Certificate of Coverage

PLAN 27: Direct Smart HSA

UnitedHealthcare® Oxford

2018 | 2019

Oxford Health Insurance, Inc.
Direct HSA Plan Summary of Benefits
Freedom Network
Abel HR, Inc

Primary Care and Preventive Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Preventive Care		
Well-Baby and Well-Child Care	No Charge	20% Coinsurance
Adult Periodic Physical Examinations	No Charge	Deductible and 20% Coinsurance
Well-Woman Examinations, Family Planning and Breast Pumps	No Charge	Deductible and 20% Coinsurance
Screening for Prostate Cancer	No Charge	Deductible and 20% Coinsurance
Physician (Primary Care) Office and Home Visits - Treatment of Illness or Injury	$25 per visit after the Deductible has been met	Deductible and 20% Coinsurance
Physician (Primary Care) Hospital Visits	No Charge	Deductible and 20% Coinsurance
Diabetes Services (Primary Care)		
Supplies, Education and Self-Management	Supplies - $25 per 31-day supply of each item after the Deductible has been met Education and Self-Management - $25 per visit after the Deductible has been met	Deductible and 20% Coinsurance
Diabetes Medications	Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense	Deductible and 20% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance, Inc.
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Primary Care and Preventive Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Elective Termination of Pregnancy- This benefit is limited to a maximum of one procedure per Calendar Year.	Office Visits - $40 per visit after the Deductible has been met Inpatient Facility - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met Outpatient Facility - $200 per visit after the Deductible has been met	Deductible and 20% Coinsurance

