

OXFORD HEALTH INSURANCE, INC. CT P FRDM NG 15/40/1000/100 PPO 23 - Non-Gated SUMMARY OF COVERAGE

Freedom Network

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible	Single	\$1,000	\$4,000
	Family	\$2,000	\$8,000
Coinsurance		None	20%
Maximum Out-Of-Pocket:	Single	\$4,000	\$8,000
(Including Deductible)	Family	\$8,000	\$16,000
Financial Accumulation Period:		Calendar Year	Calendar Year
Out-of-Network Reimbursement:		Not Applicable	100% of Medicare

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.

Infant and Polastiric Preventive Care No Charge Dokacible & 20% Coins No Charge No Charge No Charge No Charge No Charge No Charge Polasticity Adult and Polastiric Vision Exam 330 copay per visit Dokacible & 50% Coins Polastiric Vision Exam Dokacible & 50% Coins Dokacible & 20% Coins Do	ance ance ance ance ance ance ance ance
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BENEFIT	IN-NETWORK	OUT-OF-NETWORK			
ALLERGY CARE					
Testing and Treatment**	\$40 copay per visit	Deductible & 20% Coinsurance			
ALTERNATIVE MEDICINE					
ALTERNATIVE MEDICINE Chiropractic Care - 30 visits per Calendar Year**	\$40 copay per visit	Deductible & 20% Coinsurance			
Naturopathic Care - Unlimited	\$40 copay per visit	Deductible & 20% Coinsurance			
REHABILITATION SERVICES					
Inpatient - Limited to 90 Days per Calendar Year/combined with	No Charge after Deductible	Deductible & 20% Coinsurance			
Skilled Nursing - Inpatient**	-				
Outpatient - Limited to 40 combined PT/OT/ST visits per Calendar Year**	\$30 copay per visit	Deductible & 20% Coinsurance			
I cai · ·					
DURABLE MEDICAL EQUIPMENT					
Durable Medical Equipment - Unlimited** Precertification required for items over \$500	No Charge after Deductible	Deductible & 20% Coinsurance			
Treer inculor required for tems over \$500					
MEDICAL SUPPLIES					
Medical Supplies When Medically Necessary**	Supplies obtained from your Physician are subject to the applicable cost share.	Deductible & 20% Coinsurance			
	Supplies obtained through the pharmacy are based on Tier.				
	are based on Tier.				
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					
Basic, Comprehensive and Advanced Infertility Services. (Covers all services in co Specialist Office Visit**	•	D. J			
Outpatient Facility Service**	\$40 copay per visit No Charge after Deductible	Deductible & 20% Coinsurance Deductible & 20% Coinsurance			
					
Inpatient Facility Service**	No Charge after Deductible	Deductible & 20% Coinsurance			
INFERTILITY MEDICATIONS					
Infertility Medications**					
For infertility medications, refer to the Outpatient Prescription Drug benefit. The cost share amount will be based on the Tier Level of the prescribed medication.					
HEARING AIDS					
Hearing Aids - Unlimited	No Charge after Deductible	Deductible & 20% Coinsurance			
OUTPATIENT PRESCRIPTION DRUGS - RETAIL The Prescription Drug Benefit is based on a Per Calendar Year limit for any applicable deductibles and/or maximum limits.					
The Frest phon Ding Dength is stated on a Fee Catendar Tear timit for any appreciate academics amon maximum timits.					
Tier 1	\$5 copay	Deductible & 20% Coinsurance			
Tier 2	\$60 copay	Deductible & 20% Coinsurance			
Tier 3 Tier 4	50% Coinsurance to \$500 max per script 50% Coinsurance to \$750 max per script	Deductible & 20% Coinsurance Deductible & 20% Coinsurance			
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER					
Tier 1 Tier 2	\$12.50 copay \$150 copay	Deductible & 20% Coinsurance Deductible & 20% Coinsurance			
Tier 3	50% Coinsurance to \$1,250 max per script	Deductible & 20% Coinsurance			
Tier 4	50% Coinsurance to \$1,875 max per script	Deductible & 20% Coinsurance			

${\bf DEPENDENT\ ELIGIBILITY:}$

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.

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.

 $Benefits\ are\ subject\ to\ final\ approval\ by\ the\ Department\ of\ Insurance\ and\ therefore\ may\ be\ subject\ to\ change.$

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^{**}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.

^{**}Precertification is required for Pediatric Orthodontia services only