

## OXFORD HEALTH INSURANCE, INC. NJ S GDST GT 20/70/2500/50 EPO ADV 19 - Gated SUMMARY OF COVERAGE

## The Group Name Garden State Network

BENEFIT		IN-NETWORK	OUT-OF-NETWORK
FINANCIAL			
Deductible:	Single	\$2,500	Not Covered
	Family	\$5,000	Not Covered
Coinsurance		50%	Not Covered
Maximum Out-Of-Pocket:	Single	\$7,500	Not Covered
(Including Deductible)	Family	\$15,000	Not Covered
Financial Accumulation Period:		Contract Year	Not Applicable
Out-of-Network Reimbursement:		Not Applicable	Not Applicable

Financial Accumulation Period:	Contract Year	Not Applicable	
Out-of-Network Reimbursement:	Not Applicable	Not Applicable	
<b>Please Note:</b> All Copayments, Deductibles, and Coinsurance (medical an	nd prescription) paid for In-Network Covered Services contribute to	o the In-Network, Out-of-Pocket Maximum.	
PREVENTIVE CARE			
Pediatric (over 1 year) and Adult Preventive Care	No Charge	Not Covered	
nfant 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)	\$20 Copay per visit	Not Covered	
rediatric Vision Hardware: (Up to age 19)	50% Coinsurance	Not Covered	
OUTPATIENT CARE			
Primary Care Physician Office Visits	\$20 Copay per visit	Not Covered	
pecialist Office Visits*	\$70 Copay per visit	Not Covered	
Outpatient Surgery - Hospital Setting	Deductible & 50% Coinsurance	Not Covered	
Outpatient Surgery - Freestanding Facility	Deductible & 50% Coinsurance	Not Covered	
Laboratory Services - Hospital Setting	Deductible & 50% Coinsurance	Not Covered	
Laboratory Services - Freestanding Facility	Deductible & 50% Coinsurance	Not Covered	
Radiology Services - Hospital Setting	Deductible & 50% Coinsurance	Not Covered	
Radiology Services - Freestanding Facility	Deductible & 50% Coinsurance	Not Covered	
MRIS, MRAS, CT SCANS, AND PET SCANS			
Outpatient Hospital Services	Deductible & 50% Coinsurance	Not Covered	
Freestanding Radiology Facility	Deductible & 50% Coinsurance	Not Covered	
HOSPITAL CARE			
hysician's and Surgeon's Services	Deductible & 50% Coinsurance	Not Covered	
emi-Private Room and Board	Deductible & 50% Coinsurance	Not Covered	
All Drugs and Medication	Deductible & 50% Coinsurance	Not Covered	
EMERGENCY CARE			
Ambulance Service When Medically Necessary	Deductible & 50% Coinsurance	Deductible & 50% Coinsurance	
At Hospital Emergency Room (waived if admitted)	Deductible & 50% Coinsurance then \$100 Copay	Deductible & 50% Coinsurance then \$10	
If member is admitted to the hospital, notification is required.)		Copay	
Emergency Care in Urgi-Center	\$60 Copay per visit	Not Covered	
MATERNITY CARE			
renatal and Post-Natal Care	No Charge	Not Covered	
Hospital Services for Mother and Child	Deductible & 50% Coinsurance	Not Covered	
KILLED NURSING FACILITY			
Inlimited	Deductible & 50% Coinsurance	Not Covered	
IOSDICE CARE			
HOSPICE CARE  npatient Care	Deductible & 50% Coinsurance	Not Covered	
	Φ <b>T</b> O G	Not Covered	
Home Hospice - Unlimited	\$70 Copay per visit	110t Covered	
HOME HEALTH CARE  Home Care Visits - 60 visits per Calendar Year	\$70 Copay per visit	Not Covered	
Physician House Calls	\$70 Copay per visit	Not Covered  Not Covered	
UBSTANCE USE DISORDER SERVICES			
npatient Rehabilitation	Deductible & 50% Coinsurance	Not Covered	
Outpatient Rehabilitation	\$30 Copay per visit	Not Covered	
Outpatient Partial Hospitalization	Deductible & 50% Coinsurance	Not Covered	
JISM CS EDO 01 01 10 v 2	0	January 1, 2010	

NJSM\_GS EPO\_01.01.19\_v.3 0 January 1, 2019