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Physician (Specialist) Office and Home Visits	$40 per visit after the Deductible has been met	Deductible and 20% Coinsurance
Physician (Specialist) Hospital Visits	No Charge	Deductible and 20% Coinsurance
Diabetes Services (Specialty Care)		
Supplies, Education and Self-Management	Supplies - $40 per 31-day supply of each item after the Deductible has been met Education and Self-Management - $40 per visit after the Deductible has been met	Deductible and 20% Coinsurance
Diabetes Medications	Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense	Deductible and 20% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Maternity and Newborn Care	Maternity Care - $25 for initial visit only after the Deductible has been met Inpatient hospital services are Covered subject to: the inpatient facility Out-of-Pocket Expense. *Routine prenatal office visits, as well as certain lab tests and counseling services as described in the United States Preventive Services Task Force A and B recommendations and the Health Resources and Services Administration women's health coverage requirements are considered preventive care and are covered at* ***No Charge*** .	Deductible and 20% Coinsurance
Allergy Testing and Treatment	$40 per visit after the Deductible has been met	Deductible and 20% Coinsurance
Rehabilitation and Habilitative Services (Physical, Speech and Occupational Therapies) Inpatient services are limited to 60 days per Calendar Year. Outpatient services are limited to 60 visits per Calendar Year.	Outpatient - $40 per visit after the Deductible has been met Inpatient - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met	Deductible and 20% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
For Autism Spectrum Disorder and other Developmental Disabilities – Inpatient services are limited to 60 days per Calendar Year. Outpatient services are limited to 60 visits per Calendar Year. Please note that limits do not apply to the treatment of Autism Spectrum Disorder.	Outpatient - $40 per visit after the Deductible has been met Inpatient - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met	Deductible and 20% Coinsurance
Reconstructive and Corrective Surgery	Office Visits - $40 per visit after the Deductible has been met Inpatient Facility - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met Outpatient Hospital Services - $200 per visit after the Deductible has been met Outpatient Ambulatory Surgical Center - $200 per visit after the Deductible has been met Physician Fees for Surgical and Medical Services - No Charge after the Deductible has been met	Deductible and 20% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Gender Dysphoria Services	Office Visits - $40 per visit after the Deductible has been met Inpatient Facility - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met Outpatient Hospital Services - $200 per visit after the Deductible has been met Outpatient Ambulatory Surgical Center - $200 per visit after the Deductible has been met Physician Fees for Surgical and Medical Services - No Charge after the Deductible has been met	Deductible and 20% Coinsurance
Oral Surgery	Office Visits - $40 per visit after the Deductible has been met Inpatient Facility - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met Outpatient Hospital Services - $200 per visit after the Deductible has been met Outpatient Ambulatory Surgical Center - $200 per visit after the Deductible has been met Physician Fees for Surgical and Medical Services - No Charge after the Deductible has been met	Deductible and 20% Coinsurance
Outpatient Cardiac Rehabilitation– This benefit is unlimited.	No Charge after Deductible has been met	Deductible and 20% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Outpatient Pulmonary Rehabilitation	No Charge after Deductible has been met	Deductible and 20% Coinsurance
Orthoptic Exercises and Corneal Topographic Procedures	No Charge after Deductible has been met	Deductible and 20% Coinsurance
Outpatient Diagnostic Services		
Laboratory Services	No Charge after Deductible has been met Please remember, unless you are receiving preadmission testing, Network Hospitals are not Network Providers for outpatient laboratory procedures and tests.	Deductible and 20% Coinsurance
Radiology Services	***Major Diagnostic Procedures:*** Office Based Services - $40 per visit after the Deductible has been met Free-Standing Radiology Center - No Charge after Deductible has been met Hospital Facility Based Services - No Charge after Deductible has been met	Deductible and 20% Coinsurance
	All other Radiology: Office Based Services - $40 per visit after the Deductible has been met Free-Standing Radiology Center - No Charge after Deductible has been met Hospital Facility Based Services - No Charge after Deductible has been met	Deductible and 20% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Internal and External Prosthetic Devices **Please Note:** Reimbursement for these items will be at the same rate as under the federal Medicare reimbursement schedule.	Internal - No Charge after Deductible has been met Surgery is subject to either the inpatient or outpatient facility Out-of-Pocket Expense. External - No Charge after Deductible has been met	Deductible and 20% Coinsurance
Durable Medical Equipment, Orthotics and Braces	No Charge after Deductible has been met	Deductible and 20% Coinsurance
Medical Supplies (Non-Diabetic)	No Charge after Deductible has been met	Deductible and 20% Coinsurance
Treatment of Infertility - Limited to four completed egg retrievals (and the procedures and treatments associated with such retrievals) while covered under this plan or any plan with the same employer.	Office Visits - $40 per visit after the Deductible has been met Inpatient Facility - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met Outpatient Hospital Services - $200 per visit after the Deductible has been met Outpatient Ambulatory Surgical Center - $200 per visit after the Deductible has been met Physician Fees for Surgical and Medical Services - No Charge after Deductible has been met Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.	Deductible and 20% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Transplants	Transplants performed at Our approved facilities are Covered: Subject to the Inpatient facility Out-of-Pocket Expense When performed at other Network facilities – the services are Covered as an out-of-network benefit.	Deductible and 20% Coinsurance
Clinical Trials	Office Visits - $40 per visit after the Deductible has been met Inpatient Facility - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met Outpatient Hospital Services - $200 per visit after the Deductible has been met Outpatient Ambulatory Surgical Center - $200 per visit after the Deductible has been met Physician Fees for Surgical and Medical Services - No Charge after the Deductible has been met	Deductible and 20% Coinsurance
Home Health Care – This benefit is limited to 60 visits per Calendar Year.	$40 per visit after the Deductible has been met	Deductible and 20% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Chemotherapy	No Charge after Deductible has been met Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.	Deductible and 20% Coinsurance
Hemodialysis	Office Visits - $40 per visit after the Deductible has been met Inpatient Facility - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met Outpatient Facility - $200 per visit after the Deductible has been met Physician Fees for Surgical and Medical Services - No Charge after the Deductible has been met	Deductible and 20% Coinsurance
Second and Third Opinions	At Your Request - $40 per visit after the Deductible has been met At Our Request – No Charge	Deductible and 20% Coinsurance
Chiropractic Services- Out-of-Network coverage is limited to $500 per Member, per Calendar Year.	$30 per visit after the Deductible has been met	Deductible and 50% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Hearing Aids – For Members through age 15, coverage for hearing aids is limited to one hearing aid for each hearing-impaired ear every 24 months. For Members age 16 and older, coverage for hearing aids is limited to $5,000 per hearing aid for each hearing-impaired ear every 24 months.	No Charge after Deductible has been met	Deductible and 20% Coinsurance
New Jersey Early Intervention Family Cost Share Expense for Autism and other Developmental Disabilities	$25 per monthly expense after the Deductible has been met	
Nutritional Counseling	$40 per visit after the Deductible has been met	Deductible and 20% Coinsurance
Obesity Surgery- limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy. Obesity surgery must be received at a Designated Facility to receive in-network benefits.	Office Visits - $40 per visit after the Deductible has been met Inpatient Facility - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met Outpatient Hospital Services - $200 per visit after the Deductible has been met Outpatient Ambulatory Surgical Center - $200 per visit after the Deductible has been met Physician Fees for Surgical and Medical Services - No Charge after the Deductible has been met	Deductible and 20% Coinsurance

