



Certificate of Coverage

PLAN 20: Freedom Access 1



2018 | 2019



**Oxford Health Insurance, Inc.
Access Plan Summary of Benefits
Freedom 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>
Preventive Care		
Well-Baby and Well-Child Care	No Charge	20% Coinsurance
Adult Periodic Physical Examinations	No Charge	Deductible and 20% Coinsurance
Well-Woman Examinations, Family Planning and Breast Pumps	No Charge	Deductible and 20% Coinsurance
Screening for Prostate Cancer	No Charge	Deductible and 20% Coinsurance
Physician (Primary Care) Office and Home Visits - Treatment of Illness or Injury	\$20 per visit	Deductible and 20% Coinsurance
Physician (Primary Care) Hospital Visits	No Charge	Deductible and 20% Coinsurance
Diabetes Services (Primary Care)		
Supplies, Education and Self-Management	Supplies - \$20 per 31-day supply of each item Education and Self-Management - \$20 per visit	Deductible and 20% Coinsurance
Diabetes Medications	Prescription Medications - Covered subject to the applicable Prescription Drug Out-of-Pocket Expense	Deductible and 20% Coinsurance
Elective Termination of Pregnancy - This benefit is limited to a maximum of one procedure per Calendar Year.	Office Visits - \$20 per visit Inpatient Facility - No Charge Outpatient Facility - No Charge	Deductible and 20% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance, Inc.
Access 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>
Physician (Specialist) Office and Home Visits	\$20 per visit	Deductible and 20% Coinsurance
Physician (Specialist) Hospital Visits	No Charge	Deductible and 20% Coinsurance
Diabetes Services (Specialty Care)		
Supplies, Education and Self-Management	Supplies - \$20 per 31-day supply of each item	Deductible and 20% Coinsurance
	Education and Self-Management - \$20 per visit	
Diabetes Medications	Prescription Medications - Covered subject to the applicable Prescription Drug Out-of-Pocket Expense	Deductible and 20% Coinsurance
Maternity and Newborn Care	Maternity Care - \$20 for initial visit only	Deductible and 20% Coinsurance
	Inpatient hospital services are Covered subject to: the inpatient facility Out-of-Pocket Expense.	
	<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 No Charge.</i>	
Allergy Testing and Treatment	\$20 per visit	Deductible and 20% 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>
Rehabilitation and Habilitative Services (Physical, Speech and Occupational Therapies) Inpatient services are limited to 60 days per Calendar Year. Outpatient services are limited to 60 visits per Calendar Year.	Outpatient - \$20 per visit	Deductible and 20% Coinsurance
	Inpatient - No Charge	Deductible and 20% Coinsurance
For Autism Spectrum Disorder and other Developmental Disabilities – Inpatient services are limited to 60 days per Calendar Year. Outpatient services are limited to 60 visits per Calendar Year. Please note that limits do not apply to the treatment of Autism Spectrum Disorder.	Outpatient - \$20 per visit	Deductible and 20% Coinsurance
	Inpatient - No Charge	Deductible and 20% Coinsurance
Reconstructive and Corrective Surgery	Office Visits - \$20 per visit	Deductible and 20% Coinsurance
	Inpatient Facility - No Charge	
	Outpatient Hospital Services - No Charge	
	Outpatient Ambulatory Surgical Center - No Charge	
	Physician Fees for Surgical and Medical Services - No Charge	

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Gender Dysphoria Services	Office Visits - \$20 per visit	Deductible and 20% Coinsurance
	Inpatient Facility - No Charge	
	Outpatient Hospital Services - No Charge	
	Outpatient Ambulatory Surgical Center - No Charge	
	Physician Fees for Surgical and Medical Services - No Charge	
Oral Surgery	Office Visits - \$20 per visit	Deductible and 20% Coinsurance
	Inpatient Facility - No Charge	
	Outpatient Hospital Services - No Charge	
	Outpatient Ambulatory Surgical Center - No Charge	
	Physician Fees for Surgical and Medical Services - No Charge	
Outpatient Cardiac Rehabilitation – This benefit is unlimited.	No Charge	Deductible and 20% Coinsurance
Outpatient Pulmonary Rehabilitation	No Charge	Deductible and 20% Coinsurance
Orthoptic Exercises and Corneal Topographic Procedures	No Charge	Deductible and 20% Coinsurance

