HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
MAXIMUM LIFETIME BENEFIT AMOUNT	Unlimited per Covered Person Lifetime (Combined In & Out-of-network Maximum; and Includes all other Maximums noted under this Plan)		
DEDUCTIBLE, PER CALENDAR YEAR			
Per Covered Person	NOT APPLICABLE	$100	
Per Family Unit	NOT APPLICABLE	$200	
COPAYMENT			
Physician Office Visits	$15 Copayment per Visit	NOT APPLICABLE	Copayment does not apply to Preventive Care
Physician Visits after Hours or Home Visits	$15 Copayment per Visit	NOT APPLICABLE	
Specialist Office Visits	$25 Copayment per Visit	NOT APPLICABLE	
Initial OB/GYN Visit	$15 Copayment Initial Visit	NOT APPLICABLE	
CAT & PET Scans; MRIs	$50 Copayment per service	NOT APPLICABLE	
Emergency Room Visit *(facility)*	$50 Copayment per Visit	$50 Copayment per Visit	Copayment is waived if admitted
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Per Covered Person	$ 650*	$2,000**	See Note Below
Per Family Unit	$1,300*	$5,000**	See Note Below
***Note:** The Maximum In-network Out-of-pocket includes Copayments*)* and any Coinsurance. It does not include Pre-certification Non-compliance Penalties. ****Note:** The maximum Out-of-network Coinsurance does NOT include the Deductible, Precertification Non-compliance Penalty amount and any expense related to Out-of-network Inpatient & Outpatient Non-biologically based Mental Disorders			
This Plan will pay the designated percentage of Covered Charges until the out-of-pocket amounts are reached, at which time this Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.			
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.			
Deductible(s) Cost Management Penalties Amounts over Usual & Reasonable Charges		Standalone Prescription Drug Copayment(s) for Plan Years beginning prior to January 1, 2015	

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
PRE-CERTIFICATION PENALTY for failure to pre-certify services	50% Reduction In Benefit	The Covered Person is responsible for making sure that all non-emergency services which require pre-certification have been approved prior to having services performed. Pre-certification can be verified by contacting Customer Service	

The non-compliance Penalty for the services below is a 50% reduction in benefits payable:

All Inpatient Confinements, including:
- Skilled Nursing Facility
- Inpatient Mental Disorders (*Biologically & Non-biologically based)*
- Inpatient Substance Abuse *(Alcohol & Drug Related) (Detoxification & Rehabilitation)*
- Emergency Admissions within two (2) business days

Inpatient Surgery
Outpatient Surgery
MRI, CAT Scans, PET Scans
Sleep Studies
Inpatient & Outpatient Rehabilitation & Pulmonary Therapy
Physical, Occupation and Speech Therapy
Respiratory, Chemotherapy & Radiation Therapy
Home Infusion Therapy
Cardiac Rehabilitation
Genetic Testing & Counseling
Comprehensive Pain Management
Non-emergency Ambulance
Private Duty Nursing
Home Health Care
Hospice Care *(Inpatient & Outpatient)*
Orthotics *(Purchase, rental, replacement or repair exceeding $250)*
Prosthetics *(Exceeding $1,500 and up)*
Durable Medical Equipment *(Exceeding $1,500 and up)*
Transplants

Notification to the Claims Supervisor only for the following: MRI & CAT Scans; Respiratory, Chemotherapy & Radiation Therapy; Genetic Testing & Counseling *(Non-compliance Penalty Not Applicable)*

SPECIAL PROVISIONS FOR COVERED SERVICES

Preferred Provider versus Non-Participating Provider Benefit Level

Covered services rendered by a Participating Provider will be paid at the Participating Provider benefit level. Covered services rendered by an Out-of-network Provider will be paid at the Non-Participating Provider benefit level. Under the following circumstances, the Participating Provider benefit payment will be made for certain Out-of-network services:

If a Covered Person has a Medical Emergency requiring immediate care.

If a Covered Person received services by an Out-of-network Provider (for example, an anesthesiologist, radiologists, or pathologists, etc.) who is under agreement with an In-network Facility. However, all other limitations, requirements and provisions of the Plan will apply. This exception does not apply in the event of any consultations and situations in which the Covered Person (and/or the Provider selected), had the opportunity to select an In-network Provider and exercised the right to receive services from an Out-of-network Provider. Referrals by an In-network Provider to an Out-of-network Provider will be considered as Out-of-network services.

Usual and Reasonable Charges

The Usual and Reasonable Charge is a charge which is not more than the usual charge made by a provider of care, treatment, service or supply and does not exceed the usual charge made by most providers for such care, treatment service or supply in the same area. The nature and severity of the condition being treated will always be considered by this Plan. This Plan will also consider medical complications and unusual circumstances that require more time, skill or experience.

