



# Certificate of Coverage

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## PLAN 2: Direct 80-20



2018 | 2019



**Oxford Health Insurance, Inc.  
Direct Plan Summary of Benefits  
Liberty Network  
Abel HR, Inc**

<u>Primary Care and Preventive Care Covered Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<b>Preventive Care</b>		
<b>Well-Baby and Well-Child Care</b>	No Charge	40% Coinsurance
<b>Adult Periodic Physical Examinations</b>	No Charge	Deductible and 40% Coinsurance
<b>Well-Woman Examinations, Family Planning and Breast Pumps</b>	No Charge	Deductible and 40% Coinsurance
<b>Screening for Prostate Cancer</b>	No Charge	Deductible and 40% Coinsurance
<b>Physician (Primary Care) Office and Home Visits - Treatment of Illness or Injury</b>	\$25 per visit	Deductible and 40% Coinsurance
<b>Physician (Primary Care) Hospital Visits</b>	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
<b>Diabetes Services (Primary Care)</b>		
<b>Supplies, Education and Self-Management</b>	Supplies - \$25 per 31-day supply of each item  Education and Self-Management - \$25 per visit	Deductible and 40% Coinsurance
<b>Diabetes Medications</b>	Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense	Deductible and 40% Coinsurance

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**Oxford Health Insurance, Inc.  
Direct Plan Summary of Benefits**

<u>Primary Care and Preventive Care Covered Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<b>Elective Termination of Pregnancy-</b> This benefit is limited to a maximum of one procedure per Calendar Year.	Office Visits - \$40 per visit  Inpatient Facility - Deductible and 20% Coinsurance  Outpatient Facility - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
<u>Specialty Care Covered Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<b>Physician (Specialist) Office and Home Visits</b>	\$40 per visit	Deductible and 40% Coinsurance
<b>Physician (Specialist) Hospital Visits</b>	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
<b>Diabetes Services (Specialty Care)</b> <b>Supplies, Education and Self-Management</b>	Supplies - \$40 per 31-day supply of each item  Education and Self-Management - \$40 per visit	Deductible and 40% Coinsurance
<b>Diabetes Medications</b>	Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense	Deductible and 40% Coinsurance

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**Oxford Health Insurance, Inc.**

## Direct Plan Summary of Benefits

<u>Specialty Care Covered Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<b>Maternity and Newborn Care</b>	<p>Maternity Care - \$25 for initial visit only</p> <p>Inpatient hospital services are Covered subject to: the inpatient facility Out-of-Pocket Expense.</p> <p><i>Routine prenatal office visits, as well as certain lab tests and counseling services as described in the United States Preventive Services Task Force A and B recommendations and the Health Resources and Services Administration women's health coverage requirements are considered preventive care and are covered at <b>No Charge</b>.</i></p>	Deductible and 40% Coinsurance
<b>Allergy Testing and Treatment</b>	\$40 per visit	Deductible and 40% Coinsurance
<p><b>Rehabilitation and Habilitative Services (Physical, Speech and Occupational Therapies)</b></p> <p>Inpatient services are limited to 60 days per Calendar Year.</p> <p>Outpatient services are limited to 60 visits per Calendar Year.</p>	<p>Outpatient- \$40 per visit</p> <p>Inpatient - Deductible and 20% Coinsurance</p>	Deductible and 40% Coinsurance

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<u>Specialty Care Covered Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<p><b>For Autism Spectrum Disorder and other Developmental Disabilities –</b>                      Inpatient services are limited to 60 days per Calendar Year.                      Outpatient services are limited to 60 visits per Calendar Year.</p> <p>Please note that limits do not apply to the treatment of Autism Spectrum Disorder.</p>	<p>Outpatient- \$40 per visit</p> <p>Inpatient - Deductible and 20% Coinsurance</p>	<p>Deductible and 40% Coinsurance</p>
<p><b>Reconstructive and Corrective Surgery</b></p>	<p>Office Visits - \$40 per visit</p> <p>Inpatient Facility - Deductible and 20% Coinsurance</p> <p>Outpatient Hospital Services- Deductible and 20% Coinsurance</p> <p>Outpatient Ambulatory Surgical Center - Deductible and 20% Coinsurance</p> <p>Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance</p>	<p>Deductible and 40% Coinsurance</p>

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<b>Gender Dysphoria Services</b>	Office Visits - \$40 per visit	Deductible and 40% Coinsurance
	Inpatient Facility - Deductible and 20% Coinsurance	
	Outpatient Hospital Services- Deductible and 20% Coinsurance	
	Outpatient Ambulatory Surgical Center - Deductible and 20% Coinsurance	
	Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance	
<b>Oral Surgery</b>	Office Visits - \$40 per visit	Deductible and 40% Coinsurance
	Inpatient Facility - Deductible and 20% Coinsurance	
	Outpatient Hospital Services- Deductible and 20% Coinsurance	
	Outpatient Ambulatory Surgical Center - Deductible and 20% Coinsurance	
	Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance	

