OXFORD HEALTH INSURANCE, INC.
NJ G LBTY NG 30/50/1000/80 EPO 19 - Non-Gated
SUMMARY OF COVERAGE

Network

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	$1,000	Not Covered
	Family	$2,000	Not Covered
Coinsurance		20%	Not Covered
Maximum Out-Of-Pocket:	Single	$4,250	Not Covered
(Including Deductible)	Family	$8,500	Not Covered
Financial Accumulation Period:		Calendar Year	Not Applicable
Out-of-Network Reimbursement:		Not Applicable	Not Applicable

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.*

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
Pediatric (over 1 year) and Adult Preventive Care	No Charge	Not Covered
Infant Preventive Care (under 1 year)	No Charge	Not Covered
Preventive Dental for Children (Up to age 19)	No Charge after Deductible	Not Covered
Pediatric Vision Exam (Up to age 19)	$30 Copay per visit	Not Covered
Pediatric Vision Hardware: (Up to age 19)	50% Coinsurance	Not Covered
OUTPATIENT CARE		
Primary Care Physician Office Visits	$30 Copay per visit	Not Covered
Specialist Office Visits	$50 Copay per visit	Not Covered
Outpatient Surgery - Hospital Setting	$150 Copay per visit	Not Covered
Outpatient Surgery - Freestanding Facility	$75 Copay per visit	Not Covered
Laboratory Services	No Charge	Not Covered
Radiology Services	Deductible & 20% Coinsurance	Not Covered
MRIs, MRAs, CT SCANS, AND PET SCANS		
Outpatient Hospital Services	Deductible & 50% Coinsurance	Not Covered
Freestanding Radiology Facility	Deductible & $100 Copay per service	Not Covered
HOSPITAL CARE		
Physician's and Surgeon's Services	Deductible & 20% Coinsurance	Not Covered
Semi-Private Room and Board	Deductible & 20% Coinsurance	Not Covered
All Drugs and Medication	Deductible & 20% Coinsurance	Not Covered
EMERGENCY CARE		
Ambulance Service When Medically Necessary	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
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	$50 Copay per visit	Not Covered
MATERNITY CARE		
Prenatal and Post-Natal Care	No Charge	Not Covered
Hospital Services for Mother and Child	Deductible & 20% Coinsurance	Not Covered
SKILLED NURSING FACILITY		
Unlimited	Deductible & 20% Coinsurance	Not Covered
HOSPICE CARE		
Inpatient Care	Deductible & 20% Coinsurance	Not Covered
Home Hospice - Unlimited	$50 Copay per visit	Not Covered
HOME HEALTH CARE		
Home Care Visits - 60 visits per Calendar Year	$50 Copay per visit	Not Covered
Physician House Calls	$50 Copay per visit	Not Covered
SUBSTANCE USE DISORDER SERVICES		
Inpatient Rehabilitation	Deductible & 20% Coinsurance	Not Covered
Outpatient Rehabilitation	$30 Copay per visit	Not Covered
Outpatient Partial Hospitalization	No Charge	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
Inpatient Rehabilitation	Deductible & 20% Coinsurance	Not Covered
Outpatient Rehabilitation	$30 Copay per visit	Not Covered
Outpatient Partial Hospitalization	No Charge	Not Covered
ALLERGY CARE		
Testing and Treatment	$50 Copay per visit	Not Covered
ALTERNATIVE MEDICINE		
Chiropractic Care - 30 Visits per Calendar Year	$30 Copay per visit	Not Covered
SHORT TERM REHABILITATION		
Inpatient - Unlimited	Deductible & 20% Coinsurance	Not Covered
Outpatient Visits - Limited to 30 combined PT/OT visits per Calendar Year	$50 Copay per visit	Not Covered
HABILITATIVE SERVICES		
Inpatient - Unlimited	Deductible & 20% Coinsurance	Not Covered
Outpatient Visits 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 visit	Not Covered
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment - Unlimited *Precertification required for items over $500*	No Charge	Not Covered
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary	Deductible & 20% Coinsurance	Not Covered
HEARING AIDS		
Hearing Aids (through age 15) - Limited to 1 hearing aid for each hearing impaired ear every 24 months.	No Charge	Not Covered
EXERCISE FACILITY		
Subscriber	$200 reimbursement per 6 month period	Not Covered
Spouse	$100 reimbursement per 6 month period	Not Covered
OUTPATIENT PRESCRIPTION DRUGS - RETAIL		
The Prescription Drug Benefit is based on a Per Calendar 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.

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.