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Hospital & Facility Based Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Hospital Services	Inpatient - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met Outpatient - $200 per visit after the Deductible has been met	Deductible and 20% Coinsurance
Outpatient Ambulatory Surgical Center	$200 per visit after the Deductible has been met	Deductible and 20% Coinsurance
Skilled Nursing Facility Services- This benefit is limited to 30 days per Calendar Year.	$400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met (waived if the Member is transferred from a hospital to a Skilled Nursing Facility)	Deductible and 20% Coinsurance

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Hospital & Facility Based Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Hospice Services- This benefit is limited to 180 days (inpatient and outpatient combined) per Lifetime. 5 sessions for bereavement counseling are available to the Member's family either before or after the Member's death.	Inpatient - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met Outpatient - $40 per visit after the Deductible has been met Home Health Care - $40 per visit after the Deductible has been met Skilled Nursing Facility - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met (waived if the Member is transferred from a hospital to a Skilled Nursing Facility)	Deductible and 20% Coinsurance
Physician Fees for Surgical and Medical Services	Physician Fees for Surgical and Medical Services - No Charge after the Deductible has been met	Deductible and 20% Coinsurance

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Mental Health Services and Substance Use Disorder Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Mental Health Services - This benefit is provided to the same extent as other surgical or medical benefits Covered under the Certificate.	Office Visits/Outpatient - $40 per visit after the Deductible has been met Inpatient Facility - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met Partial Hospitalization/Intensive Outpatient Treatment - No Charge after Deductible has been met Physician Fees for Surgical and Medical Services - No Charge after the Deductible has been met	Deductible and 20% Coinsurance
Substance Use Disorder Services – This benefit is provided to the same extent as other surgical or medical benefits Covered under the Certificate.	Office Visits/Outpatient - $40 per visit after the Deductible has been met Inpatient Facility - $400 Copayment per day up to 5 day maximum Copayment per Calendar Year after the Deductible has been met Partial Hospitalization/Intensive Outpatient Treatment - No Charge after Deductible has been met Physician Fees for Surgical and Medical Services - No Charge after the Deductible has been met	Deductible and 20% Coinsurance

Medical Emergency Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Hospital Emergency Room Visits	$100 per visit (waived if Member is admitted to the Hospital) after the Deductible has been met	Medical Emergencies (as defined in the Certificate) are Covered as an In-Network benefit.

