Oxford Health Plans (NY), Inc.
Oxford Exclusive Metro Plan
Freedom Network
Summary of Coverage
The Cotswold Group, Inc.

BENEFIT	IN-NETWORK
FINANCIAL	
Deductible: Single	None
Deductible: Family	None
Coinsurance	None
Maximum Out-Of-Pocket: Single	Not Applicable
Maximum Out-Of-Pocket: Family	Not Applicable
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	$15 copay per visit
Specialist Office Visits	$30 copay per visit
Ambulatory surgery **	$150 per incident
Laboratory services	At Participating Laboratories Only; No Charge
Magnetic Resonance Imaging (MRI)	No Charge
ALLERGY CARE	
Initial visit, and all subsequent visits	$30 copay per visit
HOSPITAL CARE	
Physician's and surgeon's services **	No Charge
Semi-private room and board **	$150 per incident
All drugs and medication	No Charge
EMERGENCY CARE	
Ambulance service when Medically Necessary**	No Charge
At hospital emergency room** *(If a member is admitted to the hospital, notification is required)*	$75 copay; waived if admitted
Emergency Care in Urgi-Center**	$30 copay per visit
MATERNITY CARE	
Prenatal and post-natal care **	$15 copay per initial visit only
Hospital services for mother and child **	$150 per incident

BENEFIT	IN-NETWORK
SHORT TERM REHABILITATION	
60 consec. inpatient days per condition / lifetime**	$150 per incident
60 outpatient visits per condition/lifetime	$30 copay per visit
HOME HEALTH CARE	
40 home care visits **	$30 copay per visit
Physician house calls	$15/30 copay per visit
SKILLED NURSING FACILITY	
200 days per calendar year **	$150 per incident
SUBSTANCE ABUSE	
7 days of inpatient detox. per calendar year **	$150 per incident
30 days of inpatient rehab. per calendar year **	$150 per incident
60 outpatient rehab. visits per calendar year **	No Charge
MENTAL HEALTH CARE	
30 days of inpatient care per calendar year **	$150 per incident
30 outpatient visits per calendar year**	50% Copayment
PRESCRIPTION DRUGS	
Per generic prescription ***	$10 copay
Per preferred brand name prescription ***	$25 copay
Per brand name prescription ***	$50 copay
$50 Brand only Deductible	
ALTERNATIVE MEDICINE	
Chiropractic care**	$30 copay per visit
HOSPICE CARE	
Inpatient care**	$150 per incident
Outpatient care**	$150 per incident
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

BENEFIT	IN-NETWORK

OTHER COVERAGE

DURABLE MEDICAL EQUIPMENT (When Medically Necessary **) (This benefit is limited to $1500 per calendar year)	No Charge when ordered by an Oxford Participating Physician
Medical Supplies, when Medically Necessary ** ($1500 per calendar year combined with DME)	No charge when order by a participating physician

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.
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 applicable retail pharmacy copays. (Generic drugs will be subject to the Generic copay & Brand Name Drugs will be subject to the Brand name copays).
The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles and/or maximum limits.

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.