**OXFORD HEALTH INSURANCE, INC.**
**NY S FRDM NG 30/60/2250/70 PPO HSA 23 - Non-Gated**
**SUMMARY OF COVERAGE**

**Freedom Network**

| BENEFIT | | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|---|
| **FINANCIAL** | | | |
| Deductible: | Single* | $2,250 | $6,000 |
| | Family | $4,500 | $12,000 |
| Coinsurance | | 30% | 50% |
| Maximum Out-Of-Pocket: | Single | $7,350 | $15,000 |
| (Including Deductible) | Family | $14,700 | $30,000 |
| 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.*

**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.*

| | | |
|---|---|---|
| **PREVENTIVE CARE** | | |
| Adult Preventive Care<br>****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 & 50% 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<br>*Please see your Certificate for more information about the Additional Vision coverage* | $10 copay | $40 Allowance |
| **OUTPATIENT CARE** | | |
| Primary Care Physician Office Visits | Deductible and then $30 copay per visit | Deductible & 50% Coinsurance |
| Specialist Office Visits | Deductible and then $60 copay per visit | Deductible & 50% Coinsurance |
| Virtual Visits | No Charge after Deductible | Not Covered |
| Outpatient Surgery - Hospital Setting** | Deductible and then $250 copay per visit | Deductible & 50% Coinsurance |
| Outpatient Surgery - Freestanding Facility** | Deductible and then $150 copay per visit | Deductible & 50% Coinsurance |
| Laboratory Services** | Deductible & 30% Coinsurance | Not Covered |
| Radiology Services** | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| **DIABETIC SUPPLIES AND MEDICATIONS** | | |
| Diabetic Supplies** | Deductible and then $30 copay | Deductible & 50% Coinsurance |
| Diabetic Medications** | Deductible and then $30 copay | Deductible & 50% Coinsurance |
| **MRIs, MRAs, CT SCANS, AND PET SCANS** | | |
| Outpatient Hospital Services** | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| Freestanding Radiology Facility** | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| **HOSPITAL CARE** | | |
| Physician's and Surgeon's Services** | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| Semi-Private Room and Board** | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| All Drugs and Medication | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| **EMERGENCY CARE** | | |
| Ambulance Service When Medically Necessary | Deductible & 30% Coinsurance | Deductible & 30% Coinsurance |
| At Hospital Emergency Room *(waived if admitted)*<br>*(If member is admitted to the hospital, notification is required.)* | Deductible & 50% Coinsurance | Deductible & 50% Coinsurance |
| Emergency Care in Urgi-Center | Deductible and then $75 copay per visit | Deductible & 50% Coinsurance |
| **MATERNITY CARE** | | |
| Prenatal and Post-Natal Care | No Charge | Deductible & 50% Coinsurance |
| Hospital Services for Mother and Child** | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| **SKILLED NURSING FACILITY** | | |
| 200 days per Plan Year.** | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| **HOSPICE CARE** | | |
| Inpatient Care** | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| Home Hospice - Unlimited.** | Deductible and then $60 copay per visit | Deductible & 50% Coinsurance |
| **HOME HEALTH CARE** | | |
| Home Care Visits - 40 visits per Plan Year.** | Deductible and then $60 copay per visit | Deductible & 50% Coinsurance |
| Physician House Calls** | Deductible and then $60 copay per visit | Deductible & 50% Coinsurance |
| **SUBSTANCE USE DISORDER SERVICES** | | |
| Inpatient Rehabilitation** | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| Outpatient Rehabilitation | Deductible and then $30 copay per visit | Deductible & 50% Coinsurance |
| Outpatient Partial Hospitalization** | No Charge after Deductible | Deductible & 50% Coinsurance |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **MENTAL HEALTH CARE** | | |
| Inpatient Care** | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| Outpatient Visits | Deductible and then $30 copay per visit | Deductible & 50% Coinsurance |
| Outpatient Partial Hospitalization** | No Charge after Deductible | Deductible & 50% Coinsurance |
| **ALLERGY CARE** | | |
| Testing and Treatment** | Deductible and then $60 copay per visit | Deductible & 50% Coinsurance |
| **ALTERNATIVE MEDICINE** | | |
| Chiropractic Care - Unlimited.** | Deductible and then $60 copay per visit | Deductible & 50% Coinsurance |
| **SHORT TERM REHABILITATION** | | |
| Inpatient - Limited to 60 combined days per Plan Year.** | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.** | Deductible and then $60 copay per visit | Deductible & 50% Coinsurance |
| **HABILITATIVE SERVICES** | | |
| Inpatient - Limited to 60 combined days per Plan Year.** | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year.** | Deductible and then $60 copay per visit | Deductible & 50% Coinsurance |
| **DURABLE MEDICAL EQUIPMENT** | | |
| Durable Medical Equipment - Unlimited.** *Precertification required for items over $500* | Deductible & 30% Coinsurance | Not Covered |
| **MEDICAL SUPPLIES** | | |
| Medical Supplies When Medically Necessary** | Deductible & 30% Coinsurance | Deductible & 50% Coinsurance |
| **HEARING AIDS** | | |
| Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years. | Deductible & 30% Coinsurance | Deductible & 50% 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** | Subject to Plan Deductible listed above | |
| **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.***