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

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	None	$3,000
	Family	None	$6,000
Coinsurance		None	30%
Maximum Out-Of-Pocket:	Single	$2,500	$7,500
(Including Deductible)	Family	$5,000	$15,000
Financial Accumulation Period:		Calendar Year	Calendar 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	No Charge	Not Covered***
Infant and Pediatric Preventive Care	No Charge	Deductible & 30% Coinsurance
Preventive Dental for Children (Up to age 19)****	No Charge after $100 Ded indiv / $200 Ded family.	Deductible & 50% Coinsurance
Pediatric Vision Exam (Up to age 19)	$20 copay per visit	Deductible & 50% Coinsurance
Pediatric Vision Hardware (Up to age 19)	50% Coinsurance	Deductible & 50% Coinsurance
OUTPATIENT CARE		
Primary Care Physician Office Visits	$20 copay per visit	Deductible & 30% Coinsurance
Specialist Office Visits	$40 copay per visit	Deductible & 30% Coinsurance
Outpatient Surgery - Hospital Setting**	$300 copay per visit	Deductible & 30% Coinsurance
Outpatient Surgery - Freestanding Facility**	$100 copay per visit	Deductible & 30% Coinsurance
Laboratory Services**	No Charge	Deductible & 30% Coinsurance
Radiology Services**	$90 copay per service	Deductible & 30% Coinsurance
DIABETIC SUPPLIES AND MEDICATIONS		
Diabetic Supplies**	$20 copay per visit	Deductible & 30% Coinsurance
Diabetic Medications**	$20 copay per visit	Deductible & 30% Coinsurance
MRIs, MRAs, CT SCANS, AND PET SCANS		
Outpatient Hospital Services**	$100 copay per service	Deductible & 30% Coinsurance
Freestanding Radiology Facility**	No Charge	Deductible & 30% Coinsurance
HOSPITAL CARE		
Physician's and Surgeon's Services**	No Charge	Deductible & 30% Coinsurance
Semi-Private Room and Board**	$400 copay per admission	Deductible & 30% Coinsurance
All Drugs and Medication	No Charge	Deductible & 30% Coinsurance
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	Deductible & 30% Coinsurance
MATERNITY CARE		
Prenatal and Post-Natal Care	No Charge	Deductible & 30% Coinsurance
Hospital Services for Mother and Child**	$400 copay per admission	Deductible & 30% Coinsurance
SKILLED NURSING FACILITY		
200 days per Calendar Year.**	$400 copay per admission	Deductible & 30% Coinsurance
HOSPICE CARE		
Inpatient Care**	$400 copay per admission	Deductible & 30% Coinsurance
Home Hospice - Unlimited.**	$40 copay per visit	Deductible & 30% Coinsurance
HOME HEALTH CARE		
Home Healthcare Visits - 40 visits per Calendar Year.**	$40 copay per visit	Deductible & 30% Coinsurance
Physician House Calls**	$40 copay per visit	Deductible & 30% Coinsurance
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation**	$400 copay per admission	Deductible & 30% Coinsurance
Outpatient Rehabilitation	$40 copay per visit	Deductible & 30% Coinsurance
Outpatient Partial Hospitalization**	$40 copay per visit	Deductible & 30% Coinsurance

BENEFIT IN-NETWORK OUT-OF-NETWORK

MENTAL HEALTH CARE		
Inpatient Care**	$400 copay per admission	Deductible & 30% Coinsurance
Outpatient Visits	$40 copay per visit	Deductible & 30% Coinsurance
Outpatient Partial Hospitalization**	$40 copay per visit	Deductible & 30% Coinsurance
ALLERGY CARE		
Testing and Treatment**	$40 copay per visit	Deductible & 30% Coinsurance
ALTERNATIVE MEDICINE		
Chiropractic Care - Unlimited Visits **	$40 copay per visit	Deductible & 30% Coinsurance
SHORT TERM REHABILITATION		
Inpatient - Limited to 60 combined PT/OT/ST days per Calendar Year.**	$400 copay per admission	Deductible & 30% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Calendar Year. **	$40 copay per visit	Deductible & 30% Coinsurance
HABILITATIVE SERVICES		
Inpatient - Limited to 60 combined PT/OT/ST days per Calendar Year.**	$400 copay per admission	Deductible & 30% Coinsurance
Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Calendar Year. **	$40 copay per visit	Deductible & 30% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment - Unlimited.** *Precertification required for items over $500*	No Charge	Deductible & 30% Coinsurance
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary**	No Charge	Deductible & 30% Coinsurance
HEARING AIDS		
Hearing Aids - Coverage is limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	No Charge	Deductible & 30% 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	$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.

**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

***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.