



**OXFORD HEALTH PLANS, INC.
SOLE PROPRIETOR HSA EXCLUSIVE
SUMMARY OF COVERAGE
Freedom Network**

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 (If member is admitted to the Hospital, notification is required)	No Charge after the Deductible
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 ** (combined w/office visits)	No Charge
60 office visits per Calendar Year ** (combined w/outpatient visits)	No Charge after the Deductible

BENEFIT	IN-NETWORK
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MENTAL HEALTH CARE

30 days of Inpatient care per Calendar Year **	No Charge after the Deductible
30 Outpatient visits per Calendar Year** (combined w/office visits)	No Charge after the Deductible
30 office visits per Calendar Year** (combined w/outpatient visits)	No Charge after the Deductible

PRESCRIPTION DRUGS

(Includes Oral Contraceptives)	Subject to Plan Deductible
Generic Drugs****	\$15 copayment
Brand Name Drugs****	50% coinsurance

ALTERNATIVE MEDICINE

Chiropractic care	No Charge after the Deductible
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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. Limited to a single purchase (including repair/replacement) every 3 years.	No Charge after the Deductible
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OTHER COVERAGE

Medical Supplies** \$1,500 per Calendar Year combined with Durable Medical Equipment	No Charge after the Deductible
Durable Medical Equipment** \$1,500 per Calendar Year combined with Medical Supplies Precertification for items \$500 or more.	No Charge after the Deductible
Exercise Facility Subscriber Spouse	\$200 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 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.