TOWNSHIP OF PEMBERTON
PLATINUM PLAN
SCHEDULE OF BENEFITS
FEBRUARY 1, 2019

Medical Benefits

Maximum Benefit Per Covered Person Per Calendar Year For:	
Outpatient Physical Therapy	30 Visits
Outpatient Speech Therapy	30 Visits
Outpatient Occupational Therapy	30 Visits
Private Duty Nursing	30 Visits
Chiropractic Care	26 Visits
Routine Preventive Care – Nonpreferred Providers Only	$500
Routine Vision Examination	1 Visit
Maximum Benefit Per Covered Person Every Two (2) Years For:	
Vision Hardware	$100
Maximum Benefit Per Covered Person Every Thirty-Six (36) Months For:	
Hearing Aids	$1,000

Deductible Per Calendar Year:	***Preferred Provider***	***Nonpreferred Provider***
Individual (Per Person)	-0-	$250
Family (2 Individuals)	-0-	$500
Out-of-Pocket Expense Limit Per Calendar Year:		
Individual (Per Person)	$400	$1,000
Family (2 Individuals)	$1,000	$2,000

Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.

Coinsurance:

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit*, for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance***.

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Inpatient Hospital	100%	80%
Preadmission Testing	100%	80%
Outpatient Surgery Performed at a Hospital – Facility Charges	100%	80%
Outpatient Surgery Performed at an Ambulatory/Freestanding Surgical Facility	100%	80%
Birthing Center	100%	80%
Emergency Room Services		
Emergency Care	100% (after $25 copay)	*100% (after $25 copay)
Non-Emergency Care	100% (after $100 copay)	Not Covered

* **Deductible Waived**
One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Urgent Care Center	100% (after $10 copay)	80%
In-Store Health Clinic Visit	100% (after $10 copay)	80%
Ambulance Services	100%	*100%
Physician Services		
Office Visit		
Primary Care Physician	100% (after $10 copay)	80%
Specialist Physician	100% (after $15 copay)	80%
Inpatient Physician Visits		
Primary Care Physician	100%	80%
Specialist Physician	100%	80%
Inpatient Physician Visits at an Extended Care Facility	100%	80%
Inpatient Consultations	100%	80%
Surgery	100%	80%
Allergy Injections/Serum		
Primary Care Physician (if no office visit charge)	100% (after $10 copay)	80%
Specialist Physician (if no office visit charge)	100% (after $15 copay)	80%
Pathology		
Primary Care Physician (if no office visit charge)	100% (after $10 copay)	80%
Specialist Physician (if no office visit charge)	100% (after $15 copay)	80%

* **Deductible Waived**

One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Anesthesiology	100%	80%
Radiology		
Primary Care Physician (if no office visit charge)	100% (after $10 copay)	80%
Specialist Physician (if no office visit charge)	100% (after $15 copay)	80%
Telemedicine Visit *(from Teladoc)*	$0 ***Copay***	
Telemedicine Behavioral Health Visit *(from Teladoc)*		
Initial psychiatric evaluation	$10 ***Copay***	
Subsequent consults with a psychiatrist	$10 ***Copay***	
Consults with a therapist other than a psychiatrist	$10 ***Copay***	
Diagnostic Services and Supplies		
Inpatient Facility Charges	100%	80%
Outpatient Facility Charges	90%	80%
Independent Laboratory	100% (after $10 copay)	80%
Second Surgical Opinion	100%	80%
Extended Care Facility	100%	80%
Home Health Care	100%	80%
Hospice Care Limitation: 15 visits ***maximum benefit*** for family bereavement counseling within 6 months of death of ***covered person***	100%	80%
Durable Medical Equipment	100%	80%
Prostheses/Orthotics	100%	80%
Routine Preventive Care Limitation: $500 ***maximum benefit*** per calendar year nonpreferred providers only	100%	80%