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Medical Emergency Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Ambulance Services	No Charge after Deductible has been met	All Covered ambulance services for Medical Emergencies will be Covered as an In-Network benefit when Medically Necessary. For Non-emergency ambulance services - Deductible and 20% Coinsurance
Urgent Care Covered Services	**In-Network Out-of-Pocket Expenses**	**Out-of-Network Out-of-Pocket Expenses**
Urgent Care	$40 per visit after the Deductible has been met	Deductible and 20% Coinsurance

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Additional Coverage	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Outpatient Prescription Drugs **Retail Benefit -** The Out-of-Pocket Expenses are applied to each 31-day supply of a Prescription Drug to a maximum of a 90-day supply.	**Triple Tier** Tier 1 Prescription Drug Products- $25 Copayment after the Deductible has been met Tier 2 Prescription Drug Products- $50 Copayment after the Deductible has been met Tier 3 Prescription Drug Products- $75 Copayment after the Deductible has been met You are not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications. Prescription Drug expenses are included in the Plan Deductible. You must first meet the Plan Deductible before Copayments or Coinsurance will apply. Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.	Not Covered

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Additional Coverage	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Outpatient Prescription Drugs **Mail Order Benefit -** up to a 90-day supply of Prescription Drugs will be provided.	You will be responsible for 2 retail Copayments for Prescription Drugs.	Not Covered
	Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.	
Exercise Facility Reimbursement	We will reimburse a Subscriber $200 per six-months. We will reimburse a Subscriber's spouse, civil union partner or domestic partner (if the Group has purchased this coverage) $100 per six-months. The Member must complete 50 visits within the six-month period.	

Precertification List

Breast Pumps, Insulin Pumps, Inpatient admissions for obstetrical services, Allergy Testing and Treatment performed outside a physician's office, Inpatient Rehabilitation Services, Inpatient Admission for Reconstructive and Corrective Surgery, Outpatient Cardiac Rehabilitation, Outpatient Pulmonary Rehabilitation, Orthoptic Exercises and Corneal Topographic Procedures, Inpatient Admission for Oral Surgery, Laboratory Procedures (Precertification is not required for routine blood work and screening tests), Major Diagnostic Procedures, Infertility Services, Chemotherapy, Internal Prosthetic Devices, Durable Medical Equipment (Precertification required before purchase of $500 or more), Transplants, Clinical Trials, Home Health Care, Services Delivered in the Home, Medical Supplies, Hemodialysis, Home Treatment of Hemophilia, Chiropractic Services, Inpatient Hospital Services, Outpatient Hospital Services, Ambulatory Surgical Center Services, Inpatient or In-Home Hospice Services, Skilled Nursing Facility Services, Inpatient and Intermediate Care Substance Use Disorder Services, Inpatient and Intermediate Care Mental Health Services, Non-Urgent Ambulance Services, and Gender Dysphoria Services.

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Additional Plan Information	
Plan Deductible for In-Network Covered Services	Individual: $2,000 per Calendar Year Family: $4,000 per Calendar Year Prescription Drug expenses are included in the Plan Deductible. The Individual Deductible is only applicable to employees with no Dependent coverage. The Family Deductible applies when the employee and at least one other family member is covered. If the Family Deductible applies, the entire Family Deductible must be satisfied before coverage under this Plan is available.
Plan Deductible for Out-of-Network Covered Services	Individual: $4,000 per Calendar Year Family: $8,000 per Calendar Year Prescription Drug expenses are included in the Plan Deductible. The Individual Deductible is only applicable to employees with no Dependent coverage. The Family Deductible applies when the employee and at least one other family member is covered. If the Family Deductible applies, the entire Family Deductible must be satisfied before coverage under this Plan is available.
Deductible for Prescription Drugs	Subject to the Plan Deductible listed in this section. Please note that benefits for oral chemotherapeutic agents are not subject to the Deductible for Prescription Drugs. The Deductible is waived for PPACA Zero Cost Share Preventive Care Medications.

