

NJ Individual Basic and Essential EPO

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 30 visits maximum per covered person, per calendar year
Practitioner Visits for Illness or Injury (includes urgent care facility visits, office visit and inpatient hospital visits)	100% coverage up to a \$700 maximum per covered person, per calendar year
Wellness Benefit	100% coverage up to \$600 maximum per covered person, per calendar year

Exclusions from Coverage: Other Outpatient Care Items

Ambulance Services	Not covered
Chemotherapy	Not covered
Diabetic Supplies, Self Education and Management	Not covered
Durable Medical Equipment (DME)	Not covered
Fertility Enhancement Services and Procedures	Not covered
Home Health Care Services (including visits)	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 (except practitioner charges for delivery and complications)	Not covered
Prescription Drugs	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 up to 90 days maximum, per calendar year
Inpatient Practitioner Visits	See practitioner visits for illness or injury under Outpatient Care

Exclusions from Coverage: Other Inpatient Care Items

Hospice Care	Not covered
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 provided in the Oxford Individual Basic and Essential Health Care Services Plan Certificate.

