**OXFORD HEALTH PLANS (CT), INC.**
**Designated HMO PLAN**
**SUMMARY OF COVERAGE**
**Liberty Network**
**INNOWAVE MARKETING GROUP LLC**
**$3,000 HMO Plan with Rx Deductible**

| BENEFIT | | Designated Network/In-Network |
|---|---|---|
| **FINANCIAL** | | |
| Deductible: | Single | $3,000 |
| | Family | $6,000 |
| Coinsurance | | None |
| Maximum Out-of-Pocket: | Single | $6,000 |
| (Including Deductible) | Family | $12,000 |
| Financial Accumulation Period: | | Policy Year |

*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.*

| BENEFIT | Designated Network | In-Network |
|---|---|---|
| **PREVENTIVE CARE** | | |
| Adult Preventive Care | No Charge | No Charge |
| Infant and Pediatric Preventive Care | No Charge | No Charge |
| **OUTPATIENT CARE** | | |
| Primary Care Physician Office Visits | No Charge | $25 copay per visit |
| Specialist Office Visits* | $40 copay per visit | $65 copay per visit |
| Virtual Visits | No Charge | No Charge |
| Outpatient Surgery - Hospital Setting | No Charge after Deductible | No Charge after Deductible |
| Outpatient Surgery - Freestanding Facility | No Charge after Deductible | No Charge after Deductible |
| Designated Diagnostic Provider Laboratory Services | $20 copay per service | $20 copay per service |
| Non-Designated Diagnostic Provider Laboratory Services | Deductible & 50% Coinsurance | Deductible & 50% Coinsurance |
| *(See your Certificate of Coverage for additional Lab details)* | | |
| Radiology Services | No Charge after Deductible | No Charge after Deductible |
| **MRIs, MRAs, CT SCANS, AND PET SCANS** | | |
| Freestanding Radiology Facility** | No Charge after Deductible | No Charge after Deductible |
| Outpatient Hospital Services** | No Charge after Deductible | No Charge after Deductible |
| **HOSPITAL CARE** | | |
| Physician's and Surgeon's Services | No Charge after Deductible | No Charge after Deductible |
| Semi-Private Room and Board | No Charge after Deductible | No Charge after Deductible |
| All Drugs and Medication | No Charge after Deductible | No Charge after Deductible |
| **EMERGENCY CARE** | | |
| Ambulance Service when Medically Necessary | No Charge | No Charge |
| At Hospital Emergency Room | Deductible then $300 copay per visit | Deductible then $300 copay per visit |
| *(If member is admitted to the hospital, notification is required.)* | | |
| Emergency Care in Urgi-Center | $75 copay per visit | $75 copay per visit |
| **MATERNITY CARE** | | |
| Prenatal Care | No Charge | No Charge |
| Postnatal Care | $25 copay per visit | $25 copay per visit |
| Hospital Services for Mother and Child | No Charge after Deductible | No Charge after Deductible |
| **SKILLED NURSING FACILITY** | | |
| 90 Days per Policy Year/combined with Short-Term Rehabilitation - Inpatient | No Charge after Deductible | No Charge after Deductible |
| **HOSPICE CARE** | | |
| Inpatient Care | No Charge after Deductible | No Charge after Deductible |
| Home Hospice Care Visits | No Charge | No Charge |
| **HOME HEALTH CARE** | | |
| Home Care Visits - 100 Visits per Policy Year | No Charge | No Charge |
| Physician House Calls | $65 copay per visit | $65 copay per visit |

| BENEFIT | Designated Network | In-Network |
|---|---|---|
| **SUBSTANCE USE DISORDER SERVICES** | | |
| Inpatient Rehabilitation | No Charge after Deductible | No Charge after Deductible |
| Office Visits or Outpatient Rehabilitation | No Charge | No Charge |
| Intensive Behavioral Therapy | No Charge | No Charge |
| Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment | No Charge after Deductible | No Charge after Deductible |
| **MENTAL HEALTH CARE** | | |
| Inpatient Care | No Charge after Deductible | No Charge after Deductible |
| Office Visits or Outpatient Care | No Charge | No Charge |
| Intensive Behavioral Therapy | No Charge | No Charge |
| Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment | No Charge after Deductible | No Charge after Deductible |
| **ALLERGY CARE** | | |
| Testing and Treatment | $65 copay per visit | $65 copay per visit |
| **ALTERNATIVE MEDICINE** | | |
| Chiropractic Care - 30 Visits per Policy Year | $40 copay per visit | $65 copay per visit |
| Naturopathic Care | $65 copay per visit | $65 copay per visit |
| **SHORT TERM REHAB & HABILITATIVE SERVICES** | | |
| 90 Days per Policy Year/combined with Skilled Nursing | No Charge after Deductible | No Charge after Deductible |
| 60 Outpatient Visits per Policy Year | $30 copay per visit | $30 copay per visit |
| **DURABLE MEDICAL EQUIPMENT** | | |
| Unlimited<br>*Precertification required for items over $500* | No Charge after Deductible | No Charge after Deductible |
| **HEARING AIDS** | | |
| Hearing Aids | No Charge after Deductible | No Charge after Deductible |
| **MEDICAL SUPPLIES** | | |
| Medical Supplies when Medically Necessary | Supplies obtained from your Physician are subject to the applicable cost share.<br><br>Supplies obtained through the pharmacy are based on Tier. | Supplies obtained from your Physician are subject to the applicable cost share.<br><br>Supplies obtained through the pharmacy are based on Tier. |
| **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 | $65 copay per visit | $65 copay per visit |
| Outpatient Facility Service - Hospital Setting | No Charge after Deductible | No Charge after Deductible |
| Outpatient Facility Service - Freestanding Facility | No Charge after Deductible | No Charge after Deductible |
| Inpatient Facility Service | No Charge after Deductible | No Charge after Deductible |
| **INFERTILITY MEDICATIONS** | | |
| Infertility Medications | Covered subject to the applicable Prescription Drug Out-of-Pocket expense. | Covered subject to the applicable Prescription Drug Out-of-Pocket expense. |



BENEFIT Designated Network In-Network

| | | |
|---|---|---|
| **OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE** | $250 Deductible (waived for Tier 1 Drugs) | |

**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 | $5 copay |
| Tier 2 | $50 copay | $50 copay |
| Tier 3 | 30% Coinsurance to max of $500 per script | 30% Coinsurance to max of $500 per script |

**OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER**

| | | |
|---|---|---|
| Tier 1 | $10 copay | $10 copay |
| Tier 2 | $100 copay | $100 copay |
| Tier 3 | 30% Coinsurance to max of $1,000 per script<br>50% Coinsurance to max of $1,500 per script | 30% Coinsurance to max of $1,000 per script<br>50% Coinsurance to max of $1,500 per script |

**DEPENDENT ELIGIBILITY:**

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26. Coverage ends upon the Group's policy anniversary date following the qualifying event.

*Visits to an Oxford Participating Specialist require an authorized referral from the member's Primary Care Physician.

**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.***