OXFORD HEALTH INSURANCE, INC.
NY P FRDM NG 20/40/100 EPO 20 - Non-Gated
SUMMARY OF COVERAGE
Group Name
Freedom Network

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	None	Not Covered
	Family	None	Not Covered
Coinsurance		None	Not Covered
Maximum Out-Of-Pocket:	Single	$2,500	Not Covered
(Including Deductible)	Family	$5,000	Not Covered
Financial Accumulation Period:		Calendar Year	Not Applicable
Out-of-Network Reimbursement:		Not Applicable	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	Not Covered
Infant and Pediatric Preventive Care	No Charge	Not Covered
Preventive Dental for Children (Up to age 19)	No Charge after $100 Ded indiv / $200 Ded family	Not Covered
Pediatric Vision Exam (Up to age 19)	$20 copay per visit	Not Covered
Pediatric Vision Hardware (Up to age 19)	50% Coinsurance	Not Covered
OUTPATIENT CARE		
Primary Care Physician Office Visits	$20 copay per visit	Not Covered
Specialist Office Visits	$40 copay per visit	Not Covered
Outpatient Surgery - Hospital Setting	$300 copay per visit	Not Covered
Outpatient Surgery - Freestanding Facility	$100 copay per visit	Not Covered
Laboratory Services	No Charge	Not Covered
Radiology Services	$90 copay per service	Not Covered
DIABETIC SUPPLIES AND MEDICATIONS		
Diabetic Supplies	$20 copay	Not Covered
Diabetic Medications	$20 copay	Not Covered
MRIs, MRAs, CT SCANS, AND PET SCANS		
Outpatient Hospital Services	$100 copay per service	Not Covered
Freestanding Radiology Facility	No Charge	Not Covered
HOSPITAL CARE		
Physician's and Surgeon's Services	No Charge	Not Covered
Semi-Private Room and Board	$400 copay per admission	Not Covered
All Drugs and Medication	No Charge	Not Covered
EMERGENCY CARE		
Ambulance Service When Medically Necessary	No Charge	No Charge
At Hospital Emergency Room *(waived if admitted)*	$200 copay per visit	$200 copay per visit
(If member is admitted to the hospital, notification is required.)		
Emergency Care in Urgi-Center	$50 copay per visit	Not Covered
MATERNITY CARE		
Prenatal and Post-Natal Care	No Charge	Not Covered
Hospital Services for Mother and Child	$400 copay per admission	Not Covered
SKILLED NURSING FACILITY		
200 days per Calendar Year.	$400 copay per admission	Not Covered
HOSPICE CARE		
Inpatient Care	$400 copay per admission	Not Covered
Home Hospice - Unlimited.	$40 copay per visit	Not Covered
HOME HEALTH CARE		
Limited to 40 visits per Calendar Year.	$40 copay per visit	Not Covered
Physician House Calls	$40 copay per visit	Not Covered
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation	$400 copay per admission	Not Covered
Outpatient Rehabilitation	$40 copay per visit	Not Covered
Outpatient Partial Hospitalization	$40 copay per visit	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
Inpatient Care	$400 copay per admission	Not Covered
Outpatient Visits	$40 copay per visit	Not Covered
Outpatient Partial Hospitalization	$40 copay per visit	Not Covered
ALLERGY CARE		
Testing and Treatment	$40 copay per visit	Not Covered
ALTERNATIVE MEDICINE		
Chiropractic Care - Unlimited	$40 copay per visit	Not Covered
SHORT TERM REHABILITATION		
Inpatient - Limited to 60 combined days per Calendar Year.	$400 copay per admission	Not Covered
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Calendar Year.	$40 copay per visit	Not Covered
HABILITATIVE SERVICES		
Inpatient - Limited to 60 combined days per Calendar Year.	$400 copay per admission	Not Covered
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Calendar Year.	$40 copay per visit	Not Covered
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment - Unlimited. *Precertification required for items over $500*	No Charge	Not Covered
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary	No Charge	Not Covered
HEARING AIDS		
Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	No Charge	Not Covered
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	$50 Deductible (Waived for Tier 1 drugs)	
OUTPATIENT PRESCRIPTION DRUGS - RETAIL		
The Prescription Drug Benefit is based on a Per Calendar Year limit for any applicable deductibles and/or maximum limits.		
Tier 1	$5 copay	Not Covered
Tier 2	$30 copay	Not Covered
Tier 3	$60 copay	Not Covered
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	$12.50 copay	Not Covered
Tier 2	$75 copay	Not Covered
Tier 3	$150 copay	Not Covered

DEPENDENT ELIGIBILITY:
Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.

***Adult Out of Network Preventive Care coverage is limited to Well Woman Routine Gynecology Exams, Bone Density Testing and Screening for Prostate Cancer.

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.