Coverage and policy

At a glance

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Coverage/Policy Contact Information

Do you have benefits questions? (Please have your group number ready.)

- Please call your Account Manager or Client Services at 1-888-654-0065.
- E-mail: groupservices@oxfordhealth.com. In general, we will respond within 24 hours.

Do you need to direct an employee with benefit questions?

- Members can call our Customer Service Department at 1-800-444-6222, Monday through Friday, 8:00 AM to 6:00 PM

Do you need to confirm a referral?

- www.oxfordhealth.com
- Oxford Express® 1-800-444-6222, 24 hours a day/7 days a week

Other helpful reference information:

- Precertification for diagnostic procedures at CareCore National: 1-877-773-2884 (1-877-PREAUTH)
- Pharmacy Customer Service from Medco Health Solutions:
  - 1-800-905-0201
  - www.medcohealth.com
- Oxford On-Call®: 1-800-201-4911, 24 hours a day/7 days a week (available only to members in Connecticut, New Jersey, and New York)

There are many benefits to being a member — and many different plans to choose from. We created this overview of the common characteristics of our primary products, as well as the key procedures for accessing medical care.

Since the benefits for each plan vary somewhat, be sure you read your group’s Summary of Benefits and Certificate of Coverage carefully — they are your definitive source for information about your group’s coverage.
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**What is a Primary Care Physician (PCP)?**

The PCP is a participating physician who acts as the member’s personal physician, providing routine exams and other basic medical care. The PCP is responsible for:

- Knowing the member’s medical history
- Maintaining the member’s medical records
- Providing routine exams and basic medical care
- Referring members of gated plans requiring referrals to specialists. The PCP coordinates all aspects of care and access to in-network services in the following way:
  - After authorizing a referral, a PCP reports the diagnosis or problem definition to the consulting specialist.
  - After the initial contact, the specialist works closely with the PCP to facilitate continuity of care. The specialist is responsible for issuing a written report to the PCP, detailing the results of the consultation, as well as any ongoing treatment programs.

**What is the Difference Between In-network and Out-of-Network Coverage?**

- In-network services are those provided by participating providers or providers participating with one of our affiliated networks. In order to obtain services at the in-network level of cost share, a member must use a provider who participates with his/her network and obtain any applicable referrals. Urgent care may be covered on an in-network basis, whether it is rendered by a participating provider or not. A member should check his/her *Summary of Benefits and Certificate of Coverage* in order to determine the specific coverage available to him/her.

- If a member’s plan provides out-of-network coverage, a member can seek care from providers who do not participate in his/her network. Covered services obtained from non-participating providers will be subject to a higher level of cost share than those services obtained from participating providers. Not all services are covered on an out-of-network basis. A member should check his/her *Summary of Benefits and Certificate of Coverage* in order to determine the specific coverage available to him/her.

**How Our Referral Policy Works**

Please note this only applies to plans that require a referral.

**What is a Referral?**

A referral is an electronic communication submitted to us by a member’s PCP, Primary Provider of OB/GYN services or participating specialist (in certain circumstances) who directs a member to a participating specialist for covered services. When a member needs medical care that is outside the scope of his/her PCP’s or OB/GYN’s practice, a referral can be generated to a participating specialist, hospital, or other ancillary provider*. The referral allows a member to receive covered services from a participating specialist on an in-network basis.

* Please note: referrals are not a substitute for precertification and are not a guarantee of coverage.
Who Can Issue a Referral?

- Any participating PCP or OB/GYN can issue a referral to a participating specialist, hospital, or ancillary provider.
- Participating specialists can only issue referrals for certain types of covered services, as outlined in the grid below:

<table>
<thead>
<tr>
<th>If the provider is ……</th>
<th>Then they can submit referrals for:</th>
</tr>
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<tbody>
<tr>
<td>Any participating specialist</td>
<td>Any diagnostic procedure***</td>
</tr>
<tr>
<td>A participating general surgeon, gynecological oncologist, hematologist oncologist, pain management specialist, chiropractor, neurologist**, orthopedist**, psychiatrist**, neurosurgeon**, or rheumatologist**</td>
<td>Any diagnostic procedure, as well as therapeutic services***, such as physical and occupational therapy (for commercial products)</td>
</tr>
<tr>
<td>A participating nephrologist**, oncologist**, infectious disease (HIV) specialist**</td>
<td>All specialist care***</td>
</tr>
</tbody>
</table>

- Oxford On-Call® may issue an urgent, same day referral when a member calls and is experiencing urgent medical symptoms.
- Our Behavioral Health Department can issue a referral directly to the member if he/she is uncomfortable approaching his/her PCP for a referral to a behavioral health specialist.