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**Oxford Health Insurance, Inc.
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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>
Outpatient Diagnostic Services		
Laboratory Services	No Charge	Deductible and 20% Coinsurance
	Please remember, unless you are receiving preadmission testing, Network Hospitals are not Network Providers for outpatient laboratory procedures and tests.	
Radiology Services		
	Major Diagnostic Procedures:	
	Office Based Services - \$20 per visit	Deductible and 20% Coinsurance
	Free-Standing Radiology Center - No Charge	
	Hospital Facility Based Services - No Charge	
	All other Radiology:	
	Office Based Services - \$20 per visit	Deductible and 20% Coinsurance
	Free-Standing Radiology Center - No Charge	
	Hospital Facility Based Services - No Charge	
Internal and External Prosthetic Devices	Internal - No Charge. Surgery is subject to either the inpatient or outpatient facility Out-of-Pocket Expense.	Deductible and 20% Coinsurance
Please Note: Reimbursement for these items will be at the same rate as under the federal Medicare reimbursement schedule.	External - No Charge	

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**Oxford Health Insurance, Inc.
Access 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>
Durable Medical Equipment, Orthotics and Braces	No Charge	Deductible and 20% Coinsurance
Medical Supplies (Non-Diabetic)	No Charge	Deductible and 20% Coinsurance
Treatment of Infertility – 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.	Office Visits - \$20 per visit Inpatient Facility - No Charge Outpatient Hospital Services - No Charge Outpatient Ambulatory Surgical Center - No Charge Physician Fees for Surgical and Medical Services - No Charge Prescription Medications - Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.	Deductible and 20% Coinsurance
Transplants	Transplants performed at Our approved facilities are Covered: at No Charge. <u>When performed at other Network facilities</u> – the services are Covered as an out-of-network benefit.	Deductible and 20% Coinsurance

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Oxford Health Insurance, Inc.
Access 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>
Clinical Trials	Office Visits - \$20 per visit	Deductible and 20% Coinsurance
	Inpatient Facility - No Charge	
	Outpatient Hospital Services - No Charge	
	Outpatient Ambulatory Surgical Center - No Charge	
	Physician Fees for Surgical and Medical Services - No Charge	
Home Health Care - This benefit is limited to 60 visits per calendar year.	No Charge	Deductible and 20% Coinsurance
Chemotherapy	No Charge	Deductible and 20% Coinsurance
	Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.	
Hemodialysis	Office Visits - No Charge	Deductible and 20% Coinsurance
	Inpatient Facility - No Charge	
	Outpatient Facility - No Charge	
	Physician Fees for Surgical and Medical Services - No Charge	
Second and Third Opinions	At Your Request - \$20 per visit	Deductible and 20% Coinsurance
	At Our Request - No Charge	

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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>Chiropractic Services - Out-of-Network coverage is limited to \$500 per Member, per Calendar Year.</p>	\$20 per visit	Deductible and 50% Coinsurance
<p>Hearing Aids - For Members through age 15, coverage for hearing aids is limited to one hearing aid for each hearing-impaired ear every 24 months.</p> <p>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.</p>	No Charge	Deductible and 20% Coinsurance
<p>New Jersey Early Intervention Family Cost Share Expense for Autism and other Developmental Disabilities</p>	\$20 per monthly expense	
<p>Nutritional Counseling</p>	\$20 per visit	Deductible and 20% Coinsurance
<p>Obesity Surgery -limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy.</p> <p>Obesity surgery must be received at a Designated Facility to receive in-network benefits.</p>	Office Visits - \$20 per visit Inpatient Facility - No Charge Outpatient Hospital Services - No Charge Outpatient Ambulatory Surgical Center - No Charge Physician Fees for Surgical and Medical Services - No Charge	Deductible and 20% Coinsurance

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Oxford Health Insurance, Inc.

