OXFORD HEALTH PLANS
A UnitedHealthcare Company

OXFORD HEALTH PLANS, INC.
OXFORD HSA EXCLUSIVE
SUMMARY OF COVERAGE
Freedom Network
Chamber Benefit Group

BENEFIT	**IN-NETWORK**
FINANCIAL	
Deductible: Single	$2,850
Family	$5,700
Coinsurance	0%
Medical Maximum Out-Of-Pocket: Single	$2,850
Family	$5,700
Maximum Lifetime Benefit Per Member	Unlimited
PREVENTIVE CARE	
Physical Examination	No Charge
Routine pediatric care	No Charge
Immunizations	No Charge
OUTPATIENT CARE	
Primary Care Physician office visits	Covered 100% after Deductible.
Specialist Office Visits	Covered 100% after Deductible.
Ambulatory surgery **	Covered 100% after Deductible.
Laboratory services	Covered 100% after Deductible.
Radiology Services	Covered 100% after Deductible.
ALLERGY CARE	
Initial visit, and all subsequent visits	Covered 100% after Deductible.
HOSPITAL CARE	
Physician's and surgeon's services **	Covered 100% after Deductible.
Semi-private room and board **	Covered 100% after Deductible.
All drugs and medication	Covered 100% after Deductible.
EMERGENCY CARE	
Ambulance service when Medically Necessary**	Covered 100% after Deductible.
At hospital emergency room** (If member is admitted to the Hospital, notification is required)	Covered 100% after the Deductible is met. (waived if admitted).
Emergency Care in Urgi-Center**	Covered 100% after Deductible.
MATERNITY CARE	
Prenatal and post-natal care **	Covered 100% after Deductible.
Hospital services for mother and child **	Covered 100% after Deductible.
SHORT TERM REHABILITATION	
60 consec. inpatient days per condition / lifetime**	Covered 100% after Deductible.
60 outpatient visits per condition /lifetime	Covered 100% after Deductible.
HOME HEALTH CARE	
40 home care visits per calendar year**	Covered 100% after Deductible.
Physician house calls	Covered 100% after Deductible.
SKILLED NURSING FACILITY	
200 days per calendar year **	Covered 100% after Deductible.
SUBSTANCE ABUSE	
7 days of inpatient detox. per calendar year **	Covered 100% after Deductible.
30 days of inpatient rehab. per calendar year **	Covered 100% after Deductible.
60 outpt rehab. visits per cal year ** (combined w/office visits)	Covered 100% after Deductible.
60 office visits per calendar year ** (combined w/oupt visits)	Covered 100% after Deductible.

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BENEFIT	IN-NETWORK
MENTAL HEALTH CARE	
30 days of Inpatient care per Calendar Year**	Covered 100% after Deductible.
30 Outpatient visits per Calendar Year** (combined w/office visits)	Covered 100% after Deductible.
30 office visits per Calendar Year** (combined w/outpatient visits)	Covered 100% after Deductible.
Biologically Based Mental Health Services & Services for Children with Serious Emotional Disorders (Visits for Biologically based services will count toward Non-Biologically based service limits.)	
Inpatient Care**	Covered 100% after Deductible.
Outpatient Care**	Covered 100% after Deductible.
Office Visit**	Covered 100% after Deductible.
PRESCRIPTION DRUGS	
	Subject to Plan Deductible listed above
Tier 1***	$10 copayment
Tier 2***	$25 copayment
Tier 3*** (Includes Oral Contraceptives)	$50 copayment
ALTERNATIVE MEDICINE	
Chiropractic care**	Covered 100% after Deductible.
HOSPICE CARE	
Inpatient care**	Covered 100% after Deductible.
Outpatient care**	Covered 100% after Deductible.
210 Days per calendar year (combined in/outpatient days)	
EXERCISE FACILITY	
Subscriber	$200 reimbursement per 6 month period
Spouse	$100 reimbursement per 6 month period
OTHER COVERAGE	
DURABLE MEDICAL EQUIPMENT (When Medically Necessary **) ($1500 per calendar year combined combined with Medical Supplies)	Covered 100% after Deductible.
Medical Supplies, when Medically Necessary ** ($1500 per calendar year combined with DME)	Covered 100% after Deductible.

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 medications ordered through the Mail Order Drug Program are subject to 2 applicable retail pharmacy copays.
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.