

OXFORD HEALTH PLANS (NY), INC.
Freedom Plan
SUMMARY OF BENEFITS
Long Island University

COVERED SERVICES	IN-NETWORK*	OUT-OF-NETWORK**
Primary and Preventive Care		
Physician Office and Home Visits	No Charge for Preventive Care Visits \$10 copay per visit for treatment of illness or injury. Two well-woman examinations per Calendar Year, Pap tests, and age appropriate mammograms are Covered at No Charge.	Preventive care is available only to Members age 19 and under and is subject to Deductible and 20% Coinsurance. Office or home visits for treatment of illness or injury are covered subject to deductible and 20% Coinsurance. Some procedures require Precertification. Please see your Certificate. Female Members may receive an annual Pap test and/or age appropriate mammogram subject to 20% Coinsurance and Deductible. Well-woman examinations are not Covered.
Inpatient Hospital Visits	No Charge	Covered subject to the Deductible and 20% Coinsurance.

*The In-Network benefits are provided through your HMO Certificate of Coverage & Member Handbook issued to you by Oxford Health Plans (NY) Inc. In order for a Covered Service to be Covered In-Network, the service must be obtained in accordance with terms and conditions of the HMO Certificate. All Covered Services must be provided or arranged by the Member's PCP or Network OB/GYN.

**The Out-of-Network benefits are provided through your Supplemental Certificate of Coverage & Member Handbook issued to you by Oxford Health Insurance Inc. Covered Services are reimbursed only in accordance with its terms and conditions.

IMPORTANT: PLEASE REVIEW MAXIMUMS AND LIMITATIONS (Pages 8 & 9)

COVERED SERVICES**IN-NETWORK****OUT-OF-NETWORK****Primary and Preventive Care (cont.)**

Diabetes Education and Self-Management	\$10 copay per visit	Covered subject to the Deductible and 20% Coinsurance.
Diabetic Supplies	The lesser of \$10 or 20% of the cost of the item.	Covered subject to the Deductible and 20% Coinsurance. Precertification is required for the purchase of an insulin pump.

Specialty Care

Physician Office and Home Visits	\$10 copay per visit	Covered subject to the Deductible and 20% Coinsurance. Some procedures require Precertification. Please see your Certificate.
Inpatient Hospital Visit	No Charge	Covered subject to the Deductible and 20% Coinsurance.
Obstetrical Services (Including prenatal and postnatal)	\$10 copay per initial visit	Covered subject to the Deductible and 20% Coinsurance. Precertification is required.
Elective termination of Pregnancy	No Charge, We pay a maximum benefit of \$350 per procedure.	Covered subject to the Deductible and 20% Coinsurance. We pay a maximum benefit of \$350 per procedure.
Chiropractic Care	\$10 copay per visit	Covered subject to the Deductible and 20% Coinsurance.

COVERED SERVICES**IN-NETWORK****OUT-OF-NETWORK****Specialty Care (cont.)**

Treatment of Infertility

Specialist Office Visits

\$10 copay per visit

IN-NETWORK BENEFIT ONLY

Outpatient Facility Services

No Charge

IN-NETWORK BENEFIT ONLY

Allergy Testing and Treatment

\$10 copay per visit

Covered subject to the Deductible and 20%
Coinsurance.Rehabilitation Services (Physical,
Speech, and Occupational Therapy)

Outpatient

\$10 copay per visit

Covered subject to the Deductible and 20%
Coinsurance.

Inpatient

No Charge

Covered subject to the Deductible and 20%
Coinsurance. **Precertification is required.**

Oral Surgery

No Charge

Covered subject to the Deductible and 20%
Coinsurance. **Precertification is required.**Pediatric Preventive Dental
(Through age 11)

No Charge

The services of Non-Network dentists are
Covered under the terms of the HMO Certificate.

