UnitedHealthcare®
Oxford

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

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
Out-of-Network Reimbursement:		Not Applicable	140% of Medicare[1]

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 then $25 copay	Deductible & 20% Coinsurance
Specialist Office Visits	Deductible then $40 copay	Deductible & 20% Coinsurance
Outpatient Surgery - Hospital Setting**	Deductible then $200 copay	Deductible & 20% Coinsurance
Outpatient Surgery - Freestanding Facility**	Deductible then $200 copay	Deductible & 20% Coinsurance
Laboratory Services Participating**	No Charge after Deductible	Deductible & 20% Coinsurance
(See your Certificate of Coverage for additional Lab details)		
Radiology Services**	No Charge after Deductible	Deductible & 20% Coinsurance

Services performed at a non-participating Ambulatory Surgical centers and Laboratories are reimbursed at Oxford's Fee Schedule and therefore may result in significant out of pocket costs.

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 then $400 per day up to $2,000 max per year	Deductible & 20% Coinsurance
All Drugs and Medication	No Charge after Deductible	Deductible & 20% Coinsurance

Services performed at a non-participating Ambulatory Surgical centers are reimbursed at Oxford's Fee Schedule and therefore may result in significant out of pocket costs.

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 then $40 copay	Deductible & 20% Coinsurance
MATERNITY CARE		
Routine Prenatal and Post-Natal Care**	No Charge	Deductible & 20% Coinsurance
Hospital Services for Mother and Child**	Deductible then $400 per day up to $2,000 max per year	Deductible & 20% Coinsurance
SKILLED NURSING FACILITY		
30 Days per Calendar Year**	Deductible then $400 per day up to $2,000 max per year	Deductible & 20% Coinsurance
HOSPICE CARE (180 days per lifetime combined Inpatient & Home)		
Inpatient Care**	Deductible then $400 per day up to $2,000 max per year	Deductible & 20% Coinsurance
Home Hospice Care Visits**	Deductible then $40 copay	Deductible & 20% Coinsurance
HOME HEALTH CARE		
Home Care Visits - 60 Visits per Calendar Year**	Deductible then $40 copay	Deductible & 20% Coinsurance
Physician House Calls**	Deductible then $40 copay	Deductible & 20% Coinsurance
SUBSTANCE USE DISORDER SERVICES		
Inpatient 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
Outpatient Partial Hospitalization	No Charge After Deductible	Deductible & 20% Coinsurance
MENTAL HEALTH CARE		
Inpatient Care**	Deductible then $400 per day up to $2,000 max per year	Deductible & 20% Coinsurance
Office Visits or Outpatient Care	Deductible then $30 copay	Deductible & 20% Coinsurance
Outpatient Partial Hospitalization**	No Charge After Deductible	Deductible & 20% Coinsurance
ALLERGY CARE		
Testing and Treatment**	Deductible then $40 copay	Deductible & 20% Coinsurance
CHIROPRACTIC CARE		
Chiropractic Care**	Deductible then $30 copay	Deductible & 50% Coinsurance
Out-of-Network coverage limited to $500 per Calendar Year per Member		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
SHORT TERM REHAB & HABILITATIVE SERVICES		
60 Inpatient Days per Calendar Year**	Deductible then $400 per day up to $2,000 max per year	Deductible & 20% Coinsurance
60 combined Outpatient Visits per Calendar Year**	Deductible then $40 copay	Deductible & 20% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Unlimited**	No Charge after Deductible	Deductible & 20% Coinsurance
(Precertification required for items over $500)		
Services performed at a non-participating DME Providers are reimbursed at Oxford's Fee Schedule and therefore may result in significant out of pocket costs.		
HEARING AIDS		
Hearing Aids (Age 15 & under) - Limited to 1 hearing aid for each hearing impaired ear every 24 months.	No Charge after Deductible	Deductible & 20% Coinsurance
Hearing Aids (Age 16 & over) - Limited to $5,000 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	$100 reimbursement per 6 month period	$100 reimbursement per 6 month period
INFERTILITY TREATMENT		
Specialist Office Visits**	Deductible then $40 copay	Deductible & 20% Coinsurance
Outpatient Facility Services**	Deductible then $200 copay	Deductible & 20% Coinsurance
Inpatient Facility Services**	Deductible then $400 per day up to $2,000 max per 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	Covered at Participating Pharmacies Only
Tier 2	$50 copay	Covered at Participating Pharmacies Only
Tier 3	$75 copay	Covered at Participating Pharmacies Only
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	$50 copay	Covered at Participating Pharmacies Only
Tier 2	$100 copay	Covered at Participating Pharmacies Only
Tier 3	$150 copay	Covered at Participating Pharmacies Only

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 Calendar Year.
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.

[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.