Deductible & 50% Coinsurance  Not Covered  MLERGY CARK  Forting and Treatment  LTERNATIVE MEDICINE  Distinguistion Part of the per Calendar Year  SIDORT THEM REHABILITATION  Reputer Visits  Invited to 30 combined PToT visits per Calendar Year  SIDORT THEM REHABILITATION  Reputer Visits  Invited to 30 combined PToT visits per Calendar Year  SIDORT THEM REHABILITATION  Deductible & 50% Coinsurance  Not Covered  INDIGITATIVE SERVICES  Reputer Visits  Invited to 30 contained PToT visits per Calendar Year  SIDORT THEM REHABILITATION  Deductible & 50% Coinsurance  Not Covered  Invited to 30 contained PToT visits per Calendar Year  SIDORT THEM REHABILITATION  Deductible & 50% Coinsurance  Not Covered  Invited to 30 contained PToT visits per Calendar Year  SIDORT THEM REHABILITATION  Deductible & 50% Coinsurance  Not Covered  Invited to 30 contained PToT visits per Calendar Year  SIDORT THE SERVICES  Reputer Visits  Invited to 30 contained PToT visits per Calendar Year  SIDORT THE SERVICES  Deductible & 50% Coinsurance  Not Covered  Invited to 30 contained PToT visits per Calendar Year  SIDORT THE SERVICES  Deductible & 50% Coinsurance  Not Covered  Invited to 30 contained PToT visits per Calendar Year  SIDORT THE SERVICES  SIDORT THE SERVICES  Not Covered  Invited The Service Ser	BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Not Covered	MENTAL HEALTH CARE		
Deductible & 50% Consumence   Not Covered	npatient Rehabilitation	Deductible & 50% Coinsurance	Not Covered
Deductible & 30% Coinsurance   Not Covered	Outpatient Rehabilitation	\$30 Copay per visit	Not Covered
LLEEROY CARE  Issing and Treatment  S70 Copus per visit  Not Covered  LLEERATIVE MEDICINE  Inhipopeatic Care - 30 visits per Calendar Year  S30 Copus per visit  Not Covered  HIORT TERM REHABILITATION  publicated Visits - 50 visits per Calendar Year  INDIGITATIVE SERVICES  Apatient Visits - 50 Copus per visit  Not Covered  Inhipoteatic Care - 10 visits per Calendar Year  INDIGITATIVE SERVICES  Inhipoteatic Visits per Calendar Year  INDIGITATIVE SERVICES  INDIGITATIVE			
esting and Treatment  ATTERNATIVE MEDICINE  Throporactic Care - 30 visits per Calendar Year  Not Covered  MORT TERM REHABILITATION Impatient - Unlimited  Deductible & 50% Comparance  Not Covered  Averagement - Unlimited  Deductible & 50% Comparance  Not Covered  Mort TERM REHABILITATION Impatient - Unlimited  Deductible & 50% Comparance  Not Covered  Mort TERM REHABILITATION Impatient - Unlimited  Deductible & 50% Comparance  Not Covered  Mort TERM REHABILITATION Impatient - Unlimited  Deductible & 50% Comparance  Not Covered  Mort Covered  Mort Covered  Mort Covered  Mort Covered  Despetient - Unlimited  Deductible & 50% Coinsurance  Not Covered  Mort Covered at participating pharmacies on civered  Mort Cov	Surputone I usua 1100piumizution	Beddenote & 20% Comparance	1100 001000
ATTERNATIVE MEDICINE  Thropractic Care - 30 visits per Calendar Year  \$30 Copay per visit  Not Covered  **MORT TERM REHABILITATION**  **Popular Visits - Voluntial Control of Covered Calendar Year  **Popular Visits - Voluntial Control of Covered Calendar Year  **Popular Visits - Voluntial Control of Covered Calendar Year  **Popular Visits - Voluntial Control of Covered Calendar Year  **Popular Visits - Voluntial Control of Covered Calendar Year  **Popular Visits - Voluntial Control of Covered Calendar Year  **Popular Visits - Voluntial Control of Covered Calendar Year  **Popular Visits - Voluntial Control of Covered Calendar Year  **Popular Visits - Voluntial Control of Covered Calendar Year  **Popular Visits - Voluntial Covered Covered Calendar Year  **Popular Visits - Voluntial Covered Covered Calendar Year  **Popular Visits - Voluntial Covered Covered Calendar Year  **Popular Visits Covered Covered Covered Calendar Year  **Popular Visits Covered Covered Covered Covered Covered Covered Covered Calendar Year  **Popular Visits Covered Covered Covered Covered Covered Covered Covered Calendar Year  **Popular Vis		670.0	N. G. I
