

# TOWNSHIP OF IRVINGTON – OPEN ACCESS PLAN 20

## MEDICAL PLAN DEDUCTIBLES AND MAXIMUMS

<b>SUPPLEMENTAL COVERED SERVICES AND SUPPLIES</b>	
<p>The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount.                      The Deductible applies to all services prior to benefit payment, except where noted.                      (Includes coverage for: Blood and Blood Products, Durable Medical Equipment, Inpatient Physical Rehabilitation, Private Duty Nursing Care, Prosthetic Devices, Specialized Non-Standard Infant Formulas, Treatment of Inherited Metabolic Disease, Vision Care, and Medically Necessary Wigs.)</p>	
<b>INDIVIDUAL DEDUCTIBLE</b>	\$100 per calendar year Carryover does not apply Maximums are combined for in and out-of-network Providers, except where noted.
<b>FAMILY DEDUCTIBLE</b>	\$200 per calendar year Carryover does not apply Two Family Members must each meet their individual deductibles to satisfy the family deductible.
<b>INDIVIDUAL COINSURANCE MAXIMUM</b> (The Coinsurance Maximum applies to Supplemental Covered Services and Supplies only)	\$400 per calendar year Does not include deductible Carryover does not apply Maximums are combined for in and out-of-network Providers, except where noted.
<b>FAMILY COINSURANCE MAXIMUM</b> (The Coinsurance Maximum applies to Supplemental Covered Services and Supplies only)	\$800 per calendar year Does not include deductible Carryover does not apply Two Family Members must each meet their individual Coinsurance Maximums to satisfy the family Coinsurance Maximum.
<b>BASIC COVERED SERVICES AND SUPPLIES</b>	
<p>The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount.</p>	
<b>OUT-OF-POCKET MAXIMUM</b>	\$5,000 Individual \$10,000 Family Includes Basic Copayments and Supplemental Benefit deductibles and Coinsurance listed above.
<b>LIFETIME MAXIMUM</b>	Unlimited

## MEDICAL COVERAGE SUMMARY OPEN ACCESS HMO

TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount.	The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount. The Deductible applies to all services prior to benefit payment, except where noted.
<b>ACUPUNCTURE</b>	Acupuncture is only covered when used in lieu of General Anesthesia.	See Anesthesia Benefit	See Anesthesia Benefit
<b>ALLERGY CARE</b> -Office Visit -Treatment (Injections) -Serum -Laboratory & Scratch Testing		\$20 Copay per visit Covered in full Covered in full Covered in full	See Basic Benefit See Basic Benefit See Basic Benefit See Basic Benefit
<b>AMBULANCE</b>	Services will be denied if Pre-Certification is not obtained, except in Emergency situations. Air ambulance is covered if deemed Medically Necessary by the Medical Services Team. The Plan does not cover rail or water ambulance.	Covered in full	See Basic Benefit
<b>ANESTHESIA</b> -Inpatient -Outpatient -Office		Covered in full Covered in full Covered in full	See Basic Benefit See Basic Benefit See Basic Benefit
<b>BIOFEEDBACK</b>		Not covered	Not covered
<b>BLOOD AND BLOOD PRODUCTS</b>		\$35 Copay if in the outpatient department of the Hospital	80% at all other places of service
<b>CARDIAC REHABILITATION</b> -Outpatient Hospital -Any other place of service		\$35 Copay per visit \$20 Copay per visit	See Basic Benefit See Basic Benefit
<b>CHEMOTHERAPY</b> -Outpatient Hospital -Any other place of service		Covered in full Covered in full	See Basic Benefit See Basic Benefit

The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount.	The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount. The Deductible applies to all services prior to benefit payment, except where noted.
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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>CHIROPRACTOR</b>	Maximum of 12 visits per calendar year.	\$20 Copay per visit 50% of Allowable Expense for 1 <sup>st</sup> 6 visits 25% of Allowable Expense for last 6 visits	See Basic Benefit
<b>CONVALESCENT/SKILLED NURSING FACILITY</b>	Services will be denied if Pre-Certification is not obtained. Maximum of 60 days of inpatient care per calendar year	Covered in full	See Basic Benefit
<b>DENTAL CARE COVERED UNDER MEDICAL PLAN</b>			
-Accidental Injury to Teeth	Services must be rendered within six months of the accidental injury.	Covered in full	See Basic Benefit
-Oral Surgery	Covered Services include the diagnosis and treatment of oral tumors and cysts and the surgical removal of bony or partial bony impacted teeth.	Covered in full	See Basic Benefit
<b>DIABETIC TREATMENT</b>			
-Education		\$20 Copay per visit	See Basic Benefit
-Supplies and Equipment		Covered in full	See Basic Benefit
<b>DIAGNOSTIC X-RAYS AND IMAGING TESTS</b>			
-Independent Facility		\$20 Copay per visit	See Basic Benefit
-Outpatient Hospital		\$35 Copay per visit	See Basic Benefit
-Physician's Office		\$20 Copay per visit	See Basic Benefit
<b>HIGH TECH IMAGING (SUCH AS MRI, MRA, PET AND CAT SCANS)</b>		\$20 Copay per visit	See Basic Benefit
<b>DIALYSIS OR HEMODIALYSIS</b>			
-Outpatient Hospital		Covered in full	See Basic Benefit
-Any other place of service		Covered in full	See Basic Benefit