Maximums under this Plan

Note: The maximums listed in this Plan are the total for a Participating Provider and Non-Participating Provider expenses. For example, if a maximum of sixty (60) days is listed twice under a service, the Calendar Year maximum is sixty (60) days total for both Participating and Non-Participating Providers. This total of sixty (60) days may be split between Participating Providers and Non-Participating Provider, but will never exceed sixty (60) days per Calendar Year.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Preventive Care			
Routine Well Adult Care			
Routine Well Adult Care Includes: Office Visits; Gynecological Examination; Routine Physical Examination, related diagnostic services, such as, x-rays, laboratory blood tests and immunizations/ flu shots	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Combined Maximum Benefits In & Out-of-network. Refer to list of Preventive Services that follows which is subject to change in accordance with The American College of Physicians, the US Preventive Services Task Force and the American Cancer Society.
Routine Gynecological Examination & Pap Smear	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Combined Maximum Benefit In & Out-of-network - One (1) per Calendar Year.
Routine Mammography	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Combined Maximum Benefit In & Out-of-network - One (1) baseline between ages thirty-five (35) and forty (40); one (1) per Calendar Year forty (40) and over, or more frequently if recommend by a Physician.*

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Preventive Care			
Routine Well Adult Care			
Colorectal Cancer Screening Prostate Blood Test, Fecal Occult Screening and other Diagnostic Procedures considered appropriate by the American Medical Association as Routine Screening	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Combined Maximum Benefit in & Out-of-network. This benefit applies to one of each test including the reading charge, per Calendar Year. Additional testing which is Medically Necessary will be considered as outlined in the Preventive Services that follows which is subject to change in accordance with the American Academy of Pediatrics, The American College of Physicians, the US Preventive Services Task Force and the American Cancer Society.
Prostate Screening Exam	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Routine Prostate Screening - One (1) exam per Calendar Year beginning at age fifty (50); beginning at age forty (40) for men with a family history of prostate cancer or other prostate cancer risk factors.*
Routine Hearing Screening	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Routine Vision Screening	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Preventive Care			
Routine Well Child Care			
Routine Well Child Care Includes: office visits, routine physical examination, laboratory blood tests, x-rays, hearing tests.	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Combined Maximum Benefits In & Out-of-network. Refer to list of Preventive Services that follows which is subject to change in accordance with the American Academy of Pediatrics, The American College of Physicians, the US Preventive Services Task Force.
Pediatric Immunizations and Vaccines	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Subject to change and in accordance with the American Academy of Pediatrics, The American College of Physicians, the US Preventive Services Task Force.
Lead Poisoning Screening & Testing	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge; deductible waived	
Newborn & Infant Screening for Hearing Loss - In or Outpatient Hospital	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Newborn Hearing Screening – Electrophysiological Screening Measures for an infant twenty-nine (29) to thirty-six (36) months old; or newborn from birth to twenty-eight (28) days old.*

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Preventive Care			
Routine Well Child Care			
Newborn & Infant Screening for Hearing Loss - Physician/ Specialist Office	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Newborn Hearing Screening – Electrophysiological Screening Measures for an infant twenty-nine (29) to thirty-six (36) months old; or newborn from birth to twenty-eight (28) days old.*
Inherited Metabolic Diseases, Medical Foods and Low Protein Modified Food Products	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Routine Diagnostic Testing			
Diagnostic X-ray & Laboratory Services			
Pre-Admission and Pre-Surgical Testing, within seven (7) days of a scheduled Inpatient Hospital Admission	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Diagnostic Services- X-ray and Laboratory	100% of the pre-negotiated contracted rate **Note:** CAT & PET Scans; MRIs have a $50 copayment per service	70% of the Usual & Reasonable Charge after the deductible	

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Preventive Care Services			

This list of Preventive Services that follows is subject to change in accordance with The American College of Physicians, the US Preventive Services Task Force, the American Cancer Society and the recommended Preventive Services under the Patient Protection and Affordable Care Act.

Schedule of Preventive Care

- Routine Child Care including Well Baby Visits – Routine Pediatric Care and Pediatric Immunizations in accordance with the American Academy of Pediatrics. Unlimited coverage is provided for a Dependent child birth through two (2) years of age; Unlimited, but in accordance with the frequency schedule, from three (3) years of age to an Adult, including immunizations.
- Lead Poisoning Screening &Testing.
- Newborn & Infant Screening for Hearing Loss – In or Outpatient Hospital, or Physician's Office - Newborn Hearing Screening – Electrophysiological Screening Measures for an infant twenty-nine (29) days to thirty-six (36) months old; or newborn from birth to twenty-eight (28) days old. "Electrophysiologic screening measures" means the electrical result of the application of physiologic agents. This includes, but is not limited to: (a) the procedures currently known as Auditory Brainstem Response testing (ABR); and Otoacoustic Emissions testing (OAE); and (b) any other procedure adopted.
- Routine Gynecological Examination - One (1) per Plan Year.
- Routine Pap Smear – Covered for all women twenty (20) years of age or older, or a Pap Smear as recommended by a Physician.
- Routine Mammography - One (1) baseline mammography for women thirty-five (35) years of age or older; All women forty (40) years of age or older a mammography annually, or at any age for women at risk, when recommended by a Physician.
- Routine Adult Physical Examination - Unlimited for a Covered Person for an annual Routine Physical Examination and related X-ray, Laboratory and Diagnostic Tests, including immunizations.
- Health Wellness Tests - One (1) Exam annually beginning at age twenty (20) to include, but not limited to: Routine Urinalysis & Routine Blood Test - annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol or alternatively, low density lipoprotein (LDL) level and blood high-density (HDL) level.
- Recommended Adult Immunizations and Vaccines are covered.
- Routine Vision Screening – does not include refractions.
- Genetic Testing – In accordance with the health reform.
- Routine Screening for Glaucoma - One (1) test every five (5) Years beginning at age thirty-five (35) years of age or older.
- Stool Exam – Covered Persons forty (40) years of age or older and annual stool examination for the presence of blood.
- Routine Colon Exam - A left-sided colon exam of thirty-five (35) to sixty (60) centimeters (or as the American Medical Association recommends) every five (5) years for Covered Persons age forty-five (45) years of age or older.
- Routine Colorectal Screening – Colorectal cancer screening rendered at regular intervals for (a) Covered Persons age fifty (50) or over; and (b) Covered Persons of any age who are deemed to be at high risk for this type of cancer.
- Routine Prostate Screening - Annual digital examination & prostate antigen test beginning at age forty (40).
- All Covered Persons twenty (20) years of age and older - Consultations with a Physician to discuss lifestyle behaviors that promote health and well being, such as, but not limited to: coronary artery disease, heart failure management, smoking control, nutrition and diet recommendations for diabetes, exercise plans, lower back protection, weight control, immunization practices, breast self-examination and testicular self-examination and seat belt usage in motor vehicles.