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<b>Outpatient Cardiac Rehabilitation</b> – This benefit is unlimited.	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
<b>Outpatient Pulmonary Rehabilitation</b>	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
<b>Orthoptic Exercises and Corneal Topographic Procedures</b>	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
<b>Outpatient Diagnostic Services</b> <b>Laboratory Procedures</b>	No Charge  Please remember, unless you are receiving preadmission testing, Network Hospitals are not Network Providers for outpatient laboratory procedures and tests.	Deductible and 40% Coinsurance
<b>Radiology Services</b>	<b>Major Diagnostic Procedures:</b> Office Based Services - \$40 per visit  Free-Standing Radiology Center - Deductible and 20% Coinsurance  Hospital Facility Based Services - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

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<u>Specialty Care Covered Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<b>Outpatient Diagnostic Services</b> <b>Radiology Services</b>	<i>All other Radiology:</i> Office Based Services - \$40 per visit  Free-Standing Radiology Center - Deductible and 20% Coinsurance  Hospital Facility Based Services - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
<b>Internal and External Prosthetic Devices</b>	Internal - No Charge	Deductible and 40% Coinsurance
<b>Please Note:</b> Reimbursement for these items will be at the same rate as under the federal Medicare reimbursement schedule.	Surgery is subject to either the inpatient or outpatient facility Out-of-Pocket Expense.  External - No Charge	
<b>Durable Medical Equipment, Orthotics and Braces</b>	No Charge	Deductible and 40% Coinsurance
<b>Medical Supplies</b> (Non-Diabetic)	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

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<u>Specialty Care Covered Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<p><b>Treatment of Infertility –</b>  Limited to four completed egg retrievals (and the procedures and treatments associated with such retrievals) while covered under this plan or any plan with the same employer.</p>	<p>Office Visits - \$40 per visit</p> <p>Inpatient Facility - Deductible and 20% Coinsurance</p> <p>Outpatient Hospital Services- Deductible and 20% Coinsurance</p> <p>Outpatient Ambulatory Surgical Center - Deductible and 20% Coinsurance</p> <p>Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance</p> <p>Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.</p>	<p>Deductible and 40% Coinsurance</p>
<p><b>Transplants</b></p>	<p>Transplants performed at Our approved facilities are Covered: Subject to the Inpatient facility Out-of-Pocket Expense</p> <p><u>When performed at other Network facilities</u> – the services are Covered as an out-of-network benefit.</p>	<p>Deductible and 40% Coinsurance</p>

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Direct Plan Summary of Benefits**

<u>Specialty Care Covered Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<b>Clinical Trials</b>	Office Visits - \$40 per visit	Deductible and 40% Coinsurance
	Inpatient Facility - Deductible and 20% Coinsurance	
	Outpatient Hospital Services- Deductible and 20% Coinsurance	
	Outpatient Ambulatory Surgical Center - Deductible and 20% Coinsurance	
	Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance	
<b>Home Health Care –</b> This benefit is limited to 60 visits per Calendar Year.	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
<b>Chemotherapy</b>	Chemotherapy performed in an outpatient facility is subject to Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
	Chemotherapy performed in an office setting is No Charge	
	Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.	

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Direct Plan Summary of Benefits**

<u>Specialty Care Covered Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
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<b>Hemodialysis</b>	Office Visits - No Charge	Deductible and 40% Coinsurance
	Inpatient Facility - Deductible and 20% Coinsurance	
	Outpatient Facility - Deductible and 20% Coinsurance	
	Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance	

<b>Second and Third Opinions</b>	At Your Request - \$40 per visit	Deductible and 40% Coinsurance
	At Our Request – No Charge	

<b>Chiropractic Services –</b> Out-of-Network coverage is limited to \$500 per Member, per Calendar Year.	\$30 per visit	Deductible and 50% Coinsurance
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<b>Hearing Aids –</b>  For Members through age 15, coverage for hearing aids is limited to one hearing aid for each hearing-impaired ear every 24 months.	No Charge	Deductible and 40% Coinsurance
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For Members age 16 and older, coverage for  
hearing aids is limited to \$5,000 per hearing aid  
for each hearing-impaired ear every 24 months.

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**Oxford Health Insurance, Inc.  
Direct Plan Summary of Benefits**

**New Jersey Early Intervention Family Cost Share Expense for Autism and other Developmental Disabilities**

\$25 per monthly expense

**Nutritional Counseling**

\$40 per visit

Deductible and 40% Coinsurance

**Obesity Surgery –**  
limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy.

Office Visits - \$40 per visit

Deductible and 40% Coinsurance

Inpatient Facility - Deductible and 20% Coinsurance

Obesity surgery must be received at a Designated Facility to receive in-network benefits.

