You asked. We answered.

45 ways to make the most of your health plan
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This brochure is for informational purposes only. Please refer to your Certificate of Coverage, Member Handbook and Summary of Benefits for specific details about the benefits covered under your Oxford 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 network of over 60,000 providers\(^1\)
- No charge for annual in-network physical and well woman exams with an in-network provider\(^2\)
- No charge for routine preventive in-network pediatric care, including childhood immunizations\(^3\)
- Access to your choice of OB/GYN without a referral
- Our web site, www.oxfordhealth.com, lets you conduct business with Oxford and learn about health topics at your convenience\(^4\)
- Healthcare guidance 24 hours a day, seven days a week from a registered nurse through Oxford On-Call\(^5\)
- A credentialed network of 3,500 complementary and alternative medicine practitioners in Connecticut, New York and New Jersey, including acupuncturists, chiropractors, nutritionists, massage therapists, etc.\(^5\)

These 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 Customer Service number 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 call the number on your Member ID card for assistance in other languages.

Note: The information in this brochure is only applicable to Oxford’s Connecticut, New York and New Jersey large commercial group Members with out-of-network benefits (i.e., Freedom Plan\(^6\), Liberty Plan\(^7\) or Select plan benefits). It is not applicable to Members of Oxford’s Individual plans, self-funded plans, and New Jersey small group plans.

\(^1\) Based upon June 30, 2004 data. This data represents all participating Freedom Plan\(^8\) providers except ancillary providers. Dental and complementary and alternative medicine providers are included. Providers who are multiple-boarded are counted multiple times.

\(^2\) Women enrolled in a New York plan are covered for two well-woman OB/GYN exams every year. Some plans may require copayments for these benefits. Please review your Summary of Benefits for more information.

\(^3\) Some plans may require copayments, deductibles and/or coinsurance for these benefits. Please review your Summary of Benefits for more information on your financial responsibilities.

\(^4\) Excludes periodic downtime for system maintenance.

\(^5\) Based upon September 2003 provider data. Includes acupuncturists, chiropractors, massage therapists, naturopaths, nutritionists, and yoga instructors. Provider type and availability vary by state, company and plan design.
General Information

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 the number on your Oxford ID card or 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 para ayuda en español, or the number on your Member ID card for assistance in other languages.

   Our web site, [www.oxfordhealth.com](http://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 downtime for system maintenance.

2. What should I do in case of an emergency?
   Emergency room (ER) treatment is covered both in and out of the service area. If you have a medical emergency, call 911 or seek immediate care at the nearest emergency room.

   If you receive emergency services from a non-participating hospital, you may need to submit a claim form to us (unless the provider agrees to submit the claim on your behalf). We will reimburse the hospital and attending physician(s), minus your emergency room copayment. You will be responsible for paying your applicable ER copayment to the hospital.

   **Note:** You are not required to notify Oxford of an emergency room visit that has already occurred, as long as you were treated and released without an admission. However, if you were admitted to the hospital from the ER, your ER copayment is waived and you should notify Oxford’s Medical Management Department as soon as reasonably possible.

3. What should I do if I need urgent care services?
   There may be instances when you will need services to treat a condition that does not meet our definition of medical emergency (as defined in your Certificate of Coverage) but does require immediate attention to minimize severity and prevent complications. We refer to such services as “urgent care.” Urgent care may be received at a physician’s office or urgent care center.

   Urgent care is covered both in and out of the service area. Treatment at a participating urgent care center does not require precertification. However, treatment at an urgent care center or provider’s office outside of Oxford’s network does require precertification with Oxford in order to be covered.

   Please note that if you receive urgent care that is not precertified and/or routine care from a provider outside of Oxford’s network, those services will be covered subject to applicable out-of-network deductible, coinsurance and usual, customary and reasonable (UCR) charges limitations.

4. What coverage do I have while I am traveling?
   Coverage for care received when traveling outside the United States is generally limited to emergency and urgent care. As stated in Question 2, emergencies are covered no matter where you are. The procedure is the same as previously described, regardless of whether you are in or out of the service area.

