You asked. We answered.

35 things you didn’t know about your health plan.
Make the Most of Your Healthcare Coverage

At Oxford Health Plans, we believe that helping you understand your healthcare coverage is our responsibility. We know that sometimes, healthcare can be confusing. We want to simplify it for you. We also know that every dollar you spend on care is important. This brochure of frequently asked questions was developed to help you understand your benefits so that you can make the most of them.

The following questions and answers will provide you with information about your coverage through Oxford. As you review this information, keep in mind that there are many reasons to value your Oxford membership...

- A comprehensive network of physicians and hospitals
- Annual physical with an in-network provider at no charge*
- No charge for routine preventive in-network pediatric care*
- Access to your choice of OB/GYN without referral
- Annual well-woman exam with an in-network provider at no charge*
- Around-the-clock access to information through www.oxfordhealth.com**, and healthcare guidance via Oxford On-Call*
- A credentialed network of 2,400 complementary and alternative medicine providers in Connecticut, New York, and New Jersey, including acupuncturists, chiropractors, nutritionists, massage therapists, etc.

The above items are just a few of the things we offer to assist you on your road to good health. To find out more about Oxford, speak with your benefits administrator (or designated Human Resources contact), log on to www.oxfordhealth.com, or call the number listed on your Oxford ID card.

For a hearing impaired interpreter, you may contact Oxford's TTY/ TDD line at 1-800-201-4875. Please call 1-800-303-6719 for assistance in Chinese, 1-888-201-4746 for assistance in Korean, 1-800-449-4390 para ayuda en Español, or the number on your Member ID card for assistance in other languages.

Please note: This information is only applicable to Oxford's Connecticut, New York and New Jersey commercial group Members with in-network benefits (i.e. HMO benefits). It is not applicable to Members of Oxford's Individual and Self-funded plans.

** Some plans may require copayments, deductibles and/or coinsurance for these benefits. Please review your Certificate of Coverage and Summary of Benefits for more information.

** Excludes periodic downtimes for system maintenance.
1. What are your hours of operation?

Our company business hours are Monday through Friday, 8 AM to 5 PM.

Our Customer Service hours are Monday through Friday, 8 AM to 6 PM. Customer Service can be reached at 1-800-444-6222. For a hearing impaired interpreter, you may contact Oxford’s TTY/ TDD line at 1-800-201-4875. Please call 1-800-303-6719 for assistance in Chinese, 1-888-201-4746 for assistance in Korean, 1-800-449-4390 for ayuda en Español, or the number on your Member ID card for assistance in other languages.

Our website, www.oxfordhealth.com*, and our automated telephone system, Oxford Express® at 1-800-444-6222, are available 24 hours a day, seven days a week, for your convenience.

*Excludes periodic downtimes for system maintenance.

2. What should I do in case of an emergency?

Emergency room treatment is covered both in and out of the service area. If you have a life threatening medical emergency, call 911 or seek immediate care at the nearest emergency room. Oxford only covers medical emergencies (as defined in your Certificate of Coverage) in an emergency room setting. If you have a non-life threatening condition, you may want to contact your primary care physician (PCP) first to determine the most appropriate place to receive care. If your PCP is not available, you may call Oxford On-Call®, our 24-hour healthcare guidance line at 1-800-201-4911.

Note: You are not required to notify Oxford of an emergency room visit that has already occurred, as long as you are treated and released without an admission. However, you are still responsible for the emergency room copayment, as applicable to your plan.

3. What coverage do I have while I am traveling?

If you are traveling and require emergency treatment, your emergency room treatment is covered both in and out of the service area and is payable upon claim submission. However, you are still responsible for the emergency room copayment, as applicable to your plan. If your emergency room visit results in an admission to a facility, Oxford must be notified within 48 hours of the admission or as soon as possible.

For medical emergencies that are not life threatening, please contact your primary care physician or call Oxford On-Call®, our 24-hour healthcare guidance line, at 1-800-201-4911.

Treatment at an urgent care facility outside of Oxford’s network requires precertification with Oxford in order to be covered.