Laboratory Procedures and X-ray

No Charge

Covered subject to the Deductible and 20%
Coinsurance. **Precertification is required for
PET scans and surgical endoscopic procedures.**

Diagnostic Mammography

No Charge

Covered subject to the Deductible and 20%
Coinsurance.

COVERED SERVICES**IN-NETWORK****OUT-OF-NETWORK****Specialty Care (cont.)**

Prosthetic Devices

No Charge for an internal prosthetic device

No Charge for an internal prosthetic device

External devices have no Copayment.

Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**

Transplants

Transplants performed at Our approved facilities are Covered at No Charge
Transplants performed at other Network Providers are not Covered.Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**

Home Health Services

\$10 copay per visit

Covered subject to 20% Coinsurance
Not subject to Deductible.
Precertification is required.

Second Opinions

At your request, \$10 copay per visit
At our request, No Charge

Covered subject to the Deductible and 20% Coinsurance.

Durable Medical Equipment
(when Medically necessary)

No Charge

Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**Medical Supplies
(when Medically necessary)

OUT-OF-NETWORK BENEFIT ONLY

Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**

COVERED SERVICES**IN-NETWORK****OUT-OF-NETWORK****Hospital and Other Facility Based Services**

Inpatient Hospital Services

No Charge

Covered subject to the Deductible and 20% Coinsurance per continuous confinement.
Precertification is required.

Outpatient Hospital Services and
 Ambulatory Surgical Center Services

No Charge

Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**

Skilled Nursing Facility Services

No Charge

Covered subject to the Deductible and 20% Coinsurance per continuous confinement.
Precertification is required.

Hospice Services

Inpatient

No Charge

Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**

Outpatient

No Charge

Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**

Home Health Care

\$10 copay per visit

Covered subject to a 20% Coinsurance.
 Not subject to the Deductible.
Precertification is required.

Skilled Nursing Facility Services

No Charge

Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**

Alcohol and Substance Abuse Services

Outpatient Alcohol and Substance
 Abuse Rehabilitation

No Charge

Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**

COVERED SERVICES**IN-NETWORK****OUT-OF-NETWORK****Medical Emergency Services**

Emergency Room Services

\$35 per visit (Waived if a Member becomes confined in a Hospital).
When proper notice is given, Non-Network Providers will be Covered

When proper notice is **not** given, Medical Emergencies are Covered as described in the Supplemental Certificate subject to 50% Coinsurance and Deductible.

Urgent Care Facility Services

When proper notice is given, the services of Network and Non-Network Providers are Covered at \$10 per visit (Waived if a Member becomes confined in a Hospital).

Covered subject to the Deductible and 20% Coinsurance.

Ambulance Services

No Charge

All Covered Ambulance Services will be Covered as an In-Network benefit.

Supplemental Coverage

Mental Health Services

Inpatient

Outpatient

No Charge

50% copayment per visit

COVERED IN-NETWORK ONLY

Covered subject to the Deductible and 50% Coinsurance. **Precertification is required**

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
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Supplemental Coverage (cont.)

Alcohol and Substance Abuse Rehabilitation

Detoxification	No Charge	COVERED IN-NETWORK ONLY
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Inpatient Services	No Charge	COVERED IN-NETWORK ONLY
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Prescription Drugs

Per Generic Prescription	\$2 Copay	Not Covered
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Per Brand Name Prescription	\$5 Copay	Not Covered
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(Includes Oral Contraceptives)

Important:

Coverage under the Supplemental Certificate does not duplicate coverage under the HMO Certificate. Benefits are not cumulative. Benefits received under the Supplemental Certificate reduce the amount of benefits available under the HMO Certificate and benefits received under the HMO Certificate reduce the amount of benefits available under the Supplemental Certificate.

MAXIMUMS AND LIMITATIONS

Unless otherwise indicated, the following maximums and limitations apply to both the In-Network and Out-of-Network benefits combined.

All reimbursements for Out-of-Network benefits are subject to UCR.