   Urgent care is also covered anywhere in the world. However, in order to receive treatment from a non-participating provider on an in-network basis, you must precertify these services before you receive them (please see Question 3).

5. What if I am not sure if I need urgent care or emergency care?
   Since Oxford only covers medical emergencies (as defined in your Certificate of Coverage) in an emergency room, 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. Either your PCP or an Oxford On-Call Registered Nurse will assess your need for care. He or she will direct you to the appropriate place to seek treatment.

6. 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.
7. What happens to my coverage if I retire or turn 65?

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 visiting www.oxfordhealth.com.

When you turn 65, you may become eligible for Medicare coverage. If you are still working and your employer group has 20 or more employees, Oxford will be primary unless you elect Medicare as your primary coverage. Any Member who elects Medicare as their primary coverage will no longer be eligible for coverage under their employer’s Oxford policy as of the date of election.

8. What if my spouse and I divorce?

If you and your spouse divorce, your ex-spouse has the options of COBRA, state continuation or conversion. Please see your Certificate of Coverage for details on these options.

9. 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 that is reflected on your ID card (e.g., office copayment). If you misplace your ID card, you may request a new one at any time by logging on to our web site at www.oxfordhealth.com.

Provider Network

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

In-network care refers to covered services delivered by providers and facilities that participate in the Oxford network associated with your plan. Receiving care in-network gives you several advantages: your out-of-pocket expenses will be less than if a non-participating provider is utilized, you are not required to fill out claim forms or to pay out-of-network deductibles or coinsurance, and you will be assured that the provider is board certified or board eligible and has undergone an initial credentialing process, as well as a recredentialing process on a regular basis.

Your Oxford participating provider is responsible for ensuring that any applicable precertification and other Oxford policy requirements are met. Participating providers may not charge you for any amounts in excess of your required copayment as listed on your Summary of Benefits. The practice of billing for the difference between reimbursement rates or copayments, and the actual cost of services is referred to as balance billing.

To find out which physicians and facilities participate 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.

If you access care out-of-network, you will be subject to your plan’s out-of-network coinsurance and deductibles as listed on your Summary of Benefits. Since Oxford reimburses non-participating (out-of-network) providers at usual, customary and reasonable (UCR) rates, you would be responsible for the difference between the UCR rate and the charges billed by the non-participating provider, which usually means higher out-of-pocket costs for you. You may also have to fill out claim forms and submit them to Oxford for reimbursement.

If you receive care from a non-participating provider, it is your responsibility to ensure that any applicable precertification requirements are met with Oxford. You are held financially liable, subject to state-regulated penalties, when these requirements are not met.

To find out the terms of your in-network or out-of-network coverage, please refer to your Certificate of Coverage and Summary of Benefits, or call Customer Service at the number on your Member ID card.

11. What is a primary care physician?

A primary care physician is typically an internist, family practitioner or pediatrician. For Members of a gatekeeper plan (i.e., plans that require referrals), the PCP acts as your main point of contact for medical care and coordinates any other care you need, such as a visit to a specialist or hospitalization.

Please refer to your Certificate of Coverage and Member Handbook, or speak to your benefits administrator to find out if you are required to select a PCP.
12. 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 doctors, specialists, hospitals, facilities, and more. You can request a Roster of Participating Physicians and Providers online at www.oxfordhealth.com, or through Oxford Express®, our automated telephone system, at 1-800-444-6222.

13. How do I change my PCP, and how often can I change my PCP?
If you are required to select a PCP or want to change your PCP, you can do so 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 and/or OB/GYN (if applicable) with Oxford as often as you’d like, up to once a day.

14. If I need to see a specialist, will I need a referral?
To visit an Oxford participating specialist and be eligible for in-network coverage, you may need your PCP or OB/GYN to submit an electronic referral to a participating provider. Please note that paper referrals are no longer accepted and only electronic referrals will be processed. With an authorized referral, your visit will be considered in-network. Please refer to your Member Handbook and Certificate of Coverage to find out if your plan requires referrals for visits to participating specialists.

