



OXFORD HEALTH INSURANCE, INC.
NJ S FRDM NG 2500/100 PPO HSA 20 - Non-Gated
SUMMARY OF COVERAGE

Freedom Network

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	\$2,500	\$5,000
	Family*	\$5,000	\$10,000
Coinsurance		None	50%
Maximum Out-Of-Pocket:	Single	\$6,750	\$13,700
(Including Deductible)	Family	\$13,500	\$27,400
Financial Accumulation Period:		Contract Year	Contract Year
Out-of-Network Reimbursement:		Not Applicable	110% Medicare

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.

**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.*

PREVENTIVE CARE

Pediatric (over 1 year) and Adult Preventive Care		No Charge	Deductible & 50% Coinsurance
Infant Preventive Care (under 1 year)		No Charge	Deductible & 50% Coinsurance
Preventive Dental for Children (Up to age 19)**		No Charge after Deductible	No Charge after Deductible
Pediatric Vision Exam (Up to age 19)		No Charge	Deductible & 50% Coinsurance
Pediatric Vision Hardware: (Up to age 19)		Deductible & 50% Coinsurance	Deductible & 50% Coinsurance

OUTPATIENT CARE

Primary Care Physician Office Visits		No Charge after Deductible	Deductible & 50% Coinsurance
Specialist Office Visits		No Charge after Deductible	Deductible & 50% Coinsurance
Outpatient Surgery - Hospital Setting**		No Charge after Deductible	Deductible & 50% Coinsurance
Outpatient Surgery - Freestanding Facility**		No Charge after Deductible	Deductible & 50% Coinsurance
Laboratory Services**		No Charge after Deductible	Deductible & 50% Coinsurance
Radiology Services**		No Charge after Deductible	Deductible & 50% Coinsurance

MRIs, MRAs, CT SCANS, AND PET SCANS

Outpatient Hospital Services**		No Charge after Deductible	Deductible & 50% Coinsurance
Freestanding Radiology Facility**		No Charge after Deductible	Deductible & 50% Coinsurance

HOSPITAL CARE

Physician's and Surgeon's Services **		No Charge after Deductible	Deductible & 50% Coinsurance
Semi-Private Room and Board **		Deductible then \$500 Copay per day, \$1,500 max per Calendar Year	Deductible & 50% Coinsurance
All Drugs and Medication		No Charge after Deductible	Deductible & 50% Coinsurance

EMERGENCY CARE

Ambulance Service When Medically Necessary		No Charge after Deductible	No Charge after Deductible
At Hospital Emergency Room (waived if admitted) (If member is admitted to the hospital, notification is required.)		Deductible & 20% Coinsurance then \$100 Copay	Deductible & 20% Coinsurance then \$100 Copay
Emergency Care in Urgi-Center		No Charge after Deductible	Deductible & 50% Coinsurance

MATERNITY CARE

Prenatal and Post-Natal Care**		No Charge	Deductible & 50% Coinsurance
Hospital Services for Mother and Child**		Deductible then \$500 Copay per day, \$1,500 max per Calendar Year	Deductible & 50% Coinsurance

SKILLED NURSING FACILITY**

120 days per Calendar Year Non-Network. Combined with Inpatient Rehabilitation.**		Deductible then \$500 Copay per day, \$1,500 max per Calendar Year	Deductible & 50% Coinsurance
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HOSPICE CARE

Inpatient Care**		Deductible then \$500 Copay per day, \$1,500 max per Calendar Year	Deductible & 50% Coinsurance
Home Hospice - Unlimited**		No Charge after Deductible	Deductible & 50% Coinsurance

HOME HEALTH CARE

Home Care Visits - 60 visits per Calendar Year.**		No Charge after Deductible	Deductible & 50% Coinsurance
Physician House Calls**		No Charge after Deductible	Deductible & 50% Coinsurance

SUBSTANCE USE DISORDER SERVICES

Inpatient Rehabilitation**		Deductible then \$500 Copay per day, \$1,500 max per Calendar Year	Deductible & 50% Coinsurance
Outpatient Rehabilitation		No Charge after Deductible	Deductible & 50% Coinsurance
Outpatient Partial Hospitalization**		No Charge after Deductible	Deductible & 50% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
Inpatient Rehabilitation**	Deductible then \$500 Copay per day, \$1,500 max per Calendar Year	Deductible & 50% Coinsurance
Outpatient Rehabilitation	No Charge after Deductible	Deductible & 50% Coinsurance
Outpatient Partial Hospitalization**	No Charge after Deductible	Deductible & 50% Coinsurance
ALLERGY CARE		
Testing and Treatment**	No Charge after Deductible	Deductible & 50% Coinsurance
ALTERNATIVE MEDICINE		
Chiropractic Care - 30 visits per Calendar Year**	No Charge after Deductible	Deductible & 50% Coinsurance
SHORT TERM REHABILITATION		
120 days per Calendar Year Non-Network. Combined with Skilled Nursing.**	Deductible then \$500 Copay per day, \$1,500 max per Calendar Year	Deductible & 50% Coinsurance
Outpatient Visits - Limited to 30 combined PT/OT visits per calendar year** <i>Precertification upon initial Visit**</i>	No Charge after Deductible	Deductible & 50% Coinsurance
HABILITATIVE SERVICES		
Inpatient - Unlimited**	Deductible then \$500 Copay per day, \$1,500 max per Calendar Year	Deductible & 50% Coinsurance
Outpatient Visits - Limited to 30 combined PT/OT visits per calendar year** <i>Note: Autism Spectrum Disorder limits are separate from the Rehabilitation Limit and are defined separately per NJ autism mandate.</i>	No Charge after Deductible	Deductible & 50% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment - Unlimited** <i>Precertification required for items over \$500</i>	No Charge after Deductible	Deductible & 50% Coinsurance
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary**	No Charge after Deductible	Deductible & 50% Coinsurance
HEARING AIDS		
Hearing Aids (through age 15) - Limited to 1 hearing aid for each hearing impaired ear every 24 months.	No Charge after Deductible	Deductible & 50% Coinsurance
EXERCISE FACILITY		
Subscriber	\$200 reimbursement per 6 month period	\$200 reimbursement per 6 month period
Spouse and Dependent over age 13	\$100 reimbursement per 6 month period	\$100 reimbursement per 6 month period
OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE		
	Subject to Plan Deductible listed above	
OUTPATIENT PRESCRIPTION DRUGS - RETAIL		
<i>The Prescription Drug Benefit is based on a Per Contract Year limit for any applicable deductibles and/or maximum limits.</i>		
Tier 1	\$7 Copay	Covered at participating pharmacies only
Tier 2	50% Coinsurance	Covered at participating pharmacies only
Tier 3	50% Coinsurance	Covered at participating pharmacies only
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	\$14 Copay	Covered at participating pharmacies only
Tier 2	50% Coinsurance	Covered at participating pharmacies only
Tier 3	50% Coinsurance	Covered at participating pharmacies only

DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.
Domestic Partners are covered with proper documentation.

**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.

**Precertification is required for Pediatric Orthodontia services only.

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.

Benefits are subject to final approval by the Department of Insurance and therefore may be subject to change.