







**DIFFERENCE
CARD
SUMMARY OF
BENEFITS**

SUMMARY OF BENEFITS

Plainfield Public School District | PPO Summary of Benefits | 01/01/2018

| TYPE OF VISIT | YOU PAY | DIFFERENCE CARD PAYS | HORIZON BENEFIT |
|---|-----------------|----------------------------|----------------------------|
|  Primary Care Office Visit Copay | \$15 | \$10 | \$25 |
|  Specialist Office Visit Copay | \$15 | \$35 | \$50 |
|  ER Visit Copay | \$25 | \$75 | \$100 |
|  Urgent Care Copay | \$15 | \$35 | \$50 |
|  Short- Term Therapies | \$15 | \$10 | \$25 |
|  Orthotics and Prosthetics | \$15 | \$10 | \$25 |
| In-Network Deductible* | \$0 | \$2,500 | \$2,500 |
| In-Network Coinsurance* | \$0 | \$0 | 100% |
| In-Network DME, Diabetic Supplies, Ambulance & Private Duty Nursing | 20% | \$0 | 80% |
| In-Patient Hospital/Out-Patient Surgery Facility Fee | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| In-Patient/Out-Patient Short Term Therapy Facility Fee | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| Diagnostic Imaging/X-Ray | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| Diagnostic Test- Lab Bloodwork | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| Out-of-Network Deductible | \$100 | 80% up to \$4,900 | \$5,000 |
| Out-of-Network Coinsurance | 20% after \$100 | 20% after \$4,900 | 60% after \$5,000 |
| RX Retail Copay (BeneCard) | \$6 / \$15 | N/A | \$6 / \$15 |

*Deductibles are determined on a CALENDAR year basis.

*Family Multiplier for all plans is 2Xs.

*All claims must be submitted within 3 months of the end of the plan year.

*In-network short-term therapy services rendered in a hospital/facility are not subject to a copayment.

CONTACT US

Monday – Friday
8AM to 8PM Eastern

888.343.2110

www.differencecard.com
customer@differencecard.com

Please have your provider swipe The Difference Card for the following amounts:

Primary Care Copay - \$10
Specialist Copay - \$35
Urgent Care Copay - \$35
Emergency Room Copay - \$75
Short-Term Therapies- \$10
Orthotics and Prosthetics-\$10

SUMMARY OF BENEFITS

Plainfield Public School District | OMNIA Summary of Benefits | 01/01/2018

| TYPE OF VISIT | YOU PAY | DIFFERENCE CARD PAYS | HORIZON BENEFIT |
|--|------------|----------------------------|-------------------|
| Tier 1 Primary Care Office Visit Copay | \$5 | \$0 | \$5 |
| Tier 1 Specialist Office Visit Copay | \$15 | \$0 | \$15 |
| Tier 1 Urgent Care Copay | \$15 | \$0 | \$15 |
| Tier 1 In-Patient Hospital Copay | \$0 | \$150 | \$150 |
|  Tier 2 Primary Care Office Visit Copay | \$15 | \$5 | \$20 |
|  Tier 2 Specialist Office Visit Copay | \$15 | \$15 | \$30 |
|  Tier 2 Urgent Care Copay | \$15 | \$15 | \$30 |
|  Tier 2 Short Term Therapies | \$15 | \$5 | \$20 |
|  Tier 2 Orthotics and Prosthetics | \$15 | \$5 | \$20 |
|  Tier 1 & 2 Emergency Room Copay | \$25 | \$75 | \$100 |
| Tier 1 Deductible* | \$0 | \$0 | \$0 |
| Tier 1 Coinsurance* | \$0 | \$0 | 100% |
| Tier 2 Deductible* | \$0 | \$1,500 | \$1,500 |
| Tier 2 Coinsurance* | \$0 | 20% up to \$3,000 | 80% up to \$3,000 |
| Tier 1 In/Out-Patient Hospital Facility Fee | \$0 | \$150 | \$150 |
| Tier 2 In/Out-Patient Hospital Facility Fee | \$0 | Deductible and Coinsurance | Coinsurance |
| Tier 1 & 2 Skilled Nursing Facility Fee | \$0 | \$150 | \$150 |
| RX Retail Copay (BeneCard) | \$6 / \$15 | \$0 | \$6 / \$15 |

*Deductibles are determined on a CALENDAR year basis.

*Family Multiplier for all plans is 2Xs.

*All claims must be submitted within 3 months of the end of the plan year.

