OXFORD HEALTH INSURANCE, INC.
NJ S FRDM NG 50/75/2500/60 PPO 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		40%	50%
Maximum Out-Of-Pocket:	Single	$8,150	$12,500
(Including Deductible)	Family	$16,300	$25,000
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.*

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)	$30 Copay per visit	Deductible & 50% Coinsurance
Pediatric Vision Hardware: (Up to age 19)	50% Coinsurance	Deductible & 50% Coinsurance
OUTPATIENT CARE		
Primary Care Physician Office Visits	$50 Copay per visit	Deductible & 50% Coinsurance
Specialist Office Visits	$75 Copay per visit	Deductible & 50% Coinsurance
Outpatient Surgery - Hospital Setting**	$500 Copay per visit	Deductible & 50% Coinsurance
Outpatient Surgery - Freestanding Facility**	$250 Copay per visit	Deductible & 50% Coinsurance
Laboratory Services**	$20 Copay per service	Deductible & 50% Coinsurance
Radiology Services**	Deductible & 40% Coinsurance	Deductible & 50% Coinsurance
MRIs, MRAs, CT SCANS, AND PET SCANS		
Outpatient Hospital Services**	Deductible & 50% Coinsurance	Deductible & 50% Coinsurance
Freestanding Radiology Facility**	Deductible & $100 Copay per service	Deductible & 50% Coinsurance
HOSPITAL CARE		
Physician's and Surgeon's Services **	Deductible & 40% Coinsurance	Deductible & 50% Coinsurance
Semi-Private Room and Board **	Deductible & 40% Coinsurance	Deductible & 50% Coinsurance
All Drugs and Medication	Deductible & 40% Coinsurance	Deductible & 50% Coinsurance
EMERGENCY CARE		
Ambulance Service When Medically Necessary	Deductible & 40% Coinsurance	Deductible & 40% Coinsurance
At Hospital Emergency Room *(waived if admitted)*	Deductible & 50% Coinsurance then $100 Copay per visit	Deductible & 50% Coinsurance then $100 Copay per visit
(If member is admitted to the hospital, notification is required.)		
Emergency Care in Urgi-Center	$75 Copay per visit	Deductible & 50% Coinsurance
MATERNITY CARE		
Prenatal and Post-Natal Care**	No Charge	Deductible & 50% Coinsurance
Hospital Services for Mother and Child**	Deductible & 40% Coinsurance	Deductible & 50% Coinsurance
SKILLED NURSING FACILITY**		
Unlimited**	Deductible & 40% Coinsurance	Deductible & 50% Coinsurance
HOSPICE CARE		
Inpatient Care**	Deductible & 40% Coinsurance	Deductible & 50% Coinsurance
Home Hospice - Unlimited**	$75 Copay per visit	Deductible & 50% Coinsurance
HOME HEALTH CARE		
Home Care Visits - 60 visits per Calendar Year.**	$75 Copay per visit	Deductible & 50% Coinsurance
Physician House Calls**	$75 Copay per visit	Deductible & 50% Coinsurance
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation**	Deductible & 40% Coinsurance	Deductible & 50% Coinsurance
Outpatient Rehabilitation	$25 Copay per visit	Deductible & 50% Coinsurance
Outpatient Partial Hospitalization**	No Charge	Deductible & 50% Coinsurance

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
Inpatient Rehabilitation**	Deductible & 40% Coinsurance	Deductible & 50% Coinsurance
Outpatient Rehabilitation	$25 Copay per visit	Deductible & 50% Coinsurance
Outpatient Partial Hospitalization**	No Charge	Deductible & 50% Coinsurance
ALLERGY CARE		
Testing and Treatment**	$75 Copay per visit	Deductible & 50% Coinsurance
ALTERNATIVE MEDICINE		
Chiropractic Care - 30 visits per Calendar Year**	$30 Copay per visit	Deductible & 50% Coinsurance
SHORT TERM REHABILITATION		
Inpatient - Unlimited**	Deductible & 40% Coinsurance	Deductible & 50% Coinsurance
Outpatient - Limited to 30 combined PT/OT visits per Calendar *Precertification upon initial Visit***	$50 Copay per outpatient visit	Deductible & 50% Coinsurance
HABILITATIVE SERVICES		
Inpatient - Unlimited**	Deductible & 40% Coinsurance	Deductible & 50% Coinsurance
Outpatient Visits** Outpatient - Limited to 30 combined PT/OT visits per Calendar Year. ***Note:*** *Autism Spectrum Disorder limits are separate from the Rehabilitation Limit and are defined separately per NJ autism mandate.*	$50 Copay per outpatient visit	Deductible & 50% Coinsurance
DURABLE MEDICAL EQUIPMENT		
Unlimited *Precertification required for items over $500*	No Charge	Deductible & 50% Coinsurance
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary**	Deductible & 40% Coinsurance	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	Deductible & 50% Coinsurance
EXERCISE FACILITY		
Subscriber	$200 reimbursement per 6 month period	$200 reimbursement per 6 month period
Spouse/Dependents over age 13	$100 reimbursement per 6 month period	$100 reimbursement per 6 month period
OUTPATIENT PRESCRIPTION DRUGS - RETAIL		
The Prescription Drug Benefit is based on a Per Contract 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.
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.