



OXFORD HEALTH INSURANCE, INC.
NJ G GDST NG 10/50/1000/90 EPO PA 19 - Non-Gated
SUMMARY OF COVERAGE

Garden State Network

| BENEFIT | | IN-NETWORK | OUT-OF-NETWORK |
|---|---------|---|---|
| FINANCIAL | | | |
| Deductible:* | Single* | \$1,000 | Not Covered |
| | Family | \$2,000 | Not Covered |
| Coinsurance | | 10% | Not Covered |
| Maximum Out-Of-Pocket: | Single | \$3,300 | Not Covered |
| (Including Deductible) | Family | \$6,600 | Not Covered |
| Financial Accumulation Period: | | Contract Year | Not Applicable |
| Out-of-Network Reimbursement: | | Not Applicable | Not Applicable |
| <i>Please Note: All Copayments, Deductibles, and Coinsurance (medical and prescription) paid for In-Network Covered Services contribute to the In-Network, Out-of-Pocket Maximum.</i> | | | |
| <i>*If you have a family contract, the entire family Deductible must be satisfied before coverage under this Plan is available. A family contract is a Plan that covers you and one or more dependents.</i> | | | |
| PREVENTIVE CARE | | | |
| Pediatric (over 1 year) and Adult Preventive Care | | No Charge | Not Covered |
| Infant Preventive Care (under 1 year) | | No Charge | Not Covered |
| Preventive Dental for Children (Up to age 19) | | No Charge after Deductible | Not Covered |
| Pediatric Vision Exam (Up to age 19) | | \$10 Copay per visit | Not Covered |
| Pediatric Vision Hardware: (Up to age 19) | | 50% Coinsurance | Not Covered |
| OUTPATIENT CARE | | | |
| Primary Care Physician Office Visits | | \$10 Copay per visit | Not Covered |
| Specialist Office Visits | | Deductible then \$50 Copay per visit | Not Covered |
| Outpatient Surgery - Hospital Setting | | Deductible then \$150 Copay per visit | Not Covered |
| Outpatient Surgery - Freestanding Facility | | Deductible then \$75 Copay per visit | Not Covered |
| Laboratory Services | | Deductible then \$15 Copay per service | Not Covered |
| Radiology Services | | Deductible & 10% Coinsurance | Not Covered |
| MRIs, MRAs, CT SCANS, AND PET SCANS | | | |
| Outpatient Hospital Services | | Deductible then \$100 Copay per service | Not Covered |
| Freestanding Radiology Facility | | Deductible then \$25 Copay per service | Not Covered |
| HOSPITAL CARE | | | |
| Physician's and Surgeon's Services | | Deductible & 10% Coinsurance | Not Covered |
| Semi-Private Room and Board | | Deductible then \$500 Copay per admission | Not Covered |
| All Drugs and Medication | | Deductible & 10% Coinsurance | Not Covered |
| EMERGENCY CARE | | | |
| Ambulance Service When Medically Necessary | | Deductible then \$100 Copay per transport | Deductible then \$100 Copay per transport |
| At Hospital Emergency Room (<i>copay waived if admitted</i>) | | Deductible & 50% Coinsurance then \$100 Copay | Deductible & 50% Coinsurance then \$100 Copay |
| (<i>If member is admitted to the hospital, notification is required.</i>) | | | |
| Emergency Care in Urgi-Center | | \$50 Copay per visit | Not Covered |
| MATERNITY CARE | | | |
| Prenatal and Post-Natal Care | | No Charge | Not Covered |
| Hospital Services for Mother and Child | | Deductible then \$500 Copay per admission | Not Covered |
| SKILLED NURSING FACILITY | | | |
| Unlimited | | Deductible then \$500 Copay per admission | Not Covered |
| HOSPICE CARE | | | |
| Inpatient Care | | Deductible then \$500 Copay per admission | Not Covered |
| Home Hospice - Unlimited | | Deductible then \$50 Copay per visit | Not Covered |
| HOME HEALTH CARE | | | |
| Home Care Visits - 60 visits per Calendar Year | | Deductible then \$50 Copay per visit | Not Covered |
| Physician House Calls | | Deductible then \$50 Copay per visit | Not Covered |
