**OXFORD HEALTH INSURANCE, INC.**
**NY P FRDM NG 5/15/100 EPO 24 - Non-Gated**
**SUMMARY OF COVERAGE**

**Freedom Network**

| BENEFIT | | IN-NETWORK |
|---|---|---|
| **FINANCIAL** | | |
| Deductible: | Single | None |
| | Family | None |
| Coinsurance: | | None |
| Maximum Out-Of-Pocket: | Single | $3,750 |
| (Including Deductible) | Family | $7,500 |
| 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) | $5 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 | $5 copay per visit |
| Pediatric Office Visits (Up to age 19) | Not Applicable |
| Specialist Office Visits | $15 copay per visit |
| Virtual Visits | No Charge |
| Outpatient Surgery - Hospital Setting | $100 copay per visit |
| Outpatient Surgery - Hospital Setting Per Occurrence Deductible | Not Applicable |
| Outpatient Surgery - Freestanding Facility | $50 copay per visit |
| Designated Diagnostic Provider Laboratory Services | No Charge |
| Non-Designated Diagnostic Provider Laboratory Services | $60 copay per service |
| Radiology Services | $90 copay per service |

| **DIABETIC SUPPLIES AND MEDICATIONS** | |
|---|---|
| Diabetic Supplies | $5 copay |
| Diabetic Medications | $5 copay |

| **MRIs, MRAs, CT SCANS, AND PET SCANS** | |
|---|---|
| Outpatient Hospital Services | $100 copay per service |
| Freestanding Radiology Facility | No Charge |

| **HOSPITAL CARE** | |
|---|---|
| Physician's and Surgeon's Services | No Charge |
| Semi-Private Room and Board | $200 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)* | $250 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 | $200 copay per admission |

| **SKILLED NURSING FACILITY** | |
|---|---|
| Limited to 200 days per Plan Year. | $200 copay per admission |

| **HOSPICE CARE** | |
|---|---|
| Inpatient Care | $200 copay per admission |
| Home Hospice - Unlimited. | $15 copay per visit |

| **HOME HEALTH CARE** | |
|---|---|
| Limited to 40 visits per Plan Year. | $15 copay per visit |
| Physician House Calls | $15 copay per visit |

| **SUBSTANCE USE DISORDER SERVICES** | |
|---|---|
| Inpatient Rehabilitation | $200 copay per admission |
| Outpatient Rehabilitation | $5 copay per visit |
| Outpatient Partial Hospitalization | No Charge |

| BENEFIT | IN-NETWORK |
|---|---|
| **MENTAL HEALTH CARE** | |
| Inpatient Care | $200 copay per admission |
| Outpatient Visits | $5 copay per visit |
| Outpatient Partial Hospitalization | No Charge |
| **ALLERGY CARE** | |
| Testing and Treatment | $15 copay per visit |
| **ALTERNATIVE MEDICINE** | |
| Chiropractic Care - Unlimited | $15 copay per visit |
| **SHORT TERM REHABILITATION** | |
| Inpatient - Limited to 60 combined days per Plan Year. | $200 copay per admission |
| Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year. | $15 copay per visit |
| **HABILITATIVE SERVICES** | |
| Inpatient - Limited to 60 combined days per Plan Year. | $200 copay per admission |
| Outpatient - Limited to 60 combined PT/OT/ST visits per condition per Plan Year. | $15 copay per visit |
| **DURABLE MEDICAL EQUIPMENT** | |
| Durable Medical Equipment - Unlimited.<br>*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** | $100 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 |
| Tier 2 | $35 copay |
| Tier 3 | $70 copay |
| **OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER** | |
| Tier 1 | $12.50 copay |
| Tier 2 | $87.50 copay |
| Tier 3 | $175 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.***