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Additional Plan Information	
Out-of-Pocket Maximum for In-Network Covered Services	Individual: $6,000 per Calendar Year Family: $12,000 per Calendar Year Remember, only In-Network Coinsurance and/or Copayments and the amounts paid to meet your In-Network Deductible (and Pharmacy Deductible, if applicable) count toward the In-Network Out-of-Pocket Maximum. Coinsurance paid for Out-of-Network benefits, amounts paid to meet the Out-of-Network Deductible, amounts paid for Non-Covered Services, and any amounts paid as a penalty do not count toward the In-Network, Out-of-Pocket Maximum. The individual Out-of-Pocket Maximum is only applicable to employees with no Dependent coverage. The family Out-of-Pocket Maximum applies when the employee and at least one other family member is covered. Once the applicable Out of Pocket Maximum has been reached, there is no further obligation to pay any amounts as Copayment, Deductible and/or Coinsurance for Covered Services for the remainder of the Calendar Year.
Out-of-Pocket Maximum for Out-of-Network Covered Services	Individual: $10,500 per Calendar Year Family: $21,000 per Calendar Year The individual Out-of-Pocket Maximum is only applicable to employees with no Dependent coverage. The family Out-of-Pocket Maximum applies when the employee and at least one other family member is covered. Once the applicable Out of Pocket Maximum has been reached, there is no further obligation to pay any amounts as Copayment, Deductible and/or Coinsurance for Covered Services for the remainder of the Calendar Year. Remember, only Out-of-Network Coinsurance and the amounts paid to meet your Out-of-Network Deductible count toward the Out-of-Network Out-of-Pocket Maximum. Coinsurance and/or Copayments for In-Network benefits, amounts paid to meet the In-Network Deductible, amounts in excess of Our Fee Schedule, amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the Out-of-Network Out-of-Pocket Maximum.
Precertification Penalty	If you fail to request a required Precertification for an Out-of-Network Benefit identified in the Precertification List, you will be subject to a 50% reduction in benefits for charges that would have otherwise been covered.

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Additional Plan Information	
Out-of-Network Reimbursement	Out of Network Reimbursement Amount: The Out of Network Reimbursement Amount is based upon 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception of the following: ● 50% of CMS for the same or similar laboratory service. ● 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates. Please refer to your Certificate of Coverage for more information on the Out-of-Network Reimbursement Amount.
	You are responsible for obtaining any required Precertification for services received from a Non-Network Provider. Additionally, if you want in-network coverage, **it is your responsibility to verify that a provider is a Network Provider.** Therefore when your PCP or other Network Provider arranges services for you, you should make sure that the provider is in Our Network by using Our online directory www.oxfordhealth.com, or by calling Us at the 1-800 number provided on your ID card. More information regarding Our fee schedule policy and administration is available. You may request a copy of Our fee schedule policy in the same manner as any Medical Policy. Please see your Certificate of Coverage for information on how to obtain copies of Our Policies.

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	Eligibility & Effective Dates of Coverage
Eligibility Limits	The limiting age for Dependents (as defined in the Certificate) is 26. Coverage ends at the end of the Calendar Year in which the child reaches the limiting age. Please note, extended coverage is available up to the age of 31 for Dependents who meet the definition of an Over-Age Dependent, as defined in the Certificate.
Effective Dates of Coverage	
Initial Enrollment (During initial Group Open Enrollment Period)	Coverage is effective on the effective date of the Agreement.
Newly Eligible Employee (Application within 31 days of becoming eligible)	Coverage is effective as of the date the employee became eligible.
Newly Eligible Dependent(s) (Application within 31 days of becoming eligible)	Coverage is effective as of the date the dependent became eligible. Coverage is effective at birth for newborns and newly born adopted children subject to the enrollment requirements as described in the Certificate.
Group Open Enrollment Period	Coverage is effective on the renewal date of the Agreement.

IMPORTANT: This document is not a contract. It is only a summary of your coverage. Please read your Certificate of Coverage and Member Handbook for a full description of your Covered Services, exclusions and other terms and conditions of coverage.

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