Routine medical care for covered services received from out-of-network providers is not covered.

4. What happens to my coverage if I quit my job or I’m laid off or fired?

If you and your covered dependents become ineligible due to termination of your employment for any reason (except for gross misconduct on your part), coverage may be continued under COBRA or state continuation. Please see your Certificate of Coverage for details or speak with your benefits administrator. It is the obligation of your employer to notify terminated employees of their COBRA/ state continuation rights.

5. What happens to my coverage if I turn 65 or retire?

When you turn 65, you may become eligible for Medicare coverage. If you remain actively at work after you turn 65, your coverage can be coordinated between your Oxford commercial coverage provided through your employer and your Medicare coverage. When you retire, depending on your age, you may be eligible for coverage under COBRA, state continuation, or Medicare. Oxford also has a variety of Medicare + Choice health plan offerings that you can explore by calling 1-800-303-6720, or by visiting www.oxfordhealth.com.
6. What if my spouse and I divorce?

If you and your spouse divorce, and you are the subscriber, the spouse cannot remain on your active policy. Generally, an ex-spouse may only remain on a subscriber’s active policy if your employer has purchased special (non-standard) coverage for ex-spouse coverage.

7. When should I expect to receive an Oxford ID card?

You will receive an Oxford ID card when you initially enroll with Oxford. If you or your employer make changes to your benefits plan, you may receive a replacement ID card. You will not automatically receive a new ID card when you renew with Oxford, unless a benefit change is made.

If you misplace your ID card, you can request a new ID card at any time by logging on to our web site at www.oxfordhealth.com.

Provider Network

8. What is the difference between in-network and out-of-network care?

In-network care refers to covered services received from providers and facilities that participate in the network associated with your Oxford plan. Receiving care in-network gives you several advantages: Routine preventive care is normally covered at 100 percent and all other office visits for covered services require only a copayment. In addition, you are not required to fill out Claim Forms or to pay deductibles or coinsurance.

Your participating Oxford provider is responsible for ensuring that all Oxford precertification and other Oxford policy requirements are met. Participating providers may not charge you for the difference between reimbursement rates or copayments and the actual cost of services. This practice is referred to as balance billing.

To find out which physicians and facilities are affiliated with your Oxford plan, please refer to your Roster of Participating Physicians and Providers, or utilize the Doctor Search tool on Oxford’s web site, www.oxfordhealth.com.

Members of our HMO plans do not have out-of-network benefits and, therefore, are only eligible for coverage received from participating providers. Services received from non-participating (out-of-network) providers will not be covered, with the exception of emergency care and, when precertified, urgent care.

9. What is a primary care physician and do I need to select one?

A primary care physician acts as the Member’s main point of contact for medical care and coordinates any other care the Member needs, such as a visit to a specialist or hospitalization. Primary care physicians tend to be internists, family practitioners, OB/GYNs, and pediatricians. Some open access (non-gatekeeper) plans do not require the selection of a primary care physician. Please refer to your Certificate of Coverage or speak to your benefits administrator to find out if you are required to select a PCP.

10. How do I select a network provider or get a provider directory?

You can use our online Doctor Search tool at www.oxfordhealth.com to find information on participating network doctors, specialists, hospitals, facilities, and more. You can also order a Roster of Participating Physicians and Providers online, or through Oxford Express®, our automated telephone system, at 1-800-444-6222.

11. How do I change my primary care physician and how often can I change my PCP?

You can change your primary care physician and OB/GYN (if applicable) online, at www.oxfordhealth.com, or you can call Oxford Customer Service at the number on your Oxford ID card. You can change your PCP with Oxford as often as you’d like, up to once a day. Please note that some Members of open access plans are not required to formally select a PCP.
12. My doctor belongs to a group of physicians. Can I assume that all of his/her partners are in Oxford’s network?

Not necessarily. It is always a good idea to check our web site’s Doctor Search tool or Oxford’s Roster of Participating Physicians and Providers to make sure that a doctor is in Oxford’s network.

