United Healthcare Oxford

OXFORD HEALTH INSURANCE, INC.
CT P FRDM NG 20/45/1000/100 PPO 21 - Non-Gated
SUMMARY OF COVERAGE

Freedom Network

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible	Single	$1,000	$4,000
	Family	$2,000	$8,000
Coinsurance		None	20%
Maximum Out-Of-Pocket:	Single	$4,000	$8,000
(Including Deductible)	Family	$8,000	$16,000
Financial Accumulation Period:		Policy Year	Policy Year
Out-of-Network Reimbursement:		Not Applicable	110% of Medicare

Please Note: *All Copayments, Deductibles, and Coinsurance (medical and prescription) paid for In-Network Covered Services contribute to the In-Network, Out-of-Pocket Maximum.*

PREVENTIVE CARE		
Adult Preventive Care	No Charge	Deductible & 20% Coinsurance
Infant and Pediatric Preventive Care	No Charge	Deductible & 20% Coinsurance
Preventive Dental for Children (Up to age 19)**	No Charge	No Charge after Deductible
Adult and Pediatric Vision Exam	$30 copay per visit	Deductible & 50% Coinsurance
Pediatric Vision Hardware (Up to age 19)	50% Coinsurance	Deductible & 50% Coinsurance
OUTPATIENT CARE		
Primary Care Physician Office Visits	$20 copay per visit	Deductible & 20% Coinsurance
Specialist Office Visits	$45 copay per visit	Deductible & 20% Coinsurance
Virtual Visits	No Charge	Not Covered
Outpatient Surgery - Hospital Setting**	No Charge after Deductible	Deductible & 20% Coinsurance
Outpatient Surgery - Freestanding Facility**	No Charge after Deductible	Deductible & 20% Coinsurance
Laboratory Services - Hospital Setting**	$20 copay per service	Deductible & 20% Coinsurance
Laboratory Services - Freestanding Facility**	$20 copay per service	Deductible & 20% Coinsurance
Radiology Services - Hospital Setting**	$40 copay per service	Deductible & 20% Coinsurance
Radiology Services - Freestanding Facility**	$40 copay per service	Deductible & 20% Coinsurance
MRIs, MRAs, CT SCANS, AND PET SCANS		
Outpatient Hospital Services**	$75 copay per service up to a $375 max per Calendar Year	Deductible & 20% Coinsurance
Freestanding Radiology Facility**	$75 copay per service up to a $375 max per Calendar Year	Deductible & 20% Coinsurance
HOSPITAL CARE		
Physician's and Surgeon's Services**	No Charge after Deductible	Deductible & 20% Coinsurance
Semi-Private Room and Board**	No Charge after Deductible	Deductible & 20% Coinsurance
All Drugs and Medication	No Charge after Deductible	Deductible & 20% Coinsurance
EMERGENCY CARE		
Ambulance Service When Medically Necessary	No Charge after Deductible	No Charge after Deductible
At Hospital Emergency Room *(If member is admitted to the hospital, notification is required.)*	$300 copay per visit	$300 copay per visit
Emergency Care in Urgi-Center	$45 copay per visit	Deductible & 20% Coinsurance
MATERNITY CARE		
Prenatal Care**	No Charge	Deductible & 20% Coinsurance
Postnatal Care**	$20 copay per visit	Deductible & 20% Coinsurance
Hospital Services for Mother and Child**	No Charge after Deductible	Deductible & 20% Coinsurance
SKILLED NURSING FACILITY		
90 days per Calendar Year combined with Short-Term Rehabilitation - Inpatient**	No Charge after Deductible	Deductible & 20% Coinsurance
HOSPICE CARE		
Inpatient Care**	No Charge after Deductible	Deductible & 20% Coinsurance
Home Hospice - Unlimited**	No Charge	20% Coinsurance
HOME HEALTH CARE		
Home Care Visits - 100 Visits per Calendar Year**	No Charge	20% Coinsurance
Physician House Calls**	$45 copay per visit	Deductible & 20% Coinsurance
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation**	No Charge after Deductible	Deductible & 20% Coinsurance
Outpatient Rehabilitation	$20 copay per visit	Deductible & 20% Coinsurance