Note: Other wellness tests & frequency schedules will be covered upon the recommendation of a Physician.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Hospital Services, Specialized Treatment Facilities and Services			
Hospital Services, including Room and Board, General Nursing Care, Medications, Operating Room & Related services, Oxygen Services, ICU, Diagnostic Laboratory & X-ray Services, Hospitalization for Dental Services for (a) severely disabled, or (b) a child age five (5) or under	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Limited to semi-private room rate Pre-certification Required – The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.
Intensive Care Unit	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Room and Board limited to Hospital's ICU Charge. Pre-certification Required - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.
Inpatient Newborn Care	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Subject to Medical Necessity

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Hospital Services, Specialized Treatment Facilities and Services ***(continued)***			
Inpatient Maternity	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Inpatient Maternity Care will be provided for a minimum of forty-eight (48) hours following a vaginal delivery; a minimum of ninety-six (96) hours for a cesarean delivery. This applies to both mother and child.
Birthing Center	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Room and Board limited to Facility's semi-private room rate (or an allowance equal to this rate which may be applied to the cost of private accommodations). Pre-certification Required - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum. One hundred (100) day combined In and Out-of-network Maximum Benefit per Calendar Year.*

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Other Inpatient Services			
Inpatient Chemotherapy & Radiation Therapy	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Inpatient Diagnostic Laboratory & Pathology	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Outpatient Hospital			
Outpatient Hospital	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Ambulance Service	100% of the Usual & Reasonable Charge; or pre-negotiated contracted rate	100% of the Usual & Reasonable Charge; deductible waived.	Land (Ground), air, sea transportation for medical intervention or stabilization when **Medically Necessary** to the facility of treatment.
Ambulance Service	100% of the Usual & Reasonable Charge; or pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Transportation to a facility for treatment when services cannot be provided at the inpatient facility.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Emergency Services			
Emergency Room includes all related services performed at the same visit. Follow-up treatment will not be considered under the Emergency Room benefit **Note:** Copayment Waived if Admitted. Pre-certification Required if Admitted - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)*	100% of the pre-negotiated contracted rate after the copayment	100% of the Usual & Reasonable Charge after the copayment	Use of the Emergency Room for services that are necessary due to a life or limb-threatening condition, such as excessive bleeding; broken bones; sudden onset of severe chest pains; serious burns; poisoning; unconsciousness; convulsions, or choking. Use of the Emergency Room for a condition not considered a Medical Emergency or Accidental Injury may not be covered by this Plan.
Urgent Care in the Hospital Emergency Room **Note:** Copayment Waived if Admitted. Pre-certification Required if Admitted - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)*	100% of the pre-negotiated contracted rate after the copayment	100% of the Usual & Reasonable Charge after the copayment	Urgent Care is Medically Necessary Services including a Medical Evaluation in order to treat a non-life-or-limb-threatening condition that requires care within twenty-four (24) hours.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Emergency Services			
Out-of-Area Urgent Care In the Hospital Emergency Room or another Provider **Note:** If services are received on an out-of-network basis by a non-network provider and it is determined to not be an Emergency or Urgent Care, the Covered Person may be responsible for the charges associated with the services **Note:** Copayment Waived if Admitted. Pre-certification Required if Admitted - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)*	100% of the pre-negotiated contracted rate after the copayment	100% of the Usual & Reasonable Charge after the copayment	Use of the Emergency Room for services that are necessary due to a life or limb-threatening condition, such as excessive bleeding; broken bones; sudden onset of severe chest pains; serious burns; poisoning; unconsciousness; convulsions or choking. Use of the Emergency Room for a condition not considered a Medical Emergency or Accidental Injury. Urgent Care is Medically Necessary Services including a Medical Evaluation in order to treat a non-life-or-limb-threatening condition that requires care within twenty-four (24) hours.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Outpatient Services			
Outpatient Surgical Centers	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.
Outpatient Diagnostic Laboratory & Pathology	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Network laboratory must be utilized for the Network benefit to apply; it is the Covered Person's responsibility to make sure the laboratory utilized by a Provider is a Network laboratory, even when services are performed in the Physician's office.
Outpatient Diagnostic Radiology & Therapeutic X-ray	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Outpatient Major Radiology & Imaging: PET Scans *(Pre-certification Required)* MRI & CAT Scans *(Notification only to Claims Supervisor – Non-compliance Penalty Not Applicable)*	100% of the pre-negotiated contracted rate after the copayment	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Physician Services			
Second/Third Surgical Opinion	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Maternity/Pregnancy Professional Services	100% of the pre-negotiated contracted rate after the copayment for initial visit only	70% of the Usual & Reasonable Charge after the deductible	
Allergy Testing	100% of the pre-negotiated contracted rate after the copayment	70% of the Usual & Reasonable Charge after the deductible	
Allergy Injections	100% of the pre-negotiated contracted rate after the copayment	70% of the Usual & Reasonable Charge after the deductible	
Physician Inpatient Visits	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Inpatient & Outpatient Surgery *(includes anesthesiologists)*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum. Surgery performed in the Physician's Office will be considered as specifically outlined under Office Visits and Home Visits.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Physician Services *(continued)*			
Physician Office Visits *(Includes Surgery & Diagnostic Services performed in the Physician's Office)*	100% of the pre-negotiated contracted rate after the copayment	70% of the Usual & Reasonable Charge after the deductible	Note: Copayment does not apply to Routine Well Care
Specialist Office Visit	100% of the pre-negotiated contracted rate after the copayment	70% of the Usual & Reasonable Charge after the deductible	
Alternative Care – Spinal Manipulation *(Chiropractic)*	100% of the pre-negotiated contracted rate after the copayment Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Limited to treatment received in a consecutive sixty (60) day period per acute medical episode; Combined In & Out-of-network Maximum Benefit* Must be Medically Necessary & Treatment is limited to conditions that are subject to significant improvement within the treatment period noted above. A Medical Review is provided on a regular basis to determine Medical Necessity and Appropriateness of Care.
Abortion	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Physician Services *(continued)*			
Physician Surgical Services other than Physician's Office	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.
Anesthesia	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Included are Benefits for Anesthesia Services related to Dental Services for (a) severely disabled person; or (b) a child age five (5) or under.
Inpatient Short Term Rehabilitation			
Occupational Therapy	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Speech Therapy & Cognitive Therapy	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Physical Therapy	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Inpatient & Outpatient Rehabilitation Therapy			
Inpatient & Outpatient Rehabilitation & Pulmonary Therapy Pulmonary Rehabilitation – multi-disciplinary treatment which combines Physical Therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Pre-certification Required - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum. Limited to Medically Necessary treatment received in a sixty (60) consecutive day period per Outpatient acute medical episode.* If services are provided while Inpatient they are limited to a sixty (60) consecutive day period provided during the Inpatient confinement.*

