OXFORD HEALTH INSURANCE, INC.
FREEDOM PLAN DIRECT
SUMMARY OF COVERAGE
Freedom Network

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			**UCR: at 70% HIAA**
Deductible:	Single	$1,500	$5,000
	Family	$3,000	$10,000
Coinsurance		None	40%
Maximum Out-of-Pocket:	Single	$1,500	$11,000
(Including Deductible)	Family	$3,000	$22,000
Maximum Lifetime Benefit Per Member		Unlimited	Unlimited
Financial Accumulation Period:		Contract Year	Contract Year
PREVENTIVE CARE			
Adult Preventive Care		No Charge	Deductible and 40% Coinsurance
Pediatric Preventive Care		No Charge	Deductible and 40% Coinsurance
Infant Preventive Care		No Charge	Deductible and 40% Coinsurance
Preventive Dental for Children (through age 11)		No Charge	No Charge
OUTPATIENT CARE			
Primary Care Physician Office Visits		$30 copay per visit	Deductible and 40% Coinsurance
Specialist Office Visits		$45 copay per visit	Deductible and 40% Coinsurance
Surgery **		100% after Deductible	Deductible and 40% Coinsurance
Laboratory Services		No Charge	Deductible and 40% Coinsurance
Radiology Services**		100% after Deductible	Deductible and 40% Coinsurance
HOSPITAL CARE			
Physician's and Surgeon's Services **		100% after Deductible	Deductible and 40% Coinsurance
Semi-Private Room and Board **		100% after Deductible	Deductible and 40% Coinsurance
All Drugs and Medication		100% after Deductible	Deductible and 40% Coinsurance
EMERGENCY CARE			
Ambulance Service		100% after Deductible	100% after Deductible
At Hospital Emergency Room		$150 copay	$150 copay
(If member is admitted to the hospital through the ER, notification is required)			
Emergency Care in Urgi-Center**		$45 copay per visit	Deductible and 40% Coinsurance
MATERNITY CARE			
Prenatal and Post-Natal Care**		$30 copay per initial visit	Deductible and 40% Coinsurance
Hospital Services for Mother and Child **		100% after Deductible	Deductible and 40% Coinsurance
SKILLED NURSING FACILITY			
30 days per Calendar Year **		100% after Deductible	Deductible and 40% Coinsurance
HOSPICE CARE			
Inpatient Care**		100% after Deductible	Deductible and 40% Coinsurance
Outpatient Care**		100% after Deductible	Deductible and 40% Coinsurance
HOME HEALTH CARE			
Home Care Visits - 80 visits per Calendar Year**		Covered at 100%	20% Coinsurance
Physician House Calls		$45 copay per visit	Deductible and 40% Coinsurance
SUBSTANCE ABUSE			
Inpatient Rehabilitation **		100% after Deductible	Deductible and 40% Coinsurance
Outpatient Rehabilitation**		$45 copay per visit	Deductible and 40% Coinsurance
Family Rehabilitation **		$45 copay per visit	Deductible and 40% Coinsurance
MENTAL HEALTH CARE			
Inpatient Care **		100% after Deductible	Deductible and 40% Coinsurance
Outpatient Visits**		$45 copay per visit	Deductible and 40% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
ALLERGY CARE		
Initial visit and all subsequent visits	$45 copay per visit	Deductible and 40% Coinsurance
ALTERNATIVE MEDICINE		
Chiropractic Care - 30 visits per Calendar Year	$45 copay per visit	Deductible and 40% Coinsurance
Naturopathic Care	$45 copay per visit	Deductible and 40% Coinsurance
SHORT TERM REHABILITATION		
60 Consec. Inpatient days per condition per lifetime**	100% after Deductible	Deductible and 40% Coinsurance
90 Outpatient visits per condition per lifetime	$45 copay per visit	Deductible and 40% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment**	100% after Deductible	Deductible and 40% Coinsurance
Precertification for items over $500		
MEDICAL SUPPLIES		
Medical Supplies**	$30 copay per item	Deductible and 40% Coinsurance
INFERTILITY TREATMENT		
Basic, Comprehensive Infertility Services. (Covers all services in compliance with the CT Infertility Mandate)		
Limits- Limited to members under the age of 40 and is subject to a lifetime maximum benefit during the entire time the Member is continuously Covered under plan as follows:		
Two cycle limit per lifetime for IVF, GIFT, ZIFT & low tubal ovum transfer		
Three cycle limit per lifetime for Intrauterine insemination		
Four cycle limit per lifetime for Ovulation induction		
If administered by ObGyn**	$30 copay per visit	Deductible and 40% Coinsurance
Specialist Office Visits**	$45 copay per visit	Deductible and 40% Coinsurance
Outpatient Care**	100% after Deductible	Deductible and 40% Coinsurance
INFERTILITY MEDICATIONS		
Infertility Medications	$45 copay per item	Deductible and 40% Coinsurance
HEARING AIDS		
Hearing Aids	100% after Deductible	Deductible and 40% Coinsurance
PRESCRIPTION DRUGS (Includes Oral Contraceptives)	$50 Deductible (Waived for Generic Drugs)	
Generic*****	$7 copayment	Deductible and 40% Coinsurance
Brand Name****	$20 copayment	Deductible and 40% Coinsurance
OTHER COVERAGE		
Diabetic Supplies	$30 copay per item	Deductible and 40% Coinsurance
The Oxford Enhanced Dental Plan	See Dental Brochure for coverage	IN-NETWORK COVERAGE ONLY
Vision Exam: One exam per 12 month period	$50 Reimbursement	$50 Reimbursement
Vision Hardware: One set of appliances per 24 month period	$70 Reimbursement	$70 Reimbursement

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

If the provider is your PCP, the lower copay will apply. If the provider is a Specialist, the higher copay applies (unless he/she has been authorized as your PCP).
** These services require **precertification** through Oxford. You must call Oxford at 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.

****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 your 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