OXFORD HEALTH INSURANCE, INC.
EPO PLAN
SUMMARY OF COVERAGE
Freedom Network
UNITED STATES FUND FOR UNICEF

BENEFIT		In-Network
FINANCIAL		
Deductible:	Single	None
	Family	None
Coinsurance		None
Maximum Out-of-Pocket:	Single	$2,500
(Including Deductible)	Family	$5,000
Financial Accumulation Period:		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
Infant and Pediatric Preventive Care	No Charge
OUTPATIENT CARE	
Primary Care Physician Office Visits	$25 copay per visit
Specialist Office Visits	$40 copay per visit
Virtual Visits	No Charge
Outpatient Surgery - Hospital Setting	$250 copay per visit
Outpatient Surgery - Freestanding Facility	$250 copay per visit
Preferred Laboratory Network	No Charge
Non-Preferred Laboratory Services - Hospital Setting	$60 copay per visit
Non-Preferred Laboratory Services - Freestanding Facility	$60 copay per visit
(See your Certificate of Coverage for additional Lab details)	
Radiology Services - Hospital Setting	No Charge
Radiology Services - Freestanding Facility	No Charge
DIABETIC SUPPLIES AND MEDICATIONS	
Diabetic Supplies	$25 copay
Diabetic Medications	$25 copay
MRIs, MRAs, CT SCANS, AND PET SCANS	
Outpatient Hospital Services	No Charge
Freestanding Radiology Facility	No Charge
HOSPITAL CARE	
Physician's and Surgeon's Services	No Charge
Semi-Private Room and Board	$500 copay per admission
All Drugs and Medication	No Charge
EMERGENCY CARE	
Ambulance Service when Medically Necessary	No Charge
At Hospital Emergency Room	$300 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
MATERNITY CARE	
Routine Prenatal and Post-Natal Care	No Charge
Hospital Services for Mother and Child	$500 copay per admission
SKILLED NURSING FACILITY	
30 Days per Calendar Year	$500 copay per admission
HOSPICE CARE	
Inpatient Care	$500 copay per admission
Home Hospice Care Visits	$40 copay per visit
HOME HEALTH CARE	
Home Care Visits - 40 visits per Calendar Year	$40 copay per visit
Physician House Calls	$40 copay per visit
SUBSTANCE USE DISORDER SERVICES	
Inpatient Rehabilitation	$500 copay per admission
Office Visits or Outpatient Rehabilitation	$25 copay per visit
Outpatient Partial Hospitalization	No Charge
MENTAL HEALTH CARE	
Inpatient Care	$500 copay per admission
Office Visits or Outpatient Care	$25 copay per visit
Outpatient Partial Hospitalization	No Charge

BENEFIT	In-Network
ALLERGY CARE	
Testing and Treatment	$40 copay per visit
CHIROPRACTIC CARE	
Chiropractic Care	$40 copay per visit
SHORT TERM REHAB OR HABILITATIVE SERVICES	
Inpatient limited to 60 Days per Calendar Year	$500 copay per admission
Outpatient limited to 60 combined PT/OT/ST Visits per Calendar Year	$40 copay per visit
DURABLE MEDICAL EQUIPMENT	
Unlimited *(Precert required for items over $500)*	No Charge
HEARING AIDS	
Limited to a single purchase (including repair/replacement) every 3 Years.	No Charge
MEDICAL SUPPLIES	
Medical Supplies when Medically Necessary	No Charge
EXERCISE FACILITY	
Subscriber	$200 reimbursement per 6 month period
Spouse/Dependents over age 13	$100 reimbursement per 6 month period
INFERTILITY	
(Covers all services in compliance with the NY Infertility Mandate)	
Specialist Office Visits	$40 copay per visit
Inpatient Facility Services	$500 copay per admission
Outpatient Surgery - Hospital Setting	$250 copay per visit
Outpatient Surgery - Freestanding Facility	$250 copay per visit
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
Tier 2	$35 copay
Tier 3	$75 copay
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER	
Tier 1	$37.50 copay
Tier 2	$87.50 copay
Tier 3	$187.50 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.

Please be advised this sample summary of coverage is provided for informational purposes only. The information contained herein is subject to the 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.