay per visit
Outpatient Surgery - Hospital Setting		Deductible and 10% Coinsurance
Outpatient Surgery - Freestanding Facility		Deductible and 10% Coinsurance
Laboratory Services Participating		No Charge
<i>(See your Certificate of Coverage for additional Lab details)</i>		
Radiology Services		Deductible and 10% Coinsurance
DIABETIC SUPPLIES AND MEDICATIONS		
Diabetic Supplies		\$25 copay per visit
Diabetic Medications		\$25 copay per visit
MRIs, MRAs, CT SCANS, AND PET SCANS		
Outpatient Hospital Services		Deductible and 10% Coinsurance
Freestanding Radiology Facility		Deductible and 10% Coinsurance
HOSPITAL CARE		
Physician's and Surgeon's Services		Deductible and 10% Coinsurance
Semi-Private Room and Board		Deductible and 10% Coinsurance
All Drugs and Medication		Deductible and 10% Coinsurance
EMERGENCY CARE		
Ambulance Service when Medically Necessary		No Charge
At Hospital Emergency Room		\$100 copay per visit; waived if admitted
<i>(If member is admitted to the hospital, notification is required)</i>		
Emergency Care in Urgi-Center		\$40 copay per visit
MATERNITY CARE		
Routine Prenatal and Post-Natal Care		No Charge
Hospital Services for Mother and Child		Deductible and 10% Coinsurance
SKILLED NURSING FACILITY		
30 Days per Calendar Year		Deductible and 10% Coinsurance
HOSPICE CARE		
Inpatient Care		Deductible and 10% Coinsurance
Home Hospice Care Visits		\$40 copay per visit
HOME HEALTH CARE		
Home Care Visits - 60 Visits per Calendar Year		\$40 copay per visit
Physician House Calls		\$40 copay per visit
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation		Deductible and 10% Coinsurance
Office Visits or Outpatient Rehabilitation		\$40 copay per visit
Outpatient Partial Hospitalization		No Charge after Deductible
MENTAL HEALTH CARE		
Inpatient Care		Deductible and 10% Coinsurance
Office Visits or Outpatient Care		\$40 copay per visit
Outpatient Partial Hospitalization		No Charge after Deductible
ALLERGY CARE		
Testing and Treatment		\$40 copay per visit

BENEFIT	In-Network
CHIROPRACTIC CARE	
Chiropractic Care	\$40 copay per visit
SHORT TERM REHAB OR HABILITATIVE SERVICES	
Inpatient limited to 60 Days per Calendar Year	Deductible and 10% Coinsurance
Outpatient limited to 60 combined PT/OT/ST Visits per Calendar Year	\$40 copay per visit
DURABLE MEDICAL EQUIPMENT	
Unlimited (Precert required for items over \$500)	Deductible and 10% Coinsurance
HEARING AIDS	
Limited to a single purchase (including repair/replacement) every 3 Years.	Deductible and 10% Coinsurance
MEDICAL SUPPLIES	
Medical Supplies when Medically Necessary	Deductible and 10% Coinsurance
EXERCISE FACILITY	
Subscriber	\$200 reimbursement per 6 month period
Spouse	\$100 reimbursement per 6 month period

OUTPATIENT PRESCRIPTION DRUGS - RETAIL

The Prescription Drug Benefit is based on a per Calendar Year limit for any applicable deductibles and/or maximum limits.

Tier 1	\$10 copay
Tier 2	\$25 copay
Tier 3	\$50 copay

OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER

Tier 1	\$25.00 copay
Tier 2	\$62.50 copay
Tier 3	\$125.00 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 Calendar Year

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.