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Outpatient Short Term Rehabilitation			
Occupational Therapy* Treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by Sickness or Injury, congenital anomaly or prior therapeutic intervention. Also includes medically prescribed treatment concerned with improving the ability to perform tasks required for independent function where such function has been permanently lost or reduced by Sickness or Injury, congenital anomaly or prior therapeutic intervention.	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum. Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement can be expected within sixty (60) days. A Medical Review is provided on a regular basis to determine Medical Necessity and Appropriateness of Care.
***Note: In & Out-of-network** - Services covered are therapeutic exercises, testing and soft tissue mobilization; physical modalities utilizing heat, cold, water, light, air, electricity, sound, massage, mobilization and mechanical stimulations; reconditioning, including work reconditioning, whichever is applicable. Short-term Rehabilitative Services Maximum Benefits, in any, do not apply to Autism.			

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Outpatient Short Term Rehabilitation ***(continued)***			
Speech Therapy* Treatment of speech and language disorders due to Sickness, surgery, Injury, congenital and developmental anomalies, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum. Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement can be expected within sixty (60) days. A Medical Review is provided on a regular basis to determine Medical Necessity and Appropriateness of Care.
***Note: In & Out-of-network -** Services covered are therapeutic exercises, testing and soft tissue mobilization; physical modalities utilizing heat, cold, water, light, air, electricity, sound, massage, mobilization and mechanical stimulations; reconditioning, including work reconditioning, whichever is applicable. Short-term Rehabilitative Services Maximum Benefits, if any, do not apply to Autism.			

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Outpatient Short Term Rehabilitation ***(continued)***			
Physical Therapy* Treatment of physical disabilities or impairments resulting from Sickness, Injury, congenital anomaly, or prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum. Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement can be expected within sixty (60) days. A Medical Review is provided on a regular basis to determine Medical Necessity and Appropriateness of Care.
***Note: In & Out-of-network** - Services covered are therapeutic exercises, testing and soft tissue mobilization; physical modalities utilizing heat, cold, water, light, air, electricity, sound, massage, mobilization and mechanical stimulations; reconditioning, including work reconditioning, whichever is applicable. Short-term Rehabilitative Services Maximum Benefits, if any, do not apply to Autism.			

