OXFORD HEALTH INSURANCE, INC.
FREEDOM PLAN HSA DIRECT
SUMMARY OF COVERAGE
Freedom Network
Abel HR

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	$2,000	$4,000
	Family	$4,000*	$8,000
Coinsurance		None	20%
Maximum Out-of-Pocket:	Single	$6,000	$10,500
(Including Deductible)	Family	$12,000	$21,000
Financial Accumulation Period:		Calendar Year	Calendar Year

Please Note: All Copayments, Deductibles, and Coinsurance (medical and prescription) paid for In-Network Covered Services contribute to the In-Network, Out-of-Pocket Maximum.

PREVENTIVE CARE		
Adult Preventive Care	No Charge	Deductible & 20% Coinsurance
Infant and Pediatric Preventive Care	No Charge	Deductible & 20% Coinsurance
OUTPATIENT CARE		
Primary Care Physician Office Visits	Deductible & $25 copay per visit	Deductible & 20% Coinsurance
Specialist Office Visits	Deductible & $40 copay per visit	Deductible & 20% Coinsurance
Virtual Visits	No Charge after Deductible	In-Network Benefit Only
Outpatient Surgery - Hospital Setting**	Deductible & $200 copay	Deductible & 20% Coinsurance
Outpatient Surgery - Freestanding Facility**	Deductible & $200 copay	Deductible & 20% Coinsurance
Laboratory Services - Hospital Setting**	No Charge after Deductible	Deductible & 20% Coinsurance
Laboratory Services - Freestanding Facility**	No Charge after Deductible	Deductible & 20% Coinsurance
(See your Certificate of Coverage for additional Lab details)		
Radiology Services - Hospital Setting**	No Charge after Deductible	Deductible & 20% Coinsurance
Radiology Services - Freestanding Facility**	No Charge after Deductible	Deductible & 20% Coinsurance
MRIs, MRAs, CT SCANS, AND PET SCANS		
Outpatient Hospital Services**	No Charge after Deductible	Deductible & 20% Coinsurance
Freestanding Radiology Facility**	No Charge after Deductible	Deductible & 20% Coinsurance
HOSPITAL CARE		
Physician's and Surgeon's Services**	No Charge after Deductible	Deductible & 20% Coinsurance
Semi-Private Room and Board**	Deductible & $400 per day up to $2,000 max per Calendar Year	Deductible & 20% Coinsurance
All Drugs and Medication	No Charge after Deductible	Deductible & 20% Coinsurance
EMERGENCY CARE		
Ambulance Services when Medically Necessary**	No Charge after Deductible	No Charge after Deductible
At Hospital Emergency Room	Deductible then $100 copay	Deductible then $100 copay
(If member is admitted to the hospital, notification is required)		
Emergency Care in Urgi-Center	Deductible & $40 copay per visit	Deductible & 20% Coinsurance
MATERNITY CARE		
Routine Prenatal and Post-Natal Care**	No Charge	Deductible & 20% Coinsurance
Hospital Services for Mother and Child**	Deductible & $400 per day up to $2,000 max per Calendar Year	Deductible & 20% Coinsurance
SKILLED NURSING FACILITY		
30 Days per ,Calendar Year**	Deductible & $400 per day up to $2,000 max per Calendar Year	Deductible & 20% Coinsurance
HOSPICE CARE (180 days per lifetime combined Inpatient & Home)		
Inpatient Care**	Deductible & $400 per day up to $2,000 max per Calendar Year	Deductible & 20% Coinsurance
Home Hospice Care Visits**	Deductible & $40 copay per visit	Deductible & 20% Coinsurance
HOME HEALTH CARE		
Home Care Visits - 60 Visits per Calendar Year**	Deductible & $40 copay per visit	Deductible & 20% Coinsurance
Physician House Calls**	Deductible & $40 copay per visit	Deductible & 20% Coinsurance
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation**	Deductible & $400 per day up to $2,000 max per Calendar Year	Deductible & 20% Coinsurance
Office Visits or Outpatient Rehabilitation	Deductible & $40 copay per visit	Deductible & 20% Coinsurance
Intensive Behavioral Therapy**	Deductible & $40 copay per visit	Deductible & 20% Coinsurance
	No Charge after Deductible	Deductible & 20% Coinsurance