Short FERN REHABILITATION  Septient - Unlimited Deductible & 50% Coinsurance Not Covered  Dupoteint Visits - So Copay per visit Not Covered  Molt Covered  M	Testing and Treatment	\$70 Copay per visit	Not Covered
HORT TERM REHABILITATION  Impatient Unlimited Deductible & 50% Coinsurance Not Covered  Diagnatient Unlimited Deductible & 50% Coinsurance Not Covered  ABBLITATIVE SERVICES  Deductible & 50% Coinsurance Not Covered  ABBLITATIVE SERVICES  Diagnatient Unlimited Deductible & 50% Coinsurance Not Covered  Diagnatient Unlimited Not Covered  Diagnatient Visits  So Copay per visit Not Covered  Diagnatient Visits Not Covered Not Covered Not Covered  Diagnatient Visits Not Covered Not Covered Not Covered  Diagnatient Visits Not Covered Diagnaties Not			
pagaient - Unlimited Deductible & 50% Coinsurance Not Covered Jungaient Visits - S50 Copay per visit Not Covered Jungaient Visits - S50 Copay per visit Not Covered Jungaient - Unlimited Deductible & 50% Coinsurance Not Covered Jungaient - Unlimited Deductible & 50% Coinsurance Not Covered Jungaient - Unlimited Despatient PEOT visits per Calendar Year Jungaient - Unlimited Despatient PEOT Visits per Calendar Year Jungaient - Unlimited Despatient PEOT Visits per Calendar Year Jungaient - Unlimited Despatient PEOT Visits per Calendar Year Jungaient - Unlimited Despatient PEOT Visits per Calendar Year Jungaient - Unlimited Despatient PEOT Visits per Calendar Year Jungaient - Unlimited Despatient PEOT Visits per Calendar Year Jungaient Visits Jungaient Visits Jungaient Visits Not Covered Jungaient Visits Jungaient Visits Not Covered Jungaient Visits Jungaie	Chiropractic Care - 30 visits per Calendar Year	\$30 Copay per visit	Not Covered
Inflantient Visits - Limited to 30 combined PT/OT visits per Calendar Year  IABILITATIVE SERVICES  IABILITATIVE SERVICES  IABILITATIVE SERVICES  Deductible & 50% Coinsurance Not Covered  Not Covered  Not Covered  Not Covered  Indicative Visits North Not Covered  Not Covered  Not Covered  Not Covered  IABILITATIVE SERVICES  Diagnated Visits Service Service Not Constrain Committed to 30 combined PT/OT visits per Calendar Year  Not Covered  IABILITATIVE SERVICES  Not Covered IABILITATIVE SERVICES  IABIL	SHORT TERM REHABILITATION		
Initiated to 30 combined PT/OT visits per Calendar Year  IABILITATIVE SERVICES  Imparient - Unlimited Deductible & 50% Coinsurance Not Covered Deductible Not Covered Deductible & 50% Coinsurance Not Covered Aparticipating pharmacies on Covered Aparticipating pharmacies on Covered Aparticipating pharmacies on Covered Aparticipating pharmacies Not Part Prescription Drug Benefit is based on a Per Contract Var limit for any applicable deductibles and/or maximum limits.  The 1 Side Copay Covered at participating pharmacies on Covered Deductible Processor Deductible Processor Deductible Processor Deductible Processor Deductible Processor Deductible Processor D	npatient - Unlimited	Deductible & 50% Coinsurance	Not Covered
Initiated to 30 combined PT/OT visits per Calendar Year  IABILITATIVE SERVICES  Imparient - Unlimited Deductible & 50% Coinsurance Not Covered Deductible Not Covered Deductible & 50% Coinsurance Not Covered Aparticipating pharmacies on Covered Aparticipating pharmacies on Covered Aparticipating pharmacies on Covered Aparticipating pharmacies Not Part Prescription Drug Benefit is based on a Per Contract Var limit for any applicable deductibles and/or maximum limits.  The 1 Side Copay Covered at participating pharmacies on Covered Deductible Processor Deductible Processor Deductible Processor Deductible Processor Deductible Processor Deductible Processor D	Outpatient Visits -	\$50 Copay per visit	Not Covered