13. What happens if my current physician is not a network provider?

If your physician is not a network provider, you can either change physicians or suggest that your provider call Oxford to become a participating provider.

If you continue to receive care from a non-participating provider, your claims for services from these providers will be denied, as you do not have out-of-network benefits.

14. What is the procedure for filing a complaint against a provider?

If you would like to file a complaint against a participating provider, please call Customer Service or submit your complaint in writing to:

Oxford Health Plans
Attention: Quality Management Department
Westchester One, 14th Floor
44 South Broadway
White Plains, NY 10601

Enrollment & Eligibility

15. How can I make sure my newborn is covered from birth?

To cover your newborn from birth, it is important that you notify Oxford within 48 hours of delivery. You can notify us of your baby’s birth online at www.oxfordhealth.com. Depending on your state of residence and plan type, you may have to submit an Addition/ Termination/ Change Form within 31 days of the birth and pay any applicable insurance premium. Please see your benefits administrator for details.

16. How do I add or delete family members from coverage?

To add newly eligible dependents or remove dependents from your plan, you must speak to your benefits administrator. Either you or your benefits administrator will be responsible for submitting an Addition/ Termination/ Change Form to Oxford.

17. How often can I change my benefits plan?

Depending on your employer, you may or may not be able to change your benefits plan during an annual open enrollment period. Many employers hold open enrollment periods. Your employer determines the range of benefit plans available to you. Please speak to your benefits administrator about when and how often you can change your benefits, or if you have questions about the benefits available to you.

18. How long can my child remain covered under my plan and is my child covered while in school outside of the Oxford service area?

In most cases, your child will remain covered until he or she is 21 years of age. However, the length of a child’s coverage varies based on your employer’s age limit for covering dependent children. Please see your Summary of Benefits and Certificate of Coverage for the dependent-age cut-off for your Oxford plan.

Your child’s coverage while in school outside of Oxford’s service area depends on his/her age and whether or not the child is a full-time student. Please refer to your Certificate of Coverage. If your child is a full-time student, and has not yet reached the age cut-off, your child will be eligible for in-network coverage while in the service area if you supply the proper student verification materials to Oxford.

When outside the service area, your child will be eligible for urgent care coverage, if precertified by Oxford, and emergency coverage on an in-network basis. All other services will not be eligible for coverage.
19. How do I know if I am covered for services like mental health, dental and vision?

Mental health, vision and dental benefits may or may not be components of your benefits plan. If your employer has purchased benefits or a rider for those services, you are covered for medically necessary treatment. Please check with your Summary of Benefits or see your benefits administrator.

20. What types of services are not covered?

There are certain services, treatments and procedures that are not covered by your plan. Coverage varies based upon the plan you or your employer has selected. However in most cases, the following services are typically not covered by Oxford: services which are not medically necessary; cosmetic or personal care; education and learning associated with learning disabilities; experimental or investigational treatments and procedures; and certain vision, hearing, speech and dental care. Please refer to the Exclusions and Limitations section of your Summary of Benefits and Certificate of Coverage for information about your coverage exclusions.

21. What services require precertification or a referral?

If you are a Member of a gatekeeper plan, you are required to obtain a referral from your Oxford primary care physician, OB/GYN or pediatrician in order to be eligible for in-network coverage of office visits to a participating specialist. Your physician must submit all referrals electronically to Oxford before services are provided. To find out if your provider has submitted a referral to Oxford or to check the status of your referral, log on to www.oxfordhealth.com or call Oxford Customer Service.

Most outpatient (ambulatory surgery) and all inpatient services require precertification with Oxford, or with one of Oxford’s delegated agencies. Referrals cannot be used in lieu of precertification. When accessing care from participating providers, it is your Oxford participating provider’s responsibility to precertify services with Oxford. If you are accessing care from a non-participating provider, it is your responsibility to ensure services are precertified with Oxford.

In order to determine which services require referrals or precertification, please refer to your Certificate of Coverage or Individual Contract, or call Customer Service or contact your primary care physician.