To visit an out-of-network specialist, you will need a referral, but may be required to pay a deductible and a portion of the specialist fee, as defined in your Summary of Benefits. You may also need to submit a claim form.

15. Do women need a referral to visit their OB/GYN?
A referral is never necessary for visits to a participating Oxford OB/GYN. Most plans permit one well-woman exam with a participating provider every six months at no charge. Check your Certificate of Coverage and Summary of Benefits, or speak with your benefits administrator to determine the details of your coverage.

Note: Even though OB/GYNs can issue referrals for all types of services, they can’t be listed as a Member’s PCP unless an exception has been granted.

16. What if I need care after my doctor’s office is closed?
For non-emergency situations when your doctor is unavailable, you may contact Oxford On-Call®, our healthcare guidance service. This service is staffed by Oxford’s Registered Nurses and is available by phone 24 hours a day, 365 days a year; the number is on your ID card. On-Call nurses can identify caller symptoms and recommend next steps, whether it is a visit to an urgent care center, an appointment with a physician or self-care options.

17. 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 through the Doctor Search tool, or Oxford’s Roster of Participating Physicians and Providers to make sure that a doctor is in the network associated with your plan.

18. What happens if my current physician is not a participating provider?
In order to receive in-network coverage, you must select a provider who participates in the network associated with your plan. If you continue to receive care from a non-participating provider, your claims will be paid subject to the out-of-network deductible, coinsurance and UCR charges.

19. Can I get an annual physical?
In order to help you achieve optimal health, Oxford covers routine annual physicals. Check your Summary of Benefits and Certificate of Coverage, or speak with your benefits administrator to determine the details of your coverage.

20. How does Oxford work with physicians to help coordinate care?
In order to help promote coordinated, medically effective, efficient care by participating physicians, Oxford’s Healthcare Services Department precertifies admissions and certain procedures, in addition to providing a review of services and coordinating with participating providers on discharge planning, case management and disease management services. Precertification requirements vary by plan design.
21. What if I need to have lab work done or x-rays taken?
Laboratory work and radiology services ordered by your physician are covered either in-network when rendered by Oxford’s participating providers or out-of-network when rendered by a provider who is not part of Oxford’s network. Please note that many outpatient radiology services require precertification, which is your responsibility when services are received out-of-network. Check your Summary of Benefits and Certificate of Coverage for more information.

22. What is the procedure for filing a complaint against an Oxford participating provider?
If you would like to file a complaint against a participating provider, please call Oxford Customer Service or submit your complaint in writing to:

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

23. What standard benefits are included in my Oxford coverage at no charge?
Because Oxford wants to help you along your road to health, we offer a wide range of preventive programs and services. These range from wellness programs to reminders for routine care. Most plans permit one routine physical with your PCP at no charge. Please check your Summary of Benefits for details on this benefit and other benefits that may be available at no charge.

24. 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 or by calling Customer Service at the number on your Member ID Card. 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 or contact Oxford for more details.

25. When can I enroll with Oxford?
Generally, you may only enroll during your company's annual open enrollment period. You can speak to your benefits administrator to determine when you may be eligible to enroll.

26. How do I add or delete family members from my coverage?
For most plans, newly eligible dependents must be added within 31 days of becoming eligible (by marriage, birth or adoption). To add newly eligible dependents or to 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 if required by your plan. Please refer to your Certificate of Coverage for details on eligibility.

27. How often can I change my benefits plan?
Depending on your employer group, you may or may not be able to change your benefits plan during an open enrollment period. Many employers hold annual 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.

28. How are children covered under my plan and how long can my child remain covered under my plan? — Is my child covered while in school outside of the Oxford service area?
If your children are enrolled, they are covered as dependents under your plan. Your dependents may receive the benefits that are covered under your plan including childhood immunizations, adolescent well care and routine pediatric care.

The length of a child’s coverage varies based on your employer group’s age limit for covering dependent children. Please see your Summary of Benefits and Certificate of Coverage for the dependent age cut-off that applies to your plan.