The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount.

The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount. The Deductible applies to all services prior to benefit payment, except where noted.

TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>DURABLE MEDICAL EQUIPMENT (DME)</b> <i>Including, but not limited to:</i>  -Disposable Medical Supplies  -Prosthetics (External and Internal)  -Foot Orthotics  -Orthotics (Braces) -Oxygen	Wigs covered if hair loss is due to radiation or chemotherapy or second degree burns and are subject to a maximum of \$500 maximum per calendar year. Repairs and dental prosthetics are not covered. Only covered following bone surgery of the foot to maintain post surgical bone alignment. Also covered for diabetics if determined to be Medically Necessary by the Medical Services Team.	See Supplemental Benefit  See Supplemental Benefit  See Supplemental Benefit  Covered in full  See Supplemental Benefit See Supplemental Benefit	80%  80%  80%  See Basic Benefit  80% 80%
<b>ENTERAL FORMULA</b>	Services will be denied if Pre-Certification is not obtained	See Supplemental Benefit	80%

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>FAMILY PLANNING SERVICES</b>			
-Elective Sterilization Procedures		Covered in full	See Basic Benefit
-Voluntary Termination of Pregnancy	Maximum of two per calendar year and four per Lifetime. (Not covered for Dependent Children)	Covered in full	See Basic Benefit
-Infertility Treatment Guidelines apply – Refer to your Plan Document for more information on this benefit	Includes coverage for infertility services as mandated by New Jersey law. Egg retrievals are limited to four per Lifetime.	Covered as described under type of service rendered	See Basic Benefit
-Contraceptive Devices		Covered in full	See Basic Benefit
-Contraceptive Management Office Visit		\$20 Copay per visit	See Basic Benefit
<b>GENETIC TESTING</b>	The Plan covers genetic testing when Medically Necessary or medically appropriate as determined by the Medical Services Team criteria and peer-reviewed literature.	Covered as described under type of service rendered	See Basic Benefit
<b>HOME HEALTH CARE</b>	Services will be denied if Pre-Certification is not obtained. Maximum of 100 visits per calendar year		
-Aide, Nurse, or any other Authorized Agency Employee		Covered in full	See Basic Benefit
-Home IV Therapy and Respiratory Care		Covered in full	See Basic Benefit
<b>HOSPICE CARE</b>	Maximum of \$10,000 per Lifetime		
-Inpatient	Includes coverage for seven days of respite care per Lifetime	Covered in full	See Basic Benefit
-Home		Covered in full	See Basic Benefit

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>HOSPITAL FACILITY</b> <u>Inpatient Hospital</u>	Services will be denied if Pre-Certification is not obtained. Maximum of 365 days per calendar year	Covered in full	See Basic Benefit
<u>Outpatient Hospital</u>			
-Emergency Room for a medical Emergency	Includes ER Physician.	\$35 Copay per visit Waived if admitted	See Basic Benefit
-Emergency Room used for a Non-Emergency		Not covered	Not covered
-Outpatient Surgical Center		\$35 Copay per visit	See Basic Benefit
-Clinic		\$20 Copay per visit	See Basic Benefit
<b>INFUSION THERAPY</b>		Covered in full	See Basic Benefit
<b>LABORATORY</b>			
-Independent Facility		Covered in full	See Basic Benefit
-Outpatient Hospital		Covered in full	See Basic Benefit
-Physician's Office		Covered in full	See Basic Benefit
<b>MASSAGE THERAPY</b> (When rendered by a Licensed Massage Therapist)		Not covered	Not covered