Note: Members of open access (non-gatekeeper plans) do not need referrals to see in-network specialists, however, precertification requirements still apply. Members of non-gatekeeper plans have “No Referral Required” printed on their Oxford ID cards.

22. What happens if I don’t get a referral or precertification before receiving services?

It is your participating Oxford provider’s responsibility to submit referrals to Oxford. If you do not have a referral prior to receiving care from an Oxford participating provider, your services may be denied.

It is also your provider’s responsibility to obtain precertification. In order to receive precertification for services, your Oxford participating provider must contact Oxford. If precertification is not obtained prior to services being rendered, your claim may be denied. In most cases, your participating provider cannot bill you for covered services he or she failed to precertify.

If precertification is requested but denied by Oxford as not medically necessary, and you still choose to receive the non-covered services, your claim will be denied and in most instances, you will be financially liable.

Note: Members of open access (non-gatekeeper) plans do not need referrals to see in-network specialists, however, precertification requirements still apply.
23. What if I disagree with a decision that Oxford has made regarding a precertification decision, coverage decision, or claim payment?

You have the right to appeal any adverse determination made by Oxford, including precertification/authorization decisions or claim payment decisions.

If you or your provider requested precertification of services from Oxford, and Oxford did not approve those services, you or your Oxford provider can call Oxford Customer Service or send a letter requesting an appeal to:

Oxford Health Plans
Clinical Appeals
P.O. Box 7078
Bridgeport, CT 06601

If you would like to dispute the amount a claim was reimbursed by Oxford, please call Oxford Customer Service or send a letter requesting an appeal to:

Oxford Health Plans
P.O. Box 7073
Bridgeport, CT 06601

A full description of your grievance or appeal rights will be (a) attached to Oxford’s letter informing you of the denial of your request for precertification, or (b) attached to your Explanation of Benefits (EOB) if your claim was denied or not paid in full.

24. What if waiting for Oxford to decide on my grievance or appeal would be harmful to my health?

Occasionally, medical circumstances require that certain procedures be performed without significant delay. For non-medical necessity reviews, when the time frames of the normal Grievance and Appeals process would significantly increase the risk to your health, Oxford’s Grievance Review Board will, upon your request for an Expedited Review, respond verbally on an expedited basis and will thereafter send written verification of the board’s decision. If the board determines that there are no grounds for an Expedited Review, you will be notified immediately and the request will be handled in the normal time frames.

For medical necessity reviews, if you are in an ongoing course of treatment and are seeking continued or extended services, or your provider believes that an immediate appeal is necessary because the time frames of the appeal process would significantly increase the risk to your health, you, your designee or your provider may request an Expedited Utilization Review Appeal. The appeal may be made in writing or by telephone by calling the Customer Service number on your Oxford ID card. Your appeal will then be reviewed on an expedited basis in accordance with the procedures set forth in your Certificate of Coverage. Retrospective final adverse determinations cannot be appealed on an expedited basis for Members of New Jersey or New York plans.

25. What is Coordination of Benefits?

Coordination of benefits (COB) is a process by which insurance and managed care companies coordinate coverage and payment of medical services for Members covered under more than one health plan.

Oxford sends a Coordination of Benefits Form when new Members enroll or when Oxford receives a claim that indicates another carrier is primary. You can download a COB Form from oxfordhealth.com or complete the form you received and mail it to:

Oxford Health Plans
P.O. Box 7071
Bridgeport, CT 06601-9630
26. How do I file a claim and how long do I have to file it?

You should not have to submit claims for services provided by Oxford participating providers. They should submit the claim directly to Oxford, after collecting the appropriate copayment from you.

If you receive care from an in-network provider and receive a bill for anything other than an office copayment, forward the bill directly to:

Oxford Health Plans  
P.O. Box 7082  
Bridgeport, CT 06601-7082

All requests for reimbursement must be made within 180 days of the date that covered services were rendered. Oxford will not be liable for a claim that is submitted more than 180 days after the date services were rendered. For Members of New York insurance products underwritten by Oxford Health Insurance, Inc., if it is not reasonably possible to submit claims within 180 days of the date of service, such claims must be submitted as soon as reasonably possible thereafter.

