



OXFORD HEALTH PLANS, INC.
 OXFORD HSA DIRECT
 SUMMARY OF COVERAGE
 Freedom Network
 LIA Health Alliance



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
Pediatric Preventive Care		No Charge	Deductible and 30% Coinsurance
Infant Preventive Care		No Charge	
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		No charge for UHC Lab Network providers All other providers are subject to Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Radiology services		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Preventive Mammograms		No Charge	Deductible and 30% Coinsurance
ALLERGY CARE			
Initial visit, and all subsequent 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		Deductible and 10% Coinsurance	Deductible and 10% Coinsurance
At hospital Emergency Room (If Member is admitted to the hospital through the ER, notification is required)		Deductible and 10% Coinsurance	Deductible and 10% Coinsurance
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 per 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 per Calendar Year **		Deductible and 10% Coinsurance	Deductible and 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 Outpt rehab. visits per Calendar Year** (combined w/office visits)		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
60 office visits per Calendar Year** (combined w/outpatient visits)		Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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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 (combined w/office visits)**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
30 office visits per Calendar Year (combined w/outpatient visits)**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

PRESCRIPTION DRUGS

Includes Contraceptives	Subject to plan Deductible listed above, then	
Generic****	\$15 copayment	Covered Only at Participating Pharmacies
Brand Name****	50% copayment	

HOSPICE CARE (210 Days)

Inpatient Care**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Outpatient Care**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

HEARING AIDS

Coverage is limited to \$1,500 per calendar year. Limited to a single purchase (including repair/replacement) every 3 years.	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
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OTHER COVERAGE

Medical Supplies**	OUT-OF-NETWORK BENEFIT ONLY	Deductible and 30% Coinsurance
Durable Medical Equipment** \$1500 limit per Calendar Year Precertification for items \$500 or more.	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Exercise Reimbursement		
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

DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 19, or age 23 if a full time student. 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 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 medication ordered through the Mail Order Drug Program are subject to 2 retail pharmacy copays for Generic Drugs and 50% copayment for Brand Name Drugs.

The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles and/or maximum limits.

Pharmacy claims are subject to the in-network deductible. Once the deductible has been satisfied, the applicable prescription drug copay will apply based on the option selected at plan inception.

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 disorder 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.

¹The 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.