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment**		
MENTAL HEALTH CARE		
Inpatient Care**	Deductible & $400 per day up to $2,000 max per Calendar Year	Deductible & 20% Coinsurance
Office Visits or Outpatient Care	Deductible & $40 copay per visit	Deductible & 20% Coinsurance
Intensive Behavioral Therapy**	Deductible & $40 copay per visit	Deductible & 20% Coinsurance
	No Charge after Deductible	Deductible & 20% Coinsurance
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment**		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
ALLERGY CARE		
Testing and Treatment**	Deductible & $40 copay per visit	Deductible & 20% Coinsurance
CHIROPRACTIC CARE		
Chiropractic Care** *Out-of-Network coverage limited to $500 per Calendar Year per Member*	Deductible & $30 copay per visit	Deductible & 50% Coinsurance
SHORT TERM REHAB & HABILITATIVE SERVICES		
60 Inpatient Days per Calendar Year**	Deductible & $400 per day up to $2,000 max per Calendar Year	Deductible & 20% Coinsurance
60 combined Outpatient Visits per Calendar Year**	Deductible & $40 copay per visit	Deductible & 20% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Unlimited** *(Precertification required for items over $500)*	No Charge after Deductible	Deductible & 20% Coinsurance
HEARING AIDS		
Hearing Aids - Limited to 1 hearing aid for each hearing impaired ear every 24 months.	No Charge after Deductible	Deductible & 20% Coinsurance
MEDICAL SUPPLIES		
Medical Supplies when Medically Necessary**	No Charge after Deductible	Deductible & 20% Coinsurance
EXERCISE FACILITY		
Subscriber	$200 reimbursement per 6 month period	$200 reimbursement per 6 month period
Spouse/Dependents over age 13	$100 reimbursement per 6 month period	$100 reimbursement per 6 month period
INFERTILITY TREATMENT		
Specialist Office Visits**	Deductible & $40 copay per visit	Deductible & 20% Coinsurance
Outpatient Freestanding Facility Services**	Deductible & $200 copay	Deductible & 20% Coinsurance
Outpatient Hospital Facility Services**	Deductible & $200 copay	Deductible & 20% Coinsurance
Inpatient Facility Services**	Deductible & $400 per day up to $2,000 max per Calendar Year	Deductible & 20% Coinsurance
INFERTILITY MEDICATIONS		
Infertility Medications**	Covered subject to the applicable Prescription Drug Out-Of-Pocket Expense.	Deductible & 20% Coinsurance
OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE	Subject to Plan Deductible then applicable Prescription Drug Copay	
OUTPATIENT PRESCRIPTION DRUGS - RETAIL		
The Prescription Drug Benefit is based on a per Calendar Year Limit for any applicable deductibles and/or maximum limits.		
Tier 1	$25 copay	$25 copay
Tier 2	$50 copay	$50 copay
Tier 3	$75 copay	$75 copay
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	$50 copay	$50 copay
Tier 2	$100 copay	$100 copay
Tier 3	$150 copay	$150 copay

DEPENDENT ELIGIBILITY:
Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.
Benefits discontinue at the end of the Month.
Domestic Partners covered with proper documentation.

*If you have a family contract the entire family Deductible must be satisfied before coverage under this Plan is available. A family contract is a Plan that covers you and one or more Dependents.
** These services require **precertification** through Oxford. Members must call Oxford at 1-800-444-6222 at least 14 days in advance of request of treatment to request precertification.
**Mental health and substance use disorder services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

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 the 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, or, unless otherwise stated, dental services and vision correction services and supplies.