OXFORD HEALTH INSURANCE, INC.
Freedom Plan Access
SUMMARY OF COVERAGE
Freedom Network
BBC Studios Americas, Inc
Access Plan

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	None	$2,000
	Family	None	$4,000
Coinsurance:		None	20%
Maximum Out-of-Pocket:	Single	$2,500	$4,000
(Including Deductible)	Family	$5,000	$8,000
Financial Accumulation Period:		Calendar Year	Calendar Year

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	In-Network Benefit Only***
Infant and Pediatric Preventive Care	No Charge	Deductible & 20% Coinsurance
OUTPATIENT CARE		
Primary Care Physician Office Visits	$25 copay per visit	Deductible & 20% Coinsurance
Specialist Office Visits	$40 copay per visit	Deductible & 20% Coinsurance
Virtual Visits	No Charge	In-Network Benefit Only
Outpatient Surgery - Hospital Setting**	$250 copay per visit	Deductible & 20% Coinsurance
Outpatient Surgery - Freestanding Facility**	$250 copay per visit	Deductible & 20% Coinsurance
Preferred Laboratory Network	No Charge	In-Network Benefit Only
Non-Preferred Laboratory Services - Hospital Setting**	$60 copay per visit	In-Network Benefit Only
Non-Preferred Laboratory Services - Freestanding Facility**	$60 copay per visit	In-Network Benefit Only
(See your Certificate of Coverage for additional Lab details)		
Radiology Services - Hospital Setting**	No Charge	Deductible & 20% Coinsurance
Radiology Services - Freestanding Facility**	No Charge	Deductible & 20% Coinsurance
DIABETIC SUPPLIES AND MEDICATIONS		
Diabetic Supplies**	$25 copay	Deductible & 20% Coinsurance
Diabetic Medications**	$25 copay	Deductible & 20% Coinsurance
MRIs, MRAs, CT SCANS AND PET SCANS		
Outpatient Hospital Services**	No Charge	Deductible & 20% Coinsurance
Freestanding Radiology Facility**	No Charge	Deductible & 20% Coinsurance
HOSPITAL CARE		
Physician's and Surgeon's Services**	No Charge	Deductible & 20% Coinsurance
Semi-Private Room and Board**	$500 copay per admission	Deductible & 20% Coinsurance
All Drugs and Medication	No Charge	Deductible & 20% Coinsurance
EMERGENCY CARE		
Ambulance Service when Medically Necessary**	No Charge	No Charge
At Hospital Emergency Room	$150 copay per visit, waived if admitted	$150 copay per visit, waived if admitted
(If member is admitted to the hospital, notification is required)		
Emergency Care in Urgi-Center	$40 copay per visit	Deductible & 20% Coinsurance
MATERNITY CARE		
Routine Prenatal and Post-Natal Care**	No Charge	Deductible & 20% Coinsurance
Hospital Services for Mother and Child**	$500 copay per admission	Deductible & 20% Coinsurance
SKILLED NURSING FACILITY		
30 Days per Calendar Year**	$500 copay per admission	Deductible & 20% Coinsurance
HOSPICE CARE		
Inpatient Care**	$500 copay per admission	Deductible & 20% Coinsurance
Home Hospice Care Visits	$40 copay per visit	Deductible & 20% Coinsurance
HOME HEALTH CARE		
Home Care Visits - 40 visits per Calendar Year**	$40 copay per visit	Deductible & 20% Coinsurance
Physician House Calls**	$40 copay per visit	Deductible & 20% Coinsurance
Home Infusion In-network coverage only		
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation**	$500 copay per admission	Deductible & 20% Coinsurance
Office Visits or Outpatient Rehabilitation	$25 copay per visit	Deductible & 20% Coinsurance
Intensive Behavioral Therapy**	No Charge	Deductible & 20% Coinsurance
	No Charge	Deductible & 20% Coinsurance
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment**		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
Inpatient Care**	$500 copay per admission	Deductible & 20% Coinsurance
Office Visits or Outpatient Care	$40 copay per visit	Deductible & 20% Coinsurance
Intensive Behavioral Therapy**	No Charge	Deductible & 20% Coinsurance
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment**	No Charge	Deductible & 20% Coinsurance
ALLERGY CARE		
Testing and Treatment**	$40 copay per visit	Deductible & 20% Coinsurance
CHIROPRACTIC CARE		
Chiropractic Care**	$40 copay per visit	Deductible & 20% Coinsurance
SHORT TERM REHAB OR HABILITATIVE SERVICES		
Inpatient limited to 60 days per Calendar Year**	$500 copay per admission	Deductible & 20% Coinsurance
Outpatient limited to 90 combined PT/OT/ST visits per Calendar Year**	$40 copay per visit	Deductible & 20% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Unlimited** *(Precert required for items over $500)*	No Charge when ordered by an Oxford Participating Physician	In-Network Benefit Only
HEARING AIDS		
Limited to a single purchase (including repair/replacement) every 3 Years.	No Charge	Deductible & 20% Coinsurance
MEDICAL SUPPLIES		
Medical Supplies when Medically Necessary**	No Charge	Deductible & 20% 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
INFERTILITY TREATMENT		
(Covers all services in compliance with the NY Infertility Mandate)		
Specialist Office Visits**	$40 copay per visit	Deductible & 20% Coinsurance
Inpatient Facility Services**	$500 copay per admission	Deductible & 20% Coinsurance
Outpatient Surgery - Hospital Setting**	$250 copay per visit	Deductible & 20% Coinsurance
Outpatient Surgery - Freestanding Facility**	$250 copay per visit	Deductible & 20% Coinsurance
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	$15 copay	$15 copay
Tier 2	$30 copay	$30 copay
Tier 3	$60 copay	$60 copay
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	$37.50 copay	$37.50 copay
Tier 2	$75.00 copay	$75.00 copay
Tier 3	$150.00 copay	$150.00 copay

DEPENDENT ELIGIBILITY:
Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.
Benefits discontinue at the end of the Month.

Domestic Partners covered with proper documentation.

**Precertification required through Oxford for certain out-of-network services. 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.

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

Please be advised this sample summary of coverage is provided for informational purposes only. The information contained herein is subject to approval of the New York Department of Insurance and Oxford home office approval as appropriate. 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, Workers' Compensation, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.