**OXFORD HEALTH INSURANCE, INC.**
**Freedom Plan Direct**
**SUMMARY OF COVERAGE**

**NY Direct Plan 3**

| BENEFIT | | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|---|
| **FINANCIAL** | | | |
| Deductible: | Single | $1,000 | $1,000 |
| | Family | $2,500 | $2,500 |
| Coinsurance | | 20% | 40% |
| Maximum Out-Of-Pocket: | Single | $3,000 | $5,000 |
| (Including Deductible) | Family | $7,500 | $12,500 |
| Maximum Lifetime Benefit Per Member | | Unlimited | Unlimited |
| Financial Accumulation Period | | Calendar Year | Calendar Year |
| Out-of-Network Reimbursement | | N/A | 140% of Medicare[1] |
| **PREVENTIVE CARE** | | | |
| Adult Preventive Care | | No Charge | In-Network Benefit Only |
| Infant and Pediatric Preventive Care | | No Charge | Deductible and 40% Coinsurance $300 annual maximum |
| Immunizations | | No Charge | Deductible and 40% Coinsurance |
| **OUTPATIENT CARE** | | | |
| Primary Care Physician office visits | | $25 copay per visit | Deductible and 40% Coinsurance |
| Specialist Office Visits | | $40 copay per visit | Deductible and 40% Coinsurance |
| Surgery ** | | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| Laboratory services | | At Participating Laboratories; No Charge | Deductible and 40% Coinsurance |
| Radiology services including PT, CT scans, Magnetic Resonance Imaging (MRI) ** | | 50% copayment to max of $100 | Deductible and 40% Coinsurance **Precertification is required for Out of Network PET scans, MRAs, surgical endoscopic procedures, MRIs Nuclear Medicine, CT Scans, and Bone Density Studies.** |
| Screening Mammograms | | Covered at 100% | Deductible and 40% Coinsurance |
| **ALLERGY CARE** | | | |
| Initial visit, and all subsequent referral visits | | $40 copay per visit | Deductible and 40% Coinsurance |
| **HOSPITAL CARE** | | | |
| Physician's and surgeon's services ** | | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| Semi-private room and board ** | | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| All drugs and medication | | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| **EMERGENCY CARE** | | | |
| Ambulance service when Medically Necessary | | Deductible and 20% Coinsurance | Deductible and 20% Coinsurance |
| At hospital emergency room | | $200 copay per visit | $200 copay per visit |
| *(If member is admitted to the hospital through the ER, notification is required)* | | | |
| Emergency Care in Urgi-Center | | $40 copay per visit | Deductible and 40% Coinsurance |
| **MATERNITY CARE** | | | |
| Prenatal and post-natal care | | $25 copay per initial visit | Deductible and 40% Coinsurance |
| Hospital services for mother and child ** | | Deductible and 20%% Coinsurance | Deductible and 40% Coinsurance |
| **SHORT TERM REHABILITATION** | | | |
| 60 consec. inpatient days per condition / lifetime** | | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| 60 outpatient visits per condition per lifetime | | $40 copay per visit | Deductible and 40% Coinsurance |
| **HOME HEALTH CARE** | | | |
| 40 home care visits ** | | Subject to 20% Coinsurance | Subject to 25% Coinsurance |
| Physician house calls | | $40 copay per visit | Deductible and 40% Coinsurance |
| **SKILLED NURSING FACILITY** | | | |
| 200 days per calendar year** | | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| **SUBSTANCE ABUSE** | | | |
| 7 days of inpatient detox. per calendar year ** | | Deductible and 20% Coinsurance | In-Network Benefit Only |
| 30 days of inpatient rehab. per calendar year ** | | Deductible and 20% Coinsurance | In-Network Benefit Only |
| 60 outpatient rehab. visits per calendar year | | $40 copay per visit | Deductible and 40% Coinsurance |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **MENTAL HEALTH CARE** | | |
| 30 days of Inpatient care per calendar year** | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| 30 visits of Outpatient care per calendar year** | $40 copay per visit | Deductible and 40% Coinsurance |
| Office visits (visits combined with Outpatient care)** | $40 copay per visit | Deductible and 40% Coinsurance |
| **PRESCRIPTION DRUGS** | $50 Deductible (Waived for Generic Drugs) | |
| Generic | $15 Copayment | Covered at Participating Pharmacies Only |
| Brand Name | 50% Coinsurance | |
| Includes Contraceptives | | |
| **HOSPICE CARE (210 days)** | | |
| Inpatient care ** | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| Outpatient care ** | Deductible and 20% Coinsurance | Deductible and 40% 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 |
| **HEARING AIDS** | | |
| Coverage is limited to $1,500. Limited to a single purchase (including repair/replacement) every 3 years. | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| **OTHER ITEMS** | | |
| Medical Supplies, when Medically Necessary | OUT-OF-NETWORK BENEFIT ONLY | Deductible and 40% Coinsurance |
| **Durable Equipment**, when Medically Necessary **(precert required on items over $500)** (This benefit is limited to $1,500 per calendar year.) | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |

**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. You 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 abuse services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

****Prescription medications ordered through the Mail Order Drug Program are subject to 2.5 retail pharmacy copays for Generic Drugs and 50% coinsurance for Brand Name Drugs.

****The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles.

**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.

IMPORTANT: If you live and work in a state other than New York, please check the back of the certificate for extraterritorial benefits rider.
Based on the state of your residence, additional coverage may be available to you.
**Please be advised this quote is for informational purposes only. The information contained herein is subject to both state regulatory and Oxford home office approval as appropria**

[1]When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.