papatient - Unlimited Deductible & 50% Coinsurance Not Covered  Dupatient Visits Not Covered  Dupatient Visits Spectrum Disorder limits are separate from the Rehabilitation Limit and are defined separately per NJ autism mendate.  DURABLE MEDICAL EQUIPMENT  Durable Medical Equipment - Unlimited No Charge Not Covered  MEDICAL SUPPLIES  Medical Supplies When Medically Necessary Deductible & 50% Coinsurance Not Covered  MEDICAL SUPPLIES  Medical Supplies When Medically Necessary Deductible & 50% Coinsurance Not Covered  MEDICAL SUPPLIES  Medical Supplies When Medically Necessary Deductible & 50% Coinsurance Not Covered  MEDICAL SUPPLIES  Medical Supplies When Medically Necessary Deductible & 50% Coinsurance Not Covered  MEDICAL SUPPLIES  MOT Covered  Not Covered  Not Covered at Participating pharmacies on Covered Aparticipating pharmacies on Covered at participating pharmac	-		
papatient - Unlimited Deductible & 50% Coinsurance Not Covered  Dupatient Visits So Copuy per visit Not Covered  Dipatient Visits Privor Visits per Calendar Year  Mote: Autims Disorder limits are separate from the Rehabilitation Limit and are defined separately per NI autism mondate.  DURABLE MEDICAL EQUIPMENT  Durable Medical Equipment - Unlimited No Charge Not Covered  MEDICAL SUPPLIES  deficial supplies When Medically Necessary Deductible & 50% Coinsurance Not Covered  MEDICAL SUPPLIES  deficial Supplies When Medically Necessary Deductible & 50% Coinsurance Not Covered  MEDICAL SUPPLIES  deficial supplies When Medically Necessary Deductible & 50% Coinsurance Not Covered  MEDICAL SUPPLIES  deficial Supplies When Medically Necessary Deductible of No Charge Not Covered  Mote Covered  Mote Covered  Mote Covered  Not Covered or participating pharmacies on Covered at participating pharmacies	HARILITATIVE SERVICES		
Active Activities per Calendar Year Note: Activities Spectrum Disorder limits are separate from the Rehabilitation Limit and are defined separately per N autism mandate.  DURABLE MEDICAL EQUIPMENT  Durable Medical Equipment - Unlimited No Charge Not Covered  Precertification required for items over \$500  AEDICAL SUPPLIES  dedical Supplies When Medically Necessary Deductible & 50% Coinsurance Not Covered  HEARING AIDS  Earing Aids (through age 15) - Limited to 1 hearing aid for an hearing impaired ear every 24 months  EXERCISE FACILITY  Subscriber Supplies FACILITY  Subscriber Supplies System of Mot Covered System of Mot Covered Not Covered at participating pharmacies on Not Covered at partic		Deductible & 50% Coinsurance	Not Covered
Avoir: Autism Spectram Disorder limits are separate from the Rehabilitation Limit and are defined separately per NJ autism mandate.  **CURABLE MEDICAL EQUIPMENT**  **Durable Medical Equipment - Unlimited**  **Precertification required for items over \$500  **MEDICAL SUPPLIES**  **Medical Supplies When Medically Necessary**  **Deductible & 50% Coinsurance**  **Not Covered**  **BEARNG AIDS**  **BEARNG AIDS**  **BEARING AIDS**  **BEARING AIDS**  **BEARING AIDS**  **EXERCISE FACILITY**  **Subscriber**  **SUBSCREAM of through age 15) - Limited to 1 hearing aid for act hearing impaired ear every 24 months*  **EXERCISE FACILITY**  **Subscriber**  **SUBSCREAM of through age 15) - Deductible & 50% Coinsurance**  **Not Covered at Not Covered at Not Covered and hearing impaired ear every 24 months*  **EXERCISE FACILITY**  **Subscriber**  **SUBSCREAM of through age 15) - Limited to 1 hearing aid for act hearing impaired ear every 24 months*  **EXERCISE FACILITY**  **SUBSCREAM of through age 15) - Limited to 1 hearing aid for act hearing impaired ear every 24 months*  **EXERCISE FACILITY**  **SUBSCREAM of through age 15) - Limited to 1 hearing aid for act hearing impaired ear every 24 months*  **EXERCISE FACILITY*  **SUBSCREAM