* **Deductible Waived**
One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Routine Colorectal Screenings	100%	80%
Women's Preventive Services	100%	80%
Routine Vision Limitation: 1 visit ***maximum benefit*** per calendar year	100% (after $10 copay)	*100% (after $10 copay)
Vision Hardware Limitation: $100 ***maximum benefit*** every 2 years	100%	*100%
Routine Hearing Exam	100% (after $10 copay)	80%
Hearing Aids Limitation: $1,000 ***maximum benefit*** every 36 months	100%	*100%
Mental & Nervous Disorders and Chemical Dependency Care		
Inpatient Services	100%	80%
Partial Confinement	100%	80%
Office Visit	100% (after $10 copay)	80%
Outpatient Therapy Services		
Physical Therapy Limitation: 30 visits ***maximum benefit*** per calendar year	100% (after $15 copay)	80%
Speech Therapy Limitation: 30 visits ***maximum benefit*** per calendar year	100% (after $15 copay)	80%
Occupational Therapy Limitation: 30 visits ***maximum benefit*** per calendar year	100% (after $15 copay)	80%
All Other Covered Outpatient Therapies	100%	80%
Private Duty Nursing Limitation: 30 visits ***maximum benefit*** per calendar year	100%	80%
Chiropractic Care Limitation: 26 visits maximum visits per calendar year	100% (after $15 copay)	80%
Podiatry Office Visit	100% (after $15 copay)	80%

* **Deductible Waived**

One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Diabetic Education	100% (after $10 copay)	80%
Golden Triangle Specialty Network, LLC. Renal Network	100%	N/A
All Other Covered Expenses	100%	80%

* **Deductible Waived**
One copay per provider per date of service

Prescription Drug Program

Deductible Per Calendar Year Per Person	$6,200 Individual / $12,200 Family
Pharmacy Option	
Prescription Drug Card	100% after ***copay***
Copay	Flu Shot at a Caremark Pharmacy: $10 ***copay*** Contraceptives: $0 ***copay*** (Generic or with no generic equivalent) Generic: $5 ***copay*** Single Source Brand Name: $10 ***copay*** Multiple Source Brand Name: $25 ***copay***
Limitation: 34 day supply	
Mail Order Option	
Mail Order Prescription	100% after ***copay***
Copay	Contraceptives: $0 ***copay*** (Generic or with no generic equivalent) Generic: $5 ***copay*** Single Source Brand Name: $15 ***copay*** Multiple Source Brand Name: $35 ***copay***
Limitation: 90 day supply	

Received and accepted for Township of Pemberton

By:________________________________

Title:________________________________

Date:________________________________

TOWNSHIP OF PEMBERTON
GOLD PLAN
SCHEDULE OF BENEFITS
FEBRUARY 1, 2019

Medical Benefits

Maximum Benefit Per Covered Person Per Calendar Year For:	
Outpatient Physical Therapy	30 Visits
Outpatient Speech Therapy	30 Visits
Outpatient Occupational Therapy	30 Visits
Private Duty Nursing	30 Visits
Chiropractic Care	26 Visits
Routine Preventive Care – Nonpreferred Providers Only	$500
Routine Vision Examination	1 Visit
Maximum Benefit Per Covered Person Every Two (2) Years For:	
Vision Hardware	$100
Maximum Benefit Per Covered Person Every Thirty-Six (36) Months For:	
Hearing Aids	$1,000

	Preferred Provider	*Nonpreferred Provider*
Deductible Per Calendar Year:		
Individual (Per Person)	$250	$500
Family (2 Individuals)	$500	$1,000
Out-of-Pocket Expense Limit Per Calendar Year:		
Individual (Per Person)	$750	$1,500
Family (2 Individuals)	$1,500	$3,000

Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.

Coinsurance:

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit*, for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance***.

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Inpatient Hospital	*90% (after $100 copay per day; maximum of 5 copays per calendar year)	80%
Preadmission Testing	*100%	80%
Outpatient Surgery Performed at a Hospital – Facility Charges	90% (after $200 copay)	80%
Outpatient Surgery Performed at an Ambulatory/Freestanding Surgical Facility	*100% (after $100 copay)	80%
Birthing Center	*90% (after $100 copay per day; maximum of 5 copays per calendar year)	80%

* **Deductible Waived**
One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Emergency Room Services		
Emergency Care	*100% (after $50 copay)	*100% (after $50 copay)
Non-Emergency Care	*100% (after $150 copay)	Not Covered
Urgent Care Center	*100% (after $20 copay)	80%
In-Store Health Clinic Visit	*100% (after $15 copay)	80%
Ambulance Services	*100%	*100%
Physician Services		
Office Visit		
Primary Care Physician	*100% (after $15 copay)	80%
Specialist Physician	*100% (after $25 copay)	80%
Inpatient Physician Visits		
Primary Care Physician	90%	80%
Specialist Physician	90%	80%
Inpatient Physician Visits at an Extended Care Facility	90%	80%
Inpatient Consultations	90%	80%
Surgery	90%	80%
Allergy Injections/Serum		
Primary Care Physician (if no office visit charge)	*100% (after $15 copay)	80%
Specialist Physician (if no office visit charge)	*100% (after $25 copay)	80%

