Oxford Health Insurance, Inc.
New York HSA Direct Plan
Summary of Benefits
Freedom Network
The New School

Primary and Preventive Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Physician Office and Home Visits		
Preventive Care	Adults - No Charge Please Note: For adults, related radiological tests (including mammograms) and most procedures (e.g. colonoscopy) will be Covered subject to Deductible and 10% Coinsurance. Children - No Charge	Adults - Not Covered Children - Deductible and 30% Coinsurance
Primary Care for Treatment of Illness or Injury	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Physician Hospital Visits	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Well-Woman Exams - This benefit includes two well-woman examinations, age appropriate screening mammograms and two Pap tests.	No Charge Please Note: Preventive Screening Mammograms performed in accordance with the well-woman schedule in your Certificate are Covered at No Charge. All other mammograms will be Covered subject to Deductible and 10% Coinsurance.	Please Note: Well-woman examinations are Covered In-Network only.
Diabetes Education & Self-Management	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Diabetic Supplies and Medications	No Charge after the Deductible has been met	Deductible and 30% Coinsurance
Pediatric Preventive Dental - Coverage is provided through age 11 for one visit per Calendar Year.	No Charge	No Charge

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-Network and Out-of-Network Covered Services combined.

Oxford Health Insurance, Inc.
New York HSA Direct Plan
Summary of Benefits

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Physician (Specialist) Office and Home Visits	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Allergy Testing & Treatment	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Chiropractic Services	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Obstetrical Services - Coverage includes prenatal and postnatal care.	Deductible and 10% Coinsurance Inpatient hospital services are Covered subject to Deductible and 10% Coinsurance.	Deductible and 30% Coinsurance
Laboratory Procedures	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
X-ray Examinations	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Diagnostic Mammography	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Radiology Services (Facility Based)	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Durable Medical Equipment - Coverage is unlimited.	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Hearing Aids - Coverage is limited to a maximum payment by Us of $5,000. Benefits are limited to a single purchase (including repair/replacement) every three Years.	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Medical Supplies	No In-Network Benefit	Deductible and 30% Coinsurance
Prosthetic Devices (External)	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Prosthetic Devices (Internal)	Deductible and 10% Coinsurance. Surgery is subject to either the inpatient or outpatient facility Out-of-Pocket Expense (if any).	Deductible and 30% Coinsurance
Second Opinions	At your request - Deductible and 10% Coinsurance At Our request - No Charge	Deductible and 30% Coinsurance
Transplants	When performed at Our approved facilities - Deductible and 10% Coinsurance When performed at other Network facilities - The services will be Covered on an Out-of-Network basis.	Deductible and 30% Coinsurance Deductible and 30% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-Network and Out-of-Network Covered Services combined.

Oxford Health Insurance, Inc.
New York HSA Direct Plan
Summary of Benefits

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Oral Surgery	All Specialist visits are subject to the Specialist Office Visit Out-of-Pocket Expense. All outpatient and inpatient facility visits are subject to the appropriate facility Out-of-Pocket Expense (if any).	Deductible and 30% Coinsurance
Short-Term Rehabilitative Services (Physical, Speech and Occupational) - Inpatient services are limited to one consecutive 60-day period per condition, per lifetime. Outpatient services are limited to 60 visits per condition, per lifetime. Please Note: This outpatient benefit is in addition to the Outpatient Long-Term Rehabilitation benefit. The combined maximum for both benefits is 100 visits.	All Specialist visits are subject to the Specialist Office Visit Out-of-Pocket Expense. All outpatient and inpatient facility visits are subject to the appropriate facility Out-of-Pocket Expense (if any).	Deductible and 30% Coinsurance
Infertility Services (Basic & Comprehensive) Please Note: Advanced Infertility Services are Not Covered.	All Specialist visits are subject to the Specialist Office Visit Out-of-Pocket Expense. All outpatient and inpatient facility visits are subject to the appropriate facility Out-of-Pocket Expense (if any).	Deductible and 30% Coinsurance
Elective Termination of Pregnancy - We Cover one procedure. This benefit is limited to a maximum of $350 per procedure.	All Specialist visits are subject to the Specialist Office Visit Out-of-Pocket Expense. All outpatient and inpatient facility visits are subject to the appropriate facility Out-of-Pocket Expense (if any).	Deductible and 30% Coinsurance
Home Health Care - This benefit is limited to 40 visits.	Deductible and 10% Coinsurance	Deductible and 25% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-Network and Out-of-Network Covered Services combined.

