OXFORD HEALTH INSURANCE, INC.
FREEDOM PLAN METRO
SUMMARY OF COVERAGE
LIBERTY NETWORK
NY Metro Access $30/50

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
FINANCIAL		
Deductible Single	None	$3,000
Family	None	$7,500
Coinsurance	None	30%
Maximum Out-of-Pocket: Single	Not Applicable	$6,000 (Including Deductible)
Family	Not Applicable	$18,000 (Including Deductible)
Maximum Lifetime Benefit Per Member	Unlimited	Unlimited
Out-of-Network Reimbursement	N/A	140% of Medicare[1]
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	$30 copay per visit	Subject to Deductible & Coinsurance
Specialist office visits	$50 copay per visit	Subject to Deductible & Coinsurance
Surgery **	$500 copay per visit	Subject to Deductible & Coinsurance
Laboratory services	No Charge for UHC Lab Network providers	Subject to Deductible & Coinsurance
Magnetic Resonance Imaging (MRI) **	50% copayment to a max of $100	Subject to Deductible & Coinsurance
ALLERGY CARE		
Initial visit, and all subsequent visits	$50 copay per visit	Subject to Deductible & Coinsurance
HOSPITAL CARE		
Physician's and surgeon's services	No Charge	Subject to Deductible & Coinsurance
Semi-private room and board **	$500 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	$200 copay; (waived if admitted)	$200 copay; (waived if admitted)
(If member is admitted to the Hospital, notification is required)		
Emergency Care in Urgi-Center	$50 copay per visit	Subject to Deductible & Coinsurance
MATERNITY CARE		
Prenatal and Post-natal care **	$30 copay per initial visit	Subject to Deductible & Coinsurance
Hospital services for mother and child **	$500 per admission	Subject to Deductible & Coinsurance
SHORT TERM REHABILITATION		
60 consec. Inpatient days per condition per lifetime**	$500 per admission	Subject to Deductible & Coinsurance
60 Outpatient visits per condition per lifetime	$50 copay per visit	Subject to Deductible & Coinsurance
HOME HEALTH CARE		
40 Home care visits**	$50 copay per visit	Subject to a 20% Coinsurance.
Physician house calls	$50 copay per visit	Subject to Deductible & Coinsurance
SKILLED NURSING FACILITY		
200 days per Calendar Year**	$500 per admission	Subject to Deductible & Coinsurance
CHIROPRACTIC CARE		
Chiropractic care	$50 copay per visit	Subject to Deductible & Coinsurance
SUBSTANCE ABUSE		
7 days of Inpatient detox. per Calendar Year**	$500 per admission	Subject to Deductible & 50% Coinsurance
30 days of Inpatient rehab. per Calendar Year**	$500 per admission	Subject to Deductible & 50% Coinsurance
60 Outpatient rehab. visits per Calendar Year**	$50 copay per visit	Subject to Deductible & Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
30 days of Inpatient care per Calendar Year**	$500 per admission	Subject to Deductible & Coinsurance
Outpatient visits per Calendar Year**	$50 copay per visit	Subject to Deductible & Coinsurance
30 Office visits (combined w/outpatient visits)**	$50 copay per visit	Subject to Deductible & Coinsurance
PRESCRIPTION DRUGS		
Includes Oral Contraceptives	$50 Deductible (Waived for Generic Drugs)	
Generic	$15 copayment	Covered at Participating Pharmacies Only
Brand Name	50% coinsurance	
HOSPICE CARE (210 days)		
Inpatient care	$500 per admission	Subject to Deductible & Coinsurance
Outpatient care	$500 copay per visit	Subject to Deductible & Coinsurance
EXERCISE FACILITY		
Subscriber		$200 reimbursement per 6 month period
Spouse		$100 reimbursement per 6 month period
HEARING AIDS		
Coverage is limited to $1,500. Limited to a single purchase (including repair/replacement) every 3 years.	No Charge	Subject to Deductible & Coinsurance
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 26.
Benefits discontinue at the end of the Calendar Year.

****The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles and/or maximum limits.

****Prescription medications ordered through the Mail Order Drug Program are subject to 2.5 retail pharmacy copays for Generic Drugs and 50% coinsurance for Brand Name Drugs.

** These services require **Precertification** through Oxford. You must call Oxford at 1-800-444-6222 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.
Refer to the 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.

[1]Medicare MNRP: An Out-of-Network Fee Schedule based upon 140% of Medicare. When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.

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.