



BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>FINANCIAL</b>		<b>UCR: 70% of HIAA</b>
Deductible: Single	None	\$300
Deductible: Family	None	\$750
Coinsurance	None	30%
Maximum Out-Of-Pocket: Single	Not Applicable	\$3,300 (Including Deductible)
Maximum Out-Of-Pocket: Family	Not Applicable	\$8,250 (Including Deductible)
Maximum Lifetime Benefit Per Member	Unlimited	Unlimited
<b>PREVENTIVE CARE</b>		
Adult Preventive Care	No Charge	INN Network Benefit only
Pediatric Preventive Care	No Charge	Subject to Deductible and Coinsurance (through age 19)
Immunizations	No Charge	No Charge
Preventive dental for children (Under age 12)	No Charge	No charge
<b>OUTPATIENT CARE</b>		
Primary Care Physician office visits	\$10 copay per visit	Subject to Deductible & Coinsurance
Specialist Office Visits*	\$10 copay per visit	Subject to Deductible & Coinsurance
Surgery **	No Charge	Subject to Deductible & Coinsurance
Laboratory services	At Participating Laboratories Only; No Charge	Subject to Deductible & Coinsurance
Magnetic Resonance Imaging (MRI) **	No Charge	Subject to Deductible & Coinsurance
<b>ALLERGY CARE</b>		
Initial visit, and all subsequent referral visits*	\$10 copay per visit	Subject to Deductible & Coinsurance
<b>HOSPITAL CARE</b>		
Physician's and surgeon's services **	No Charge	Subject to Deductible & Coinsurance **
Semi-private room and board **	No Charge	Subject to Deductible & Coinsurance **
All drugs and medication	No Charge	Subject to Deductible & Coinsurance
<b>EMERGENCY CARE</b>		
Ambulance service when Medically Necessary	No Charge	No Charge
At hospital emergency room (If a member is admitted to the hospital, notification is required)	\$50 copay; waived if admitted	\$50 copay; waived if admitted
Emergency Care in Urgi-Center**	\$10 copay per visit	Subject to Deductible & Coinsurance**
<b>MATERNITY CARE</b>		
Prenatal and post-natal care **	\$10 copay per initial visit	Subject to Deductible & Coinsurance **
Hospital services for mother and child **	No Charge	Subject to Deductible & Coinsurance **
<b>SHORT TERM REHABILITATION</b>		
60 consec. inpatient days per condition / lifetime**	No Charge	Subject to Deductible & Coinsurance**
90 outpatient visits per condition / lifetime*	\$10 copay per visit	Subject to Deductible & Coinsurance
<b>HOME HEALTH CARE</b>		
60 home care visits **	\$10 copay per visit	Subject to a 20% Coinsurance.
Physician house calls	\$10 copay per visit	Subject to Deductible & Coinsurance
<b>SKILLED NURSING FACILITY</b>		
30 days per calendar year**	No Charge	Subject to Deductible & Coinsurance **



A UnitedHealthcare Company

Freedom Network

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>SUBSTANCE ABUSE</b>		
7 days of inpatient detox. per calendar year **	No Charge	IN-NETWORK BENEFIT ONLY
30 days of inpatient rehab. per calendar year **	No Charge	IN-NETWORK BENEFIT ONLY
60 outpatient rehab. visits per calendar year **	No Charge	Subject to Deductible & Coinsurance **
<b>MENTAL HEALTH CARE</b>		
30 days of Inpatient care per Calendar Year**	No Charge	Subject to Deductible & Coinsurance
30 Outpatient visits per Calendar Year**	\$10 copay per visit	Subject to Deductible & Coinsurance
30 Office visits (combined w/outpatient visits)**	\$10 copay per visit	Subject to Deductible & Coinsurance
Biologically Based Mental Health Services & Services for Children with Serious Emotional Disorders (Visits for Biologically based services will count toward Non-Biologically based service limits.)		
Inpatient Care**	No Charge	Subject to Deductible & Coinsurance
Outpatient Care**	\$10 copay per visit	Subject to Deductible & Coinsurance
Office Visit**	\$10 copay per visit	Subject to Deductible & Coinsurance
<b>CHIROPRACTIC CARE</b>		
Chiropractic care	\$10 copay per visit	Subject to Deductible and Coinsurance
<b>HOSPICE CARE (210 days per Calendar year)</b>		
Inpatient Care**	No Charge	Subject to Deductible & Coinsurance **
Outpatient care**	No Charge	Subject to Deductible & Coinsurance **
<b>EXERCISE FACILITY</b>		
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
<b>OTHER COVERAGE</b>		
Durable Medical Equipment ** ** precert required for items over \$500 (This benefit is limited to \$1,500 per calendar year)	No Charge when ordered by a Oxford Participating Physician	Subject to Deductible & Coinsurance **
Medical Supplies**	OUT-OF-NETWORK BENEFIT ONLY	Subject to Deductible & Coinsurance **
<b>PRESCRIPTION DRUGS</b>		
Tier 1***	\$10 copayment	Covered at Participating Pharmacies only
Tier 2***	\$25 copayment	Covered at Participating Pharmacies only
Tier 3***	\$50 copayment	Covered at Participating Pharmacies only
(Includes Oral Contraceptives)		



A UnitedHealthcare Company

OXFORD HEALTH PLANS (NY), INC.  
FREEDOM PLAN  
SUMMARY OF COVERAGE  
Freedom Network

Page 3 of 3

#### DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 19, or age 23 if a full time student. Benefits discontinue at the end of the Calendar Year.

**Domestic Partners are covered with proper documentation.**

\*Visits to an Oxford participating specialist require an authorized referral from your Primary Care Physician.

\*\* These services require **precertification** through Oxford. You must call Oxford at 800-444-6222 at least 14 days in advance of request. Mental health and substance abuse 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 2 applicable retail pharmacy copays. The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles and/or maximum limits.

**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, hearing aids, or, unless otherwise stated, dental services, and vision correction services and supplies.

**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 appropriate.**