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>MATERNITY CARE-MOTHER</b> (Refer to Diagnostic X-rays, Imaging Tests and Laboratory for benefits related to maternity) -Inpatient Hospital or Birthing Center  -Physician for Prenatal Care and Delivery	Maternity care is not covered for Dependent Children  Services will be denied if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section and the additional stay is not Post-Certified.	Covered in full  \$20 Copay for the initial visit only	See Basic Benefit  See Basic Benefit
<b>MENTAL ILLNESS SERVICES</b>  -Inpatient  -Inpatient Physician  -Outpatient/Office	Note: Refer to <i>medical benefits</i> (e.g. Hospital and Physician) for Biologically Based Illnesses.  Services will be denied if Pre-Certification is not obtained. (Hospital or Behavioral Health Care Facility) Maximum of 30 days per calendar year with a 45 day Lifetime maximum. Partial Hospitalization is covered. Two partial days equal one inpatient day. Maximum of 30 days per calendar year with a 45 day Lifetime maximum.  Maximum of 20 visits per calendar year.	Covered in full  Covered in full  \$25 Copay per visit	See Basic Benefit  See Basic Benefit  See Basic Benefit

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>MODIFIED FOOD PRODUCT</b>	Must be determined to be Medically Necessary and appropriate by the attending physician. Also includes coverage for specialized, non-standard infant formulas only if the infant Family Member has not responded to milk-based formulas.	See Supplemental Benefit	80%
<b>NEWBORN CARE</b> (Prior to Discharge)	<b>When Plan covers both Mother and Baby</b>		
-Hospital		Covered in full	See Basic Benefit
-Physician		Covered in full	See Basic Benefit
-Newborn Circumcision		Covered in full	See Basic Benefit
<b>NEWBORN CARE</b> (Prior to Discharge)	<b>When Plan covers the Baby but not the Mother</b>		
-Hospital	Services will be denied if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section and the additional stay is not Post-Certified.	Covered in full	See Basic Benefit
-Physician		Covered in full	See Basic Benefit
-Newborn Circumcision		Covered in full	See Basic Benefit
<b>NUTRITIONAL COUNSELING</b>	Maximum of three visits per calendar year	\$20 Copay per visit	See Basic Benefit
<b>OBESITY TREATMENT</b> Guidelines apply – Refer to your Plan Document for more information on this benefit	Obesity surgery is covered only if deemed Medically Necessary by the Medical Services Team.	Covered as described under type of service rendered	Covered as described under type of service rendered

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<b>OCCUPATIONAL THERAPY</b> -Outpatient Hospital -Any other place of service	Maximum of 25 visits per calendar year	\$35 Copay per visit \$20 Copay per visit	See Basic Benefit See Basic Benefit
<b>ORGAN TRANSPLANTS</b> Guidelines apply – Refer to your Plan Document for more information on this benefit	Services will be denied if Pre-Certification is not obtained.	Covered as described under type of service rendered	See Basic Benefit
<b>PHYSICAL REHABILITATION FACILITY</b>	Services will be denied if Pre-Certification is not obtained. Maximum of 60 inpatient days per calendar year	See Supplemental Benefit	80%
<b>PHYSICAL THERAPY</b> -Outpatient Hospital -Any other place of service	Maximum of 25 visits per calendar year	\$35 Copay per visit \$20 Copay per visit	See Basic Benefit See Basic Benefit
<b>PHYSICIAN</b> -Inpatient -Office -Home  <u>Consultation (Specialist)</u> -Inpatient -Outpatient -Office <u>Second Medical Opinion</u>		Covered in full \$20 Copay per visit \$25 Copay between 7am-9pm \$35 Copay between 9pm-7am  Covered in full \$35 Copay per visit \$20 Copay per visit Covered in full	See Basic Benefit See Basic Benefit See Basic Benefit  See Basic Benefit See Basic Benefit See Basic Benefit See Basic Benefit
<b>PREADMISSION TESTING</b>	Testing must be performed within seven days of admission	\$35 Copay per visit	See Basic Benefit

