Certificate of Coverage

PLAN 7: Direct 90-10 *$500 Deductible*

UnitedHealthcare®
Oxford

2018 | 2019

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

Primary Care and Preventive Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Preventive Care		
Well-Baby and Well-Child Care	No Charge	30% Coinsurance
Adult Periodic Physical Examinations	No Charge	Deductible and 30% Coinsurance
Well-Woman Examinations, Family Planning and Breast Pumps	No Charge	Deductible and 30% Coinsurance
Screening for Prostate Cancer	No Charge	Deductible and 30% Coinsurance
Physician (Primary Care) Office and Home Visits - Treatment of Illness or Injury	$25 per visit	Deductible and 30% Coinsurance
Physician (Primary Care) Hospital Visits	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Diabetes Services (Primary Care)		
Supplies, Education and Self-Management	Supplies - $25 per 31-day supply of each item Education and Self-Management - $25 per visit	Deductible and 30% Coinsurance
Diabetes Medications	Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense	Deductible and 30% Coinsurance

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

Primary Care and Preventive Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Elective Termination of Pregnancy- This benefit is limited to a maximum of one procedure per Calendar Year.	Office Visits - $40 per visit Inpatient Facility - Deductible and 10% Coinsurance Outpatient Facility - Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Specialty Care Covered Services	**In-Network Out-of-Pocket Expenses**	**Out-of-Network Out-of-Pocket Expenses**
Physician (Specialist) Office and Home Visits	$40 per visit	Deductible and 30% Coinsurance
Physician (Specialist) Hospital Visits	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Diabetes Services (Specialty Care) **Supplies, Education and Self-Management**	Supplies - $40 per 31-day supply of each item Education and Self-Management - $40 per visit	Deductible and 30% Coinsurance
Diabetes Medications	Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense	Deductible and 30% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Maternity and Newborn Care	Maternity Care - $25 for initial visit only Inpatient hospital services are Covered subject to: the inpatient facility Out-of-Pocket Expense. *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*** .	Deductible and 30% Coinsurance
Allergy Testing and Treatment	$40 per visit	Deductible and 30% Coinsurance
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- $40 per visit Inpatient - Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
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- $40 per visit Inpatient - Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Reconstructive and Corrective Surgery	Office Visits - $40 per visit Inpatient Facility - Deductible and 10% Coinsurance Outpatient Hospital Services- Deductible and 10% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Gender Dysphoria Services	Office Visits - $40 per visit Inpatient Facility - Deductible and 10% Coinsurance Outpatient Hospital Services- Deductible and 10% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Oral Surgery	Office Visits - $40 per visit Inpatient Facility - Deductible and 10% Coinsurance Outpatient Hospital Services- Deductible and 10% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Outpatient Cardiac Rehabilitation– This benefit is unlimited.	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Outpatient Pulmonary Rehabilitation	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Orthoptic Exercises and Corneal Topographic Procedures	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Outpatient Diagnostic Services		
Laboratory Procedures	No Charge Please remember, unless you are receiving preadmission testing, Network Hospitals are not Network Providers for outpatient laboratory procedures and tests.	Deductible and 30% Coinsurance
Radiology Services	***Major Diagnostic Procedures:*** Office Based Services - $40 per visit Free-Standing Radiology Center - Deductible and 10% Coinsurance Hospital Facility Based Services - Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Outpatient Diagnostic Services **Radiology Services**	***All other Radiology:*** Office Based Services - $40 per visit Free-Standing Radiology Center - Deductible and 10% Coinsurance Hospital Facility Based Services - Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Internal and External Prosthetic Devices **Please Note:** Reimbursement for these items will be at the same rate as under the federal Medicare reimbursement schedule.	Internal - No Charge Surgery is subject to either the inpatient or outpatient facility Out-of-Pocket Expense. External - No Charge	Deductible and 30% Coinsurance
Durable Medical Equipment, Orthotics and Braces	No Charge	Deductible and 30% Coinsurance
Medical Supplies (Non-Diabetic)	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
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 - $40 per visit Inpatient Facility - Deductible and 10% Coinsurance Outpatient Hospital Services- Deductible and 10% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.	Deductible and 30% Coinsurance
Transplants	Transplants performed at Our approved facilities are Covered: Subject to the Inpatient facility Out-of-Pocket Expense When performed at other Network facilities – the services are Covered as an out-of-network benefit.	Deductible and 30% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Clinical Trials	Office Visits - $40 per visit Inpatient Facility - Deductible and 10% Coinsurance Outpatient Hospital Services- Deductible and 10% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Home Health Care – This benefit is limited to 60 visits per Calendar Year.	Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Chemotherapy	Chemotherapy performed in an outpatient facility is subject to Deductible and 10% 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.	Deductible and 30% Coinsurance

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Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses

Hemodialysis	Office Visits - No Charge	Deductible and 30% Coinsurance
	Inpatient Facility - Deductible and 10% Coinsurance	
	Outpatient Facility - Deductible and 10% Coinsurance	
	Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance	
Second and Third Opinions	At Your Request - $40 per visit	Deductible and 30% Coinsurance
	At Our Request – No Charge	
Chiropractic Services – Out-of-Network coverage is limited to $500 per Member, per Calendar Year.	$30 per visit	Deductible and 50% Coinsurance
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. 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.	No Charge	Deductible and 30% Coinsurance

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Direct Plan Summary of Benefits

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses

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 30% Coinsurance
Obesity Surgery – limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy. Obesity surgery must be received at a Designated Facility to receive in-network benefits.	Office Visits - $40 per visit Inpatient Facility - Deductible and 10% Coinsurance Outpatient Hospital Services- Deductible and 10% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

Hospital & Facility Based Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Hospital Services	Inpatient - Deductible and 10% Coinsurance Outpatient - Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Outpatient Ambulatory Surgical Center	Deductible and 10% Coinsurance	Deductible and 30% 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 10% Coinsurance	Deductible and 30% 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 10% Coinsurance Outpatient - Deductible and 10% Coinsurance Home Health Care - Deductible and 10% Coinsurance Skilled Nursing Facility Services - Deductible and 10% Coinsurance	Deductible and 30% Coinsurance
Physician Fees for Surgical and Medical Services	Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance	Deductible and 30% 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 Inpatient Facility - Deductible and 10% Coinsurance Partial Hospitalization/Intensive Outpatient Treatment - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance	Deductible and 30% 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 Inpatient Facility - Deductible and 10% Coinsurance Partial Hospitalization/Intensive Outpatient Treatment - Deductible and 10% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 10% Coinsurance	Deductible and 30% Coinsurance

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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	$100 per visit (waived if Member is admitted to the Hospital)	Medical Emergencies (as defined in the Certificate) are Covered as an In-Network benefit.

Ambulance Services	Deductible and 10% 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 30% Coinsurance

Urgent Care Covered Services	**In-Network Out-of-Pocket Expenses**	**Out-of-Network Out-of-Pocket Expenses**
Urgent Care	$40 per visit	Deductible and 30% Coinsurance

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Additional Coverage	**In-Network Out-of-Pocket Expenses**	**Out-of-Network Out-of-Pocket Expenses**
Outpatient Prescription Drugs **Retail Benefit -** The Out-of-Pocket Expenses are applied to each	**Triple Tier -** 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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Additional Coverage	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Mail Order Benefit - 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: $500 per Calendar Year Family: $1,000 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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Additional Plan Information

Out-of-Network Reimbursement

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, 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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