Your child’s coverage while in school depends on his/her age and whether or not the child is a full-time student. 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. Please refer to your Summary of Benefits and Certificate of Coverage for specific information.
When outside the service area, routine care will be subject to the out-of-network deductible, coinsurance and UCR limitations, except for precertified urgent care and emergency care, which will be covered in-network. Members of New York plans may be able to receive coverage for students who are on a medical leave of absence. Please see your Certificate of Coverage for specific information.

Covered Services & Related Processes

29. How do I know what services I have coverage for?

The Covered Services Section of your Certificate of Coverage describes the services that are covered under your plan. Additionally, your employer may choose to purchase supplemental coverage such as prescription, vision or dental benefits. The supplemental coverage (if any) that has been purchased as part of your plan will be included in the Supplemental Services Section of your Certificate of Coverage. To determine your financial responsibility for covered services, please refer to your Summary of Benefits.

30. 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. Please refer to the Exclusions and Limitations Section of your Certificate of Coverage for information about your coverage exclusions.

31. What services require a referral or precertification?

If you are a Member of a gatekeeper plan, you are required to obtain a referral from your Oxford PCP, OB/GYN or participating specialist (in certain instances) in order to be eligible for in-network coverage for services rendered by a participating specialist. Your physician must submit all referrals electronically to Oxford before services are provided. If you choose to see a participating specialist without a referral, your services will be treated as out-of-network, and thus subject to the applicable out-of-network deductible, coinsurance and UCR charges.

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

To find out if your provider has submitted a referral to Oxford or to check the status of a referral, log on to www.oxfordhealth.com or call Oxford Customer Service.

Most outpatient and all inpatient services require precertification with Oxford. 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.

Precertification requirements vary by plan design. In order to determine the referral or precertification requirements of your plan, please refer to your Certificate of Coverage or Summary of Benefits, call Customer Service or contact your primary care physician.

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

It is your Oxford participating provider’s responsibility to submit referrals to Oxford electronically. If you do not have a referral prior to receiving covered services from an Oxford participating specialist, your claims may be paid subject to the out-of-network deductible and coinsurance, and UCR limitations.

If services require precertification, your Oxford network provider must contact Oxford directly. If precertification is not obtained prior to services being rendered, the participating provider’s claims may be denied. Your provider cannot bill you for 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 you will be financially liable for the cost of the services. Please call Customer Service for more details.

If you receive care from a non-participating provider, it is your responsibility to precertify services with Oxford. If precertification is required but not obtained prior to the service being delivered, the service will be denied or paid subject to penalty, and you will be financially liable for any billed charges in excess of Oxford’s reimbursement. Please refer to your Summary of Benefits for the specific penalty that applies to using out-of-network services for your plan.
33. **What is medical necessity?**

Services or supplies required to treat or identify your illness or injury are considered medically necessary if they are:

- Consistent with the symptoms or diagnosis and treatment of your condition; and

- Appropriate with regard to standards of good medical practice; and

- Not solely for your convenience or the convenience of any provider; and

- The most appropriate supply or level of service that can safely be provided. For inpatient services, it further means that your condition cannot safely be diagnosed or treated on an outpatient basis.

Determinations of medical necessity are based upon established clinical criteria written by independent physician experts from national professional organizations regarding current best practices for care. This is known as “evidence-based medicine.” Oxford’s clinical staff includes registered nurses and medical doctors — trained professionals with clinical experience. Evidence-based standards are used to achieve cost savings and improve quality. Whether care is too little, too late or too much, too often, the result can be ineffective care. This contributes to industry-wide healthcare cost increases and higher out-of-pocket expenses for you and your family.

34. **What if I disagree with a decision that Oxford has made regarding a precertification, 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 coverage for those services, you or your Oxford provider can call Oxford Customer Service or send a letter requesting an appeal to:

**Oxford Health Plans**  
P.O. Box 7073  
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**  
Clinical Appeals  
P.O. Box 7078  
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, and (c) included in the Grievance and Appeals section of the Member handbook.

35. **What if waiting for you 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. In these instances, you may request an Expedited Review. Please refer to the Grievance and Appeal section of your Member Handbook for specific information on Expedited Appeals.