| SUBSTANCE USE DISORDER SERVICES | | | |
| Inpatient Rehabilitation | | Deductible then \$500 Copay per admission | Not Covered |
| Outpatient Rehabilitation | | \$30 Copay per visit | Not Covered |
| Outpatient Partial Hospitalization | | No Charge after Deductible | Not Covered |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|--|
| MENTAL HEALTH CARE | | |
| Inpatient Rehabilitation | Deductible then \$500 Copay per admission | Not Covered |
| Outpatient Rehabilitation | \$30 Copay per visit | Not Covered |
| Outpatient Partial Hospitalization | No Charge after Deductible | Not Covered |
| ALLERGY CARE | | |
| Testing and Treatment | Deductible then \$50 Copay per visit | Not Covered |
| ALTERNATIVE MEDICINE | | |
| Chiropractic Care - 30 Visits per Calendar Year | \$30 Copay per visit | Not Covered |
| SHORT TERM REHABILITATION | | |
| Inpatient - Unlimited | Deductible then \$500 Copay per admission | Not Covered |
| Outpatient Visits - Limited to 30 combined PT/OT visits per Calendar year <i>Prerecertification upon initial Visit**</i> | Deductible then \$50 Copay per visit | Not Covered |
| HABILITATIVE SERVICES | | |
| Inpatient - Unlimited | Deductible then \$500 Copay per admission | Not Covered |
| Outpatient Visits Limited to 30 combined PT/OT visits per Calendar year <i>Note: Autism Spectrum Disorder limits are separate from the Rehabilitation Limit and are defined separately per NJ autism mandate.</i> | Deductible then \$50 Copay per visit | Not Covered |
| DURABLE MEDICAL EQUIPMENT | | |
| Durable Medical Equipment - Unlimited <i>Prerecertification required for items over \$500</i> | \$10 Copay per item | Not Covered |
| MEDICAL SUPPLIES | | |
| Medical Supplies When Medically Necessary | Deductible & 10% Coinsurance | Not Covered |
| HEARING AIDS | | |
| Hearing Aids (through age 15) - Limited to 1 hearing aid for each hearing impaired ear every 24 months. | \$10 Copay per item | Not Covered |
| EXERCISE FACILITY | | |
| Subscriber | \$200 reimbursement per 6 month period | Not Covered |
| Spouse | \$100 reimbursement per 6 month period | Not Covered |
| OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE | | |
| | Subject to Plan Deductible listed above (waived for Tier 1) | |
| OUTPATIENT PRESCRIPTION DRUGS - RETAIL | | |
| <i>The Prescription Drug Benefit is based on a Per Contract Year limit for any applicable deductibles and/or maximum limits.</i> | | |
| Tier 1 | \$10 Copay | Covered at participating pharmacies only |
| Tier 2 | \$40 Copay | Covered at participating pharmacies only |
| Tier 3 | \$70 Copay | Covered at participating pharmacies only |
| OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER | | |
| Tier 1 | \$20 Copay | Covered at participating pharmacies only |
| Tier 2 | \$80 Copay | Covered at participating pharmacies only |
| Tier 3 | \$140 Copay | Covered at participating pharmacies only |

DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.
Domestic Partners are covered with proper documentation.

Please Note: This sample summary of coverage is provided for informational purposes only. The applicable Summary of Benefits will be issued to eligible enrolled members as part of the Certificate of Coverage. Coverage is subject to the terms and conditions of the Certificate.

Refer to the Certificate of Coverage for a more complete listing of all benefits, limitations, and exclusions which include, among other services not authorized by Oxford, cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorders, Worker's Compensation, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.

Benefits are subject to final approval by the Department of Insurance and therefore may be subject to change.