

OXFORD HEALTH INSURANCE, INC. FREEDOM PLAN HSA DIRECT SUMMARY OF COVERAGE Freedom Network ABEL HR, INC. PLAN 27

		ABEL HR, INC. PLAN 27	
BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	\$2,000	\$4,000
1	Family	\$4,000*	\$8,000
oinsurance	2	None	20%
	C:1-		
	Single	\$6,000	\$10,500
(Including Deductible)	Family	\$12,000	\$21,000
inancial Accumulation Period:		Calendar Year	Calendar Year
Out-of-Network Reimbursement:		Not Applicable	140% of Medicare ¹
lease Note: All Copayments, Deductibles, a Dut-of-Pocket Maximum.	nd Coinsurance	(medical and prescription) paid for In-Network Covered Services contri-	bute to the In-Network,
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Adult Preventive Care		No Charge	Deductible & 20% Coinsurance
nfant and Pediatric Preventive Care		No Charge	Deductible & 20% Coinsurance
DUTPATIENT CARE			
rimary Care Physician Office Visits		Deductible then \$25 copay	Deductible & 20% Coinsurance
pecialist Office Visits		Deductible then \$40 copay	Deductible & 20% Coinsurance
utpatient Surgery - Hospital Setting**		Deductible then \$200 copay	Deductible & 20% Coinsurance
utpatient Surgery - Freestanding Facility**		Deductible then \$200 copay	Deductible & 20% Coinsurance
aboratory Services Participating**		No Charge after Deductible	Deductible & 20% Coinsurance
See your Certificate of Coverage for addition	ıal Lab details)		
adiology Services**	ulator: Sureda 1	No Charge after Deductible	Deductible & 20% Coinsurance
ervices performed at a non-participating Amb	ulatory Surgical	centers and Laboratories are reimbursed at Oxford's Fee Schedule and the	refore may result in significant out of pocket costs.
IRIs, MRAs, CT SCANS, AND PET SCA putpatient Hospital Services**	NS	No Charge after Deductible	Deductible & 20% Coinsurance
reestanding Radiology Facility**		No Charge after Deductible	Deductible & 20% Coinsurance
OSPITAL CARE			
hysician's and Surgeon's Services**		No Charge after Deductible	Deductible & 20% Coinsurance
emi-Private Room and Board**		Deductible then \$400 per day up to \$2,000 max per year	Deductible & 20% Coinsurance
Il Drugs and Medication		No Charge after Deductible	Deductible & 20% Coinsurance
MERGENCY CARE			
Ambulance Services when Medically Necessa	ry**	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, notifice Emergency Care in Urgi-Center	ation is required) Deductible then \$40 copay	Deductible & 20% Coinsurance
incigency care in orgi-center		Deddenole dion \$40 copay	Deductible & 20% Consulance
IATERNITY CARE		No Charge	Deductible & 20% Coinsurance
Iospital Services for Mother and Child**		Deductible then \$400 per day up to \$2,000 max per year	Deductible & 20% Coinsurance
KILLED NURSING FACILITY			
0 Days per Calendar Year**		Deductible then \$400 per day up to \$2,000 max per year	Deductible & 20% Coinsurance
IOSPICE CARE (180 days per lifetime co	mbined Inpatie	nt & Home)	
npatient Care**		Deductible then \$400 per day up to \$2,000 max per year	Deductible & 20% Coinsurance
Iome Hospice Care Visits**		Deductible then \$40 copay	Deductible & 20% Coinsurance
IOME HEALTH CARE			
Iome Care Visits - 60 Visits per Calendar Ye	ar**	Deductible then \$40 copay	Deductible & 20% Coinsurance
Physician House Calls**		Deductible then \$40 copay	Deductible & 20% Coinsurance
UBSTANCE USE DISORDER SERVICE	ES		
npatient Rehabilitation**		Deductible then \$400 per day up to \$2,000 max per year	Deductible & 20% Coinsurance
Office Visits or Outpatient Rehabilitation		Deductible then \$30 copay	Deductible & 20% Coinsurance
utpatient Partial Hospitalization		No Charge After Deductible	Deductible & 20% Coinsurance
IENTAL HEALTH CARE			
apatient Care**		Deductible then \$400 per day up to \$2,000 max per year	Deductible & 20% Coinsurance
ffice Visits or Outpatient Care utpatient Partial Hospitalization**		Deductible then \$30 copay No Charge After Deductible	Deductible & 20% Coinsurance Deductible & 20% Coinsurance
		-	
LLERGY CARE esting and Treatment**		Deductible then \$40 copay	Deductible & 20% Coinsurance
C C			
CHIROPRACTIC CARE		Deductible then \$30 copay	Deductible & 50% Coinsurance
		_ success and \$50 copuj	Deddedete ee 5070 Comburance
out-of-Network coverage limited to \$500 er Calendar Year per Member			
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		ers must call Oxford at 1-800-444-6222 at least 14 days in advance of	of	
⁶ These services require precertification through Oxford. Members must call Oxford at 1-800-444-6222 at least 14 days in advance of	uest 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.

¹ Out of Network Reimbursement Amount: The Out of Network Reimbursement Amount is based upon [100 – 225]% 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.