



OXFORD HEALTH PLANS (NJ), INC.
NJ S LBTY NG 15/60/2400/90 HMO PA 19 - Non-Gated
SUMMARY OF COVERAGE
The Group Name
Liberty Network

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	\$2,400	Not Covered
	Family	\$4,800	Not Covered
Coinsurance		10%	Not Covered
Maximum Out-Of-Pocket:	Single	\$7,500	Not Covered
(Including Deductible)	Family	\$15,000	Not Covered
Financial Accumulation Period:		Contract 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.

**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	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)		\$15 Copay per visit	Not Covered
Pediatric Vision Hardware: (Up to age 19)		50% Coinsurance	Not Covered

OUTPATIENT CARE

Primary Care Physician Office Visits		\$15 Copay per visit	Not Covered
Specialist Office Visits		Deductible then \$60 Copay per visit	Not Covered
Outpatient Surgery - Hospital Setting		Deductible then \$300 Copay per visit	Not Covered
Outpatient Surgery - Freestanding Facility		Deductible then \$100 Copay per visit	Not Covered
Laboratory Services		Deductible then \$15 Copay per service	Not Covered
Radiology Services		Deductible & 10% Coinsurance	Not Covered

MRIs, MRAs, CT SCANS, AND PET SCANS

Outpatient Hospital Services		Deductible & 50% Coinsurance	Not Covered
Freestanding Radiology Facility		No Charge after Deductible	Not Covered

HOSPITAL CARE

Physician's and Surgeon's Services		Deductible & 10% Coinsurance	Not Covered
Semi-Private Room and Board		Deductible then \$250 Copay per day, \$1,250 max per admission, \$2,500 max per Calendar Year	Not Covered
All Drugs and Medication		Deductible & 10% Coinsurance	Not Covered

EMERGENCY CARE

Ambulance Service When Medically Necessary		Deductible then \$100 Copay per transport	Deductible then \$100 Copay per transport
At Hospital Emergency Room (<i>copay waived if admitted</i>)		Deductible & 50% Coinsurance then \$100 Copay	Deductible & 50% Coinsurance then \$100 Copay
(<i>If member is admitted to the hospital, notification is required.</i>)			
Emergency Care in Urgi-Center		\$60 Copay per visit	Not Covered

MATERNITY CARE

Prenatal and Post-Natal Care		No Charge	Not Covered
Hospital Services for Mother and Child		Deductible then \$250 Copay per day, \$1,250 max per admission, \$2,500 max per Calendar Year	Not Covered

SKILLED NURSING FACILITY

Unlimited		Deductible then \$250 Copay per day, \$1,250 max per admission, \$2,500 max per Calendar Year	Not Covered
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HOSPICE CARE

Inpatient Care		Deductible then \$250 Copay per day, \$1,250 max per admission, \$2,500 max per Calendar Year	Not Covered
Home Hospice - Unlimited		Deductible then \$60 Copay per visit	Not Covered

HOME HEALTH CARE

Home Care Visits - 60 visits per Calendar Year		Deductible then \$60 Copay per visit	Not Covered
Physician House Calls		Deductible then \$60 Copay per visit	Not Covered

SUBSTANCE USE DISORDER SERVICES

Inpatient Rehabilitation		Deductible then \$250 Copay per day, \$1,250 max per admission, \$2,500 max per Calendar Year	Not Covered
Outpatient Rehabilitation		\$30 Copay per visit	Not Covered
Outpatient Partial Hospitalization		No Charge after Deductible	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH CARE		
Inpatient Rehabilitation	Deductible then \$250 Copay per day, \$1,250 max per admission, \$2,500 max per Calendar Year	Not Covered
Outpatient Rehabilitation	\$30 Copay per visit	Not Covered
Outpatient Partial Hospitalization	No Charge after Deductible	Not Covered
ALLERGY CARE		
Testing and Treatment	Deductible then \$60 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 then \$250 Copay per day, \$1,250 max per admission, \$2,500 max per Calendar Year	Not Covered
Outpatient Visits - Limited to 30 combined PT/OT visits per Calendar year <i>Precertification upon initial Visit**</i>	Deductible then \$50 Copay per visit	Not Covered
HABILITATIVE SERVICES		
Inpatient - Unlimited	Deductible then \$250 Copay per day, \$1,250 max per admission, \$2,500 max per Calendar Year	Not Covered
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>	Deductible then \$50 Copay per visit	Not Covered
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment - Unlimited <i>Precertification required for items over \$500</i>	\$15 Copay per item	Not Covered
MEDICAL SUPPLIES		
Medical Supplies When Medically Necessary	Deductible & 10% Coinsurance	Not Covered
HEARING AIDS		
Hearing Aids (through age 15) - Limited to 1 hearing aid for each hearing impaired ear every 24 months.	\$15 Copay per item	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 - DEDUCTIBLE	Subject to Plan Deductible listed above (waived for Tier 1)	
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	\$10 Copay	Covered at participating pharmacies only
Tier 2	\$40 Copay	Covered at participating pharmacies only
Tier 3	\$70 Copay	Covered at participating pharmacies only
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Tier 1	\$20 Copay	Covered at participating pharmacies only
Tier 2	\$80 Copay	Covered at participating pharmacies only
Tier 3	\$140 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.