Outpatient Partial Hospitalization	No Charge after Deductible	Deductible & 20% Coinsurance
MENTAL HEALTH CARE		
Inpatient Care**	No Charge after Deductible	Deductible & 20% Coinsurance
Outpatient Visits	$20 copay per visit	Deductible & 20% Coinsurance
Outpatient Partial Hospitalization**	No Charge after Deductible	Deductible & 20% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
ALLERGY CARE		
Testing and Treatment**	$45 copay per visit	Deductible & 20% Coinsurance
ALTERNATIVE MEDICINE		
Chiropractic Care - 30 visits per Calendar Year**	$45 copay per visit	Deductible & 20% Coinsurance
Naturopathic Care - Unlimited	$45 copay per visit	Deductible & 20% Coinsurance
REHABILITATION SERVICES		
Inpatient - Limited to 90 Days per Calendar Year/combined with Skilled Nursing - Inpatient**	No Charge after Deductible	Deductible & 20% Coinsurance
Outpatient - Limited to 40 combined PT/OT/ST visits per Calendar Year**	$30 copay per visit	Deductible & 20% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment - Unlimited** *Precertification required for items over $500*	No Charge after Deductible	Deductible & 20% Coinsurance
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary**	Supplies obtained from your Physician are subject to the applicable cost share. Supplies obtained through the pharmacy are based on Tier.	Deductible & 20% Coinsurance
EXERCISE FACILITY		
Subscriber	$200 reimbursement per 6-month period	$200 reimbursement per 6-month period
Spouse/Dependents over age 13	$100 reimbursement per 6-month period	$100 reimbursement per 6-month period
INFERTILITY TREATMENT		
Basic, Comprehensive and Advanced Infertility Services. (Covers all services in compliance with the CT Infertility Mandate)		
Specialist Office Visit**	$45 copay per visit	Deductible & 20% Coinsurance
Outpatient Facility Service**	No Charge after Deductible	Deductible & 20% Coinsurance
Inpatient Facility Service**	No Charge after Deductible	Deductible & 20% Coinsurance
INFERTILITY MEDICATIONS		
Infertility Medications**		
For infertility medications, refer to the Outpatient Prescription Drug benefit. The cost share amount will be based on the Tier Level of the prescribed medication.		
HEARING AIDS		
Hearing Aids - Unlimited	No Charge after Deductible	Deductible & 20% Coinsurance
OUTPATIENT PRESCRIPTION DRUGS - RETAIL		
The Prescription Drug Benefit is based on a Per Policy Year limit for any applicable deductibles and/or maximum limits.		
Tier 1	$5 copay	Deductible & 20% Coinsurance
Tier 2	$60 copay	Deductible & 20% Coinsurance
Tier 3	50% Coinsurance to $500 max per script	Deductible & 20% Coinsurance
Tier 4	50% Coinsurance to $750 max per script	Deductible & 20% Coinsurance
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	$12.50 copay	Deductible & 20% Coinsurance
Tier 2	$150 copay	Deductible & 20% Coinsurance
Tier 3	50% Coinsurance to $1,250 max per script	Deductible & 20% Coinsurance
Tier 4	50% Coinsurance to $1,875 max per script	Deductible & 20% Coinsurance

DEPENDENT ELIGIBILITY:
Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.

Domestic Partners are covered with proper documentation.

These services require **precertification through Oxford. Members must call Oxford at 1-800-444-6222 at least 14 days in advance of request of treatment to request precertification.
**Mental health and substance use disorder services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.
**Precertification is required for Pediatric Orthodontia services only

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 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.

Benefits are subject to final approval by the Department of Insurance and therefore may be subject to change.