



OXFORD HEALTH INSURANCE, INC.
FREEDOM PLAN CLASSIC
SUMMARY OF COVERAGE
Freedom Network
Community Healthcare Network, Inc.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
FINANCIAL		
Deductible: Single	None	UCR: 70% of HIAA \$500
Family	None	\$1,250
Coinsurance	None	20%
Maximum Out-of-Pocket: Single	Not Applicable	\$2,500
(Including Deductible) Family	Not Applicable	\$6,250
Maximum Lifetime Benefit per Member	Unlimited	Unlimited
PREVENTIVE CARE		
Adult Preventive Care	No Charge	Deductible & 20% Coinsurance
<i>Service received Out-of-Network is limited to \$300.</i>		
Infant and Pediatric Preventive Care	No Charge	Deductible & 20% Coinsurance
<i>Service received Out-of-Network is limited to \$300.</i>		
Preventive Dental for Children (Through Age 11)	No Charge	No Charge
OUTPATIENT CARE		
Primary Care Physician Office Visits	\$15 copay per visit	Deductible & 20% Coinsurance
Specialist Office Visits*	\$25 copay per visit	Deductible & 20% Coinsurance
Outpatient Facility Surgery **	\$50 copay	Deductible & 20% Coinsurance
Laboratory Services	At Participating Laboratories; No Charge	Deductible & 20% Coinsurance
MRIs, MRAs, PET Scan, CT Scan, Ultrasound **	No Charge	Deductible & 20% Coinsurance
Radiology Services **	No Charge	Deductible & 20% Coinsurance
HOSPITAL CARE		
Physician's and Surgeon's Services **	No Charge	Deductible & 20% Coinsurance
Semi-Private Room and Board **	\$100 copay per continuous confinement	Deductible & 20% Coinsurance
All Drugs and Medication	No Charge	Deductible & 20% Coinsurance
EMERGENCY CARE		
Ambulance Service When Medically Necessary	No Charge	No Charge
At Hospital Emergency Room	\$50 copay, waived if admitted	\$50 copay, waived if admitted
<i>(If member is admitted to the hospital, notification is required)</i>		
Emergency Care in Urgi-Center	\$25 copay per visit	Deductible & 20% Coinsurance
MATERNITY CARE		
Prenatal and Post-Natal Care **	\$15 copay per initial visit	Deductible & 20% Coinsurance
Hospital Services For Mother and Child **	\$100 copay per continuous confinement	Deductible & 20% Coinsurance
SKILLED NURSING FACILITY		
Unlimited Days **	\$100 copay per continuous confinement	Deductible & 20% Coinsurance
HOSPICE CARE (210 days per lifetime combined inpatient, outpatient & home)		
Inpatient Care **	\$100 copay per continuous confinement	Deductible & 20% Coinsurance
Outpatient Care **	\$50 copay	Deductible & 20% Coinsurance
Home Hospice Care **	\$25 copay per visit	Subject to a 20% Coinsurance
HOME HEALTH CARE		
Home Care Visits - Unlimited **	\$25 copay per visit	Subject to a 20% Coinsurance
Physician House Calls	\$25 copay per visit	Deductible & 20% Coinsurance
ALCOHOL AND SUBSTANCE ABUSE		
7 Days of Inpatient Detox. per Calendar Year **	\$100 copay per continuous confinement	Deductible & 50% Coinsurance
30 Days of Inpatient Rehab. per Calendar Year **	\$100 copay per continuous confinement	Deductible & 50% Coinsurance
60 Outpatient Rehab. Visits per Calendar Year **	No Charge	Deductible & 20% Coinsurance
MENTAL HEALTH CARE		
30 Days of Inpatient Care per Calendar Year (Visits for Biologically based services will count toward this limit) **	\$100 copay per continuous confinement	Deductible & 20% Coinsurance
30 Visits for Outpatient Care per Calendar Year (Visits for Biologically based services will count toward this limit) **		
Outpatient Facility **	\$25 copay per visit	Deductible & 20% Coinsurance
Office Visits **	\$25 copay per visit	Deductible & 20% Coinsurance
Biologically Based Mental Health Services & Services for Children with Serious Emotional Disorders		
Outpatient Care **	\$100 copay per continuous confinement	Deductible & 20% Coinsurance
Outpatient Facility **	\$25 copay per visit	Deductible & 20% Coinsurance
Office Visits **	\$25 copay per visit	Deductible & 20% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
ALLERGY CARE		
Testing and Treatment*	\$25 copay per visit	Deductible & 20% Coinsurance
ALTERNATIVE MEDICINE		
Chiropractic Care	\$25 copay per visit	Deductible & 20% Coinsurance
Acupuncture Care	\$25 copay per visit	In-Network Benefit Only
SHORT TERM REHABILITATION		
60 Consec. Inpatient Days per Condition / Lifetime **	\$100 copay per continuous confinement	Deductible & 20% Coinsurance
90 Outpatient Visits per Condition / Lifetime <i>Precertification after initial Visit **</i>	\$25 copay per visit	Deductible & 20% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment <i>(Precert required for items over \$500 **)</i>	No charge when ordered by an Oxford Participating Physician	Deductible & 20% Coinsurance
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary	Out-Of-Network Benefit Only	Deductible & 20% 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
ELECTIVE TERMINATION OF PREGNANCY		
\$350 maximum for one procedure per member per Calendar Year	No Charge	Deductible & 20% Coinsurance
ADVANCED INFERTILITY TREATMENT (\$10,000 per lifetime)		
Specialist Office Visits **	\$25 copay per visit	In-Network Benefit Only
Inpatient Facility Services **	\$100 copay per continuous confinement	In-Network Benefit Only
Outpatient Facility Services **	\$50 copay	In-Network Benefit Only
PRESCRIPTION DRUGS (Includes Oral Contraceptives)		
Tier 1 ***	\$10 copay	Only Covered at Participating Pharmacies
Tier 2 ***	\$20 copay	Only Covered at Participating Pharmacies
Tier 3 ***	\$50 copay	Only Covered at Participating Pharmacies
OTHER COVERAGE		
Vision Exam: One Exam Every 12 Months	\$50 reimbursement	\$50 reimbursement
Vision Hardware: One Set of Appliances Every 24 Months	\$70 reimbursement	\$70 reimbursement

DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 19, or age 25 if a full time student. Benefits discontinue at the end of the Calendar Year.

Domestic Partners covered with proper documentation.

*In-Network visits to an Oxford Participating Specialist require an authorized referral from your PCP.

** These services require **precertification** through Oxford. You must call Oxford at 1-800-444-6222 at least 14 days in advance of treatment to request precertification. Out-of-network Urgent Care, when properly precertified may be paid at member's copay.

***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 two applicable retail pharmacy copays.

***The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductible 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, Workers' Compensation, military service-related conditions, hearing aids, or, unless otherwise stated, dental services and vision correction services and supplies.