

III. OXFORD USA FREEDOM DIRECT PLAN DESIGNS

HEALTH BENEFITS

Options	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6
Copayment	\$15 PCP \$25 Specialist	\$25 PCP \$40 Specialist	\$25 PCP \$40 Specialist	N/A	N/A	N/A
Single * Deductible	\$500/\$1,000	\$500/\$1,000	\$1,000/\$2,000	\$500/\$1,000	\$2,000/\$2,000	\$1,000/\$2,000
Family * Deductible	\$1,000/\$2,000	\$1,000/\$2,000	\$2,000/\$4,000	\$1,000/\$2,000	\$4,000/\$4,000	\$2,000/\$4,000
Coinsurance *	90%/70%	80%/60%	80%/60%	90%/70%	90%/70%	80%/60%
Single Max. * Out-of-Pocket	\$1,500/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000	\$1,500/\$4,000	\$3,000/\$5,000	\$3,000/\$6,000
Family Max. * Out-of-Pocket	\$3,000/\$8,000	\$5,000/\$10,000	\$6,000/\$12,000	\$3,000/\$8,000	\$6,000/\$10,000	\$6,000/\$12,000

DIRECT OPTIONS:

- Vision Care Rider Domestic Partner

PRESCRIPTION DRUG BENEFITS

Copayment Information:

- Standard (Plan Copayment) Available only with office visit copayment plans

Optional Riders (Generic/Preferred Brand/Brand Copayment)

- \$7/\$15/\$25 \$10/\$25/\$50* \$15/50%* \$5/\$15/\$50* \$7/\$20/\$50* \$7/\$15/\$35*

*Pharmacy Deductible (Waived for generic drugs): None \$50 \$100

IV. OXFORD USA HSA DIRECT PLAN DESIGNS

OXFORD HSA DIRECT

Note: Groups enrolling in the Oxford HSA Direct must also fill out an Oxford HSA Banking Notification Form (#7423)

HEALTH BENEFITS: Freedom Network Liberty Network

Options	Plan1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5	<input type="checkbox"/> Plan 6
Single Deductible** (In-network/Out-of-network)	\$1,100/\$2,000	\$2,000/\$2,000	\$2,500/\$2,500	\$1,100/\$2,000	\$2,000/\$2,000	\$2,500/\$2,500
Family Deductible** (In-network/Out-of-network)	\$2,200/\$4,000	\$4,000/\$4,000	\$5,000/\$5,000	\$2,200/\$4,000	\$4,000/\$4,000	\$5,000/\$5,000
Coinsurance (In-network/Out-of-network)	80%/60%	90%/70%	90%/70%	100%/70%	100%/70%	100%/70%
Single Medical Out-of-pocket Maximum (In-network/Out-of-network) (Family = 2x)	\$3,100/\$6,000	\$3,000/\$5,000	\$3,500/\$5,500	\$1,100/\$5,000	\$2,000/\$5,000	\$2,500/\$5,500

IV. OXFORD USA HSA DIRECT PLAN DESIGNS (CON'T)

PRESCRIPTION DRUG BENEFITS:** (REQUIRED)

Generic/Preferred Brand/Brand Copayment (once the in-network deductible has been satisfied)

\$7/\$15/\$35 \$10/\$25/\$50 \$15/50%

Oral Contraceptives: Yes No (Qualified State Exempt Groups Only)

****NOTE:** All in-network medical and pharmacy services are subject to the in-network deductible. Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copay will apply based on the option selected at plan inception. Out-of-network benefits are accumulated separately.

OXFORD HSA DIRECT OPTIONS (ALL INFORMATION IS SUBJECT TO HOME OFFICE APPROVAL)

Vision Domestic Partner Physical Therapy 90 Rider (30 visits standard)

V. SIGNATURE

This Addendum forms a part of the Application between the Group and Us. In the event of a conflict between the provisions of this Addendum and the Application, the provisions of this Addendum will prevail. All other terms and conditions of the Application remain in full force and effect. Nothing contained in this Addendum will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Application to which this Addendum is attached, other than as specifically stated herein.

Dated at: _____ on _____

Print Name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

Witness to Signature

Note: *If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.*