of through age 15) - Limited to 1 hearing aid for act hearing impaired ear every 24 months*  **EXERCISE FACILITY*  **SUBSCREAM of through age 15) - Limited to 1 hearing aid for act hearing impaired ear every 24 months*  **EXERCISE FACILITY*  **SUBSCREAM of through age 15) - Limited to 1 hearing aid for act hearing impaired ear every 24 months*  **EXERCISE FACILITY*  **SUBSCREAM of through age 15) - Limited to 1 hearing aid for act hearing impaired ear every 24 months*  **EXERCISE FACILITY*  **SUBSCREAM of through age 15) - Limited to 1 hearing aid for act hearing impaired ear every 24 months*  **SUBSCREAM of through age 15) - Limited to 1 hearing aid for act hearing impaired ear every 24 months*  **SUBSCREAM of through age 15) - Limited to 1 hearing aid for act hearing and through age 15) - Limited to	Dutactiont Vicita	\$50 Congression	Not Coursed
No Charge Not Covered  AEDICAL SUPPLIES  Bedical Supplies When Medically Necessary Deductible & 50% Coinsurance Not Covered  AERING AIDS  Bearing Aids (through age 15) - Limited to 1 hearing aid for No Charge Not Covered  AERING AIDS  Bearing Aids (through age 15) - Limited to 1 hearing aid for No Charge Not Covered  AERICAL SUPPLIES  Bearing Aids (through age 15) - Limited to 1 hearing aid for No Charge Not Covered  AERING AIDS  Bearing Aids (through age 15) - Limited to 1 hearing aid for No Charge Not Covered  AERING FACILITY  Bearing Aids (through age 15) - Limited to 1 hearing aid for No Charge Not Covered  AERING FACILITY  Bearing Aids (through age 15) - Limited to 1 hearing aid for No Charge Not Covered  ACTION FACILITY  BEARING FACILITY  BUTTATIENT PRESCRIPTION DRUGS - DEDUCTIBLE S150 Deductible (waived for Tier 1)  BUTTATIENT PRESCRIPTION DRUGS - RETAIL  The Prescription Drug Benefit is based on a Per Contract Year limit for any applicable deductibles and/or maximum limits.  Fier 1 S15 Copay Covered at participating pharmacies on S150 Copay Covered at participating pharmacies on Covered A150 Covered A	•	\$50 Copay per visit	Not Covered
DURABLE MEDICAL EQUIPMENT  Durable Medical Equipment - Unlimited No Charge Not Covered  Precertification required for items over \$500  #### Actional Supplies When Medically Necessary    Deductible & 50% Coinsurance   Deductible & 50% Coinsurance   Not Covered   Deductible & 50% Coinsurance   Not Covered   HEARING AIDS   Hearing Aids (through age 15) - Limited to 1 hearing aid for   No Charge   Not Covered   Supplies FACILITY   Widescriber   Supplies FACILITY   Widescriber   Supplies FACILITY   Widescriber   Supplies FACILITY   Widescriber   Supplies FACILITY   Supplies FACILITY   Widescriber   Supplies FACILITY   Suppl			
Durable Medical Equipment - Unlimited No Charge Not Covered recertification required for items over \$500  MEDICAL SUPPLIES  Actical Supplies When Medically Necessary Deductible & 50% Coinsurance Not Covered HEARING AIDS  Hearing Aids (through age 15) - Limited to 1 hearing aid for No Charge Not Covered at participating pharmacies on fier 3  EXERCISE FACILITY  Authority PRESCRIPTION DRUGS - DEDUCTIBLE \$150 Deductible (waived for Tier 1)  DUTPATIENT PRESCRIPTION DRUGS - RETAIL  The Prescription Drug Benefit is based on a Per Contract Year limit for any applicable deductibles and/or maximum limits.  Tier 1 \$15 Copay Covered at participating pharmacies on fier 3  TOWN TOWN TOWN TOWN TOWN TOWN TOWN TOWN	• · · · · · · · · · · · · · · · · · · ·		
### Precertification required for items over \$500  #### MEDICAL SUPPLIES  #### Medical Supplies When Medically Necessary  #### Deductible & 50% Coinsurance  #### Not Covered  ##### Not Covered  ##################################	-		
MEDICAL SUPPLIES  Medical Supplies When Medically Necessary  Deductible & 50% Coinsurance  Not Covered  Medical Supplies When Medically Necessary  Deductible & 50% Coinsurance  Not Covered  Not Covered at participating pharmacies on		No Charge	Not Covered