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>PREVENTATIVE/WELL CARE</b>			
-Bone Density Testing	Covered as recommended by the attending physician.	\$20 Copay per visit	See Basic Benefit
-Colonoscopy/Sigmoidoscopy	Routine colon cancer screenings are covered for Family Members 45 years of age or older as recommended by the attending physician	\$35 Copay per visit	See Basic Benefit
-GYN Office Visit	Maximum of one routine gynecological exam per calendar year (includes pap smear)	\$20 Copay per visit	See Basic Benefit
-PAP Smear	Maximum of one routine pap smear every calendar year	Covered in full	See Basic Benefit
-Mammogram	Maximum of one baseline mammogram for women age 35 to 40; one routine mammogram per calendar year for women 40 years of age or older	\$20 Copay per visit	See Basic Benefit
-Prostate Cancer Screening (PSA)	Maximum of one exam per calendar year for adult male Family Members	Digital exam-\$20 Copay Lab testing is-covered with a \$20 Copay	See Basic Benefit
-Routine Vision Services	Eye exams are limited to one per calendar year and must be performed by a participating Provider.	\$20 Copay per visit for eye exams 100% up to \$50 maximum every two calendar years for eyeglasses and contact lenses	See Basic Benefit
-Routine Hearing Exam and Hearing Aids		Not covered	Not covered
-Routine Adult Physical	For adults age 20 and older. Maximum of one visit per calendar year (Includes appropriate labs, x-rays and immunizations)	\$20 Copay per visit	See Basic Benefit
-Well Child Care	For Children under age 20 (Includes appropriate labs, x-rays, lead poisoning screening, and immunizations as recommended by the attending physician)	\$20 Copay per visit	See Basic Benefit

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>PRIVATE DUTY NURSING</b>	Maximum of 60 eight-hour shifts per calendar year per Family Member	See Supplemental Benefit	80%
<b>RADIATION THERAPY</b> -Outpatient Hospital -Any other place of service		Covered in full Covered in full	See Basic Benefit See Basic Benefit
<b>RESPIRATORY THERAPY</b> -Outpatient Hospital -Any other place of service	Maximum of 25 visits per calendar year	\$35 Copay per visit \$20 Copay per visit	See Basic Benefit See Basic Benefit
<b>SMOKING CESSATION</b>		Not covered	Not covered
<b>SPEECH THERAPY</b> -Outpatient Hospital -Any other place of service	Maximum of 25 visits per calendar year	\$35 Copay per visit \$20 Copay per visit	See Basic Benefit See Basic Benefit
<b>SUBSTANCE ABUSE TREATMENT</b> -Detoxification -Inpatient Rehabilitation	Services will be denied if Pre-Certification is not obtained. (Hospital or Behavioral Health Care Facility) Maximum of 30 days per calendar year with a 45 day lifetime maximum. The Lifetime maximum will not apply in a Behavioral Health Care Facility. Partial Hospitalization is covered. Two partial days equal one inpatient day.	Covered in full Covered in full	See Basic Benefit See Basic Benefit
-Inpatient Physician	Maximum of 30 days per calendar year with a 45 day lifetime maximum. The Lifetime maximum will not apply in a licensed alcohol and drug residential treatment facility.	100% to a maximum of \$100 per day	See Basic Benefit
-Outpatient/Office	Maximum of 20 visits per calendar year.	\$25 Copay per visit	See Basic Benefit

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>SURGERY</b> (Refer to Hospital Facility, Surgery Center or Anesthesia for benefits related to surgery) <u>Surgeon</u> -Inpatient -Outpatient -Office  <u>Assistant Surgeon</u> <u>Second Surgical Opinion</u> -Voluntary -Mandatory		Covered in full Covered in full \$20 Copay per visit  Covered in full  Covered in full Not Required	See Basic Benefit See Basic Benefit See Basic Benefit  See Basic Benefit  See Basic Benefit Not Required
<b>SURGERY CENTER</b> (Freestanding Surgical Facility)		\$35 Copay per surgical session	See Basic Benefit
<b>TEMPOROMANDIBULAR JOINT DISORDER (TMJ)</b>		Not covered	Not covered
<b>URGENT CARE FACILITY</b>		\$35 Copay per visit	See Basic Benefit

## PRESCRIPTION DRUG PLAN

TYPE OF PROGRAM	IMPORTANT PROVISIONS	BENEFIT
RETAIL DRUGS	For each 30-day supply	\$10.00 Copay – Generic Drugs \$20.00 Copay – Brand Name Drugs
MAIL ORDER MAINTENANCE DRUGS	Up to a 90-day supply	\$ 0.00 Copay – Generic Drugs \$ 0.00 Copay – Brand Name Drugs
DIABETIC SUPPLIES AND INSULIN		See Benefit for Retail and Mail Order Maintenance Drugs
SPECIALTY DRUGS		See Benefit for Retail and Mail Order Maintenance Drugs
<p>Copays under the Prescription Drug Plan do not apply toward the Medical Out-of-Pocket Maximum. Prescriptions purchased at an Out-of-Network Pharmacy are covered as described above.</p>		
<p>Contact your Pharmacy Administrator for prescription drug coverage inquiries. Your Pharmacy Administrator's contact information is located on your Benefit Identification Card.</p>		

**Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.**

# TOWNSHIP OF IRVINGTON – OPEN ACCESS PLAN 5

## MEDICAL PLAN DEDUCTIBLES AND MAXIMUMS

<b>SUPPLEMENTAL COVERED SERVICES AND SUPPLIES</b> The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount. The Deductible applies to all services prior to benefit payment, except where noted. (Includes coverage for: Blood and Blood Products, Durable Medical Equipment, Inpatient Physical Rehabilitation, Private Duty Nursing Care, Prosthetic Devices, Specialized Non-Standard Infant Formulas, Treatment of Inherited Metabolic Disease, Vision Care, and Medically Necessary Wigs.)	
<b>INDIVIDUAL DEDUCTIBLE</b>	\$100 per calendar year Carryover does not apply Maximums are combined for in and out-of-network Providers, except where noted.
<b>FAMILY DEDUCTIBLE</b>	\$200 per calendar year Carryover does not apply Two Family Members must each meet their individual deductibles to satisfy the family deductible.
<b>INDIVIDUAL COINSURANCE MAXIMUM</b> (The Coinsurance Maximum applies to Supplemental Covered Services and Supplies only)	\$400 per calendar year Does not include deductible Carryover does not apply Maximums are combined for in and out-of-network Providers, except where noted.
<b>FAMILY COINSURANCE MAXIMUM</b> (The Coinsurance Maximum applies to Supplemental Covered Services and Supplies only)	\$800 per calendar year Does not include deductible Carryover does not apply Two Family Members must each meet their individual Coinsurance Maximums to satisfy the family Coinsurance Maximum.
<b>BASIC COVERED SERVICES AND SUPPLIES</b> The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount.	
<b>OUT-OF-POCKET MAXIMUM</b>	\$5,000 Individual \$10,000 Family Includes Basic Copayments and Supplemental Benefit deductibles and Coinsurance listed above.
<b>LIFETIME MAXIMUM</b>	Unlimited

## MEDICAL COVERAGE SUMMARY OPEN ACCESS HMO

TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount.	The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount. The Deductible applies to all services prior to benefit payment, except where noted.
<b>ACUPUNCTURE</b>	Acupuncture is only covered when used in lieu of General Anesthesia.	See Anesthesia Benefit	See Anesthesia Benefit
<b>ALLERGY CARE</b> -Office Visit -Treatment (Injections) -Serum -Laboratory & Scratch Testing		\$5 Copay per visit Covered in full Covered in full Covered in full	See Basic Benefit See Basic Benefit See Basic Benefit See Basic Benefit
<b>AMBULANCE</b>	Services will be denied if Pre-Certification is not obtained, except in Emergency situations. Air ambulance is covered if deemed Medically Necessary by the Medical Services Team. The Plan does not cover rail or water ambulance.	Covered in full	See Basic Benefit
<b>ANESTHESIA</b> -Inpatient -Outpatient -Office		Covered in full Covered in full Covered in full	See Basic Benefit See Basic Benefit See Basic Benefit
<b>BIOFEEDBACK</b>		Not covered	Not covered
<b>BLOOD AND BLOOD PRODUCTS</b>		\$35 Copay if in the outpatient department of the Hospital	80% at all other places of service
<b>CARDIAC REHABILITATION</b> -Outpatient Hospital -Any other place of service		\$35 Copay per visit \$5 Copay per visit	See Basic Benefit See Basic Benefit
<b>CHEMOTHERAPY</b> -Outpatient Hospital -Any other place of service		Covered in full Covered in full	See Basic Benefit See Basic Benefit

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>CHIROPRACTOR</b>	Maximum of 12 visits per calendar year.	\$5 Copay per visit 50% of Allowable Expense for 1 <sup>st</sup> 6 visits 25% of Allowable Expense for last 6 visits	See Basic Benefit
<b>CONVALESCENT/SKILLED NURSING FACILITY</b>	Services will be denied if Pre-Certification is not obtained. Maximum of 60 days of inpatient care per calendar year	Covered in full	See Basic Benefit
<b>DENTAL CARE COVERED UNDER MEDICAL PLAN</b>			
-Accidental Injury to Teeth	Services must be rendered within six months of the accidental injury.	Covered in full	See Basic Benefit
-Oral Surgery	Covered Services include the diagnosis and treatment of oral tumors and cysts and the surgical removal of bony or partial bony impacted teeth.	Covered in full	See Basic Benefit
<b>DIABETIC TREATMENT</b>			
-Education		\$5 Copay per visit	See Basic Benefit
-Supplies and Equipment		Covered in full	See Basic Benefit
<b>DIAGNOSTIC X-RAYS AND IMAGING TESTS</b>			
-Independent Facility		\$5 Copay per visit	See Basic Benefit
-Outpatient Hospital		\$35 Copay per visit	See Basic Benefit
-Physician's Office		\$5 Copay per visit	See Basic Benefit
<b>HIGH TECH IMAGING (SUCH AS MRI, MRA, PET AND CAT SCANS)</b>		\$5 Copay per visit	See Basic Benefit
<b>DIALYSIS OR HEMODIALYSIS</b>			
-Outpatient Hospital		Covered in full	See Basic Benefit
-Any other place of service		Covered in full	See Basic Benefit

