



OXFORD HEALTH INSURANCE, INC.  
 NJ G LBTY NG 30/65/1500/80 PPO 19 - Non-Gated  
 SUMMARY OF COVERAGE

Liberty Network

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
<b>FINANCIAL</b>			
Deductible:	Single	\$1,500	\$4,000
	Family	\$3,000	\$8,000
Coinsurance		20%	40%
Maximum Out-Of-Pocket:	Single	\$3,750	\$9,000
(Including Deductible)	Family	\$7,500	\$18,000
Financial Accumulation Period:		Calendar Year	Calendar 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 & 40% Coinsurance
Infant Preventive Care (under 1 year)		No Charge	Deductible & 40% 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		\$30 Copay per visit	Deductible & 40% Coinsurance
Specialist Office Visits		\$65 Copay per visit	Deductible & 40% Coinsurance
Outpatient Surgery - Hospital Setting**		Deductible & 50% Coinsurance	Deductible & 40% Coinsurance
Outpatient Surgery - Freestanding Facility**		Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Laboratory Services**		No Charge	Deductible & 40% Coinsurance
Radiology Services**		Deductible & 20% Coinsurance	Deductible & 40% Coinsurance

**MRIs, MRAs, CT SCANS, AND PET SCANS**

Outpatient Hospital Services**		Deductible & 50% Coinsurance	Deductible & 40% Coinsurance
Freestanding Radiology Facility**		Deductible & \$100 Copay per service	Deductible & 40% Coinsurance

**HOSPITAL CARE**

Physician's and Surgeon's Services **		Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Semi-Private Room and Board **		Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
All Drugs and Medication		Deductible & 20% Coinsurance	Deductible & 40% Coinsurance

**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 & 50% Coinsurance then \$100 Copay	Deductible & 50% Coinsurance then \$100 Copay
Emergency Care in Urgi-Center		\$50 Copay per visit	Deductible & 40% Coinsurance

**MATERNITY CARE**

Prenatal and Post-Natal Care**		No Charge	Deductible & 40% Coinsurance
Hospital Services for Mother and Child**		Deductible & 20% Coinsurance	Deductible & 40% Coinsurance

**SKILLED NURSING FACILITY\*\***

120 days per Calendar Year Non-Network. Combined with Inpatient Rehabilitation.**		Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
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**HOSPICE CARE**

Inpatient Care**		Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Home Hospice - Unlimited**		\$65 Copay per visit	Deductible & 40% Coinsurance

**HOME HEALTH CARE**

Home Care Visits - 60 visits per Calendar Year.**		\$65 Copay per visit	Deductible & 40% Coinsurance
Physician House Calls**		\$65 Copay per visit	Deductible & 40% Coinsurance

**SUBSTANCE USE DISORDER SERVICES**

Inpatient Rehabilitation**		Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Outpatient Rehabilitation		\$30 Copay per visit	Deductible & 40% Coinsurance
Outpatient Partial Hospitalization**		Deductible & 20% Coinsurance	Deductible & 40% Coinsurance

<b>BENEFIT</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>MENTAL HEALTH CARE</b>		
Inpatient Rehabilitation**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Outpatient Rehabilitation	\$30 Copay per visit	Deductible & 40% Coinsurance
Outpatient Partial Hospitalization**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
<b>ALLERGY CARE</b>		
Testing and Treatment**	\$65 Copay per visit	Deductible & 40% Coinsurance
<b>ALTERNATIVE MEDICINE</b>		
Chiropractic Care - 30 visits per Calendar Year**	\$30 Copay per visit	Deductible & 40% Coinsurance
<b>SHORT TERM REHABILITATION</b>		
120 days per Calendar Year Non-Network. Combined with Skilled Nursing.**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
Outpatient Visits - Limited to 30 combined PT/OT visits per Calendar year <i>Precertification upon initial Visit**</i>	\$50 Copay per visit	Deductible & 40% Coinsurance
<b>HABILITATIVE SERVICES</b>		
Inpatient - Unlimited**	Deductible & 20% Coinsurance	Deductible & 40% 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>	\$50 Copay per visit	Deductible & 40% Coinsurance
<b>DURABLE MEDICAL EQUIPMENT</b>		
Durable Medical Equipment - Unlimited** <i>Precertification required for items over \$500</i>	No Charge	Deductible & 40% Coinsurance
<b>MEDICAL SUPPLIES</b>		
Medical Supplies When Medically Necessary**	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
<b>HEARING AIDS</b>		
Hearing Aids (through age 15) - Limited to 1 hearing aid for each hearing impaired ear every 24 months.	No Charge	Deductible & 40% Coinsurance
<b>EXERCISE FACILITY</b>		
Subscriber	\$200 reimbursement per 6 month period	\$200 reimbursement per 6 month period
Spouse	\$100 reimbursement per 6 month period	\$100 reimbursement per 6 month period
<b>OUTPATIENT PRESCRIPTION DRUGS - RETAIL</b>		
<i>The Prescription Drug Benefit is based on a Per Calendar Year limit for any applicable deductibles and/or maximum limits.</i>		
Tier 1	\$10 Copay	Covered at participating pharmacies only
Tier 2	\$25 Copay	Covered at participating pharmacies only
Tier 3	\$50 Copay	Covered at participating pharmacies only
<b>OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER</b>		
Tier 1	\$20 Copay	Covered at participating pharmacies only
Tier 2	\$50 Copay	Covered at participating pharmacies only
Tier 3	\$100 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.**