

NJ Individual Basic and Essential Enhanced Summary of Coverage

In-Network Coverage Only

Outpatient Care

Alcohol & Substance Abuse	30% coinsurance per visit, up to 30 visits maximum per covered person, per calendar year
Ambulatory Surgical Facility	\$250 copayment per covered person, per surgery
Biologically Based Mental Illness	
Outpatient Care	30% coinsurance per visit, up to 30 visits maximum per covered person, per calendar year
Emergency Room Services	\$100 copayment per covered person, per visit
Outpatient Diagnostic Testing	100% coverage up to a \$500 maximum per covered person, per calendar year
Outpatient Physical Therapy	\$20 copayment per visit, up to 40 visits maximum per covered person, per calendar year
Practitioner Visits for Illness or Injury	\$25 copayment (includes urgent care facility visits, office visit and inpatient hospital visits)
Wellness Benefit	100% coverage
Prescription Drugs	\$20 copayment for generic drugs and 50% coinsurance after you meet the \$500 annual Prescription Drug Deductible for brand-named drugs
Durable Medical Equipment (DME)	50% coinsurance up to \$3,000 annual maximum
Home Healthcare	50% coinsurance
Hospice	50% coinsurance up to \$3,000 annual maximum

Exclusions from Coverage: Other Outpatient Care Items

Ambulance Services	Not covered
Chemotherapy	Not covered
Diabetic Supplies, Self-education and Management	Not covered
Fertility Enhancement Services and Procedures	Not covered
Infusion Therapy	Not covered
Medical Supplies	Not covered
Nutritional Counseling	Not covered
Occupational and Speech Therapy	Not covered
Postnatal Care	Not covered
Prenatal Care (excluding practitioner charges for delivery and complications)	Not covered
Private Duty Nursing	Not covered
Second Surgical Opinion	Not covered
Temporomandibular Joint Disorder Treatment	Not covered
Therapeutic Manipulation	Not covered
Therapeutic Injections	Not covered
Transplants	Not covered
Treatment of Non-biologically Based Mental Illness	Not covered
Out-of-Network Services Other Than Emergency	Not covered



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Inpatient Care

Alcohol & Substance Abuse Inpatient

Facility Services

30% coinsurance after a \$500 per confinement deductible;
up to 30 days maximum, per calendar year

Inpatient for Biologically Based Mental Illness

30% coinsurance after a \$500 per confinement deductible;
up to 90 days maximum, per calendar year

Inpatient Facility Services

\$500 copayment per covered person per period of confinement

Inpatient Practitioner Visits

See practitioner visits for illness or injury under Outpatient Care

Exclusions from Coverage: Other Inpatient Care Items

Skilled Nursing Care

Not covered

Out of Network services other than Emergency

Not Covered

DEPENDENT ELIGIBILITY:

Eligible dependents include subscriber's spouse and dependent child(ren) until the child(ren) reach age 26. A Dependent's coverage ends when the Dependent becomes eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or the Dependent is no longer a Dependent, as defined in the Contract. Coverage ends at 12:01 a.m. on the date the first of these events occurs.

¹The family deductible is the equivalent of two single deductibles. The maximum amount an individual family member can credit toward the family deductible may not exceed the single deductible.

The Following Services Require Pre-approval:

Inpatient hospital admissions and procedures, as more specifically detailed in the Oxford Individual Basic and Essential Healthcare Services Plan Certificate.

