



**HSA DIRECT<sup>SM</sup>**  
**SUMMARY OF COVERAGE**  
**FREEDOM NETWORK**  
**NEW YORK SOLE PROPRIETORS**



<b>BENEFIT</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>FINANCIAL</b>		<b>UCR: 70% of HIAA</b>
Deductible: Single	\$2,850	\$2,850
Family	\$5,700	\$5,700
Coinsurance	10%	30%
Maximum Out-Of-Pocket: Single	\$3,850	\$5,850
(Including Deductible) Family	\$7,700	\$11,700
Maximum Lifetime Benefit Per Member	Unlimited	Unlimited
<b>PREVENTIVE CARE</b>		
Adult Preventive Care	No Charge	In-Network Benefit Only
Infant and Pediatric Preventive Care	No Charge	Deductible and 30% Coinsurance \$300 annual maximum
Immunizations	No Charge	Deductible and 30% Coinsurance
<b>OUTPATIENT CARE</b>		
Primary Care Physician office visits	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Specialist Office Visits	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Surgery **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Laboratory services	At Participating Laboratories Covered at 100%	Deductible and 30% Coinsurance
Radiology services including PT, CT scans, Magnetic Resonance Imaging (MRI) **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance <b>Precertification is required for Out of Network PET scans, MRAs, surgical endoscopic procedures, MRIs Nuclear Medicine, CT Scans, and Bone Density Studies.</b>
Screening Mammograms	Covered at 100%	Deductible and 30% Coinsurance
<b>ALLERGY CARE</b>		
Initial visit, and all subsequent referral visits	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
<b>HOSPITAL CARE</b>		
Physician's and surgeon's services **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Semi-private room and board **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
All drugs and medication	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
<b>EMERGENCY CARE</b>		
Ambulance service when Medically Necessary	Deductible and 10% Coinsurance	Deductible and 10% Coinsurance
At hospital emergency room <i>(If member is admitted to the hospital through the ER, notification is required)</i>	Deductible and 10% Coinsurance	Deductible and 10% Coinsurance
Emergency Care in Urgi-Center	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
<b>MATERNITY CARE</b>		
Prenatal and post-natal care	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Hospital services for mother and child **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
<b>SHORT TERM REHABILITATION</b>		
60 consec. inpatient days per condition / lifetime**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
60 outpatient visits per condition per lifetime	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
<b>HOME HEALTH CARE</b>		
40 home care visits **	Subject to 10% Coinsurance	Subject to 25% Coinsurance
Physician house calls	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
<b>SKILLED NURSING FACILITY</b>		
200 days per calendar year**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
<b>SUBSTANCE ABUSE</b>		
7 days of inpatient detox. per calendar year **	Deductible and 10% Coinsurance	In-Network Benefit Only
30 days of inpatient rehab. per calendar year **	Deductible and 10% Coinsurance	In-Network Benefit Only
60 outpatient rehab. visits per calendar year	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>MENTAL HEALTH CARE</b>		
30 days of Inpatient care per calendar year**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
30 visits of Outpatient care per calendar year**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Office visits (visits combined with Outpatient care)**	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
<b>PRESCRIPTION DRUGS</b>		
	Plan Deductible Deductible (Waived for Generic Drugs)	
Generic***	\$15 copayment	Covered at Participating Pharmacies Only
Brand Name***	50% coinsurance	Covered at Participating Pharmacies Only
Includes Contraceptives		
<b>HOSPICE CARE (210 days)</b>		
Inpatient care **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Outpatient care **	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
<b>EXERCISE FACILITY</b>		
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
<b>OTHER ITEMS</b>		
Medical Supplies, when Medically Necessary	OUT-OF-NETWORK BENEFIT ONLY	Deductible and 30% Coinsurance
<b>Durable Equipment</b> , when Medically Necessary	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
**(precert required on items over \$500)		
(This benefit is limited to \$1500 per calendar year.)		

**DEPENDENT ELIGIBILITY:**

Eligible dependents include the employee's spouse and dependent children until the child reaches age 19, or age 23 if a full time student.  
Benefits discontinue at the end of the Calendar Year.  
Domestic Partners are covered with proper documentation.

\*\* These services require **precertification** through Oxford. You 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 abuse services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

\*\*\*\*Prescription medications ordered through the Mail Order Drug Program are subject to 2 retail pharmacy copays for Generic Drugs and 50% coinsurance for Brand Name Drugs.

\*\*\*\*The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles and/or maximum limits.

**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 your 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, hearing aids, or, unless otherwise stated, dental services and vision correction services and supplies.

IMPORTANT: If you live and work in a state other than New York, please check the back of your certificate for extraterritorial benefits rider.  
Based on the state of your residence, additional coverage may be available to you.

**Please be advised this quote is for informational purposes only. The information contained herein is subject to both state regulatory and Oxford home office approval as appropriate.**