



**OXFORD HEALTH INSURANCE, INC.**  
**NY G FRDM NG 1500/90 PPO HSA 23 - Non-Gated**  
**SUMMARY OF COVERAGE**

**Freedom Network**

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>FINANCIAL</b>		
Deductible:		
Single*	\$1,500	\$4,000
Family	\$3,000	\$8,000
Coinsurance	10%	40%
Maximum Out-Of-Pocket:		
Single	\$5,750	\$10,000
(Including Deductible)		
Family	\$11,500	\$20,000
Financial Accumulation Period:	Policy Year	Policy Year
Out-of-Network Reimbursement:	Not Applicable	140% of Medicare
 <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>		
 <i>*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.</i>		
<b>PREVENTIVE CARE</b>		
Adult Preventive Care	No Charge	Limited Coverage***
<i>***Please see your Certificate for a complete list of Preventive Care benefits covered Out-of-Network</i>		
Infant and Pediatric Preventive Care	No Charge	Deductible & 40% Coinsurance
Preventive Dental for Children (Up to age 19)****	No Charge after Deductible	Deductible & 50% Coinsurance
Pediatric Vision Exam (Up to age 19)	No Charge	Deductible & 50% Coinsurance
Pediatric Vision Hardware (Up to age 19)	Deductible & 50% Coinsurance	Deductible & 50% Coinsurance
Additional Coverage Adult and Pediatric Vision Exam	\$10 copay	\$40 Allowance
<i>Please see your Certificate for more information about the Additional Vision coverage</i>		
<b>OUTPATIENT CARE</b>		
Primary Care Physician Office Visits	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Specialist Office Visits	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Virtual Visits	No Charge after Deductible	Not Covered
Outpatient Surgery - Hospital Setting**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Outpatient Surgery - Freestanding Facility**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Laboratory Services**	Deductible & 10% Coinsurance	Not Covered
Radiology Services**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>DIABETIC SUPPLIES AND MEDICATIONS</b>		
Diabetic Supplies**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Diabetic Medications**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>MRIs, MRAs, CT SCANS, AND PET SCANS</b>		
Outpatient Hospital Services**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Freestanding Radiology Facility**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>HOSPITAL CARE</b>		
Physician's and Surgeon's Services**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Semi-Private Room and Board**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
All Drugs and Medication	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>EMERGENCY CARE</b>		
Ambulance Service When Medically Necessary	Deductible & 10% Coinsurance	Deductible & 10% Coinsurance
At Hospital Emergency Room (waived if admitted)	Deductible & 50% Coinsurance	Deductible & 50% Coinsurance
<i>(If member is admitted to the hospital, notification is required.)</i>		
Emergency Care in Urgi-Center	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>MATERNITY CARE</b>		
Prenatal and Post-Natal Care	No Charge	Deductible & 40% Coinsurance
Hospital Services for Mother and Child**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>SKILLED NURSING FACILITY</b>		
200 days per Plan Year.**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>HOSPICE CARE</b>		
Inpatient Care**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Home Hospice - Unlimited.**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>HOME HEALTH CARE</b>		
Home Care Visits - 40 visits per Plan Year.**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Physician House Calls**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>SUBSTANCE USE DISORDER SERVICES</b>		
Inpatient Rehabilitation**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Outpatient Rehabilitation	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Outpatient Partial Hospitalization**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>MENTAL HEALTH CARE</b>		
Inpatient Care**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Outpatient Visits	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Outpatient Partial Hospitalization**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>ALLERGY CARE</b>		
Testing and Treatment**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>ALTERNATIVE MEDICINE</b>		
Chiropractic Care - Unlimited.**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>SHORT TERM REHABILITATION</b>		
Inpatient - Limited to 60 combined days per Plan Year.**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>HABILITATIVE SERVICES</b>		
Inpatient - Limited to 60 combined days per Plan Year.**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>DURABLE MEDICAL EQUIPMENT</b>		
Durable Medical Equipment - Unlimited.** <i>Precertification required for items over \$500</i>	Deductible & 10% Coinsurance	Not Covered
<b>MEDICAL SUPPLIES</b>		
Medical Supplies When Medically Necessary**	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>HEARING AIDS</b>		
Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	Deductible & 10% Coinsurance	Deductible & 40% Coinsurance
<b>EXERCISE FACILITY</b>		
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
<b>OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE</b>		
	Subject to Plan Deductible listed above	
<b>OUTPATIENT PRESCRIPTION DRUGS - RETAIL</b>		
<i>The Prescription Drug Benefit is based on a Per Policy Year limit for any applicable deductibles and/or maximum limits.</i>		
Tier 1	\$10 copay	Not Covered
Tier 2	\$40 copay	Not Covered
Tier 3	\$80 copay	Not Covered
<b>OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER</b>		
Tier 1	\$25 copay	Not Covered
Tier 2	\$100 copay	Not Covered
Tier 3	\$200 copay	Not Covered

**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.

\*\*These services require precertification through Oxford. Members must call Oxford at 1-800-444-6222 at least 14 days in advance of request of treatment to request precertification.

\*\*Mental health and substance use disorder services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

\*\*\*\*Precertification is required for Pediatric Orthodontia services only

**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.*