In addition, 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 standard time frames of the Utilization Appeal process would significantly increase the risk to your health, you, your designee or your provider may request an Expedited Utilization Appeal. Please refer to the Grievance and Appeal section of your Member Handbook for specific information on Expedited Utilization Appeals.

36. **What is coordination of benefits?**

Coordination of benefits (COB) is a process used by insurance and managed care companies to 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 [www.oxfordhealth.com](http://www.oxfordhealth.com) or complete the form you received and mail it to:

**Oxford Health Plans**  
COB Department  
P.O. Box 7071  
Bridgeport, CT 06601-9630
37. 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. The participating provider 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 the copayment identified on your Summary of Benefits, forward the bill to:

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

Many non-participating providers will bill Oxford directly, and then bill you for the difference after Oxford processes their portion of the claim. However, they are not required to do this.

If you receive a bill for out-of-network services, you must submit a claim form in order to receive payment, subject to applicable deductible, coinsurance and usual customary and reasonable (UCR) charge limitations. You must legibly complete all applicable areas of a claim form and send it to the address given above. The claim must include the patient’s name, the provider’s name, address and federal tax identification number (FTIN), the date of service, and a diagnosis and description of service or the procedural (CPT) code. If you would like payment to go directly to the provider, you must indicate this on the claim form. An itemized bill on the provider’s letterhead, containing the required information, can be used in lieu of a claim form.

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. Except as otherwise specified in your Certificate of Coverage, failure to request reimbursement within the required time does not bar reimbursement if it was not reasonably possible to submit within the time frame due to physical or mental incapacitation. However, the request must be made as soon as reasonably possible as determined by Oxford.

Certain plans may have specific time frames regarding the submission of claims. Please refer to your Certificate of Coverage for specific limitations/maximums.

38. 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 Customer Service at the number on your ID card.

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

A deductible is the amount of eligible expenses a Member must pay each calendar year (or contract year, depending on your plan) before the insurance company 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, an insurance company might pay 80 percent of the allowable charge, with the Member responsible for the remaining 20 percent; the 20 percent amount is referred to as the coinsurance amount. Deductibles and coinsurance usually apply to out-of-network services, though some plans have in-network deductibles and coinsurance as well.

A copayment is the fixed dollar amount (e.g., $15) you are required to pay directly to a participating provider at the time covered services are rendered, regardless of the cost of the service. Your copayment is listed on your Oxford ID card.

Please refer to your Summary of Benefits for the deductibles, coinsurance and copayments that apply to your plan.

Pharmacy

Note: This section only applies to Members who have pharmacy coverage through Oxford. Please check the Supplemental Coverage Section of your Certificate of Coverage to see if this benefit has been purchased for you.

40. 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).
41. What is the difference between generic and brand name drugs?

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 may differ based on whether a drug is generic or brand name.

For plans with more than one tier of out-of-pocket expenses, you will pay the lowest out-of-pocket cost for generic drugs.

42. 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 may be covered under your pharmacy benefit. 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 single tier*, 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 generic drugs.

Members who have a three-tier prescription drug benefit have an additional copayment tier for preferred brand drugs. The preferred brand drug copayment is generally more than the copayment for a generic drug, but less than the copayment for a non-preferred brand name drug. Please refer to your Summary of Benefits to determine the out-of-pocket costs associated with your pharmacy plan.

The Preferred Drug List applies only to three-tier plans and includes those drugs that are generic or that have been designated as preferred brand. This list is provided to offer Members and their physicians a choice from a wide selection of preferred drugs 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 the Supplemental Coverage Section of your Certificate of Coverage for details about your pharmacy coverage and copayments.

* If you have a single tier drug plan, you will have the same copayment regardless of whether the drug is generic or brand.

43. 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.

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

Only certain long-term 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. Please refer to your Summary of Benefits to determine if you have mail-order pharmacy coverage.

45. 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 FDA or manufacturers’ 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.

We hope you find this information helpful and look forward to your continued membership with Oxford.