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>DURABLE MEDICAL EQUIPMENT (DME)</b> <i>Including, but not limited to:</i>		See Supplemental Benefit	80%
-Disposable Medical Supplies		See Supplemental Benefit	80%
-Prosthetics (External and Internal)	Wigs covered if hair loss is due to radiation or chemotherapy or second degree burns and are subject to a maximum of \$500 maximum per calendar year. Repairs and dental prosthetics are not covered.	See Supplemental Benefit	80%
-Foot Orthotics	Only covered following bone surgery of the foot to maintain post surgical bone alignment. Also covered for diabetics if determined to be Medically Necessary by the Medical Services Team.	Covered in full	See Basic Benefit
-Orthotics (Braces)		See Supplemental Benefit	80%
-Oxygen		See Supplemental Benefit	80%
<b>ENTERAL FORMULA</b>	Services will be denied if Pre-Certification is not obtained	See Supplemental Benefit	80%

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>FAMILY PLANNING SERVICES</b>			
-Elective Sterilization Procedures		Covered in full	See Basic Benefit
-Voluntary Termination of Pregnancy	Maximum of two per calendar year and four per Lifetime. (Not covered for Dependent Children)	Covered in full	See Basic Benefit
-Infertility Treatment Guidelines apply – Refer to your Plan Document for more information on this benefit	Includes coverage for infertility services as mandated by New Jersey law. Egg retrievals are limited to four per Lifetime.	Covered as described under type of service rendered	See Basic Benefit
-Contraceptive Devices		Covered in full	See Basic Benefit
-Contraceptive Management Office Visit		\$5 Copay per visit	See Basic Benefit
<b>GENETIC TESTING</b>	The Plan covers genetic testing when Medically Necessary or medically appropriate as determined by the Medical Services Team criteria and peer-reviewed literature.	Covered as described under type of service rendered	See Basic Benefit
<b>HOME HEALTH CARE</b>	Services will be denied if Pre-Certification is not obtained. Maximum of 100 visits per calendar year		
-Aide, Nurse, or any other Authorized Agency Employee		Covered in full	See Basic Benefit
-Home IV Therapy and Respiratory Care		Covered in full	See Basic Benefit
<b>HOSPICE CARE</b>	Maximum of \$10,000 per Lifetime		
-Inpatient	Includes coverage for seven days of respite care per Lifetime	Covered in full	See Basic Benefit
-Home		Covered in full	See Basic Benefit

		The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount.	The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount. The Deductible applies to all services prior to benefit payment, except where noted.
TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>HOSPITAL FACILITY</b> <u>Inpatient Hospital</u>  <u>Outpatient Hospital</u>  -Emergency Room for a medical Emergency  -Emergency Room used for a Non-Emergency  -Outpatient Surgical Center  -Clinic	Services will be denied if Pre-Certification is not obtained. Maximum of 365 days per calendar year  Includes ER Physician.	Covered in full	See Basic Benefit
		\$35 Copay per visit Waived if admitted	See Basic Benefit
		Not covered	Not covered
		\$35 Copay per visit	See Basic Benefit
		\$5 Copay per visit	See Basic Benefit
<b>INFUSION THERAPY</b>		Covered in full	See Basic Benefit
<b>LABORATORY</b> -Independent Facility -Outpatient Hospital -Physician's Office		Covered in full	See Basic Benefit
		Covered in full	See Basic Benefit
		Covered in full	See Basic Benefit
<b>MASSAGE THERAPY</b> (When rendered by a Licensed Massage Therapist)		Not covered	Not covered