Oxford Health Insurance, Inc.
New York HSA Direct Plan
Summary of Benefits

Hospital & Facility Based Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Inpatient Hospital Services	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Outpatient Hospital & Ambulatory Surgical Center	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Skilled Nursing Facility Services - This benefit is limited to 30 days.	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Outpatient Alcohol & Substance Abuse Rehabilitation	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Inpatient Mental Health Services (including Biologically Based Mental Health Services & Services for Children with Serious Emotional Disorders)	All inpatient facility visits are subject to the appropriate facility Out-of-Pocket Expense (if any).	Deductible and 30% Coinsurance
Outpatient Mental Health Services and Partial Hospitalization (including Biologically Based Mental Health Services & Services for Children with Serious Emotional Disorders)	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Hospice Services - This benefit is limited to 210 days (combined inpatient, outpatient and home hospice). 5 sessions of bereavement counseling are available for the Member's family either before or after the death of the Member.	All Specialist visits are subject to the Specialist Office Visit Out-of-Pocket Expense. All outpatient and inpatient facility visits are subject to the appropriate facility Out-of-Pocket Expense (if any).	Deductible and 30% Coinsurance
Home Hospice - This benefit is limited to 210 days (combined inpatient, outpatient and home hospice).	Deductible and 10% Coinsurance	Deductible and 25% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-Network and Out-of-Network Covered Services combined.

Oxford Health Insurance, Inc.
New York HSA Direct Plan
Summary of Benefits

Medical Emergency & Urgent Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Ambulance Services	Deductible and 10% Coinsurance	All Emergency Ambulance Services will be Covered as an In-Network benefit. Coverage for Non-Emergency Ambulance services is subject to Deductible and 30% Coinsurance.
Emergency Room Services	Deductible and 10% Coinsurance	When proper notice is given, Emergency Room Services will be Covered as an In-Network benefit. When proper notice is not given, Medical Emergency Admissions are Covered subject to Deductible and 50% Coinsurance.
Urgent Care Facility Services	Deductible and 10% Coinsurance	When proper notice is given, Urgent Care Facility Services will be Covered as an In-Network benefit. When proper notice is not given, Urgent Care Facility Services are Covered subject to Deductible and 30% Coinsurance.

Supplemental Coverage	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Inpatient Alcohol & Substance Abuse Rehabilitation & Detoxification Services	All inpatient facility visits are subject to the appropriate facility Out-of-Pocket Expense (if any).	Deductible and 30% Coinsurance
Outpatient Long-Term Physical Rehabilitation Services - This benefit is in addition to the Outpatient Short-Term Rehabilitation benefit. The combined maximum is 100 visits.	All Specialist visits are subject to the Specialist Office Visit Out-of-Pocket Expense. All outpatient and inpatient facility visits are subject to the appropriate facility Out-of-Pocket Expense (if any).	Deductible and 30% Coinsurance
Vision Care	Exams: Within one 12-month period We will reimburse you $50 for one vision examination. Appliances: Within one 24-month period We will reimburse you $200 for one set of appliances.	

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-Network and Out-of-Network Covered Services combined.

Oxford Health Insurance, Inc.
New York HSA Direct Plan
Summary of Benefits

Supplemental Coverage	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Outpatient Prescription Drugs - Subject to the Plan Deductible per member per Calendar Year		
Retail Benefit	**Triple Tier** Tier 1 - $10 Copayment Tier 2 - $25 Copayment Tier 3 - $50 Copayment Please Note: The above Copayments are applied to each 31-day supply of a Prescription Drug.	Not Covered
Mail Order Benefit	You will be responsible for 2 retail copayments for each 90-day supply of Prescription Drugs.	Not Covered

Precertification List

Please Note: Unless otherwise indicated, Precertification applies to both In-Network and Out-of-Network benefits. Your Network Provider is responsible for obtaining Precertification for In-Network Services. You are responsible for obtaining Precertification for Out-of-Network services. If you fail to obtain a required Precertification for an Out-of-Network Benefit, you will be subject to the Precertification Penalty identified in the Additional Plan Information Section.

