UnitedHealthcare
OXFORD

OXFORD HEALTH INSURANCE, INC.
SUMMARY OF COVERAGE
NJ

POS Plan C
FREEDOM NETWORK

BENEFIT		IN-NETWORK	OUT-OF-NETWORK[1]
FINANCIAL			
Deductible:	Single	None	$1,000
	Family	None	$2,000
Coinsurance		None	30%
Coinsurance Maximum Limit:		N/A	$10000
Maximum Lifetime Benefit Per Member		Unlimited	Unlimited
PREVENTIVE SERVICES			
Preventive care $750 OON Max (under 1 year old)		No Charge	Not subject to Deductible and Coinsurance
Preventive care $500 OON Max (1 year and over)		No Charge	Not subject to Deductible and Coinsurance
Immunizations and lead poisoning screening and treatments for children		No Charge	Subject to 30% Coinsurance
OUTPATIENT CARE			
Physician office visits		$20 copay per visit	Subject to Deductible & 30% Coinsurance
Ambulatory Surgery**		$20 copay per visit	Subject to Deductible & 30% Coinsurance**
Second Surgical Opinions**		$20 copay per visit	Subject to Deductible & 30% Coinsurance**
Pre-admission testing**		$20 copay per visit	Subject to Deductible & 30% Coinsurance**
Allergy care visits		$20 copay per visit	Subject to Deductible & 30% Coinsurance
Podiatric care visits		$20 copay per visit	Subject to Deductible & 30% Coinsurance
Physical/Occupational Therapy		$20 copay per visit	Subject to Deductible & 30% Coinsurance
Combined maximum 30 visits per calendar year			
Speech/Cognitive Therapy		$20 copay per visit	Subject to Deductible & 30% Coinsurance
Combined maximum 30 visits per calendar year			
Physician house calls		$20 copay per visit	Subject to Deductible & 30% Coinsurance
Laboratory services		At Participating Labs; No Charge	Subject to Deductible & 30% Coinsurance
Magnetic Resonance Imaging (MRI)		No Charge	Subject to Deductible & 30% Coinsurance
Therapeutic Manipulation			
30 visits per calendar year		$20 copay per visit	Subject to Deductible & 30% Coinsurance
SPECIAL SERVICES			
Home Health Care**		No Charge	Subject to Deductible & 30% Coinsurance**
Skilled Nursing Care**		$250 per day , up to $1250 per confinement, to a maximum of $2500 per Calendar Year	Subject to Deductible & 30% Coinsurance**
Hospice Care**		$250 per day , up to $1250 per confinement, to a maximum of $2500 per Calendar Year	Subject to Deductible & 30% Coinsurance**
HOSPITAL CARE			
Physician's and surgeon's services **		No Charge	Subject to Deductible & 30% Coinsurance**
Semi-private room and board **		$250 per day , up to $1250 per confinement, to a maximum of $2500 per Calendar Year	Subject to Deductible & 30% Coinsurance**
All drugs and medication		No Charge	Subject to Deductible & 30% Coinsurance
Inpatient Surgery**		No Charge	Subject to Deductible & 30% Coinsurance**

BENEFIT	IN-NETWORK	OUT-OF-NETWORK*
EMERGENCY CARE		
(Oxford must be contacted within 48 hours)		
Ambulance service when Medically Necessary	No Charge	Subject to Deductible & 30% Coinsurance
At hospital emergency room	$100 copay; waived if admitted	$100 copay; waived if admitted
Emergency Care in Urgi-Center	$20 copay per visit	Subject to Deductible & 30% Coinsurance
MATERNITY CARE		
Prenatal 1st visit	$20 copay per initial visit	Subject to Deductible & 30% Coinsurance
Prenatal and post-natal care	No Charge after Initial visit	Subject to Deductible & 30% Coinsurance
Birthing centers	$20 copay per visit	Subject to Deductible & 30% Coinsurance
Hospital services for mother and child **	$250 per day , up to $1250 per confinement, to a maximum of $2500 per Calendar Year	Subject to Deductible & 30% Coinsurance**
SUBSTANCE ABUSE At approved facilities only		
Outpatient visits	$20 copay per visit	Subject to Deductible & 30% Coinsurance**
Inpatient care**	$250 per day , up to $1250 per confinement, to a maximum of $2500 per Calendar Year	Subject to Deductible & 30% Coinsurance
MENTAL HEALTH CARE		
Inpatient Care ** Biologically Based Conditions	$250 per day , up to $1250 per confinement, to a maximum of $2500 per Calendar Year	Subject to Deductible & 30% Coinsurance**
Inpatient Care ** Non-Biologically Based Conditions	$250 per day , up to $1250 per confinement, to a maximum of $2500 per Calendar Year	Subject to Deductible & 30% Coinsurance**
Outpatient Visits** Biologically Based Conditions	$20 copay per visit	Subject to Deductible & 30% Coinsurance**
Outpatient Visits** Non-Biologically Based Conditions	$20 copay per visit	Subject to Deductible & 30% Coinsurance**
HEARING AIDS		
Coverage is limited to $5,000 per hearing aid for each hearing impaired ear every 24 months. Accessories, fittings and repairs are not subject to the $5,000 limit.	No Charge	Subject to Deductible & 30% Coinsurance
PRESCRIPTION DRUGS		
(Includes Oral Contraceptives)		
Tier 1	$7 copayment	Covered at Participating Pharmacies Only
Tier 2	$15 copayment	
Tier 3	$25 copayment	
OTHER ITEMS		
Medical Supplies, when Medically Necessary **	OUT-OF-NETWORK BENEFIT ONLY	Subject to Deductible & 30% Coinsurance**
Durable Equipment, when Medically Necessary **	No Charge if pre-certified by Oxford in advance and ordered by an Oxford Participating Physician	Subject to Deductible & 30% Coinsurance**
Prosthetics	No Charge	Subject to Deductible & 30% Coinsurance
Orthotics	No Charge	Subject to Deductible & 30% Coinsurance

DEPENDENT ELIGIBILITY:
Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.
Benefits discontinue at the end of the Calendar Year.