Medical Supplies When Medically Necessary  Deductible & 50% Coinsurance  Not Covered  HEARING AIDS  Tearing Aids (through age 15) - Limited to 1 hearing aid for ach hearing impaired ear every 24 months  EXERCISE FACILITY  Subscriber \$200 reimbursement per 6 month period Not Covered for Supplies with period Not Covered Not Covered  DUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE \$150 Deductible (waived for Tier 1)  DUTPATIENT PRESCRIPTION DRUGS - RETAIL  The Prescription Drug Benefit is based on a Per Contract Year limit for any applicable deductibles and/or maximum limits.  Tier 1 \$15 Copay Covered at participating pharmacies on Tier 3 \$75 Copay Covered at participating pharmacies on Covered at participating pharmac	Precertification required for items over \$500		
Hearing Aids (through age 15) - Limited to 1 hearing aid for ach hearing impaired ear every 24 months  EXERCISE FACILITY  Subscriber \$200 reimbursement per 6 month period Not Covered Popuse \$100 reimbursement per 6 month period Not Covered Not Covered  DUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE \$150 Deductible (waived for Tier 1)  DUTPATIENT PRESCRIPTION DRUGS - RETAIL  The Prescription Drug Benefit is based on a Per Contract Year limit for any applicable deductibles and/or maximum limits.  Fier 1 \$15 Copay Covered at participating pharmacies on Fier 2 \$50 Copay Covered at participating pharmacies on Fier 3 \$75 Copay Covered at participating pharmacies on Covered at participating pharmacies on Fier 2 \$30 Copay Covered at participating pharmacies on Covered Average of Popus Covered at participating pharmacies on Supplication Prescription Drugs - Mail Order  DUTPATIENT PRESCRIPTION DRUGS - Mail ORDER  Fier 1 \$30 Copay Covered at participating pharmacies on Covered at participating pharmacies on Supplication Prescription Prescriptio			
Hearing Aids (through age 15) - Limited to 1 hearing aid for ach hearing impaired ear every 24 months  EXERCISE FACILITY  Subscriber  \$200 reimbursement per 6 month period Spouse  \$100 reimbursement per 6 month period Not Covered  Not Covered at participating pharmacies on  Size 2  \$50 Copay  Covered at participating pharmacies on  DUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER  Tier 1  \$30 Copay  Covered at participating pharmacies on  Covered at participating pharmacies on  Covered at participating pharmacies on  Size 2  \$100 Copay  Covered at participating pharmacies on	Medical Supplies When Medically Necessary	Deductible & 50% Coinsurance	Not Covered
EXERCISE FACILITY  Subscriber Sub	HEARING AIDS		
EXERCISE FACILITY  Subscriber Spouse \$200 reimbursement per 6 month period Not Covered at participating pharmacies on Covered at participating pharmacies on Not Covered at participating pharmacies on	Hearing Aids (through age 15) - Limited to 1 hearing aid for	No Charge	Not Covered
Subscriber \$200 reimbursement per 6 month period Not Covered \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pharmacies on \$100 reimbursement per 6 month period Not Covered at participating pha	ach hearing impaired ear every 24 months		
subscriber store and service store and service store and service store and service store at participating pharmacies on store 2 store at participating pharmacies on store 3 store 2 store at participating pharmacies on store 3 store 2 store 3 stor	EXERCISE FACILITY		