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Other Outpatient Short Term Rehabilitation			
Hand Therapy, Orthoptic Therapy and Lymphedema Therapy	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement can be expected within sixty (60) days. Orthoptic/Pleoptic Therapy is limited to eight (8) visits per Calendar Year.* A Medical Review is provided on a regular basis to determine Medical Necessity and Appropriateness of Care.
***Note: In & Out-of-network** - Services covered are therapeutic exercises, testing and soft tissue mobilization; physical modalities utilizing heat, cold, water, light, air, electricity, sound, massage, mobilization and mechanical stimulations; reconditioning, including work reconditioning; orthoptic/pleoptic therapy provided by a licensed ophthalmologist or optometrist.			
Cardiac Rehabilitation Therapy	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required - The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Other Outpatient Short Term Rehabilitation ***(continued)***			
Inhalation Therapy Radiation Therapy Respiration Therapy *(Notification only to Claims Supervisor – Non-compliance Penalty Not Applicable)* Infusion Therapy *(See also Home Infusion Therapy)*			Infusion & Inhalation Therapy includes, but not limited to parenteral and enteral nutrition, antibiotic therapy, pain management and hydration therapy.
Cognitive Therapy* *(Notification only to Claims Supervisor – Non-compliance Penalty Not Applicable)*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement can be expected within sixty (60) days.* A Medical Review is provided on a regular basis to determine Medical Necessity and Appropriateness of Care.
***Note: In & Out-of-network** – Cognitive Therapy is a therapeutic approach designed to improve cognitive functioning after central nervous system Injury or trauma, which includes therapy methods that retrain or alleviate problems caused by deficits in attention, visual processing, language, memory reasoning and problem solving. Used to reinforce learning patterns of behavior or to establish new compensatory mechanisms for the impaired neurologic system.			
Developmental Disorders and Autism Special Provisions			
This Plan provides coverage, for a Covered Person under twenty-one (21) years of age, for expenses incurred for the screening and diagnosing of autism or other developmental disabilities. When the primary diagnosis is autism or another developmental disability, this Plan shall provide coverage for the expenses incurred for Medically Necessary behavioral interventions based on the principles of applied behavioral analysis and related behavioral programs, occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. Any such treatment will not be denied on the basis that the treatment is not restorative. The treatment plan required shall include all elements necessary for this Plan to determine the appropriate benefits, including, but not limited to: diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the attending Physician's prescription and written review and approval. An updated treatment plan may be requested every six (6) months from the attending Physician to review the Medical Necessity, unless a more frequent review is necessary due to emerging clinical circumstances. The above benefit provision may be subject to utilization review, including periodic review, to determine continued Medical Necessity and Appropriateness of care for specific therapies and interventions.			
Early Intervention Autism/ Developmental Disabilities	100% of the pre-negotiated contracted rate	70% of the Usual and Reasonable Charge after the Deductible	Includes Physical, Speech and Occupational Therapy.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Mental Disorders ***(Non-biologically based)***			
Inpatient Mental Disorders *(Non-biologically based)* Unused Inpatient days/visits may be exchanged based on Medical Necessity for up to sixty (60) additional Outpatient visits per Calendar Year; or may be exchanged for Partial Hospitalization visits on an exchange of one (1) Inpatient day equals two (2) Partial Hospitalization visits *(Refer to Partial Hospitalization)*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum. **Out-of-network** benefits are limited to a fifty (50) Inpatient day/visit Maximum Benefit per Calendar Year.* **Out-of-network** - Up to thirty (30) additional Inpatient days per Calendar Year through a one (1) for two (2) exchanges with available Outpatient visits/ sessions.
Partial Hospitalization Balance of Inpatient days/ visits may be exchanged on a one (1) Inpatient day equals two (2) Partial Hospitalization visits	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	Calendar Year Maximum Benefit Applies* *(Refer to Inpatient Mental Disorder Benefits)*
Outpatient Mental Disorders *(Non-biologically based)*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	**Out-of-network** - Up to thirty (30) additional Inpatient days per Calendar Year through a one (1) for two (2) exchanges with available Outpatient visits/ sessions.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Mental Disorders ***(Biologically based)***			
Inpatient Mental Disorders *(Biologically based)*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.
Partial Hospitalization Balance of Inpatient days/ visits may be exchanged on a one (1) Inpatient day equals two (2) Partial Hospitalization visits	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Outpatient Mental Disorders *(Biologically based)*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Substance Abuse ***(Drug Related)***			
Inpatient Substance Abuse *(Drug Related)* Unused Inpatient days can be exchanged for Partial Hospitalization visits *(Refer to Partial Hospitalization)* **In & Out of Network** - Up to thirty (30) additional Inpatient days per Calendar Year through a one (1) for two (2) exchanges with available Outpatient visits/sessions.*	100% of the pre-negotiated contracted rate Maximum Benefits Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum. **In-network** - Thirty (30) Inpatient day/visit In-network Maximum Benefit per Calendar Year.* **Out-of-network** - Fifty (50) Inpatient day/visit Out-of-network Maximum Benefit per Calendar Year.*
Inpatient Substance Abuse *(Drug Related)* Detoxification Services	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum. **In & Out-of-network** – Inpatient & Outpatient twenty-eight (28) days Maximum Benefit per episode.*