Out-of-Network Benefits	Out-of-Network benefits are unlimited during the entire time the Member is Covered.
Diabetic Supplies	Diabetic Supplies will only be supplied in amounts consistent with the Member's treatment plan as developed by the Member's Physician. Only basic models of blood glucose monitors are Covered unless the Member has special needs relating to poor vision or blindness.
Elective termination of Pregnancy	We Cover one procedure per Member, per Contract Year. We pay a maximum benefit of \$350 per procedure.
Treatment of Infertility	We Cover only one cycle of Advanced Infertility Treatment. This includes one egg harvesting and one transfer during a two-year period. The maximum benefit is \$10,000 per Member, per lifetime. This benefit is available only In-Network.
Rehabilitative Therapy Services (physical, speech, and occupational therapy)	Inpatient Rehabilitative therapy is Covered for one consecutive 60-day period per condition per lifetime. Outpatient Rehabilitative therapy is Covered for 90 visits per condition per lifetime.
Transplants	In-Network Coverage is available only at facilities specially approved and designated by Oxford Health Plans (NY), Inc. to perform these procedures.
Home Health Services	60 visits per Contract Year
Exercise Facility Reimbursement	We will reimburse a Subscriber \$100 per six-month period. We will reimburse the Subscriber's spouse \$50 per six-month period. The Member must complete 50 visits within the six-month period.

MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility Services	30 days per Calendar Year
Hospice Services	210 days per lifetime
Bereavement Counseling for the Member's family	5 sessions either before or after the death of the Member.
Outpatient Alcoholism and Substance Abuse Rehabilitation	60 visits per Calendar Year. Up to 20 of these visits may be used by the Member's family.
Supplemental Rider Information	
Mental Health Services	
Inpatient	30 days per Calendar Year
Outpatient	30 outpatient visits per Calendar Year.
Alcoholism and Substance Abuse Rehabilitation	
Detoxification	7 days per Calendar Year
Inpatient Services	30 days per Calendar Year
Chiropractic Services	In Network: Subject to Medical Necessity, unlimited. Out-of-Network: Subject to Medical Necessity, unlimited.

FAILURE TO PRECERTIFY

If you fail to obtain Precertification for an Out-of-Network benefit, you will be subject to a reduction in benefits. You must pay 50% of the costs for such service or supply.

DEDUCTIBLE

The applicable Deductibles for this Plan are:

Individual:	\$250
Family:	\$625

OUT-OF-POCKET LIMITS

The maximum amount you must pay in any Calendar Year for Out-of-Network covered Services is:

\$1250 for an individual and
\$3125 for a family.

Remember, only Coinsurance and the amounts paid to meet your Deductible count toward the Out-of-Pocket Maximum. Copayments for In-Network benefits, amounts in excess of the UCR, amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the out-of-pocket Maximum. Coinsurance paid for any Covered Service obtained under a Supplemental Rider (excluding State mandated offers), will not be applied toward the out-of-pocket Maximum.

COPAYMENT LIMITS

Total Copayments paid by or on behalf of a Member during a Calendar Year shall not exceed 200% of the total annual Premium Rate for individual or family coverage, whichever is applicable for services provided under the HMO Certificate in any Calendar Year, Provided application is made to the HMO by a Member within 45 days of the end of the Calendar Year to which such limitation applies. Any excess in the amount of payments will be refunded to the Member. Copayments paid for any Covered Service obtained under a Supplemental Rider (excluding State mandated offers), will not be applied toward the Copayment Limits.

ELIGIBILITY

The limiting ages for dependents (as defined in the HMO Certificate) are: under the age of and between the ages of 19 and 23 for a full-time student.

Benefits discontinue at the end of the Calendar Year.

IMPORTANT: This document is not a contract. It is only a summary of your coverage under the Freedom Plan. Please read your HMO and your Supplemental Certificates for a full description of your Covered Services, exclusions and other terms and conditions of coverage.