



BENEFIT	IN-NETWORK	OUT-OF-NETWORK
FINANCIAL		70% HIAA
Deductible: Single	None	\$1,000
Deductible: Family	None	\$3,000
Coinsurance	None	30%
Maximum Out-Of-Pocket: Single	Not applicable	\$4,000 (Including Deductible)
Maximum Out-Of-Pocket: Family	Not applicable	\$12,000 (Including Deductible)
Maximum Lifetime Benefit Per Member	Unlimited	Unlimited
PREVENTIVE CARE		
Adult Preventive Care	No Charge	IN-NETWORK BENEFIT ONLY
Pediatric Preventive Care	No Charge	No Charge
Immunizations	No Charge	No Charge
OUTPATIENT CARE		
Primary Care Physician office visits	\$15 copay per visit	Subject to Deductible & Coinsurance
Specialist Office Visits	\$25 copay per visit	Subject to Deductible & Coinsurance
Surgery **	\$100 copay	Subject to Deductible & Coinsurance
Laboratory services	No Charge	Subject to Deductible & Coinsurance
Magnetic Resonance Imaging (MRI) **	No Charge	Subject to Deductible & Coinsurance
ALLERGY CARE		
Initial visit, and all subsequent visits	\$25 copay per visit	Subject to Deductible & Coinsurance
HOSPITAL CARE		
Physician's & surgeon's services	No Charge	Subject to Deductible & Coinsurance
Semi-private room and board **	\$100 per admission	Subject to Deductible & Coinsurance
All drugs and medication	No Charge	Subject to Deductible & Coinsurance
EMERGENCY CARE		
Ambulance Service	No Charge	No Charge
At hospital emergency room (If member is admitted to the Hospital, notification is required)	\$75 copay, waived if admitted	\$75 copay, waived if admitted
Emergency Care in Urgi-Center	\$25 copay per visit	Subject to Deductible & Coinsurance
MATERNITY CARE		
Prenatal and post-natal care **	\$15 copay per initial visit	Subject to Deductible & Coinsurance
Hospital services for mother and child**	\$100 per admission	Subject to Deductible & Coinsurance
SHORT TERM REHABILITATION		
60 consec. Inpatient days per condition per lifetime**	\$100 per admission	Subject to Deductible & Coinsurance
60 outpatient visits per condition/lifetime	\$25 copay per visit	Subject to Deductible & Coinsurance
HOME HEALTH CARE		
40 home care visits**	\$25 copay per visit	Subject to 20% Coinsurance.
Physician house calls	\$25 copay per visit	Subject to Deductible & Coinsurance
SKILLED NURSING FACILITY		
200 days per calendar year**	\$100 per admission	Subject to Deductible & Coinsurance
CHIROPRACTIC CARE		
Chiropractic care	\$25 copay per visit	Subject to Deductible & Coinsurance
SUBSTANCE ABUSE		
7 days of Inpatient detox. per Calendar Year**	\$100 per admission	Subject to Deductible & 50% Coinsurance
30 days of Inpatient rehab. per Calendar Year**	\$100 per admission	Subject to Deductible & 50% Coinsurance
60 Outpatient rehab. visits per Calendar Year**	No Charge	Subject to Deductible & Coinsurance



A UnitedHealthcare Company

OXFORD HEALTH PLANS, INC.
FREEDOM METRO PLAN
 SUMMARY OF COVERAGE
 FREEDOM NETWORK

Freedom Network

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
30 days of Inpatient care per Calendar Year**	\$100 per admission	Subject to Deductible & Coinsurance
30 Outpatient visits per Calendar Year**	\$25 copay per visit	Subject to Deductible & Coinsurance
30 Office visits (combined w/outpatient visits)**	\$25 copay per visit	Subject to Deductible & Coinsurance
PRESCRIPTION DRUGS		
(Includes Oral Contraceptives)	\$50 Deductible (waived for Tier 1 Drugs)	
Tier 1***	\$10 copayment	Covered at Participating Pharmacies Only
Tier 2***	\$25 copayment	
Tier 3***	\$50 copayment	
HOSPICE CARE (210 days)		
Inpatient Care	\$100 per admission	Subject to Deductible & Coinsurance
Outpatient Care	\$100 copay	Subject to Deductible & Coinsurance
EXERCISE FACILITY		
Subscriber		\$200 reimbursement per 6 month period
Spouse		\$100 reimbursement per 6 month period
OTHER COVERAGE		
Medical Supplies**	OUT-OF-NETWORK BENEFIT ONLY	Subject to Deductible & Coinsurance
Durable Medical Equipment** \$1500 limit per Calendar Year Precertification for items \$500 or more.	No Charge	Subject to Deductible & Coinsurance

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.

** 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 for a 90 day supply.

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.