OXFORD HEALTH INSURANCE, INC.
NY G FRDM NG 25/50/100 EPO ZD 23 - Non-Gated
SUMMARY OF COVERAGE

Freedom Network

BENEFIT		IN-NETWORK
FINANCIAL		
Deductible:	Single	None
	Family	None
Coinsurance:		None
Maximum Out-Of-Pocket:	Single	$6,250
(Including Deductible)	Family	$12,500
Financial Accumulation Period:		Policy Year
Out-of-Network Reimbursement:		Not Applicable

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	No Charge
Infant and Pediatric Preventive Care	No Charge
Preventive Dental for Children (Up to age 19)	No Charge after $100 Ded Indiv / $200 Ded Family
Pediatric Vision Exam (Up to age 19)	$25 copay per visit
Pediatric Vision Hardware (Up to age 19)	50% Coinsurance
Additional Coverage Adult and Pediatric Vision Exam	$10 copay
Please see your Certificate for more information about the Additional Vision coverage	

OUTPATIENT CARE	
Primary Care Physician Office Visits	$25 copay per visit
Pediatric Office Visits (Up to age 19)	$5 copay per visit
Specialist Office Visits	$50 copay per visit
Virtual Visits	No Charge
Outpatient Surgery - Hospital Setting	$500 copay per visit
Outpatient Surgery - Hospital Setting Per Occurrence Deductible	Not Applicable
Outpatient Surgery - Freestanding Facility	$150 copay per visit
Designated Diagnostic Provider Laboratory Services	No Charge
Non-Designated Diagnostic Provider Laboratory Services	$60 copay per service
Radiology Services	$50 copay per service

DIABETIC SUPPLIES AND MEDICATIONS	
Diabetic Supplies	$25 copay
Diabetic Medications	$25 copay

MRIs, MRAs, CT SCANS, AND PET SCANS	
Outpatient Hospital Services	$150 copay per service
Freestanding Radiology Facility	$150 copay per service

HOSPITAL CARE	
Physician's and Surgeon's Services	$250 copay
Semi-Private Room and Board	$500 copay per admission
All Drugs and Medication	No Charge

EMERGENCY CARE	
Ambulance Service When Medically Necessary	No Charge
At Hospital Emergency Room *(waived if admitted)*	$750 copay per visit
(If member is admitted to the hospital, notification is required.)	
Emergency Care in Urgi-Center	$50 copay per visit

MATERNITY CARE	
Prenatal and Post-Natal Care	No Charge
Hospital Services for Mother and Child	$500 copay per admission

SKILLED NURSING FACILITY	
Limited to 200 days per Plan Year.	$500 copay per admission

HOSPICE CARE	
Inpatient Care	$500 copay per admission
Home Hospice - Unlimited.	$50 copay per visit

HOME HEALTH CARE	
Limited to 40 visits per Plan Year.	$50 copay per visit
Physician House Calls	$50 copay per visit

SUBSTANCE USE DISORDER SERVICES	
Inpatient Care	$500 copay per admission
Outpatient Visits	$25 copay per visit
Outpatient Pediatric Office Visits (Up to age 19)	$5 copay per visit
Outpatient Partial Hospitalization	No Charge

BENEFIT	IN-NETWORK
MENTAL HEALTH CARE	
Inpatient Care	$500 copay per admission
Outpatient Visits	$25 copay per visit
Outpatient Pediatric Office Visits (Up to age 19)	$5 copay per visit
Outpatient Partial Hospitalization	No Charge
ALLERGY CARE	
Testing and Treatment	$50 copay per visit
ALTERNATIVE MEDICINE	
Chiropractic Care - Unlimited	$50 copay per visit
SHORT TERM REHABILITATION	
Inpatient - Limited to 60 combined days per Plan Year.	$500 copay per admission
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	$50 copay per visit
HABILITATIVE SERVICES	
Inpatient - Limited to 60 combined days per Plan Year.	$500 copay per admission
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	$50 copay per visit
DURABLE MEDICAL EQUIPMENT	
Durable Medical Equipment - Unlimited. *Precertification required for items over $500*	No Charge
MEDICAL SUPPLIES	
Medical Supplies When Medically Necessary	No Charge
HEARING AIDS	
Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	No Charge
EXERCISE FACILITY	
Subscriber	$200 reimbursement per 6 month period
Spouse/Dependents over age 13	$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
Tier 2	$65 copay
Tier 3	$95 copay
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER	
Tier 1	$25 copay
Tier 2	$162.50 copay
Tier 3	$237.50 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.