**OXFORD HEALTH INSURANCE, INC.**
**Freedom Plan Direct**
**SUMMARY OF COVERAGE**

**NY Direct Plan 3**

| BENEFIT | | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|---|
| **FINANCIAL** | | | |
| Deductible: | Single | $1,000 | $1,000 |
| | Family | $2,500 | $2,500 |
| Coinsurance | | 20% | 40% |
| Maximum Out-Of-Pocket: | Single | $3,000 | $5,000 |
| (Including Deductible) | Family | $7,500 | $12,500 |
| Maximum Lifetime Benefit Per Member | | Unlimited | Unlimited |
| Financial Accumulation Period | | Contract Year | Contract Year |
| Out-of-Network Reimbursement | | N/A | 140% of Medicare[1] |
| **PREVENTIVE CARE** | | | |
| Adult Preventive Care | | No Charge | In-Network Benefit Only |
| Infant and Pediatric Preventive Care | | No Charge | Deductible and 40% Coinsurance $300 annual maximum |
| Immunizations | | No Charge | Deductible and 40% Coinsurance |
| **OUTPATIENT CARE** | | | |
| Primary Care Physician office visits | | $25 copay per visit | Deductible and 40% Coinsurance |
| Specialist Office Visits | | $40 copay per visit | Deductible and 40% Coinsurance |
| Surgery ** | | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| Laboratory services | | At Participating Laboratories; No Charge | Deductible and 40% Coinsurance |
| Radiology services including PT, CT scans, Magnetic Resonance Imaging (MRI) ** | | 50% copayment to max of $100 | Deductible and 40% Coinsurance **Precertification is required for Out of Network PET scans, MRAs, surgical endoscopic procedures, MRIs Nuclear Medicine, CT Scans, and Bone Density Studies.** |
| Screening Mammograms | | Covered at 100% | Deductible and 40% Coinsurance |
| **ALLERGY CARE** | | | |
| Initial visit, and all subsequent referral visits | | $40 copay per visit | Deductible and 40% Coinsurance |
| **HOSPITAL CARE** | | | |
| Physician's and surgeon's services ** | | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| Semi-private room and board ** | | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| All drugs and medication | | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| **EMERGENCY CARE** | | | |
| Ambulance service when Medically Necessary | | Deductible and 20% Coinsurance | Deductible and 20% Coinsurance |
| At hospital emergency room | | $200 copay per visit | $200 copay per visit |
| *(If member is admitted to the hospital through the ER, notification is required)* | | | |
| Emergency Care in Urgi-Center | | $40 copay per visit | Deductible and 40% Coinsurance |
| **MATERNITY CARE** | | | |
| Prenatal and post-natal care | | $25 copay per initial visit | Deductible and 40% Coinsurance |
| Hospital services for mother and child ** | | Deductible and 20%% Coinsurance | Deductible and 40% Coinsurance |
| **SHORT TERM REHABILITATION** | | | |
| 60 consec. inpatient days per condition / lifetime** | | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| 60 outpatient visits per condition per lifetime | | $40 copay per visit | Deductible and 40% Coinsurance |
| **HOME HEALTH CARE** | | | |
| 40 home care visits ** | | Subject to 20% Coinsurance | Subject to 25% Coinsurance |
| Physician house calls | | $40 copay per visit | Deductible and 40% Coinsurance |
| **SKILLED NURSING FACILITY** | | | |
| 200 days per calendar year** | | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| **SUBSTANCE ABUSE** | | | |
| 7 days of inpatient detox. per calendar year ** | | Deductible and 20% Coinsurance | In-Network Benefit Only |
| 30 days of inpatient rehab. per calendar year ** | | Deductible and 20% Coinsurance | In-Network Benefit Only |
| 60 outpatient rehab. visits per calendar year | | $40 copay per visit | Deductible and 40% Coinsurance |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **MENTAL HEALTH CARE** | | |
| 30 days of Inpatient care per calendar year** | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| 30 visits of Outpatient care per calendar year** | $40 copay per visit | Deductible and 40% Coinsurance |
| Office visits (visits combined with Outpatient care)** | $40 copay per visit | Deductible and 40% Coinsurance |
| **PRESCRIPTION DRUGS** | $50 Deductible (Waived for Generic Drugs) | |
| Generic | $15 Copayment | Covered at Participating Pharmacies Only |
| Brand Name | 50% Coinsurance | |
| Includes Contraceptives | | |
| **HOSPICE CARE (210 days)** | | |
| Inpatient care ** | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| Outpatient care ** | Deductible and 20% Coinsurance | Deductible and 40% 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 |
| **HEARING AIDS** | | |
| Coverage is limited to $1,500. Limited to a single purchase (including repair/replacement) every 3 years. | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |
| **OTHER ITEMS** | | |
| Medical Supplies, when Medically Necessary | OUT-OF-NETWORK BENEFIT ONLY | Deductible and 40% Coinsurance |
| **Durable Equipment**, when Medically Necessary **(precert required on items over $500)** (This benefit is limited to $1,500 per calendar year.) | Deductible and 20% Coinsurance | Deductible and 40% Coinsurance |

**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. You 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 abuse services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

****Prescription medications ordered through the Mail Order Drug Program are subject to 2.5 retail pharmacy copays for Generic Drugs and 50% coinsurance for Brand Name Drugs.

****The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles.

**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.

IMPORTANT: If you live and work in a state other than New York, please check the back of the certificate for extraterritorial benefits rider.
Based on the state of your residence, additional coverage may be available to you.
**Please be advised this quote is for informational purposes only. The information contained herein is subject to both state regulatory and Oxford home office approval as appropria**

[1]When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.