* **Deductible Waived**
One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Pathology		
Primary Care Physician (if no office visit charge)	*100% (after $15 copay)	80%
Specialist Physician (if no office visit charge)	*100% (after $25 copay)	80%
Anesthesiology	90%	80%
Radiology		
Primary Care Physician (if no office visit charge)	*100% (after $15 copay)	80%
Specialist Physician (if no office visit charge)	*100% (after $25 copay)	80%
Telemedicine Visit *(from Teladoc)*	$0 ***Copay***	
Telemedicine Behavioral Health Visit *(from Teladoc)*		
Initial psychiatric evaluation	$15 ***Copay***	
Subsequent consults with a psychiatrist	$15 ***Copay***	
Consults with a therapist other than a psychiatrist	$15 ***Copay***	
Diagnostic Services and Supplies		
Inpatient Facility Charges	90%	80%
Outpatient Facility Charges	90%	80%
Independent Laboratory	*100% (after $25 copay)	80%
Independent MRI/MRA, Pet Scan, CT Scan Facility	*100% (after $50 copay)	80%
Second Surgical Opinion	*100%	80%
Extended Care Facility	*100% (after $100 copay per day)	80%
Home Health Care	90%	80%

* **Deductible Waived**
One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Hospice Care Limitation: 15 visits ***maximum benefit*** for family bereavement counseling within 6 months of death of ***covered person***	90%	80%
Durable Medical Equipment	90%	80%
Prostheses/Orthotics	90%	80%
Routine Preventive Care Limitation: $500 ***maximum benefit*** per calendar year nonpreferred providers only	*100%	80%
Routine Colorectal Screenings	*100%	80%
Women's Preventive Services	*100%	80%
Routine Vision Limitation: 1 visit ***maximum benefit*** per calendar year	*100% (after $10 copay)	*100% (after $10 copay)
Vision Hardware Limitation: $100 ***maximum benefit*** every 2 years	*100%	*100%
Routine Hearing Exam	*100% (after $10 copay)	80%
Hearing Aids Limitation: $1,000 ***maximum benefit*** every 36 months	*100%	*100%
Mental & Nervous Disorders and Chemical Dependency Care		
Inpatient Services	*100% (after $100 copay per day; maximum of 5 copays per calendar year)	80%
Partial Confinement	*100%	80%
Office Visit	*100% (after $15 copay)	80%

* **Deductible Waived**
One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Outpatient Therapy Services		
Physical Therapy Limitation: 30 visits ***maximum benefit*** per calendar year	*100% (after $15 copay)	80%
Speech Therapy Limitation: 30 visits ***maximum benefit*** per calendar year	*100% (after $15 copay)	80%
Occupational Therapy Limitation: 30 visits ***maximum benefit*** per calendar year	*100% (after $15 copay)	80%
All Other Covered Outpatient Therapies	90%	80%
Private Duty Nursing Limitation: 30 visits ***maximum benefit*** per calendar year	90%	80%
Chiropractic Care Limitation: 26 visits maximum visits per calendar year	*100% (after $25 copay)	80%
Podiatry Office Visit	*100% (after $25 copay)	80%
Diabetic Education	*100% (after $15 copay)	80%
Golden Triangle Specialty Network, LLC. Renal Network	*100%	N/A
All Other Covered Expenses	90%	80%

* **Deductible Waived**
One copay per provider per date of service

Prescription Drug Program

Deductible Per Calendar Year Per Person	$5,850 Individual / $11,700 Family
Pharmacy Option	
Prescription Drug Card	100% after ***copay***
Copay	Flu Shot at a Caremark Pharmacy: $10 ***copay***
	Contraceptives: $0 ***copay*** (Generic or with no generic equivalent)
	Generic: $10 ***copay***
	Single Source Brand Name: $15 ***copay***
	Multiple Source Brand Name: $30 ***copay***
Limitation: 34 day supply	
Mail Order Option	
Mail Order Prescription	100% after ***copay***
Copay	Contraceptives: $0 ***copay*** (Generic or with no generic equivalent)
	Generic: $10 ***copay***
	Single Source Brand Name: $20 ***copay***
	Multiple Source Brand Name: $40 ***copay***
Limitation: 90 day supply	

