OXFORD HEALTH INSURANCE, INC.
FREEDOM PLAN DIRECT
SUMMARY OF COVERAGE
Freedom Network
INNOWAVE MARKETING GROUP LLC
PPO Plan

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	$2,500	$5,000
	Family	$5,000	$10,000
Coinsurance:		None	20%
Maximum Out-of-Pocket:	Single	$5,000	$10,000
(Including Deductible)	Family	$10,000	$20,000
Financial Accumulation Period		Calendar Year	Calendar Year
Out-of-Network Reimbursement:		Not Applicable	140% 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
OUTPATIENT CARE		
Primary Care Physician Office Visits	$30 copay per visit	Deductible & 20% Coinsurance
Specialist Office Visits	$50 copay per visit	Deductible & 20% Coinsurance
Virtual Visits	No Charge	In-Network Benefit Only
Outpatient Surgery - Hospital Setting**	Deductible then $500 copay per visit	Deductible & 20% Coinsurance
Outpatient Surgery - Freestanding Facility**	Deductible then $250 copay per visit	Deductible & 20% Coinsurance
Designated Diagnostic Provider Laboratory Services**	$10 copay per service	Deductible & 20% Coinsurance
Non-Designated Diagnostic Provider Laboratory Services** *(See your Certificate of Coverage for additional Lab details)*	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance
Radiology Services**	$40 copay per service	Deductible & 20% Coinsurance
MRIs, MRAs, CT SCANS, & PET SCANS		
Freestanding Radiology Facility**	$75 copay per service up to $375 max	Deductible & 20% Coinsurance
Outpatient Hospital Services**	$75 copay per service up to $375 max	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.)*	$150 copay per visit, waived if admitted	$150 copay per visit, waived if admitted
Emergency Care in Urgi-Center	$75 copay per visit	Deductible & 20% Coinsurance
MATERNITY CARE		
Prenatal Care**	No Charge	Deductible & 20% Coinsurance
Postnatal Care**	$30 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 Care Visits**	No Charge	Subject to 20% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
HOME HEALTH CARE		
Home Care Visits - 100 Visits Per Calendar Year**	No Charge	Subject to 20% Coinsurance
Physician House Calls**	$50 copay per visit	Deductible & 20% Coinsurance
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation**	No Charge after Deductible	Deductible & 20% Coinsurance
Office Visits or Outpatient Rehabilitation	$50 copay per visit	Deductible & 20% Coinsurance
Intensive Behavioral Therapy**	No Charge after Deductible	Deductible & 20% Coinsurance
Outpatient Partial Hospitalization	No Charge after Deductible	Deductible & 20% Coinsurance
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment**		
MENTAL HEALTH CARE		
Inpatient Care**	No Charge after Deductible	Deductible & 20% Coinsurance
Office Visits or Outpatient Care	$50 copay per visit	Deductible & 20% Coinsurance
Intensive Behavioral Therapy**	No Charge after Deductible	Deductible & 20% Coinsurance
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment**	No Charge after Deductible	Deductible & 20% Coinsurance
ALLERGY CARE		
Testing and Treatment**	$50 copay per visit	Deductible & 20% Coinsurance
ALTERNATIVE MEDICINE		
Chiropractic Care - 30 Visits per Calendar Year**	$50 copay per visit	Deductible & 20% Coinsurance
Naturopathic Care	$50 copay per visit	Deductible & 20% Coinsurance
SHORT TERM REHAB OR HABILITATIVE SERVICES		
90 Days per Calendar Year/combined with Skilled Nursing**	No Charge after Deductible	Deductible & 20% Coinsurance
60 Outpatient Visits per Calendar Year**	$30 copay per visit	Deductible & 20% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Unlimited**	No Charge after Deductible	Deductible & 20% Coinsurance
Precertification required for items over $500		
HEARING AIDS		
Hearing Aids	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**	$50 copay per visit	Deductible & 20% Coinsurance
Outpatient Facility Service - Hospital Setting**	Deductible then $500 copay per visit	Deductible & 20% Coinsurance
Outpatient Facility Service - Freestanding Facility**	Deductible then $250 copay per visit	Deductible & 20% Coinsurance
Inpatient Facility Service**	No Charge after Deductible	Deductible & 20% Coinsurance
INFERTILITY MEDICATIONS		
Infertility Medications**	$50 copay per item	Deductible & 20% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT PRESCRIPTION DRUGS - RETAIL		
The Prescription Drug Benefit is based on a per Calendar Year limit for any applicable deductibles and/or maximum limits.		
Tier 1	$5 copay	Deductible & 20% Coinsurance
Tier 2	$50 copay	Deductible & 20% Coinsurance
Tier 3	30% Coinsurance to max of $500 per script	Deductible & 20% Coinsurance
Tier 4	50% Coinsurance to max of $750 per script	Deductible & 20% Coinsurance
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	$10 copay	Deductible & 20% Coinsurance
Tier 2	$100 copay	Deductible & 20% Coinsurance
Tier 3	30% Coinsurance to max of $1,000 per script	Deductible & 20% Coinsurance
Tier 4	50% Coinsurance to max of $1,500 per script	Deductible & 20% Coinsurance

Tier 3

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.

**Precertification required through Oxford for certain out-of-network services. 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.

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.