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<u>Hospital & Facility Based Covered Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
Hospital Services	Inpatient - No Charge	Deductible and 20% Coinsurance
	Outpatient - No Charge	
Outpatient Ambulatory Surgical Center	No Charge	Deductible and 20% Coinsurance
Skilled Nursing Facility Services - This benefit is limited to 30 days per Calendar Year.	No Charge	Deductible and 20% Coinsurance
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 - No Charge	Deductible and 20% Coinsurance
	Outpatient - No Charge	
	Home Health Care - No Charge	
	Skilled Nursing Facility Services - No Charge	
Physician Fees for Surgical and Medical Services	No Charge	Deductible and 20% Coinsurance

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Access Plan Summary of Benefits

<u>Mental Health Services and Substance Use Disorder Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<p>Mental Health Services - This benefit is provided to the same extent as other surgical or medical benefits Covered under the Certificate.</p>	<p>Office Visits/Outpatient - \$20 per visit</p> <p>Inpatient Facility - No Charge</p> <p>Partial Hospitalization/Intensive Outpatient Treatment - No Charge</p> <p>Physician Fees for Surgical and Medical Services - No Charge</p>	<p>Deductible and 20% Coinsurance</p>
<p>Substance Use Disorder Services - This benefit is provided to the same extent as other surgical or medical benefits Covered under the Certificate.</p>	<p>Office Visits/Outpatient - \$20 per visit</p> <p>Inpatient Facility - No Charge</p> <p>Partial Hospitalization/Intensive Outpatient Treatment - No Charge</p> <p>Physician Fees for Surgical and Medical Services - No Charge</p>	<p>Deductible and 20% Coinsurance</p>

<u>Medical Emergency Covered Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<p>Hospital Emergency Room Visits</p>	<p>\$100 per visit (waived if Member is admitted to the Hospital)</p>	<p>Medical Emergencies (as defined in the Certificate) are Covered as an In-Network benefit.</p>
<p>Ambulance Services</p>	<p>No Charge</p>	<p>All Covered ambulance services for Medical Emergencies will be Covered as an In-Network benefit when Medically Necessary.</p> <p>For Non-emergency ambulance services - Deductible and 20% Coinsurance</p>

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<u>Urgent Care Covered Services</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
Urgent Care	\$20 per visit	Deductible and 20% Coinsurance

<u>Additional Coverage</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
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Outpatient Prescription Drugs

Retail Benefit -

The Out-of-Pocket Expenses are applied to each 31-day supply of a Prescription Drug to a maximum of a 90-day supply.

Triple Tier

Tier 1 Prescription Drug Products- \$15 Copayment

Tier 2 Prescription Drug Products- \$35 Copayment

Tier 3 Prescription Drug Products- \$75 Copayment

Not Covered

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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Access Plan Summary of Benefits

<u>Additional Coverage</u>	<u>In-Network Out-of-Pocket Expenses</u>	<u>Out-of-Network Out-of-Pocket Expenses</u>
<p>Mail Order Benefit - Up to a 90-day supply of Prescription Drugs will be provided.</p>	<p>You will be responsible for 2 retail Copayments for Prescription Drugs.</p>	<p>Not Covered</p>
	<p>Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.</p>	
<p>Exercise Facility Reimbursement</p>	<p>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.</p>	

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

No In-Network Deductible

Plan Deductible for Out-of-Network Covered Services

Individual: \$1,000 per Calendar Year

Family: \$2,000 per Calendar Year

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

Individual: \$2,500 per Calendar Year

Family: \$5,000 per Calendar Year

Remember, only In-Network Coinsurance and/or Copayments (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: \$2,000 per Calendar Year

Family: \$4,000 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

The Group has selected an Out-of-Network Reimbursement Amount for out-of-network benefits at the 80th percentile amount reported by the FAIR Health Benchmarks database published by FAIR Health, Inc. (when applicable). This applies to all out-of-network Covered Services except for those noted below:

The following out-of-network services, supplies and drugs are reimbursed at the percentage specified below of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare reimbursement:

- Inpatient Hospital 140%
- Outpatient Hospital 140%
- Free-Standing Ambulatory Surgical Centers 140%
- Free-Standing Lab Services 50%
- Free-Standing Radiology Services 140%
- Durable Medical Equipment 45%

“Free-Standing” means the services were provided in a facility that is dedicated to providing that particular service (e.g., imaging centers, labs that are not part of a hospital and are where hospitals and other providers send specimens for analysis).

Please refer to your Certificate of Coverage for more information on the Out-of-Network Reimbursement Amount.

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Additional Plan Information

Out-of-Network Reimbursement

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, 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.

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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