27. How can I check the status of my claims and benefits?

You can check the status of your claims and benefits online by logging on to www.oxfordhealth.com or calling Oxford Customer Service at the number on the back of your ID card.

28. A provider has billed me; how do I know how much of the bill to pay?

If an in-network provider bills you for anything more than the applicable copayment (or in-network deductible and coinsurance for some plans), please call Customer Service at the number on your Oxford ID card or forward the bill directly to:

Oxford Health Plans  
P.O. Box 7082  
Bridgeport, CT 06601-7082

If an out-of-network provider bills you for covered emergency care or precertified urgent care, you must complete legibly all applicable areas of a Claim Form and send it to the address given above. An itemized bill on the provider's letterhead, containing the required information, can be used in lieu of a Claim Form. All other out-of-network services are not covered.

29. What is the difference between deductibles, coinsurance, and copayments?

Deductible and coinsurance usually apply to out-of-network services, but may apply to in-network services for certain plans, such as Freedom Plan® DirectSM and Liberty Plan DirectSM. A deductible is the amount of eligible expenses a Member must pay each calendar year (or contract year, depending on your plan) before Oxford will make a payment for eligible benefits.

Coinsurance is a fixed percentage of the allowable charge for the cost of medical care that the Member pays after the deductible has been paid. For example, Oxford might pay 80 percent of the allowable charge, with the Member responsible for the remaining 20 percent; the 20 percent amount is then referred to as the coinsurance amount.

A copayment is the amount you are required to pay directly to a network provider at the time covered services are rendered; it is a fixed dollar amount such as $15, regardless of the cost of the service. Your copayment amount is listed on your Oxford ID card.
Pharmacy Section

Note: The following section, Pharmacy, only applies to Members who have pharmacy coverage through Oxford.

30. Who manages pharmacy benefits at Oxford?

Medco Health Solutions, Inc., manages prescription drug benefits (retail and mail-order) for most Oxford Members. Pharmacy Customer Service can be reached 24 hours a day, seven days a week at 1-800-905-0201 (except for Thanksgiving Day and Christmas Day).

31. What is the difference between generic and brand name drugs and how does that difference affect my benefits?

According to the Food and Drug Administration (FDA), a generic drug is a medication that has the same active ingredients, dosage, strength, and method of administration as its brand name counterpart but generally costs 30 to 50 percent less than the brand name drug. Generic medications must meet the same quality standards as brand name medications in order to be approved by the FDA.

A brand name drug is a drug that was originally developed by a pharmaceutical company and patented under a trademark name. The brand name is the advertised name of the prescription drug. Not all brand name drugs have generic equivalents. Your pharmacy copayments will differ based on whether a drug is generic or brand name. For all plans, you will pay the lowest out-of-pocket cost for generic drugs.

32. What is a drug formulary and what is a preferred drug list, and how do they affect me?

The drug formulary is a list of prescription medications that will be covered by the plan unless exceptions are noted in your Certificate of Coverage and/or Prescription Drug Rider. Oxford’s pharmacy benefit includes a managed open drug formulary of outpatient prescription medications. Typically all forms (tablet, capsule, liquid, and topical) and strengths of a drug product are included in our open drug formulary.

Your prescription drug benefit is either a two-tier or a three-tier plan. If you have a two-tier drug plan, you will have one copayment amount for brand name drugs, and a lower copayment amount for a generic drug.

Members who have a three-tier prescription drug benefit have a copayment tier for preferred brand drugs, which is more than the copayment for a generic drug, but less than the copayment for a non-preferred brand name drug. The Preferred Drug List applies to three-tier plans and includes those drugs that are generic or preferred brand. This list is provided to offer Members and their physicians a choice from a wide selection of preferred drugs and to help keep the cost of prescription drug benefits affordable.