Outpatient Hospital Services- Deductible and 20% Coinsurance

Outpatient Ambulatory Surgical Center - Deductible and 20% Coinsurance

Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance

**Hospital & Facility Based Covered Services**

**In-Network Out-of-Pocket Expenses**

**Out-of-Network Out-of-Pocket Expenses**

**Hospital Services**

Inpatient - Deductible and 20% Coinsurance

Deductible and 40% Coinsurance

Outpatient - Deductible and 20% Coinsurance

**Outpatient Ambulatory Surgical Center**

Deductible and 20% Coinsurance

Deductible and 40% Coinsurance

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**Hospital & Facility Based Covered Services**

**In-Network Out-of-Pocket Expenses**

**Out-of-Network Out-of-Pocket Expenses**

**Skilled Nursing Facility Services-**

Deductible and 20% Coinsurance

Deductible and 40% Coinsurance

This benefit is limited to 30 days per Calendar Year.

**Hospice Services-**

This benefit is limited to 180 days (inpatient and outpatient combined) per Lifetime. 5 sessions for bereavement counseling are available to the Member's family either before or after the Member's death.

Inpatient - Deductible and 20% Coinsurance

Deductible and 40% Coinsurance

Outpatient - Deductible and 20% Coinsurance

Home Health Care - Deductible and 20% Coinsurance

Skilled Nursing Facility Services - Deductible and 20% Coinsurance

**Physician Fees for Surgical and Medical Services**

Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance

Deductible and 40% Coinsurance

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Mental Health Services and Substance Use  
Disorder Services

In-Network Out-of-Pocket Expenses

Out-of-Network Out-of-Pocket Expenses

**Mental Health Services –**

This benefit is provided to the same extent as other surgical or medical benefits Covered under the Certificate.

Office Visits/Outpatient - \$40 per visit

Deductible and 40% Coinsurance

Inpatient Facility - Deductible and 20% Coinsurance

Partial Hospitalization/Intensive Outpatient Treatment - Deductible and 20% Coinsurance

Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance

**Substance Use Disorder Services –**

This benefit is provided to the same extent as other surgical or medical benefits Covered under the Certificate.

Office Visits/Outpatient - \$40 per visit

Deductible and 40% Coinsurance

Inpatient Facility - Deductible and 20% Coinsurance

Partial Hospitalization/Intensive Outpatient Treatment - Deductible and 20% Coinsurance

Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance

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**Oxford Health Insurance, Inc.  
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**Medical Emergency Covered Services**

**In-Network Out-of-Pocket Expenses**

**Out-of-Network Out-of-Pocket Expenses**

**Hospital Emergency Room Visits**

Deductible and 20% Coinsurance

Medical Emergencies (as defined in the Certificate) are Covered as an In-Network benefit.

**Ambulance Services**

Deductible and 20% Coinsurance

All Covered ambulance services for Medical Emergencies will be Covered as an In-Network benefit when Medically Necessary.

For Non-emergency ambulances services - Deductible and 40% Coinsurance

<u>Urgent Care Covered Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<b>Urgent Care</b>	\$40 per visit	Deductible and 40% Coinsurance

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<u>Additional Coverage</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<b>Outpatient Prescription Drugs Retail Benefit -</b> The Out-of-Pocket Expenses are applied to each	<u>Triple Tier -</u> Tier 1 Prescription Drug Products- \$25	Not Covered

31-day supply of a Prescription Drug to a maximum of a 90-day supply.

Copayment

Tier 2 Prescription Drug Products- \$50  
Copayment after the Deductible has been met

Tier 3 Prescription Drug Products- \$75  
Copayment after the Deductible has been met

You are not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.

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<u>Additional Coverage</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<b>Mail Order Benefit -</b> up to a 90-day supply of Prescription Drugs will be provided.	You will be responsible for 2 retail Copayments for Prescription Drugs.	Not Covered



Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.

**Exercise Facility Reimbursement**

We will reimburse a Subscriber \$200 per six-months. We will reimburse a Subscriber's spouse, civil union partner or domestic partner (if the Group has purchased this coverage) \$100 per six-months. The Member must complete 50 visits within the six-month period.

