OXFORD HEALTH INSURANCE, INC.
FREEDOM PLAN ACCESS
SUMMARY OF COVERAGE
Freedom Network
The New School
Open Access 500 Plan

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	None	$500
	Family	None	$1,000
Coinsurance:		None	30%
Maximum Out-of-Pocket:	Single	Not Applicable	$3,500
(Including Deductible)	Family	Not Applicable	$7,000
Maximum Lifetime Benefit per Member		Unlimited	Unlimited
Financial Accumulation Period:		Not Applicable	Calendar Year
Out-of-Network Reimbursement:		Not Applicable	High UCR[1]
PREVENTIVE CARE			
Adult Preventive Care		No Charge	Deductible & 30% Coinsurance
Infant and Pediatric Preventive Care		No Charge	Deductible & 30% Coinsurance
Preventive Dental for Children (Through Age 11)		No Charge	No Charge
Well-Women Examinations		No Charge	Deductible & 30% Coinsurance
(Covers two such examinations per calendar year)			
OUTPATIENT CARE			
Primary Care Physician Office Visits		$30 copay per visit	Deductible & 30% Coinsurance
Specialist Office Visits		$30 copay per visit	Deductible & 30% Coinsurance
Outpatient Facility Surgery **		$50 copay	Deductible & 30% Coinsurance
Laboratory Services		At Participating Laboratories; No Charge	Deductible & 30% Coinsurance
MRIs, MRAs, PET Scan, CT Scan, Ultrasound **		No Charge	Deductible & 30% Coinsurance
Radiology Services **		No Charge	Deductible & 30% Coinsurance
HOSPITAL CARE (The copay is waived if readmitted within 90 days for the same condition)			
Physician's and Surgeon's Services **		No Charge	Deductible & 30% Coinsurance
Semi-Private Room and Board **		$100 copay per continuous confinement	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		$100 copay, waived if admitted	$100 copay, waived if admitted
(If member is admitted to the hospital, notification is required)			
Emergency Care in Urgi-Center		$30 copay per visit	Deductible & 30% Coinsurance
MATERNITY CARE (The copay is waived if readmitted within 90 days for the same condition)			
Prenatal and Post-Natal Care **		$30 copay per initial visit	Deductible & 30% Coinsurance
Hospital Services For Mother and Child **		$100 copay per continuous confinement	Deductible & 30% Coinsurance
SKILLED NURSING FACILITY (The copay is waived if readmitted within 90 days for the same condition)			
30 Days per Calendar Year **		$100 copay per continuous confinement	Deductible & 30% Coinsurance
HOSPICE CARE (210 days per lifetime combined inpatient, outpatient & home. The copay is waived if readmitted within 90 days for the same condition)			
Inpatient Care **		$100 copay per continuous confinement	Deductible & 30% Coinsurance
Outpatient Care **		$50 copay	Deductible & 30% Coinsurance
Home Hospice Care **		$30 copay per visit	Subject to a 20% Coinsurance
HOME HEALTH CARE			
Home Care Visits - Unlimited **		$30 copay per visit	Subject to a 20% Coinsurance
Physician House Calls		$30 copay per visit	Deductible & 30% Coinsurance
SUBSTANCE USE DISORDER SERVICES (The copay is waived if readmitted within 90 days for the same condition)			
Inpatient Rehabilitation**		$100 copay per continuous confinement	Deductible & 30% Coinsurance
Outpatient Rehabilitation**		$30 copay per visit	Deductible & 30% Coinsurance
Office Visits**		$30 copay per visit	Deductible & 30% Coinsurance
MENTAL HEALTH CARE (The copay is waived if readmitted within 90 days for the same condition)			
Inpatient Care**		$100 copay per continuous confinement	Deductible & 30% Coinsurance
Outpatient Care		$30 copay per visit	Deductible & 30% Coinsurance
Office Visits		$30 copay per visit	Deductible & 30% Coinsurance
ALLERGY CARE			
Testing and Treatment		$30 copay per visit	Deductible & 30% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
CHIROPRACTIC CARE		
Chiropractic Care	$30 copay per visit	Deductible & 30% Coinsurance
SHORT TERM REHABILITATION (The copay is waived if readmitted within 90 days for the same condition)		
100 Consec. Inpatient Days per Condition / Lifetime **	$100 copay per continuous confinement	Deductible & 30% Coinsurance
100 Outpatient Visits per Calendar Year	$30 copay per visit	Deductible & 30% Coinsurance
*Precertification upon initial Visit ** *		
(Short Term Care and Long Term Care Combined)		
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment	No Charge when ordered by an Oxford Participating Physician	Deductible & 30% Coinsurance
*(Precert required for items over $500 **)*		
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary	Out-of-Network Benefit Only	Deductible & 30% Coinsurance
EXERCISE FACILITY		
Subscriber	$200 reimbursement per 6 month period	$200 reimbursement per 6 month period
Spouse	$100 reimbursement per 6 month period	$100 reimbursement per 6 month period
ADVANCED INFERTILITY TREATMENT ($10,000 per lifetime. The copay is waived if readmitted within 90 days for the same condition)		
Specialist Office Visits **	$30 copay per visit	In-Network Benefit Only
Inpatient Facility Services **	$100 copay per continuous confinement	In-Network Benefit Only
Outpatient Facility Services **	$50 copay	In-Network Benefit Only
HEARING AIDS		
Coverage is limited to $5,000. Limited to a single purchase (including repair/replacement) every 3 years.	No Charge	Deductible & 30% Coinsurance
PRESCRIPTION DRUGS (Includes Oral Contraceptives)		
Tier 1 ***	$15 copay	Only Covered at Participating Pharmacies
Tier 2 ***	$25 copay	Only Covered at Participating Pharmacies
Tier 3 ***	$50 copay	Only Covered at Participating Pharmacies
OTHER COVERAGE		
Vision Exam: One Exam Every 12 Months	$50 reimbursement	$50 reimbursement
Vision Hardware: One Set of Appliances Every 24 Months	$200 reimbursement	$200 reimbursement

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 Calendar Year.

** These services require **precertification** through Oxford. Members must call Oxford at 1-800-444-6222 at least 14 days in advance of treatment to request precertification. Out-of-network Urgent Care, when properly precertified may be paid at member's copay.
**Mental health and substance use disorder services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.
***Prescription medication ordered through the Mail Order Drug Program are subject to two applicable retail pharmacy copays.

***The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductible and/or maximum limits.

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.

[1]The High UCR fee schedule contains the maximum allowable fees and is set using data from Ingenix, Inc., the Centers for Medicare and Medicaid Services (CMS) and sources recognized by the federal government and insurance industry as a basis for evaluating and establishing fees. Physician fees are generally set using 80th percentile data from the Prevailing Healthcare Charges System (PHCS) database maintained by Ingenix. We and Ingenix are related companies through common ownership by UnitedHealth Group. The fee schedule for physician-administered pharmaceutical products is based upon a percentage of Average Wholesale Price. If a data source is no longer available, we will use a comparable data source to establish fees. Additional information about how we set the UCR fee schedule and reimburse Out-of-Network Covered Services is available in the Certificate of Coverage and Member Handbook.