You can log on to www.oxfordhealth.com and select “Oxford’s Drug List” to find more pharmacy information. Please check your Summary of Benefits and your prescription drug rider for details about your pharmacy coverage and copayments.
33. Why are some drugs preferred and others non-preferred?

Drugs are selected as preferred by Oxford’s Pharmacy & Therapeutics Committee based on Members’ medical needs and out-of-pocket costs. This committee is comprised of various clinicians including pharmacists and representatives from Oxford’s Quality Management team. The committee meets on a quarterly basis to review new therapies versus current therapies so that the formulary remains responsive to the needs of our Members and providers.

34. How do I get prescriptions filled through a mail-order pharmacy?

Only certain maintenance medications can be filled through mail-order. In order to get prescriptions filled through Oxford’s participating mail-order pharmacy, your employer must purchase pharmacy coverage that includes mail-order coverage. If you have mail-order pharmacy coverage, visit www.medcohealth.com for specific instructions on filling prescriptions by mail.

35. Why do some drugs require precertification?

Precertification is designed to encourage medically appropriate and cost-effective use of medications by providing coverage only when certain medical criteria are met. It is typically required for drugs that are more likely than others to be taken incorrectly, or drugs that may be prescribed for inappropriate reasons or used in amounts that exceed the FDA’s or manufacturer’s recommendations for dosage or length of treatment. Precertification does not guarantee coverage. Oxford’s precertification requirements are based upon current medical findings, manufacturer labeling information, FDA guidelines and cost and manufacturer rebate arrangements.
Oxford strives to play an active role in your health by offering you access to a quality physician network and a host of programs and services to help meet your needs.

**Active Partner® Preventive Programs**
Our Active Partner® Preventive programs are here to support you. Exam reminders are mailed to Members who have missed an important exam within the recommended time frame. They encourage you to receive preventive care, including:

- Adolescent well-care
- Childhood immunizations
- Diabetic retinal exams
- Flu shots
- Mammograms
- Pap smears

**Healthy Mother, Healthy Baby®**
Complements the care that expectant Members receive from their doctor by providing educational information on prenatal and newborn care. Expectant mothers who notify us of their pregnancy and delivery will receive these materials.

**Healthy Mind Healthy Body® magazine**
Serves as a source of the latest information on prevention, nutrition, and exercise, as well as important benefit and coverage information delivered to you three times per year.

**www.oxfordhealth.com**
Gives Members access to personalized healthcare benefits information, and health content through the oxfordhealth Center, when it’s convenient for them*. To ensure access, Members will need to register for a user name and password.

**Active Partner® Education & Outreach**
If you or your covered family Member has a chronic health condition, we want to help. In most cases, Members are invited to enroll in these programs shortly after they are identified, at no charge. Members can also enter our Active Partner Education and Outreach Programs by self-referring or being referred by their provider.

**Better Breathing®**
Provides information to help educate Members about asthma triggers and how to avoid them, as well as the proper way to administer their medication. For information, call 1-800-665-4686.

**Living with Diabetes™**
Offers educational materials and support to help Members understand and improve control of their diabetes. For information, call 1-800-665-4686.

**Heart Smart™**
Offers educational materials and support for Members with cardiovascular disease and congestive heart failure. Educational efforts focus on improving risk factors and lifestyle modification. For information, call 1-800-665-4686.

**Rare Chronic Care**
Provides support for rare diseases such as multiple sclerosis, myasthenia gravis, hemophilia, lupus, and cystic fibrosis. For information, call 1-800-665-4686.

**Renal Disease**
Offers support for Members who experience renal failure. For information, call 1-888-201-4256.

**Oxford On-Call®**
Offers healthcare guidance from registered nurses 24 hours a day, seven days a week. For assistance, call 1-800-201-4911.

**Healthy Bonus™**
Offers Members discounts on the products and services you want most. In most cases, Members can simply present their Oxford ID card to receive exclusive discounts.

If you would like to find out more about any of the programs and services described in this brochure, log on to www.oxfordhealth.com.

Wishing you the best of health.

*Excludes periodic downtimes for system maintenance.