How Referrals are Issued

For commercial members, all referrals must be submitted electronically to us by the member's PCP, primary provider of OB/GYN services or other participating specialist.

- The member should receive a Referral Reference Number from the referring provider to bring to the specialist.
  - If a provider gives a member a hard-copy referral, the member should ask the provider to submit the referral electronically instead.
  - If the member is concerned that the proper referral process has not occurred, the member should call Customer Service at the number on the back of his/her ID card.
  - If referrals are not generated according to our guidelines, members may be required to pay all or part of the associated charges, depending on their plan.

- The specialist and member can confirm that a referral is on file through:
  - www.oxfordhealth.com; or
  - Oxford Express®, our automated interactive voice response (IVR) phone system, 1-800-444-6222.

** Adult or pediatric

*** Precertification guidelines still apply for those covered services that require precertification. In addition, the referral must be to a participating provider within the member’s applicable network.
When is Precertification Required?

Precertification (an authorization given by us that must be received before the member can obtain covered services) is required for:

- All planned inpatient hospitalizations and professional services (not including emergency inpatient admissions)
- All outpatient procedures performed at:
  - Hospital outpatient departments
  - Ambulatory surgical facilities
  - Freestanding facilities
- Any other services listed in the Certificate of Coverage and Summary of Benefits.

Who is Responsible for Obtaining Precertification?

In-network covered services: A member’s participating provider must obtain the necessary precertification directly from us.

Out-of-network covered services (not applicable to in-network only plans): When a member seeks care out-of-network, he/she will be responsible for obtaining any necessary precertification. The member should refer to his/her plan’s documents for a list of services requiring precertification. The member is responsible for calling Customer Service to precertify the procedures recommended by the out-of-network provider. Members who do not receive precertification for services received out-of-network may be obligated to pay for all charges or may be subject to a reduction in coverage, depending on their plan. Note: Emergency services do not require precertification, but notification of admission as indicated in the Certificate of Coverage. If the ER visit results in hospital admission, the member must notify Customer Service within 48 hours of the admission or as soon as reasonably possible. Please refer to the Certificate of Coverage for details.

All members should refer to their Certificate of Coverage for details regarding:

- How far in advance a procedure should be precertified
- How to obtain precertification
- Possible penalties for failure to precertify, as mentioned above.

Precertification for Diagnostic Procedures

Our Certificate of Coverage outlines the requirements for precertification for certain diagnostic procedures, including certain radiological procedures, as a condition of coverage. It is important for members to check their Certificate of Coverage or call us to determine whether certain diagnostic procedures need to be precertified prior to receiving those services.
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Unless the Certificate of Coverage states otherwise, precertification will be required for:

- CT scans
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET) scans
- Nuclear medicine studies
- Some ultrasound procedures

Participating Provider Calling to Precertify Radiology Services:

- The member’s physician can initiate an authorization by contacting CareCore National by phone (1-877-PRE-AUTH), fax, e-mail or via the web at: www.carecorenational.com.
- An authorization will be issued to the provider at the time of approval.

Member or Non-participating Provider Calling to Precertify Radiology Services:

(for members with out-of-network benefits)

- The member can initiate an authorization by either calling CareCore National at 1-877-PRE-AUTH or using CareCore’s web-based pre-certification option at www.carecorenational.com.
- If the member does not precertify the procedure, then he/she will be subject to the precertification penalty listed in his/her Summary of Benefits.
- Please note: Certain states have statutory requirements that may limit the penalty for non-precertification of out-of-network procedures for groups that have out-of-network benefits. Members should refer to their Certificate of Coverage and Summary of Benefits for details.
- For all other procedures performed by an out-of-network provider with precertification, payment will be subject to the member’s applicable deductible, coinsurance and Usual, Customary, and Reasonable (UCR) limitations.

To learn more about deductibles, coinsurance, and UCR, please go to the Claims section.

When is Voluntary Prior Approval Available for Physical Therapy, Occupational Therapy, or Chiropractic Procedures?

