

OXFORD HEALTH INSURANCE, INC. NY S FRDM NG 30/60/3000/80 EPO HSA 24 - Non-Gated SUMMARY OF COVERAGE

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	Outpatient Partial Hospitaliza	ation	No Charge after Deductible

NYSM_EPO HSA _01.01.24_v.1 January 1, 2024

BENEFIT	IN-NETWORK
MENTAL HEALTH CARE Inpatient Care	Deductible & 20% Coinsurance
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Outpatient Visits	Deductible and then \$30 copay per visit
Outpatient Partial Hospitalization	No Charge after Deductible
ALLERGY CARE	
Testing and Treatment	Deductible and then \$60 copay per visit
ALTERNATIVE MEDICINE	
Chiropractic Care - Unlimited Visits	Deductible and then \$60 copay per visit
SHORT TERM REHABILITATION	
Inpatient - Limited to 60 combined PT/OT/ST days per Plan Year.	Deductible & 20% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	Deductible and then \$60 copay per visit
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HABILITATIVE SERVICES	
Inpatient - Limited to 60 combined PT/OT/ST days per Plan Year.	Deductible & 20% Coinsurance
	Deductible and then \$60 comes man visit
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	Deductible and then \$60 copay per visit
per Flan Fear.	
DURABLE MEDICAL EQUIPMENT	
Durable Medical Equipment - Unlimited.	Deductible & 20% Coinsurance
Precertification required for items over \$500	
MEDICAL SUPPLIES	
Medical Supplies When Medically Necessary	Deductible & 20% Coinsurance
HEARING AIDS	D 1 (11 0 200) C :
Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	Deductible & 20% Coinsurance
EXERCISE FACILITY	
Subscriber 12	\$200 reimbursement per 6 month period
Spouse/Dependents over age 13	\$100 reimbursement per 6 month period
OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE	Subject to Plan Deductible listed above
OUTDATIENT DDESCRIPTION DRUGS DETAIL	
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	\$40 copay
Tier 3	\$80 copay
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER	
Tier 1	\$25 copay
Tier 2	\$100 copay
Tier 3	\$200 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.

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.