Inpatient admissions for Obstetrical Services, Inpatient Admission for Elective Termination of Pregnancy, Inpatient admissions for Allergy Testing & Treatment, Inpatient Short-Term Rehabilitative Services, Orthoptic Exercises and Corneal Topographic Procedures, Oral Surgery, Laboratory Procedures, Radiology Services- including PET scans, MRA, MRI, Nuclear Medicine, CT Scans, Ultrasound and surgical endoscopic procedures, Infertility Services, Radiation/Chemotherapy, Prosthetic Devices, Durable Medical Equipment (Precertification required before purchase), Medical Supplies, Transplants, Home Health Care, Chiropractic Services, Inpatient Hospital Services, Outpatient Hospital Services and Ambulatory Surgical Center Services, Inpatient Hospice Services, Skilled Nursing Facility Services, Inpatient Alcohol Abuse Rehabilitation & Detoxification, Inpatient Substance Abuse Rehabilitation & Detoxification, Inpatient and Outpatient Facility Biologically-Based Mental Health Services (Precertification does not apply to out of network services), Inpatient and Outpatient Facility Non-Biologically-Based Mental Health Services (Precertification does not apply to out of network services), Urgent Care Facility Services.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-Network and Out-of-Network Covered Services combined.

Oxford Health Insurance, Inc.
New York HSA Direct Plan
Summary of Benefits

Additional Plan Information
(Unless otherwise indicated, any benefit maximums and limitations apply to both the In-Network and Out-of-Network benefits **combined**.)

Plan Deductible for In-Network Covered Services including Prescription Drug Expenses	Individual: $2,000 per Calendar Year Family: $4,000 per Calendar Year 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.
Plan Deductible for Out-of-Network Covered Services	Individual: $2,000 per Calendar Year Family: $4,000 per Calendar Year 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.
Out-of-Pocket Maximum for In-Network Covered Services	Individual: $3,000 per Calendar Year Family: $6,000 per Calendar Year **Please Note**: Only Copayments, Deductibles, and Coinsurance paid for In-Network Covered Services contribute to your In-Network, Out-of-Pocket Maximum. Deductible and Coinsurance for Out-of-Network Covered Services, amounts in excess of the UCR, amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the In-Network Out-of-Pocket Maximum. Coinsurance paid for any Covered Service obtained under Supplemental Coverage (excluding State mandated offers) will not be applied toward the In-Network Out-of-Pocket Maximum.
Out-of-Pocket Maximum for Out-of-Network Covered Services	Individual: $5,000 per Calendar Year Family: $10,000 per Calendar Year **Please Note:** Only Coinsurance and Deductibles paid for Out-of-Network Covered Services contribute to your Out-of-Network, Out-of-Pocket Maximum. Copayments for In-Network benefits, amounts in excess of the UCR, amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the Out-of-Pocket Maximum. Coinsurance paid for any Covered Service obtained under Supplemental Coverage (excluding State Mandated offers) will not be applied toward the Out-of-Network Out-of-Pocket Maximum.
Precertification Penalty	The list of services that require Precertification has been attached. If you fail to obtain a required Precertification for an Out-of-Network Benefit, you will be subject to a reduction in benefits. You must pay 50% of the costs for such service or supply.
Out-of-Network Reimbursement	The Group has selected the following reimbursement methodology to reimburse Out-of-Network Covered Services: UCR Fee Schedule: The UCR Fee Schedule contains the maximum allowable fees and is set using data from Ingenix, Inc., and the Centers for Medicare and Medicaid Services (CMS) and sources recognized by the federal government and insurance industry as a basis for evaluating and establishing fees. Physician fees are generally set using 70th percentile data from the Prevailing Healthcare Charges System (PHCS) database maintained by Ingenix. We and Ingenix are related companies through common ownership by UnitedHealth Group. The fee schedule for physician-administered pharmaceutical products is based upon a percentage of Average Wholesale Price. If a data source is no longer available, we will use a comparable data source to establish fees. More information regarding Our Out-of-Network reimbursement is available by referring to your Certificate of Coverage and Member Handbook documents.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-Network and Out-of-Network Covered Services combined.

Oxford Health Insurance, Inc.
New York HSA Direct Plan
Summary of Benefits

Eligibility & Effective Dates of Coverage

Eligibility Limits	The limiting age for Dependents (as defined in the Certificate) is age 26.
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 on the effective date of the Agreement.
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, Supplemental Certificate of Coverage, and Member Handbook for a full description of your Covered Services, exclusions and other terms and conditions of coverage.

IMPORTANT: Coverage In-Network does not duplicate coverage Out-of-Network. **Benefits are not cumulative.** Benefits received In-Network reduce the amount of benefits available Out-of-Network. Benefits received Out-of-Network reduce the amount of benefits available In-Network.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-Network and Out-of-Network Covered Services combined.