



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

<b>BENEFIT</b>		<b>Designated Network/In-Network</b>
<b>FINANCIAL</b>		
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.*

<b>BENEFIT</b>	<b>Designated Network</b>	<b>In-Network</b>
<b>PREVENTIVE CARE</b>		
Adult Preventive Care	No Charge	No Charge
Infant and Pediatric Preventive Care	No Charge	No Charge
<b>OUTPATIENT CARE</b>		
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 (See your Certificate of Coverage for additional Lab details)	Deductible & 50% Coinsurance	Deductible & 50% Coinsurance
Radiology Services	No Charge after Deductible	No Charge after Deductible
<b>MRIs, MRAs, CT SCANS, AND PET SCANS</b>		
Freestanding Radiology Facility**	No Charge after Deductible	No Charge after Deductible
Outpatient Hospital Services**	No Charge after Deductible	No Charge after Deductible
<b>HOSPITAL CARE</b>		
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
<b>EMERGENCY CARE</b>		
Ambulance Service when Medically Necessary	No Charge	No Charge
At Hospital Emergency Room (If member is admitted to the hospital, notification is required.)	Deductible then \$300 copay per visit	Deductible then \$300 copay per visit
Emergency Care in Urgi-Center	\$75 copay per visit	\$75 copay per visit
<b>MATERNITY CARE</b>		
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
<b>SKILLED NURSING FACILITY</b>		
90 Days per Policy Year/combined with Short-Term Rehabilitation - Inpatient	No Charge after Deductible	No Charge after Deductible
<b>HOSPICE CARE</b>		
Inpatient Care	No Charge after Deductible	No Charge after Deductible
Home Hospice Care Visits	No Charge	No Charge
<b>HOME HEALTH CARE</b>		
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
<b><u>SUBSTANCE USE DISORDER SERVICES</u></b>		
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
<b><u>MENTAL HEALTH CARE</u></b>		
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
<b><u>ALLERGY CARE</u></b>		
Testing and Treatment	\$65 copay per visit	\$65 copay per visit
<b><u>ALTERNATIVE MEDICINE</u></b>		
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
<b><u>SHORT TERM REHAB &amp; HABILITATIVE SERVICES</u></b>		
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
<b><u>DURABLE MEDICAL EQUIPMENT</u></b>		
Unlimited <i>Precertification required for items over \$500</i>	No Charge after Deductible	No Charge after Deductible
<b><u>HEARING AIDS</u></b>		
Hearing Aids	No Charge after Deductible	No Charge after Deductible
<b><u>MEDICAL SUPPLIES</u></b>		
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.	Supplies obtained from your Physician are subject to the applicable cost share.  Supplies obtained through the pharmacy are based on Tier.
<b><u>EXERCISE FACILITY</u></b>		
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
<b><u>INFERTILITY TREATMENT</u></b>		
<b>Basic, Comprehensive and Advanced Infertility Services. (Covers all services in compliance with the CT Infertility Mandate)</b>		
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
<b><u>INFERTILITY MEDICATIONS</u></b>		
Infertility Medications	Covered subject to the applicable Prescription Drug Out-of-Pocket expense.	Covered subject to the applicable Prescription Drug Out-of-Pocket expense.

**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	30% Coinsurance to max of \$1,000 per script
	50% Coinsurance to max of \$1,500 per script	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.*