

# Oxford Freedom Silver EPO – H.S.A.

Summary of Benefits

Plan #1 · OX\_P1 FS

EPO — In-Network Only

No Referrals Required

SINGLE

**\$1,354.74**

per month\*

PARENT / CHILD(REN)

**\$2,280.58**

per month\*

COUPLE

**\$2,665.61**

per month\*

FAMILY

**\$3,768.05**

per month\*

ANNUAL DEDUCTIBLE

**\$2,500 / \$5,000**

Individual / Family — in network

COINSURANCE (YOUR SHARE)

**40% after deductible**

unless otherwise noted\*\*

OUT-OF-POCKET MAXIMUM

**\$8,000 / \$16,000**

Individual / Family — in network

| BENEFIT                                  | IN-NETWORK — WHAT YOU PAY                                                              |
|------------------------------------------|----------------------------------------------------------------------------------------|
| Office Visits (PCP / Specialist)         | \$0 / \$0 — subject to deductible & coinsurance**                                      |
| Hospital Admission                       | Subject to deductible & coinsurance**                                                  |
| Emergency Room                           | 50% coinsurance after deductible (in & out of network)                                 |
| Urgent Care                              | Subject to deductible & coinsurance**                                                  |
| Prescription Drugs                       | Generic \$10 · Preferred \$40 · Non-Preferred \$80 — subject to annual plan deductible |
| Mental Health                            | Inpatient or Outpatient: 40% coinsurance**                                             |
| Lab & X-rays                             | Subject to deductible & coinsurance**                                                  |
| Free-Standing Outpatient Facility        | Subject to deductible & coinsurance**                                                  |
| Hospital-Based Outpatient Facility       | Subject to deductible & coinsurance**                                                  |
| Major Diagnostic — Freestanding Facility | Subject to deductible & coinsurance**                                                  |
| Major Diagnostic — Hospital              | Subject to deductible & coinsurance**                                                  |
| Dependent Coverage                       | Covered to age 26                                                                      |
| Find a Doctor                            | Oxford provider lookup: <a href="http://www.oxhp.com">www.oxhp.com</a>                 |

**Out-of-Network:** Not covered, except emergency care. This plan uses the Oxford network exclusively (EPO).

\* Rates valid January 1, 2026 – December 31, 2026 and include the monthly administrative/billing fee (\$30 employee-only, \$50 all other tiers).

\*\* Coinsurance percentages shown are your share of the cost. Unless otherwise noted, coinsurance applies after the annual deductible is met.

This document is a plan summary prepared for comparison purposes only and is not the official Summary of Benefits and Coverage (SBC), policy, or certificate of coverage. It is not a comprehensive list of all benefits, limitations, or exclusions. The official plan documents govern in all cases and are available upon request.