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>MATERNITY CARE-MOTHER</b> (Refer to Diagnostic X-rays, Imaging Tests and Laboratory for benefits related to maternity) -Inpatient Hospital or Birthing Center  -Physician for Prenatal Care and Delivery	Maternity care is not covered for Dependent Children  Services will be denied if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section and the additional stay is not Post-Certified.	Covered in full  \$5 Copay for the initial visit only	See Basic Benefit  See Basic Benefit
<b>MENTAL ILLNESS SERVICES</b>  -Inpatient  -Inpatient Physician  -Outpatient/Office	Note: Refer to <i>medical benefits</i> (e.g. Hospital and Physician) for Biologically Based Illnesses.  Services will be denied if Pre-Certification is not obtained. (Hospital or Behavioral Health Care Facility) Maximum of 30 days per calendar year with a 45 day Lifetime maximum. Partial Hospitalization is covered. Two partial days equal one inpatient day. Maximum of 30 days per calendar year with a 45 day Lifetime maximum.  Maximum of 20 visits per calendar year.	Covered in full  Covered in full  \$25 Copay per visit	See Basic Benefit  See Basic Benefit  See Basic Benefit

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>MODIFIED FOOD PRODUCT</b>	Must be determined to be Medically Necessary and appropriate by the attending physician. Also includes coverage for specialized, non-standard infant formulas only if the infant Family Member has not responded to milk-based formulas.	See Supplemental Benefit	80%
<b>NEWBORN CARE (Prior to Discharge)</b>	<b>When Plan covers both Mother and Baby</b>		
-Hospital		Covered in full	See Basic Benefit
-Physician		Covered in full	See Basic Benefit
-Newborn Circumcision		Covered in full	See Basic Benefit
<b>NEWBORN CARE (Prior to Discharge)</b>	<b>When Plan covers the Baby but not the Mother</b>		
-Hospital	Services will be denied if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section and the additional stay is not Post-Certified.	Covered in full	See Basic Benefit
-Physician		Covered in full	See Basic Benefit
-Newborn Circumcision		Covered in full	See Basic Benefit
<b>NUTRITIONAL COUNSELING</b>	Maximum of three visits per calendar year	\$5 Copay per visit	See Basic Benefit
<b>OBESITY TREATMENT</b> Guidelines apply – Refer to your Plan Document for more information on this benefit	Obesity surgery is covered only if deemed Medically Necessary by the Medical Services Team.	Covered as described under type of service rendered	Covered as described under type of service rendered

TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>OCCUPATIONAL THERAPY</b> -Outpatient Hospital -Any other place of service	Maximum of 25 visits per calendar year	The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount. \$35 Copay per visit \$5 Copay per visit	The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule amount. The Deductible applies to all services prior to benefit payment, except where noted. See Basic Benefit See Basic Benefit
<b>ORGAN TRANSPLANTS</b> Guidelines apply – Refer to your Plan Document for more information on this benefit	Services will be denied if Pre-Certification is not obtained.	Covered as described under type of service rendered	See Basic Benefit
<b>PHYSICAL REHABILITATION FACILITY</b>	Services will be denied if Pre-Certification is not obtained. Maximum of 60 inpatient days per calendar year	See Supplemental Benefit	80%
<b>PHYSICAL THERAPY</b> -Outpatient Hospital -Any other place of service	Maximum of 25 visits per calendar year	\$35 Copay per visit \$5 Copay per visit	See Basic Benefit See Basic Benefit
<b>PHYSICIAN</b> -Inpatient -Office -Home <u>Consultation (Specialist)</u> -Inpatient -Outpatient -Office <u>Second Medical Opinion</u>		Covered in full \$5 Copay per visit \$25 Copay between 7am-9pm \$35 Copay between 9pm-7am Covered in full \$35 Copay per visit \$5 Copay per visit Covered in full	See Basic Benefit See Basic Benefit See Basic Benefit See Basic Benefit See Basic Benefit See Basic Benefit
<b>PREADMISSION TESTING</b>	Testing must be performed within seven days of admission	\$35 Copay per visit	See Basic Benefit

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>PREVENTATIVE/WELL CARE</b>			
-Bone Density Testing	Covered as recommended by the attending physician.	\$5 Copay per visit	See Basic Benefit
-Colonoscopy/Sigmoidoscopy	Routine colon cancer screenings are covered for Family Members 45 years of age or older as recommended by the attending physician	\$35 Copay per visit	See Basic Benefit
-GYN Office Visit	Maximum of one routine gynecological exam per calendar year (includes pap smear)	\$5 Copay per visit	See Basic Benefit
-PAP Smear	Maximum of one routine pap smear every calendar year	Covered in full	See Basic Benefit
-Mammogram	Maximum of one baseline mammogram for women age 35 to 40; one routine mammogram per calendar year for women 40 years of age or older	\$5 Copay per visit	See Basic Benefit
-Prostate Cancer Screening (PSA)	Maximum of one exam per calendar year for adult male Family Members	Digital exam-\$5 Copay Lab testing is covered with a \$5 Copay	See Basic Benefit
-Routine Vision Services	Eye exams are limited to one per calendar year and must be performed by a participating Provider.	\$5 Copay per visit for eye exams 100% up to \$50 maximum every two calendar years for eyeglasses and contact lenses	See Basic Benefit
-Routine Hearing Exam and Hearing Aids		Not covered	Not covered
-Routine Adult Physical	For adults age 20 and older. Maximum of one visit per calendar year (Includes appropriate labs, x-rays and immunizations)	\$5 Copay per visit	See Basic Benefit
-Well Child Care	For Children under age 20 (Includes appropriate labs, x-rays, lead poisoning screening, and immunizations as recommended by the attending physician)	\$5 Copay per visit	See Basic Benefit

