OXFORD HEALTH PLANS, INC.
Freedom Plan HSA Direct
SUMMARY OF COVERAGE
Sole Prop Direct

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	$2,850	$2,850
	Family	$5,700	$5,700
Coinsurance		10%	30%
Maximum Out-Of-Pocket:	Single	$3,850	$5,850
(Including Deductible)	Family	$7,700	$11,700
Maximum Lifetime Benefit Per Member		Unlimited	Unlimited
Financial Accumulation Period		Calendar Year	Calendar Year
Out-of-Network Reimbursement		N/A	Standard UCR[1]
PREVENTIVE CARE			
Adult Preventive Care		No Charge	In-Network Benefit Only
Infant and Pediatric Preventive Care		No Charge	Deductible and 30% Coinsurance $300 annual maximum
Immunizations		No Charge	Deductible and 30% Coinsurance
OUTPATIENT CARE			
Primary Care Physician office visits		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Specialist Office Visits		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Surgery **		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Laboratory services		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Radiology services including			
PT, CT scans, Magnetic Resonance Imaging (MRI) **		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance **Precertification is required for Out of Network PET scans, MRAs, surgical endoscopic prodedures, MRIs Nuclear Medicine, CT Scans, and Bone Density Studies.**
Screening Mammograms		Covered at 100%	Deductible and 30% Coinsurance
ALLERGY CARE			
Initial visit, and all subsequent referral visits		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
HOSPITAL CARE			
Physician's and surgeon's services **		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Semi-private room and board **		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
All drugs and medication		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
EMERGENCY CARE			
Ambulance service when Medically Necessary		Deductible and 10% Coinsurance	Deductible and 10% Coinsurance
At hospital emergency room		Deductible and 10% Coinsurance	Deductible and 10% Coinsurance
(If member is admitted to the hospital through the ER, notification is required)			
Emergency Care in Urgi-Center		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
MATERNITY CARE			
Prenatal and post-natal care		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Hospital services for mother and child **		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
SHORT TERM REHABILITATION			
60 consec. inpatient days per condition / lifetime**		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
60 outpatient visits per condition per lifetime		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
HOME HEALTH CARE			
40 home care visits **		Subject to 10% Coinsurance	Subject to 25% Coinsurance
Physician house calls		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
SKILLED NURSING FACILITY			
200 days per calendar year**		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
SUBSTANCE ABUSE			
7 days of inpatient detox. per calendar year **		Deductible and 10% Coinsurance	In-Network Benefit Only
30 days of inpatient rehab. per calendar year **		Deductible and 10% Coinsurance	In-Network Benefit Only
60 outpatient rehab. visits per calendar year		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
30 days of Inpatient care per calendar year**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
30 visits of Outpatient care per calendar year**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Office visits (visits combined with Outpatient care)**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Biologically Based Mental Health Services & Services for Children with Serious Emotional Disorders		
(Visits for Biologically based services will count toward Non-Biologically based service limits.)		
Inpatient Care**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Outpatient Care**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Office Visit**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
PRESCRIPTION DRUGS	Subject to Plan Deductible listed above	
Generic****	$15 copayment	Covered at Participating Pharmacies Only
Brand Name****	50% coinsurance	Covered at Participating Pharmacies Only
HOSPICE CARE (210 days)		
Inpatient care **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Outpatient care **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
EXERCISE FACILITY		
Subscriber	$200 reimbursement per 6 month period	$200 reimbursement per 6 month period
Spouse	$100 reimbursement per 6 month period	$100 reimbursement per 6 month period
HEARING AIDS		
Coverage is limited to $1,500. Limited to a single purchase (including repair/replacement) every 3 years.	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
OTHER ITEMS		
Medical Supplies, when Medically Necessary	OUT-OF-NETWORK BENEFIT ONLY	Deductible and 30% Coinsurance
Durable Equipment, when Medically Necessary **(precert required on items over $500)** (This benefit is limited to $1500 per calendar year.)	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.
Benefits discontinue at the end of the Calendar Year.

** These services require **precertification** through Oxford. You must call Oxford at 1- 800-444-6222 at least 14 days in advance of request of treatment to request precertification.
Mental health and substance abuse services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

****Prescription medications ordered through the Mail Order Drug Program are subject to 2 retail pharmacy copays for Generic Drugs and 50% coinsurance for Brand Name Drugs.

****The Prescription Drug Benefit is based on a Per Calendar Year Year Limit for any applicable deductibles.

Please Note: This sample summary of coverage is provided for informational purposes only. The applicable Summary of Benefits will be issued to eligible enrolled members as part of the Certificate of Coverage. Coverage is subject to the terms and conditions of the Certificate.
Refer to the Certificate of Coverage for a more complete listing of all benefits, limitations, and exclusions which include, among other services not authorized by Oxfor
cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorder
Worker's Compensation, military service-related conditions or unless otherwise stated, dental services and vision correction services and supplie

IMPORTANT: If you live and work in a state other than New York, please check the back of your certificate for extraterritorial benefits rider
Based on the state of your residence, additional coverage may be available to you
Please be advised this quote is for informational purposes only. The information contained herein is subject to both state regulatory and Oxford home office approval as appropriate.

[1]The Standard UCR fee schedule contains the maximum allowable fees and is set using data from Ingenix, Inc., the Centers for Medicare and Medicaid Services (CMS) and sources recognized by the federal government and insurance industry as a basis for evaluating and establishing fees. Physician fees are generally set using 70th percentile data from the Prevailing Healthcare Charges System (PHCS) database maintained by Ingenix. We and Ingenix are related companies through common ownership by UnitedHealth Group. The fee schedule for physician-administered pharmaceutical products is based upon a percentage of Average Wholesale Price. If a data source is no longer available, we will use a comparable data source to establish fees. Additional information about how we set the UCR fee schedule and reimburse Out-of-Network Covered Services is available in the Certificate of Coverage and Member Handbook.

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Refer to the Certificate of Coverage for a more complete listing of all benefits, limitations, and exclusions which include, among other services not authorized by Oxfor
cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorder
Worker's Compensation, military service-related conditions or unless otherwise stated, dental services and vision correction services and supplie

IMPORTANT: If you live and work in a state other than New York, please check the back of your certificate for extraterritorial benefits rider
Based on the state of your residence, additional coverage may be available to you
Please be advised this quote is for informational purposes only. The information contained herein is subject to both state regulatory and Oxford home office approval as appropriate.

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