OXFORD HEALTH INSURANCE, INC.
FREEDOM PLAN DIRECT
SUMMARY OF COVERAGE
LIBERTY NETWORK
Liberty Direct Plan 4

BENEFIT		IN-NETWORK	OUT-OF-NETWORK[1]
FINANCIAL			
Deductible:	Single	$500	$1000
	Family	$1000	$2000
Coinsurance		10%	30%
Maximum Out-of-Pocket:	Single	$1,500	$4,000
(Including Deductibles)	Family	$3,000	$8,000
Maximum Lifetime Benefit Per Member		Unlimited	Unlimited
Financial Accumulation Period:		Calendar Year	Calendar Year
PREVENTIVE CARE			
Preventive Care (under 1 year old)		No Charge	No Charge
Preventive Care (1 year and over)		No Charge	No Charge
Immunizations		No Charge	No Charge
Lead poisoning screening and treatments for children		No Charge	Subject to Deductible & 30% Coinsurance
OUTPATIENT CARE			
Physician Office Visits		$15 PCP/$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance
Ambulatory Surgery**		Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance
Second Surgical Opinions**		$15 PCP/$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance
Pre-admission Testing**		$15 PCP/$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance
Podiatric Care Visits		$15 PCP/$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance
Physician House Calls		$15 PCP/$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance
Laboratory Services		At Participating Labs; No Charge	Subject to Deductible & 30% Coinsurance
Magnetic Resonance Imaging (MRI)**		Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance
Therapeutic Manipulation			
30 visits per Calendar Year		$15 PCP/$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance
HOSPITAL CARE			
Physician's and Surgeon's Services**		Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance
Semi-private Room and Board**		Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance
All Drugs and Medication		Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance
Inpatient Surgery**		Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance
EMERGENCY CARE			
(Oxford must be contacted within 48 hours)			
Ambulance service when Medically Necessary		Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance
At Hospital Emergency Room		$100 copay, then subject to Deductible & 10% Coinsurance; waived if admitted	$100 copay, then subject to Deductible & 10% Coinsurance; waived if admitted
Emergency Care in Urgi-Center		$15 PCP/$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance
MATERNITY CARE			
Prenatal 1st Visit		$15 PCP/$25 Specialist copay per initial visit	Subject to Deductible & 30% Coinsurance
Prenatal and Post-natal Care**		Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance
Birthing Centers		$15 PCP/$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance
Hospital Services for Mother and Child**		Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance
SKILLED NURSING FACILITY			
Skilled Nursing Care**		Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance
HOSPICE CARE			
Hospice Care**		Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance
HOME HEALTH CARE			
Home Health Care**		Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance
SUBSTANCE ABUSE	At approved facilities only		
Outpatient Visits**		$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance
Inpatient Care**		Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
Inpatient Care**		
Biologically Based Conditions	Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance**
Inpatient Care**		
Non-Biologically Based Conditions	Subject to Deductible and 10% Coinsurance	Subject to Deductible & 30% Coinsurance**
Outpatient Visits**		
Biologically Based Conditions	$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance**
Outpatient Visits**		
Non-Biologically Based Conditions	$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance**
ALLERGY CARE		
Allergy Care Visits	$15 PCP/$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance
SHORT TERM REHABILITATION		
Physical/Occupational Therapy**	$15 PCP/$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance**
Combined maximum 30 visits per Calendar Year		
Speech/Cognitive Therapy**	$15 PCP/$25 Specialist copay per visit	Subject to Deductible & 30% Coinsurance**
Combined maximum 30 visits per Calendar Year		
DURABLE MEDICAL EQUIPMENT		
Durable Equipment, when Medically Necessary**	No Charge if pre-certified by Oxford in advance and ordered by an Oxford Participating Physician.	Subject to Deductible & 30% Coinsurance**
Prosthetics	No Charge	Subject to Deductible & 30% Coinsurance
Orthotics	No Charge	Subject to Deductible & 30% Coinsurance
HEARING AIDS		
Coverage is limited to $5,000 per hearing aid for each hearing impaired ear every 24 months. Accessories, fittings and repairs are not subject to the $5,000 limit.	No Charge	Subject to Deductible & 30% Coinsurance
MEDICAL SUPPLIES		
Medical Supplies, when Medically Necessary**	OUT-OF-NETWORK BENEFIT ONLY	Subject to Deductible & 30% Coinsurance
PRESCRIPTION DRUGS (Includes Oral Contraceptives)		
Tier 1	$7 copayment	Covered at Participating Pharmacies Only
Tier 2	$20 copayment	
Tier 3	$50 copayment	
OTHER COVERAGE		

DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.
Benefits discontinue at the end of the Calendar Year.

** These services require **pre-certification** through Oxford. You must call Oxford at 800-444-6222 at least 14 days in advance of treatment to request pre-certification.

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 and special duty nursing, learning and behavioral disorders, Worker's Compensation, military service-related conditions or unless otherwise stated, dental services and vision correction services

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