Spouse \$100 reimbursement per 6 month period Not Covered at participating pharmacies on Spour Prescription Drugs - Mail Order  DUTPATIENT PRESCRIPTION DRUGS - RETAIL  The Prescription Drug Benefit is based on a Per Contract Year limit for any applicable deductibles and/or maximum limits.  Tier 1 \$15 Copay Covered at participating pharmacies on Spour Covered at participating pharmacies on Covered at participating pharmacies on Spour Covered at participating pharmacies on Spour Covered at participating pharmacies on Covered at participating pharmacies on Spour Covered at participating pharmacies on Covered at participating pharmacies on Spour Co	ubscriber	\$200 reimbursement per 6 month period	Not Covered
DUTPATIENT PRESCRIPTION DRUGS - RETAIL The Prescription Drug Benefit is based on a Per Contract Year limit for any applicable deductibles and/or maximum limits.  Tier 1 \$15 Copay Covered at participating pharmacies on \$50 Copay Covered at participating pharmacies on \$75 Copay Covered at participating pharmacies on \$150 Copay Covered at participating p	pouse		Not Covered
The Prescription Drug Benefit is based on a Per Contract Year limit for any applicable deductibles and/or maximum limits.  Tier 1 \$15 Copay Covered at participating pharmacies on \$50 Copay Covered at participating pharmacies on \$75 C	OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE	\$150 Deductible (waived for Tier 1)	
The Prescription Drug Benefit is based on a Per Contract Year limit for any applicable deductibles and/or maximum limits.  Fier 1 \$15 Copay Covered at participating pharmacies on \$50 Copay Covered at participating pharmacies on \$75 C			
Fier 2 \$50 Copay Covered at participating pharmacies on \$75 Copay Covered at participating pharmacies on \$75 Copay Covered at participating pharmacies on Covered at participating pharmacies on Sier 1 \$30 Copay Covered at participating pharmacies on Sier 2 \$100 Copay Covered at participating pharmacies on Sier 3 \$150 Copay Covered at participating pharmacies Opay Covered at		able deductibles and/or maximum limits.	
Sier 2 \$50 Copay Covered at participating pharmacies on \$75 Copay Covered at participating pharmacies on \$100 Copay Covered at participating pharmacies on \$150 Copay Covered at participating pharmacies	ier 1	\$15 Copay	Covered at participating pharmacies only
Fier 3 \$75 Copay Covered at participating pharmacies on Courted at participating pharmacies on Courted at participating pharmacies on Covered at participating pharmacies on Sier 3 \$150 Copay Covered at participating pharmacies on Covered at participati	Tier 2		Covered at participating pharmacies only
Sier 1 \$30 Copay Covered at participating pharmacies on \$100 Copay Covered at participating pharmacies on \$150 Copay Covered at participating pharmacies on \$150 Copay Covered at participating pharmacies on \$150 Copay	Tier 3		Covered at participating pharmacies only
Sier 1 \$30 Copay Covered at participating pharmacies on \$100 Copay Covered at participating pharmacies on \$150 Copay Covered at participating pharmacies on \$150 Copay Covered at participating pharmacies on \$150 Copay	OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER		
Sier 2 \$100 Copay Covered at participating pharmacies on \$150 Copay Covered at participating pharmacies on \$150 Copay		\$30 Copay	Covered at participating pharmacies only
Sier 3 \$150 Copay Covered at participating pharmacies on			Covered at participating pharmacies only
	Tier 3		Covered at participating pharmacies only

## DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26.

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.

NJSM\_GS EPO\_01.01.19\_v.3 0 January 1, 2019

Domestic Partners are covered with proper documentation.

<sup>\*</sup>Visits to an Oxford participating Specialist require an authorized referral from the member's Primary Care Physician.