



A UnitedHealthcare Company

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

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HSA High Deductible Plan

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
FINANCIAL		UCR: 70% of HIAA
Deductible: Single	\$2,850	\$2,850
Family	\$5,700	\$5,700
Coinsurance	0%	30%
Medical Maximum Out-Of-Pocket: Single	\$2,850	\$5,850
(Including Deductible) Family	\$5,700	\$11,700
Maximum Lifetime Benefit Per Member	Unlimited	Unlimited
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	Covered 100% after Deductible	Deductible and 30% Coinsurance
Specialist Office Visits	Covered 100% after Deductible	Deductible and 30% Coinsurance
Surgery **	Covered 100% after Deductible	Deductible and 30% Coinsurance
Laboratory services	Covered 100% after Deductible	Deductible and 30% Coinsurance
Radiology services including PT, CT scans, Magnetic Resonance Imaging (MRI) **	Covered 100% after Deductible	Deductible and 30% Coinsurance
Preventive Mammograms	No Charge	Deductible and 30% Coinsurance
ALLERGY CARE		
Initial visit, and all subsequent referral visits	Covered 100% after Deductible	Deductible and 30% Coinsurance
HOSPITAL CARE		
Physician's and surgeon's services **	Covered 100% after Deductible	Deductible and 30% Coinsurance
Semi-private room and board **	Covered 100% after Deductible	Deductible and 30% Coinsurance
All drugs and medication**	Covered 100% after Deductible	Deductible and 30% Coinsurance
EMERGENCY CARE		
Ambulance Service	Covered 100% after Deductible	Covered 100% after Deductible
At hospital emergency room	Covered 100% after Deductible	Covered 100% after Deductible
Emergency Care in Urgi-Center**	Covered 100% after Deductible	Deductible and 30% Coinsurance
MATERNITY CARE		
Prenatal and post-natal care	Covered 100% after Deductible	Deductible and 30% Coinsurance
Hospital services for mother and child **	Covered 100% after Deductible	Deductible and 30% Coinsurance
SHORT TERM REHABILITATION		
60 consec. inpatient days per condition / lifetime**	Covered 100% after Deductible	Deductible and 30% Coinsurance
60 outpatient visits per condition per lifetime	Covered 100% after Deductible	Deductible and 30% Coinsurance
HOME HEALTH CARE		
40 home care visits per calendar year**	Covered 100% after Deductible	Subject to 25% Coinsurance
Physician house calls	Covered 100% after Deductible	Deductible and 30% Coinsurance
SKILLED NURSING FACILITY		
200 days per calendar year**	Covered 100% after Deductible	Deductible and 30% Coinsurance
SUBSTANCE ABUSE		
7 days of inpatient detox. per calendar year **	Covered 100% after Deductible	In-Network Benefit Only
30 days of inpatient rehab. per calendar year **	Covered 100% after Deductible	In-Network Benefit Only
60 outpt rehab. visits per cal yr (combined w/office visits)	Covered 100% after Deductible	Deductible and 30% Coinsurance
60 office visits per cal year (combined w/outpatient visits)	Covered 100% after Deductible	Deductible and 30% Coinsurance



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BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
30 days of Inpatient care per Calendar Year**	Covered 100% after Deductible	Deductible and 30% Coinsurance
30 visits of Outpatient care per Calendar Year (combined w/office visits)**	Covered 100% after Deductible	Deductible and 30% Coinsurance
30 office visits per Calendar Year (combined w/outpatient visits)**	Covered 100% after Deductible	Deductible and 30% Coinsurance
PRESCRIPTION DRUGS		
	Subject to Plan Deductible listed above	
Tier 1****	\$10 copayment	Covered at Participating Pharmacies only
Tier 2****	\$25 copayment	Covered at Participating Pharmacies only
Tier 3****	\$50 copayment	Covered at Participating Pharmacies only
Includes Contraceptives		
HOSPICE CARE (210 days combined with inpatient and outpatient)		
Inpatient care **	Covered 100% after Deductible	Deductible and 30% Coinsurance
Outpatient care **	Covered 100% after Deductible	Deductible and 30% Coinsurance
OTHER COVERAGE		
Medical Supplies- non-diabetic**	OUT-OF-NETWORK BENEFIT ONLY	Deductible and 30% Coinsurance
DURABLE MEDICAL EQUIPMENT ** precert required for items over \$500 \$1500 maximum per calendar year. Exercise Reimbursement:	Covered 100% after Deductible	Deductible and 30% Coinsurance
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.

Domestic Partners are covered with proper documentation.

** 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 medications ordered through the Mail Order Drug Program are subject to two times the applicable retail pharmacy copays for a 90 day supply.

The Prescription Drug Benefit is based on a Per Calendar 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 your 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, hearing aids, 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.