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Substance Abuse ***(Drug Related) (continued)***			
Partial Hospitalization Unused Inpatient days can be exchanged for Partial Hospitalization visits *(Refer to Partial Hospitalization)*	100% of the pre-negotiated contracted rate Maximum Benefits Apply*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefits Apply*	Calendar Year Maximum Benefit Applies* *(Refer to Inpatient Mental Disorder Benefits)*
Outpatient Detoxification Substance Abuse *(Drug Related)*	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	**In & Out-of-network** – Inpatient & Outpatient twenty-eight (28) days Maximum Benefit per episode.*
Outpatient Substance Abuse *(Drug Related)*	100% of the pre-negotiated contracted rate Maximum Benefits Apply*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefits Apply*	**In & Out-of-network** - Sixty (60) Outpatient visits per Calendar Year.*
Substance Abuse ***(Alcohol Related)***			
Inpatient Substance Abuse *(Alcohol Related)*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.
Inpatient Substance Abuse *(Alcohol Related)* Detoxification & Rehabilitation	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Substance Abuse ***(Alcohol Related) (continued)***			
Partial Hospitalization Unused Inpatient days can be exchanged for Partial Hospitalization visits *(Refer to Partial Hospitalization)*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Substance Abuse Outpatient	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Other Services & Treatment			
Wilm's Tumor	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Service include, but are not limited to, autologous bone marrow transplant when standard treatment & chemotherapy is unsuccessful.
Hearing Screening	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Performed for diagnostic purposes, which includes the periodic monitoring of all infants between the ages twenty-nine (29) days and thirty-six (36) months for delayed onset hearing.
Sleep Disorders *(Includes Sleep Apnea, Nocturnal Seizures & Narcolepsy)*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.
Artificial Limb Replacement	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required – any item over $1,500.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Other Services & Treatment			
Medical & Surgical Supplies	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
Orthotic Appliances*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the In-network deductible	Pre-certification Required – any purchase, rental, replacement or repair exceeding $250.
***Note: In & Out-of-network -** Benefits provided for the Initial purchase and fitting (per medical episode) of orthotic devices (except foot orthotics); and replacement of orthotics (except foot orthotics) for a covered Dependent child when required due to natural growth.			
Mastectomy Care*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
***Note: In & Out-of-network** – Service provided following a mastectomy on one (1) or both breasts: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications in all stages of a mastectomy, including lymphedemas.			
Breast Reconstruction Prosthesis*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required – any item over $1,500.
***Note: In & Out-of-network** – Internal & external breast prostheses include: (1) Four (4) post mastectomy bras per Calendar Year; (2) Silicone breast prostheses with a life expectancy of a minimum of two (2) years; and (3) Fabric, foam or fiber-filled breast prostheses with a life expectancy of a minimum of six (6) months.			
Prosthesis & Other Devices*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required – any single item exceeding $1,500.
***Note: In & Out-of-network** - Purchase, fitting & necessary adjustment, supplies and repairs are covered (except for dental prostheses); eyeglasses or contact lenses as a result of lost vision due to ocular surgery (cataract surgery) or injury; pinhole glasses following surgery for detached retina or lenses provided in lieu of surgery for treatment of infantile glaucoma; corneal or scleral lenses for treatment of keratoconus; or scleral lenses for retaining moisture where normal tearing is lost or inadequate; corneal or scleral lenses to reduce a corneal irregularity (other then astigmatism). Covered services include: (1) therapeutic exercise, testing and soft tissue mobilization; (2) physical modalities utilizing heat, cold, light, air, electricity, sound, water therapy, massage, mobilization or mechanical stimulation; (3) fitting of splints, braces, prostheses and other devices; (4) reconditioning, including work reconditioning; orthoptic/pleoptic therapy by an ophthalmologist or optometrist. **Replacement** of a previously provided prosthetic device is provided only when (a) there is a significant change in the condition that requires replacement; (b) the prosthetic device is defective; (c) the prosthetic device breaks because it has exceeded its life duration as determined by manufacturer; (d) it is replaced due to the normal growth pattern of a covered Dependent child which is determined to be Medically Necessary.			

