HSA EXCLUSIVE℠
SUMMARY OF COVERAGE
FREEDOM NETWORK
NEW YORK SOLE PROPRIETORS

BENEFIT		IN-NETWORK
FINANCIAL		
Deductible: Single		$2,000
Family		$4,000
Coinsurance		0%
Maximum Out-of-Pocket:	Single	$2,000
	Family	$4,000
Maximum Lifetime Benefit Per Member		Unlimited
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		Covered 100% after Deductible.
Specialist office visits		Covered 100% after Deductible.
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		Covered 100% after Deductible.
At hospital Emergency Room		Covered 100% after Deductible. (Waived if Admitted)
(If member is admitted to the Hospital, notification is required)		
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 per lifetime**		Covered 100% after Deductible.
60 Outpatient visits per condition per 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 Calendar Year** (combined w/office visits)		Covered 100% after Deductible.
60 office visits per Calendar Year** (combined w/outpatient visits)		Covered 100% after Deductible.

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.
PRESCRIPTION DRUGS	
(Includes Oral Contraceptives)	Subject to Plan Deductible listed above then,
Generic****	$15 copayment (Once the in-network deductible has been satisfied)
Brand Name****	50% copayment
ALTERNATIVE MEDICINE	
Chiropractic care**	Covered 100% after Deductible.
HOSPICE CARE (210 days)	
Inpatient care**	Covered 100% after Deductible.
Outpatient care**	Covered 100% after Deductible.
OTHER COVERAGE	
Medical Supplies**	Covered 100% after Deductible.
Durable Medical Equipment** $1500 limit per Calendar Year Precertification for items $500 or more.	Covered 100% after Deductible.
Exercise Reimbursement	
Subscriber	$200 reimbursement per 6 month period
Spouse	$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 25 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.

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 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 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.