OXFORD HEALTH INSURANCE, INC.
EPO PLAN
Liberty Network
SUMMARY OF COVERAGE
Hofstra University

BENEFIT		In-Network
FINANCIAL		
Deductible:	Single	None
	Family	None
Coinsurance		None
Maximum Out-of-Pocket:	Single	None
(Including Deductible)	Family	None
Maximum Lifetime Benefit per Member:		Unlimited
Financial Accumulation Period:		Calendar Year
PREVENTIVE CARE		
Adult Preventive Care		No Charge
Infant and Pediatric Preventive Care		No Charge
Preventive Dental for Children (Through Age 11)		No Charge
OUTPATIENT CARE		
Primary Care Physician Office Visits		$15 copay per visit
Specialist Office Visits		$15 copay per visit
Outpatient Facility Surgery**		No Charge after the Deductible has been met
Laboratory Services		At Participating Laboratories only: No Charge
MRIs, MRAs, PET Scan, CT Scan, Ultrasound **		No Charge after the Deductible has been met
Radiology Services**		No Charge after the Deductible has been met
HOSPITAL CARE		
Physician's and Surgeon's Services **		No Charge after the Deductible has been met
Semi-Private Room and Board **		No Charge after the Deductible has been met
All Drugs and Medication		No Charge after the Deductible has been met
EMERGENCY CARE		
Ambulance Service When Medically Necessary		No Charge
At Hospital Emergency Room		No Charge after the Deductible has been met
(If member is admitted to the hospital, notification is required)		
Emergency Care in Urgi-Center		$15 copay per visit
MATERNITY CARE		
Prenatal and Post-Natal Care **		$15 copay per initial visit only
Hospital Services For Mother and Child **		No Charge after the Deductible has been met
SKILLED NURSING FACILITY		
30 Days per Calendar Year**		No Charge after the Deductible has been met
HOSPICE CARE (210 days per lifetime combined Inpatient, Outpatient and Home Hospice)		
Inpatient Care**		No Charge after the Deductible has been met
Outpatient Care**		No Charge after the Deductible has been met
Home Hospice**		$15 copay per visit
HOME HEALTH CARE		
60 visits per Calendar Year**		$15 copay per visit
Physician House Calls		$15 copay per visit
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation**		No Charge after the Deductible has been met
Outpatient Rehabilitation**		$15 copay per visit
Office Visits**		$15 copay per visit
MENTAL HEALTH CARE		
Inpatient Care**		No Charge after the Deductible has been met
Outpatient Care**		$15 copay per visit
Office Visits**		$15 copay per visit

BENEFIT	In-Network
ALLERGY CARE	
Testing and Treatment	$15 copay per visit
CHIROPRACTIC CARE	
Chiropractic Care	$15 copay per visit
SHORT TERM REHABILITATION	
60 Consec. Inpatient Days per Condition / Lifetime **	No Charge after the Deductible has been met
60 Outpatient Visits per Condition / Lifetime	$15 copay per visit
*Precertification upon initial Visit***	
DURABLE MEDICAL EQUIPMENT	
Durable Medical Equipment**	No Charge after the Deductible has been met
Unlimited	
(Precert required for items over $500)	
MEDICAL SUPPLIES	
Medical Supplies When Medically Necessary	No Charge after the Deductible has been met
Unlimited	
EXERCISE FACILITY	
Subscriber	$200 reimbursement per 6 month period
Spouse	$100 reimbursement per 6 month period
ELECTIVE TERMINATION OF PREGNANCY	
$350 maximum for one procedure per member per Calendar Year	No Charge after the Deductible has been met
ADVANCED INFERTILITY TREATMENT ($10,000 per lifetime)	
Specialist Office Visits**	$15 copay per visit
Inpatient Facility Services**	No Charge after the Deductible has been met
Outpatient Facility Services**	No Charge after the Deductible has been met
HEARING AIDS	
Coverage is limited to $5,000. Limited to a single purchase (including repair/replacement) every 3 years.	No Charge after the Deductible has been met
PRESCRIPTION DRUGS (Includes Oral Contraceptives)	
Tier 1 ***	$5 copay
Tier 2 ***	$15 copay
Tier 3 ***	$25 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.

Domestic Partners covered with proper documentation.

** These services require **precertification** through Oxford. Members must call Oxford at 1-800-444-6222 at least 14 days in advance of treatment to request precertification. Out-of-network Urgent Care, when properly precertified may be paid at member's copay.
**Mental health and substance use disorder services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

***Prescription medication ordered through the Mail Order Drug Program are subject to two applicable retail pharmacy copays.

***The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductible and/or maximum limits.

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, Workers' Compensation, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.