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Other Services & Treatment (continued)			
Dental Prosthesis	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required - Treatment must be rendered within twelve (12) months of an Accidental Injury to sound natural teeth.
Dental Services *(severely disabled or child age five (5) or under)*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Limited to General Anesthesia & Hospitalization for dental services; or dental services rendered by a Dentist regardless of where dental services are provided due to a Medical Condition which requires Hospitalization or General Anesthesia.
Oral Surgery*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
***Note: In & Out-of-network** - Benefits provided for: (1) removal or exposure of teeth partially or totally covered by bone; (2) Accidental Injury to jaw or structure contiguous to the jaw or natural teeth; (3) correction of non-dental physiological condition which results in a severe functional impairment; (4) treatment of tumors & cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof or floor of the mouth.			
Diabetic Education & Supplies*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
***Note: In & Out-of-network** - Self-management education by a certified Dietician, Health Care professional or registered Pharmacist certified for diabetes instruction; Benefits provided for (1) initial diagnosis of diabetes; (2) a significant change in Covered Person's condition or symptoms; (3) upon determination that re-education or refresher is necessary.			
Autologous Blood Drawing, Storage & Transfusion	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Covered Services in conjunction with a planned episode of care that requires transfusion, including but not limited to, a surgical procedure. Storage is provided until the date of the scheduled care or procedure.
Blood & Blood Plasma	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Provided the blood has not been donated or replaced
Dialysis	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Provided in a Hospital Outpatient Facility or Freestanding Dialysis Facility. Home Dialysis will include equipment, training and medical supplies, but not Private Duty Nursing.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Other Services & Treatment *(continued)*			
Hemophilia	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Services include home treatment for bleeding episodes; services in a Hospital Outpatient Clinical Laboratory or Regional Care Center.
Durable Medical Equipment*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required - for any single item exceeding $1,500.
***Note: In & Out-of-network** – Benefits are provided for the rental (but not to exceed the total allowance of purchase) or purchase when approved by the Plan Administrator. Benefits are provided for Durable Medical Equipment (DME) that meet the following tests: (1) It is durable. (This item can withstand repeated use.); (2) It is medical equipment that is primarily and customarily used for medical purposes and is not generally useful in the absence of a Sickness or Injury; (3) It is generally not useful to a person without a Sickness or Injury; (4) It is appropriate for home use. DME includes, but is not limited to: non-reusable diabetic supplies; canes, crutches, walkers; commode chairs, home oxygen equipment; hospital beds; traction equipment; and wheelchairs. Benefits will be provided for the repair of the DME when the cost of the repair is less than the cost to replace the DME. Repair means the restoration of the DME or one (1) of its components to correct the problem due to wear or damage. Replacement means the removal and substitution of the DME or one (1) of its components necessary for proper function. If the DME breaks & is under warranty, unless it is a rental, it is the Covered Person's responsibility to work with the manufacturer to replace or repair the DME. This Plan will not replace or repair the DME due to abuse or loss.			
Nutritional Counseling	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Nutritional counseling and education for the management of disease entities which have a verified specific diagnostic criteria.
Genetic Testing & Counseling *(Notification only to the Claims Supervisor – Non-compliance Penalty Not Applicable)*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Prior Authorization is required.
Inherited Metabolic Disease	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Included is therapeutic treatment, purchase of Medical Food (Enteral Formula) & Low Protein Modified Food Products determined as Medically Necessary.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Other Services & Treatment *(continued)*			
Podiatric Care	100% of the pre-negotiated contracted rate after copayment if performed in office; otherwise 100% of the pre-negotiated contracted rate.	70% of the Usual & Reasonable Charge after the deductible	Services include capsular or surgical treatment of bunions; ingrown toenail surgery or other non-routine Medically Necessary foot care.
Medical Social Services	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Benefits provided for appropriate assistance in dealing with physical, emotional and economic impact of Sickness or disability & include pre- and post-hospitalization planning, information on available services provided through community health & social welfare agencies and related family counseling.
Home Infusion Therapy	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required – The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Other Services & Treatment *(continued)*			
Outpatient Private Duty Nursing	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required – The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.
Home Health Care	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required – The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum. Home Health Care visit will be considered a periodic visit by either a nurse or therapist or four (4) hours* of home health aide services. Services must be approved every thirty (30) days and be Medically Necessary. Custodial care is not covered.

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Other Services & Treatment *(continued)*			
Hospice Care*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required – The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.
Hospice Respite Care Counseling	100% of the pre-negotiated contracted rate Maximum Benefit Applies*	70% of the Usual & Reasonable Charge after the deductible Maximum Benefit Applies*	**Out-of-network** - Respite care is provided for a maximum of seven (7) days every six (6) months.*
***Note: In & Out-of-network** - Hospice benefits are provided to a Covered Person when the Attending Physician certifies that the Covered Person has a terminal Sickness with a medical prognosis of six (6) months or less and when the Covered Person elects to receive care primarily to relieve pain. Hospice Care is primarily comfort care, including pain relief, physical care, counseling and other services that will help the Covered Person cope with the terminal Sickness rather than cure it. Hospice Care exclusions are as follows: (1) Services and supplies for which there is no charge; (2) Research and studies directed to life lengthening methods of treatment; (3) Services and expenses incurred in regard to the Covered Person's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property; (4) Care provided by the Covered Person's family, relatives and friends; (5) Private Duty Nursing care.			

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Other Services & Treatment *(continued)*			
Human Organ Transplants*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Medical Necessary, Non-investigational and Non-experimental transplant procedures are covered under this Plan. Pre-certification Required – The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.
***Note: In & Out-of-network -** Donor coverage is provided for the Covered Person as the donor only if the recipient is a Covered Person. If there is no other source of coverage for the transplant services related to the donor the only charges that are covered under this Plan for the donor, when the recipient is a Covered Person, are as follows: (1) the removal of the organ from the donor; (2) donor preparatory pathologic and/or medical examination; and donor post surgical care.			
Family Planning*	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	
***Note: In & Out-of-network** - Benefits are provided for voluntary family planning services when provided by a Physician or reproductive health specialist. Covered services include sterilization procedures, such as tubal ligation or vasectomy. Contraceptive intrauterine devices (IUDs) and other contraceptive devices and their fitting are covered under this Medical Plan when administered in the Physician's office. Contraceptive implants, eligible injectable contraceptives and any other contraceptive drug are covered as family planning services, except if not covered by the Standalone Prescription Drug Plan.			

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Other Services & Treatment *(continued)*			
Infertility* ***Refer to Note which follows***	100% of the pre-negotiated contracted rate	70% of the Usual & Reasonable Charge after the deductible	Pre-certification Required – The Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. *(Refer to this section for additional information)* This penalty does not apply to the satisfaction of the out-of-pocket maximum.