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>PRIVATE DUTY NURSING</b>	Maximum of 60 eight-hour shifts per calendar year per Family Member	See Supplemental Benefit	80%
<b>RADIATION THERAPY</b> -Outpatient Hospital -Any other place of service		Covered in full Covered in full	See Basic Benefit See Basic Benefit
<b>RESPIRATORY THERAPY</b> -Outpatient Hospital -Any other place of service	Maximum of 25 visits per calendar year	\$35 Copay per visit \$5 Copay per visit	See Basic Benefit See Basic Benefit
<b>SMOKING CESSATION</b>		Not covered	Not covered
<b>SPEECH THERAPY</b> -Outpatient Hospital -Any other place of service	Maximum of 25 visits per calendar year	\$35 Copay per visit \$5 Copay per visit	See Basic Benefit See Basic Benefit
<b>SUBSTANCE ABUSE TREATMENT</b> -Detoxification -Inpatient Rehabilitation  -Inpatient Physician  -Outpatient/Office	Services will be denied if Pre-Certification is not obtained. (Hospital or Behavioral Health Care Facility) Maximum of 30 days per calendar year with a 45 day lifetime maximum. The Lifetime maximum will not apply in a Behavioral Health Care Facility. Partial Hospitalization is covered. Two partial days equal one inpatient day.  Maximum of 30 days per calendar year with a 45 day lifetime maximum. The Lifetime maximum will not apply in a licensed alcohol and drug residential treatment facility.  Maximum of 20 visits per calendar year.	Covered in full Covered in full  100% to a maximum of \$100 per day  \$25 Copay per visit	See Basic Benefit See Basic Benefit  See Basic Benefit  See Basic Benefit

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TYPE OF SERVICE	IMPORTANT PROVISIONS	BASIC BENEFIT	SUPPLEMENTAL BENEFIT
<b>SURGERY</b> (Refer to Hospital Facility, Surgery Center or Anesthesia for benefits related to surgery) <u>Surgeon</u> -Inpatient -Outpatient -Office  <u>Assistant Surgeon</u> <u>Second Surgical Opinion</u> -Voluntary -Mandatory		Covered in full Covered in full \$ 5 Copay per visit  Covered in full  Covered in full Not Required	See Basic Benefit See Basic Benefit See Basic Benefit  See Basic Benefit  See Basic Benefit Not Required
<b>SURGERY CENTER</b> (Freestanding Surgical Facility)		\$35 Copay per surgical session	See Basic Benefit
<b>TEMPOROMANDIBULAR JOINT DISORDER (TMJ)</b>		Not covered	Not covered
<b>URGENT CARE FACILITY</b>		\$35 Copay per visit	See Basic Benefit

## PRESCRIPTION DRUG PLAN

TYPE OF PROGRAM	IMPORTANT PROVISIONS	BENEFIT
RETAIL DRUGS	For each 30-day supply	\$ 5.00 Copay – Generic Drugs \$ 5.00 Copay – Brand Name Drugs
MAIL ORDER MAINTENANCE DRUGS	Up to a 90-day supply	\$ 0.00 Copay – Generic Drugs \$ 0.00 Copay – Brand Name Drugs
DIABETIC SUPPLIES AND INSULIN		See Benefit for Retail and Mail Order Maintenance Drugs
SPECIALTY DRUGS		See Benefit for Retail and Mail Order Maintenance Drugs
<p>Copays under the Prescription Drug Plan do not apply toward the Medical Out-of-Pocket Maximum. Prescriptions purchased at an Out-of-Network Pharmacy are covered as described above.</p>		
<p>Contact your Pharmacy Administrator for prescription drug coverage inquiries. Your Pharmacy Administrator's contact information is located on your Benefit Identification Card.</p>		

**Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.**