



OXFORD HEALTH INSURANCE, INC.  
 NY G FRDM NG 30/60/2250/70 EPO 23 - Non-Gated  
 SUMMARY OF COVERAGE

Freedom Network

BENEFIT	IN-NETWORK
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**FINANCIAL**

Deductible:	Single	\$2,250
	Family	\$4,500
Coinsurance:		30%
Maximum Out-Of-Pocket:	Single	\$8,000
	(Including Deductible) Family	\$16,000
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 Deductible
Pediatric Vision Exam (Up to age 19)	\$30 copay per visit
Pediatric Vision Hardware (Up to age 19)	50% Coinsurance
Additional Coverage Adult and Pediatric Vision Exam	\$10 copay
<i>Please see your Certificate for more information about the Additional Vision coverage</i>	

**OUTPATIENT CARE**

Primary Care Physician Office Visits	\$30 copay per visit
Pediatric Office Visits (Up to age 19)	Not Applicable
Specialist Office Visits	\$60 copay per visit
Virtual Visits	No Charge
Outpatient Surgery - Hospital Setting	Deductible & 30% Coinsurance
Outpatient Surgery - Hospital Setting Per Occurrence Deductible	Not Applicable
Outpatient Surgery - Freestanding Facility	Deductible & 30% Coinsurance
Designated Diagnostic Provider Laboratory Services	No Charge
Non-Designated Diagnostic Provider Laboratory Services	Deductible & 50% Coinsurance
Radiology Services	Deductible & 30% Coinsurance

**DIABETIC SUPPLIES AND MEDICATIONS**

Diabetic Supplies	\$30 copay
Diabetic Medications	\$30 copay

**MRIs, MRAs, CT SCANS, AND PET SCANS**

Outpatient Hospital Services	Deductible & 30% Coinsurance
Freestanding Radiology Facility	Deductible & 30% Coinsurance

**HOSPITAL CARE**

Physician's and Surgeon's Services	Deductible & 30% Coinsurance
Semi-Private Room and Board	Deductible & 30% Coinsurance
All Drugs and Medication	Deductible & 30% Coinsurance

**EMERGENCY CARE**

Ambulance Service When Medically Necessary	No Charge
At Hospital Emergency Room ( <i>waived if admitted</i> )	\$500 copay per visit
<i>(If member is admitted to the hospital, notification is required.)</i>	
Emergency Care in Urgi-Center	\$75 copay per visit

**MATERNITY CARE**

Prenatal and Post-Natal Care	No Charge
Hospital Services for Mother and Child	Deductible & 30% Coinsurance

**SKILLED NURSING FACILITY**

Limited to 200 days per Plan Year.	Deductible & 30% Coinsurance
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**HOSPICE CARE**

Inpatient Care	Deductible & 30% Coinsurance
Home Hospice - Unlimited.	\$60 copay per visit

**HOME HEALTH CARE**

Limited to 40 visits per Plan Year.	\$60 copay per visit
Physician House Calls	\$60 copay per visit

**SUBSTANCE USE DISORDER SERVICES**

Inpatient Rehabilitation	Deductible & 30% Coinsurance
Outpatient Rehabilitation	\$30 copay per visit
Outpatient Partial Hospitalization	No Charge after Deductible

BENEFIT	IN-NETWORK
<b>MENTAL HEALTH CARE</b>	
Inpatient Care	Deductible & 30% Coinsurance
Outpatient Visits	\$30 copay per visit
Outpatient Partial Hospitalization	No Charge after Deductible
<b>ALLERGY CARE</b>	
Testing and Treatment	\$60 copay per visit
<b>ALTERNATIVE MEDICINE</b>	
Chiropractic Care - Unlimited	\$60 copay per visit
<b>SHORT TERM REHABILITATION</b>	
Inpatient - Limited to 60 combined days per Plan Year.	Deductible & 30% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	\$60 copay per visit
<b>HABILITATIVE SERVICES</b>	
Inpatient - Limited to 60 combined days per Plan Year.	Deductible & 30% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.	\$60 copay per visit
<b>DURABLE MEDICAL EQUIPMENT</b>	
Durable Medical Equipment - Unlimited. <i>Precertification required for items over \$500</i>	Deductible & 30% Coinsurance
<b>MEDICAL SUPPLIES</b>	
Medical Supplies When Medically Necessary	Deductible & 30% 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 & 30% Coinsurance
<b>EXERCISE FACILITY</b>	
Subscriber	\$200 reimbursement per 6 month period
Spouse/Dependents over age 13	\$100 reimbursement per 6 month period
<b>OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE</b>	\$150 Deductible (Waived for Tier 1 drugs)
<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
Tier 2	\$40 copay
Tier 3	\$80 copay
<b>OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER</b>	
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.*