***Note: In & Out-of-network** – Benefits are provided for Inpatient and Outpatient services for expenses incurred in the diagnosis and treatment of infertility. Covered infertility services include, but are not limited to the following services performed at facilities that conform to the standards established by the American Society of Reproductive Medicine or the American College of Obstetricians & Gynecologists:

- Diagnosis & diagnostic tests;
- Medications, including injectable Infertility medications (which may be considered covered under the Standalone Prescription Drug Plan);
- Surgery, including microsurgical sperm aspiration;
- Fresh and frozen embryo transfer;
- Artificial insemination with no limit as to the number of cycles;
- Intracytoplasmic sperm injection;
- In vitro fertilization (IVF), including IVF using donor eggs and IVF where the embryo is transferred to a Gestational Carrier or Surrogate **(Refer to Note**)**;
- Zygote intrafallopian transfer (ZIFT) **(Refer to Note**)**;
- Gamete intrafallopian transfer (GIFT) **(Refer to Note**)**;
- Assisted hatching;
- Ovulation induction; and
- Egg retrievals, limited to four (4) completed egg retrievals per Lifetime of the Covered Person (Services rendered on or after 11.23.2001 count to the egg retrieval Lifetime Maximum. Documentation will be required to support and certify prior attempts): (1) where a live donor is used in the egg retrieval, the medical expenses of the donor shall be covered until the donor is released from treatment by the Reproductive Endocrinologist; (2) egg retrievals where the cost was not covered by any other health plan shall not count in determining whether the four (4) complete egg retrieval maximum has been met;
- Medical expenses associated with the egg or sperm donors, including office visits, medications, laboratory and radiological procedures/retrieval and treatment of any complications of Covered Services or procedures, including Hospitalization are covered until the donor is released from treatment by the Reproductive Endocrinologist;

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Other Services & Treatment *(continued)*			
***Note: In & Out-of-network -** Infertility *(continued)* • Medical expenses associated with the egg or sperm donors, including office visits, medications, laboratory and radiological procedures/retrieval and treatment of any complications of Covered Services or procedures, including Hospitalization are covered until the donor is released from treatment by the Reproductive Endocrinologist; • All medical expenses associated with the procedures performed on a person who is an egg or sperm donor where charges will be covered if the Covered Person's Benefits under this Medical Plan have not been exhausted. Medical expenses of an egg or sperm donor which are incurred in connection with the treatment of the Covered Person's infertility, will be covered subject to the Medical Plan provisions, as if they have been incurred by the Covered Person; • Medical expenses of Gestational Carriers are covered, including office visits, medications, laboratory and radiological procedures/ retrieval, and treatment of any complications of such Covered Services or procedures, including Hospitalization. The coverage for these Carriers which are incurred in connection with the treatment of the covered Person's infertility, will be covered subject to the Medical Plan provisions, as if they has been incurred by the Covered Person; • Medical expenses of Surrogates are covered subject to the Medical Plan provisions as if they had been incurred by the Covered Person for egg retrieval, in vitro fertilization, laboratory costs following retrieval, embryo transfer, or for artificial insemination. Expenses associated with ovulation or complication are not covered; • Thawing and preparation of frozen sperm and embryos. ***Note:** Benefits provided for IVF, ZIFT or GIFT services are limited for a Covered Person under this Medical Plan, if the Covered Person: • has used all reasonable, less expensive and medically appropriate treatment and is still unable to become pregnant or carry a pregnancy to live birth of the child(ren); • has not reached the limit of four (4) covered completed egg retrievals per Lifetime; and is forty-five (45) years or younger.			

HADDON TOWNSHIP – POS PLAN – PLAN B SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	**NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS**
Other Services & Treatment *(continued)*			
Clinical Trials*	*(Refer to actual Services being rendered for the Benefit provisions)*	*(Refer to actual Services being rendered for the Benefit provisions)*	

***Note: In & Out-of-network** - This Plan provides coverage for charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. The following criteria must be met:

- The cancer trial is listed as being sponsored by the federal government;
- The trial investigates a treatment for terminal cancer and (a) the Covered Person has failed standard therapies for the disease; (b) cannot tolerate standard therapies for the Disease; or (c) no effective non-experimental treatment for the disease exists;
- The Covered Person meets all the inclusion criteria for the clinical trial and is not treated "off protocol";
- The trial is approved by the Institutional Review Board of the institution administering the treatment.

Routine services do not include, and reimbursement will not be provided for:

- The investigation services or supply itself;
- Service or supplies listed here as exclusions;
- Services or supplies related to data collection for the clinical trial (i.e. protocol costs);

Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (i.e. device, drug, item or service supplies by a manufacturer and not yet FDA approved) without charge to the trial participant/Covered Person.

Prescription Drugs	**Refer to Standalone Prescription Drug Card Plan for Prescription Coverage** Prescription medications eligible under this Plan dispensed and administered by a licensed Physician/Provider in the Physician's office or approved environment 100% of the pre-negotiated contracted rate	**Refer to Standalone Prescription Drug Card Plan for Prescription Coverage** Prescription medications eligible under this Plan dispensed and administered by a licensed Physician/Provider in the Physician's office or approved environment 70% of the Usual & Reasonable Charge after the deductible	**Refer to Standalone Prescription Drug Card Plan for Prescription Coverage** Prescription Drugs and Medicines are covered under this Plan **ONLY** if they are not payable under the Standalone Prescription Drug Card Plan and are an eligible expense under this Plan. Medically Necessary to treat a Medical Condition. A Standalone Prescription Drug Card Plan Copayment is **NOT** eligible for reimbursement under this Medical Plan.