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Please have your provider swipe The Difference Card for the following amounts:

Tier 2 Primary Care Copay - \$5

Tier 2 Specialist Copay - \$15

Tier 2 Urgent Care Copay - \$15

Tier 1/Tier 2 ER Copay - \$75

Tier 2 Short-Term Therapy - \$5







Tier 2 Orthotics/Prosthetics - \$5

Call 888.343.2110 with any questions

OLD OXFORD

SUMMARY OF BENEFITS

Plainfield Public School District | NJ Access 1 Plan Summary of Benefits | 7/1/2018

| TYPE OF VISIT | YOU PAY | DIFFERENCE CARD PAYS | OXFORD BENEFIT |
|---|-----------------------------|----------------------------|----------------------------|
|  Primary Care Office Visit Copay | \$15 | \$35 | \$50 |
|  Specialist Office Visit Copay | \$15 | \$35 | \$50 |
|  ER Visit Copay | \$50 | \$50 | \$100 |
|  Urgent Care Copay | \$15 | \$35 | \$50 |
|  Short-Term Therapies | \$15 | \$35 | \$50 |
|  Orthotics and Prosthetics | \$15 | \$35 | \$50 |
| In-Network Deductible* | \$0 | \$2,500 | \$2,500 |
| In-Network Coinsurance* | \$0 | \$2,500 | 20% to \$2,500 |
| In-Patient Hospital Facility Fee | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| Out-Patient Surgery Facility Fee | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| In-Patient/Out-Patient Short Term Therapy Facility Fee | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| Diagnostic Imaging/X-Ray | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| Diagnostic Test-Lab Bloodwork | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| Out of Network Deductible | \$1,000 then 30% to \$1,200 | \$2,800 | \$5,000 |
| Out of Network Coinsurance | \$0 | \$10,000 | \$10,000 |
| RX Retail Copay | \$6 / \$15 | N/A | \$6 / \$15 |

*Deductibles are determined on a CALENDAR year basis.

*Family Multiplier for all plans is 2X.

*All claims must be submitted within 3 months of the end of the plan year.

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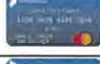


customercare@differencecard.com

Please have your provider swipe The Difference Card for the following amounts:

Primary Care Copay - \$35
Specialist Copay - \$35
ER Visit Copay - \$50
Urgent Care Copay - \$35
Short Term Therapies - \$35
Orthotics and Prosthetics - \$35

SUMMARY OF BENEFITS

Plainfield Public School District | NJ Access 2 Plan Summary of Benefits | 7/1/2018

| TYPE OF VISIT | YOU PAY | DIFFERENCE CARD PAYS | OXFORD BENEFIT |
|--|------------------------------|------------------------------------|----------------------------|
|  Primary Care Office Visit Copay | \$15 | \$35 | \$50 |
|  Specialist Office Visit Copay | \$15 | \$35 | \$50 |
|  ER Visit Copay | \$25 | \$75 | \$100 |
|  Urgent Care Copay | \$15 | \$35 | \$50 |
|  Short-Term Therapies | \$15 | \$35 | \$50 |
|  Orthotics and Prosthetics | \$15 | \$35 | \$50 |
| In-Network Deductible* | \$0 | \$2,500 | \$2,500 |
| In-Network Coinsurance* | \$0 | \$2,500 | 20% to \$2,500 |
| In-Patient Hospital Facility Fee | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| Out-Patient Surgery Facility Fee | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| In-Patient/Out-Patient Short Term Therapy Facility Fee | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| Diagnostic Imaging/X-Ray | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| Diagnostic Test-Lab Bloodwork | \$0 | Deductible and Coinsurance | Deductible and Coinsurance |
| Out of Network Deductible | \$300 then 30% up to \$1,410 | \$3,290 | \$5,000 |
| Out of Network Coinsurance | 30% up to \$3,290 | 10% to \$1,097 then 40% to \$5,613 | 40% to \$10,000 |
| RX Retail Copay | \$6 / \$15 | N/A | \$6 / \$15 |

*Deductibles are determined on a CALENDAR year basis.
 *Family Multiplier for all plans is 2X.
 *All claims must be submitted within 3 months of the end of the plan year.

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Please have your provider swipe The Difference Card for the following amounts:

- Primary Care Copay - \$35
- Specialist Copay - \$35
- ER Visit Copay - \$50
- Urgent Care Copay - \$35
- Short Term Therapies - \$35
- Orthotics and Prosthetics - \$35