OXFORD HEALTH INSURANCE, INC.
NY G FRDM NG 25/40/1500/80 PPO 23 - Non-Gated
SUMMARY OF COVERAGE

Freedom Network

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	$1,500	$4,000
	Family	$3,000	$8,000
Coinsurance:		20%	40%
Maximum Out-Of-Pocket:	Single	$7,050	$10,000
(Including Deductible)	Family	$14,100	$20,000
Financial Accumulation Period:		Policy Year	Policy Year
Out-of-Network Reimbursement:		Not Applicable	140% of Medicare

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.*

PREVENTIVE CARE		
Adult Preventive Care ****Please see your Certificate for a complete list of Preventive Care benefits covered Out-of-Network*	No Charge	Limited Coverage***
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)	$25 copay per visit	Deductible & 50% Coinsurance
Pediatric Vision Hardware (Up to age 19)	50% Coinsurance	Deductible & 50% Coinsurance
Additional Coverage Adult and Pediatric Vision Exam *Please see your Certificate for more information about the Additional Vision coverage*	$10 copay	$40 Allowance
OUTPATIENT CARE		
Primary Care Physician Office Visits	$25 copay per visit	Deductible & 40% Coinsurance
Specialist Office Visits	$40 copay per visit	Deductible & 40% Coinsurance
Virtual Visits	No Charge	Not Covered
Outpatient Surgery - Hospital Setting**	Deductible and then $250 copay per visit	Deductible & 40% Coinsurance
Outpatient Surgery - Hospital Setting Deductible**	Not Applicable	Not Applicable
Outpatient Surgery - Freestanding Facility**	Deductible and then $150 copay per visit	Deductible & 40% Coinsurance
Designated Diagnostic Provider Laboratory Services**	No Charge	Not Covered
Non-Designated Diagnostic Provider Laboratory Services**	Deductible & 50% Coinsurance	Not Covered
Radiology Services**	Deductible and then $25 copay per service	Deductible & 40% Coinsurance
DIABETIC SUPPLIES AND MEDICATIONS		
Diabetic Supplies**	$25 copay	Deductible & 40% Coinsurance
Diabetic Medications**	$25 copay	Deductible & 40% Coinsurance
MRIs, MRAs, CT SCANS, AND PET SCANS		
Outpatient Hospital Services**	Deductible and then $100 copay per service	Deductible & 40% Coinsurance
Freestanding Radiology Facility**	Deductible and then $100 copay per service	Deductible & 40% Coinsurance
HOSPITAL CARE		
Physician's and Surgeon's Services**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Semi-Private Room and Board**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
All Drugs and Medication	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
EMERGENCY CARE		
Ambulance Service When Medically Necessary	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
At Hospital Emergency Room *(waived if admitted)* *(If member is admitted to the hospital, notification is required.)*	$500 copay per visit	$500 copay per visit
Emergency Care in Urgi-Center	$75 copay per visit	Deductible & 40% Coinsurance
MATERNITY CARE		
Prenatal and Post-Natal Care	No Charge	Deductible & 40% Coinsurance
Hospital Services for Mother and Child**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
SKILLED NURSING FACILITY		
200 days per Plan Year.**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
HOSPICE CARE		
Inpatient Care**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Home Hospice - Unlimited.**	$40 copay per visit	Deductible & 40% Coinsurance
HOME HEALTH CARE		
Home Healthcare Visits - 40 visits per Plan Year.**	$40 copay per visit	Deductible & 40% Coinsurance
Physician House Calls**	$40 copay per visit	Deductible & 40% Coinsurance
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Outpatient Rehabilitation	$25 copay per visit	Deductible & 40% Coinsurance
Outpatient Partial Hospitalization**	No Charge after Deductible	Deductible & 40% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
Inpatient Care**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Outpatient Visits	$25 copay per visit	Deductible & 40% Coinsurance
Outpatient Partial Hospitalization**	No Charge after Deductible	Deductible & 40% Coinsurance
ALLERGY CARE		
Testing and Treatment**	$40 copay per visit	Deductible & 40% Coinsurance
ALTERNATIVE MEDICINE		
Chiropractic Care - Unlimited Visits **	$40 copay per visit	Deductible & 40% Coinsurance
SHORT TERM REHABILITATION		
Inpatient - Limited to 60 combined PT/OT/ST days per Plan Year.**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.**	$40 copay per visit	Deductible & 40% Coinsurance
HABILITATIVE SERVICES		
Inpatient - Limited to 60 combined PT/OT/ST days per Plan Year.**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.**	$40 copay per visit	Deductible & 40% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment - Unlimited.**	Deductible & 20% Coinsurance	Not Covered
Precertification required for items over $500		
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
HEARING AIDS		
Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
EXERCISE FACILITY		
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
OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE	$150 Deductible (Waived for Tier 1 drugs)	
OUTPATIENT PRESCRIPTION DRUGS - RETAIL		
The Prescription Drug Benefit is based on a Per Policy Year limit for any applicable deductibles and/or maximum limits.		
Tier 1	$10 copay	Not Covered
Tier 2	$40 copay	Not Covered
Tier 3	$80 copay	Not Covered
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
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.