Generally, we review out-of-network physical therapy, occupational therapy, and chiropractic services for medical necessity after services have been rendered and the claim has been submitted. This is called retrospective review. We now offer members and their providers the option of submitting a treatment plan for voluntary prior approval so they will know if some or all of a proposed treatment plan will be covered before services are obtained.
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Are In-network Physical Therapy, Occupational Therapy, and Chiropractic Services Covered?

In accordance with the member’s health plan coverage, we cover only medically necessary physical/occupational therapy and chiropractic services.

Physical/Occupational Therapy: Outpatient physical therapy and occupational therapy services that are received from in-network (participating) providers are covered based on the member’s plan (may require precertification through OrthoNet). Members should refer to their Certificate of Coverage and Summary of Benefits for more details.

Chiropractic Services: Participating chiropractors are required to pre-approve all chiropractic visits through OptumHealth for most commercial members. Please note that this requirement only applies to members whose plans require precertification. Members should refer to their Certificate of Coverage for more information regarding specific plan requirements.

Are Out-of-Network Physical Therapy, Occupational Therapy, and Chiropractic Services Covered?

In accordance with the member’s health plan coverage, we cover only medically necessary out-of-network physical/occupational therapy and chiropractic services for members whose plans provide out-of-network coverage.

In order to make a medical necessity determination, we may request written documentation of medical necessity from the out-of-network physical therapy, occupational therapy, or chiropractic provider. The member or the member’s out-of-network provider can submit this documentation. Federal laws require all providers to supply members with copies of their medical records. Both the OptumHealth Voluntary Prior Approval Process Agreement and the OrthoNet Voluntary Prior Approval Process Agreement are available on the Employer section of www.oxfordhealth.com.

How Emergencies and Urgent Care are Covered

What to do in case of an emergency:

- Members should go straight to the emergency room (ER) or call 911
- Members will be responsible for the applicable emergency room cost share or copayment
  - The cost share or copayment will be waived if the member is admitted to the hospital through the ER.
  - If the ER visit results in a hospital admission, the member must notify Customer Service within 48 hours of the admission, or as soon as reasonably possible.
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When Urgent Care is Required

Urgent care is medical care received for a condition that needs immediate attention to minimize severity and prevent complications, but is not an emergency. Members can obtain urgent care services from their PCP and/or an Urgent Care center.

- Precertification is required only if services are obtained from a non-participating urgent care facility; call Oxford On-Call at 1-800-201-4911 for precertification. Neither precertification nor referrals are required for services at participating urgent care facilities.

- If the urgent care results in a hospital admission:
  - The member (or an authorized representative) must call Customer Service at 1-800-444-6222 within 48 hours of the admission, or as soon as reasonably possible.
  - If the member fails to notify us of an urgent care admission, coverage may be reduced or denied.

- Please refer to the Certificate of Coverage for details on precertification of urgent care.

Pharmacy Coverage

If your group purchased outpatient prescription drug coverage from us you can find information regarding your coverage in your Summary of Benefits and Certificate of Coverage.

We contract with a pharmacy benefit manager, Medco Health Solutions, Inc. (Medco), to administer our retail and mail-order pharmacy services.

Working with Medco helps us to:

- Better manage prescription drug costs
- Provide members with comprehensive clinical programs and industry-leading customer service
- Offer mail-order prescription drug coverage (Note: not all pharmacy plans offer mail-order service. Refer to your Summary of Benefits or Certificate of Coverage.)

When members visit a participating pharmacy for covered prescriptions, they will only be responsible for the applicable prescription cost indicated in their Summary of Benefits.

Members who have mail-order pharmacy benefits can use Medco By Mail either online at www.medcohealth.com, or by phone at 1-800-905-0201, to fill certain maintenance prescriptions.

For Questions about Prescription Drug Coverage, Members can:

- Call Customer Service 24 hours a day at 1-800-905-0201 (except Thanksgiving and Christmas)
- View their pharmacy benefits and copayments online at the Medco web site, www.medcohealth.com
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Large Group Plans at a Glance

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Please Note: All product information is based on a 4/1/05 effective date.

*Oxford Consumer Options Suite is an electronic tool that provides employer groups of 51-99 eligible employees with flexibility in both pricing and plan design selection. By offering four plan types (Access, Classic, Direct and EPO) we offer a wide range of options to meet the diverse needs of our groups.

**Oxford USA utilizes the national UnitedHealthcare Choice Plus Network.