OXFORD HEALTH PLANS, INC.
SOLE PROPRIETOR HSA EXCLUSIVE
SUMMARY OF COVERAGE
Freedom Network
NY_HSA EPO - Sole Prop

BENEFIT		IN-NETWORK
FINANCIAL		
Deductible:	Single	$2,000
	Family	$4,000
Coinsurance		None
Maximum Out-of-Pocket:	Single	$2,000
	Family	$4,000
Maximum Lifetime Benefit Per Member		Unlimited
Financial Accumulation Period		Calendar Year
PREVENTIVE CARE		
Adult Preventive Care		No Charge
Pediatric Preventive Care		No Charge
Infant Preventive Care		No Charge
Immunizations		No Charge
OUTPATIENT CARE		
Primary Care Physician office visits		No Charge after the Deductible
Specialist office visits		No Charge after the Deductible
Surgery**		No Charge after the Deductible
Laboratory services		No Charge after the Deductible
Radiology services**		No Charge after the Deductible
ALLERGY CARE		
Initial visit, and all subsequent referral visits		No Charge after the Deductible
HOSPITAL CARE		
Physician's and surgeon's services**		No Charge after the Deductible
Semi-private room and board**		No Charge after the Deductible
All drugs and medication**		No Charge after the Deductible
EMERGENCY CARE		
Ambulance Service		No Charge
At hospital Emergency Room		No Charge after the Deductible
(If member is admitted to the Hospital, notification is required)		
Emergency Care in Urgi-Center**		No Charge after the Deductible
MATERNITY CARE		
Prenatal and Post-natal care**		No Charge after the Deductible
Hospital services for mother and child **		No Charge after the Deductible
SHORT TERM REHABILITATION		
60 consec. Inpatient days per condition per lifetime**		No Charge after the Deductible
60 Outpatient visits per condition per lifetime**		No Charge after the Deductible
HOME HEALTH CARE		
40 Home care visits per Calendar Year**		No Charge after the Deductible
Physician house calls		No Charge after the Deductible
SKILLED NURSING FACILITY		
200 days per Calendar Year **		No Charge after the Deductible
SUBSTANCE ABUSE		
7 days of Inpatient detox. per Calendar Year **		No Charge after the Deductible
30 days of Inpatient rehab. per Calendar Year **		No Charge after the Deductible
60 Outpt rehab. visits per Calendar Year **		No Charge
(combined w/office visits)		
60 office visits per Calendar Year **		No Charge after the Deductible
(combined w/outpatient visits)		

BENEFIT	IN-NETWORK
MENTAL HEALTH CARE	
30 days of Inpatient care per Calendar Year **	No Charge after the Deductible
30 Outpatient visits per Calendar Year**	No Charge after the Deductible
(combined w/office visits)	
30 office visits per Calendar Year**	No Charge after the Deductible
(combined w/outpatient visits)	
PRESCRIPTION DRUGS	Subject to Plan Deductible
(Includes Oral Contraceptives)	
Generic Drugs****	$15 copayment
Brand Name Drugs****	50% coinsurance
ALTERNATIVE MEDICINE	
Chiropractic care	No Charge after the Deductible
HOSPICE CARE (210 days)	
Inpatient care**	No Charge after the Deductible
Outpatient care**	No Charge after the Deductible
HEARING AIDS	
Coverage is limited to $1,500.	No Charge after the Deductible
Limited to a single purchase (including repair/replacement)	
every 3 years.	
OTHER COVERAGE	
Medical Supplies**	No Charge after the Deductible
$1,500 per Calendar Year combined with Durable	
Medical Equipment	
Durable Medical Equipment**	No Charge after the Deductible
$1,500 per Calendar Year combined with Medical Supplies	
Precertification for items $500 or more.	
Exercise Facility	
Subscriber	$200 reimbursement per 6 month period
Spouse	$100 reimbursement per 6 month period

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 800-444-6222 at least 14 days in advance of request.

Mental health and substance abuse services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

****Prescription medication ordered through the Mail Order Drug Program are subject to 2.5 retail pharmacy copays for Generic and 50% coinsurance for Brand Name Drugs.

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 Oxford cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorders Worker's Compensation, military service-related conditions or unless otherwise stated, dental services and vision correction services and supplies
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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