



OXFORD HEALTH INSURANCE (NY), INC.
Freedom Plan HSA Direct
SUMMARY OF COVERAGE
Sole Proprietor

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	140% of Medicare 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 procedures, 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 (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 / 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

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

Includes Contraceptives

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	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
---	--------------------------------	--------------------------------

** (pre-cert required on items over \$500)

(This benefit is limited to \$1500 per calendar year.)

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 2.5 retail pharmacy copays for Generic Drugs 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 disorder, Worker's Compensation, military service-related conditions or unless otherwise stated, dental services and vision correction services and supplies.

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.

¹When a Medicare rate is not available, reimbursement is based upon certain gap methodology, including a gap methodology using relative value data from Ingenix, Inc. We and Ingenix are related companies through common ownership by UnitedHealth Group. When a gap methodology is not available, reimbursement is based upon 50% of the provider's billed charge.