**Precertification List**

Breast Pumps, Insulin Pumps, Inpatient admissions for obstetrical services, Allergy Testing and Treatment performed outside a physician's office, Inpatient Rehabilitation Services, Inpatient Admission for Reconstructive and Corrective Surgery, Outpatient Cardiac Rehabilitation, Outpatient Pulmonary Rehabilitation, Orthoptic Exercises and Corneal Topographic Procedures, Inpatient Admission for Oral Surgery, Laboratory Procedures (Precertification is not required for routine blood work and screening tests), Major Diagnostic Procedures, Infertility Services, Chemotherapy, Internal Prosthetic Devices, Durable Medical Equipment (Precertification required before purchase of \$500 or more), Transplants, Clinical Trials, Home Health Care, Services Delivered in the Home, Medical Supplies, Hemodialysis, Home Treatment of Hemophilia, Chiropractic Services, Inpatient Hospital Services, Outpatient Hospital Services, Ambulatory Surgical Center Services, Inpatient or In-Home Hospice Services, Skilled Nursing Facility Services, Inpatient and Intermediate Care Substance Use Disorder Services, Inpatient and Intermediate Care Mental Health Services, Non-Urgent Ambulance Services, and Gender Dysphoria Services.

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**Additional Plan Information**

**Plan Deductible for In-Network Covered Services**

Individual: \$2,000 per Calendar Year  
Family: \$4,000 per Calendar Year

**Plan Deductible for Out-of-Network Covered Services**

Individual: \$2,000 per Calendar Year  
Family: \$4,000 per Calendar Year

**Deductible for Prescription Drugs**

\$100 per Member per Calendar Year. The Deductible is waived for Tier 1 Drugs.

Please note that benefits for oral chemotherapeutic agents are not subject to the Deductible for Prescription Drugs.

**Out-of-Pocket Maximum for In-Network Covered Services**

Individual: \$5,000 per Calendar Year  
Family: \$10,000 per Calendar Year

Remember, only In-Network Coinsurance and/or Copayments and the amounts paid to meet your In-Network Deductible (and Pharmacy Deductible, if applicable) count toward the In-Network Out-of-Pocket Maximum. Coinsurance paid for Out-of-Network benefits, amounts paid to meet the Out-of-Network Deductible, amounts paid for Non-Covered Services, and any amounts paid as a penalty do not count toward the In-Network, Out-of-Pocket Maximum.

**Out-of-Pocket Maximum for Out-of-Network Covered Services**

Individual: \$10,000 per Calendar Year  
Family: \$20,000 per Calendar Year

Remember, only Out-of-Network Coinsurance and the amounts paid to meet your Out-of-Network Deductible count toward the Out-of-Network Out-of-Pocket Maximum. Coinsurance and/or Copayments for In-Network benefits, amounts paid to meet the In-Network Deductible, amounts in excess of Our Fee Schedule, amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the Out-of-Network Out-of-Pocket Maximum.

**Precertification Penalty**

If you fail to request a required Precertification for an Out-of-Network Benefit identified in the Precertification List, you will be subject to a 50% reduction in benefits for charges that would have otherwise been covered.

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Out of Network Reimbursement Amount: The Out of Network Reimbursement Amount is based upon 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception of the following:

- 50% of CMS for the same or similar laboratory service.

- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.
- Please refer to your Certificate of Coverage for more information on the Out-of-Network Reimbursement Amount.

**You are responsible for obtaining any required Precertification** for services received from a Non-Network Provider.

Additionally, if you want in-network coverage, **it is your responsibility to verify that a provider is a Network Provider.** Therefore when your PCP or other Network Provider arranges services for you, you should make sure that the provider is in Our Network by using Our online directory [www.oxfordhealth.com](http://www.oxfordhealth.com), or by calling Us at the 1-800 number provided on your ID card.

More information regarding Our fee schedule policy and administration is available. You may request a copy of Our fee schedule policy in the same manner as any Medical Policy. Please see your Certificate of Coverage for information on how to obtain copies of Our Policies.

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**Eligibility & Effective Dates of Coverage**

**Eligibility Limits**

The limiting age for Dependents (as defined in the Certificate) is 26. Coverage ends at the end of the Calendar Year in which the child reaches the limiting age.

Please note, extended coverage is available up to the age of 31 for Dependents who meet the definition of an Over-Age Dependent, as defined in the Certificate.

**Effective Dates of Coverage**

**Initial Enrollment (During initial Group Open Enrollment Period)**

Coverage is effective on the effective date of the Agreement.

**Newly Eligible Employee (Application within 31 days of becoming eligible)**

Coverage is effective as of the date the employee became eligible.

**Newly Eligible Dependent(s) (Application within 31 days of becoming eligible)**

Coverage is effective as of the date the dependent became eligible. Coverage is effective at birth for newborns and newly born adopted children subject to the enrollment requirements as described in the Certificate.

**Group Open Enrollment Period**

Coverage is effective on the renewal date of the Agreement.

**IMPORTANT:** This document is not a contract. It is only a summary of your coverage. Please read your Certificate of Coverage and Member Handbook for a full description of your Covered Services, exclusions and other terms and conditions of coverage.

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