Received and accepted for Township of Pemberton

By:________________________________

Title:________________________________

Date:________________________________

TOWNSHIP OF PEMBERTON
SILVER PLAN
SCHEDULE OF BENEFITS
FEBRUARY 1, 2019

Medical Benefits

Maximum Benefit Per Covered Person Per Calendar Year For:	
Outpatient Physical Therapy	30 Visits
Outpatient Speech Therapy	30 Visits
Outpatient Occupational Therapy	30 Visits
Private Duty Nursing	30 Visits
Chiropractic Care	26 Visits
Routine Preventive Care – Nonpreferred Providers Only	$500
Routine Vision Examination	1 Visit
Maximum Benefit Per Covered Person Every Two (2) Years For:	
Vision Hardware	$100
Maximum Benefit Per Covered Person Every Thirty-Six (36) Months For:	
Hearing Aids	$1,000

	Preferred Provider	*Nonpreferred Provider*
Deductible Per Calendar Year:		
Individual (Per Person)	$500	$1,000
Family (2 Individuals)	$1,000	$2,000
Out-of-Pocket Expense Limit Per Calendar Year:		
Individual (Per Person)	$1,500	$3,000
Family (2 Individuals)	$3,000	$6,000

Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.

Coinsurance:

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit*, for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance***.

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Inpatient Hospital	85%	70%
Preadmission Testing	*100%	70%
Outpatient Surgery Performed at a Hospital – Facility Charges	85% (after $200 copay)	70%
Outpatient Surgery Performed at an Ambulatory/Freestanding Surgical Facility	85% (after $200 copay)	70%
Birthing Center	85%	70%
Emergency Room Services		
Emergency Care	*100% (after $75 copay)	*100% (after $75 copay)
Non-Emergency Care	*100% (after $200 copay)	Not Covered

* **Deductible Waived**
One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Urgent Care Center	*100% (after $25 copay)	70%
In-Store Health Clinic Visit	*100% (after $20 copay)	70%
Ambulance Services	*100%	*100%
Physician Services		
Office Visit		
Primary Care Physician	*100% (after $20 copay)	70%
Specialist Physician	*100% (after $30 copay)	70%
Inpatient Physician Visits		
Primary Care Physician	85%	70%
Specialist Physician	85% (after $30 copay)	70%
Inpatient Physician Visits at an Extended Care Facility	85%	70%
Inpatient Consultations	85%	70%
Surgery	85%	70%
Allergy Injections/Serum		
Primary Care Physician (if no office visit charge)	*100% (after $20 copay)	70%
Specialist Physician (if no office visit charge)	*100% (after $30 copay)	70%

* **Deductible Waived**
One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Pathology		
Primary Care Physician (if no office visit charge)	*100% (after $20 copay)	70%
Specialist Physician (if no office visit charge)	*100% (after $30 copay)	70%
Anesthesiology	85%	70%
Radiology		
Primary Care Physician (if no office visit charge)	*100% (after $20 copay)	70%
Specialist Physician (if no office visit charge)	*100% (after $30 copay)	70%
Telemedicine Visit *(from Teladoc)*	$0 ***Copay***	
Telemedicine Behavioral Health Visit *(from Teladoc)*		
Initial psychiatric evaluation	$20 ***Copay***	
Subsequent consults with a psychiatrist	$20 ***Copay***	
Consults with a therapist other than a psychiatrist	$20 ***Copay***	
Diagnostic Services and Supplies		
Inpatient Facility Charges	85%	70%
Outpatient Facility Charges	85%	70%
Independent Laboratory	*100% (after $30 copay)	70%
Independent MRI/MRA, Pet Scan, CT Scan Facility	*100% (after $75 copay)	70%
Second Surgical Opinion	*100%	70%
Extended Care Facility	85%	70%
Home Health Care	85%	70%
Hospice Care Limitation: 15 visits ***maximum benefit*** for family bereavement counseling within 6 months of death of ***covered person***	85%	70%

* **Deductible Waived**
One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Durable Medical Equipment	85%	70%
Prostheses/Orthotics	85%	70%
Routine Preventive Care Limitation: $500 ***maximum benefit*** per calendar year nonpreferred providers only	*100%	70%
Routine Colorectal Screenings	*100%	70%
Women's Preventive Services	*100%	70%
Routine Vision Limitation: 1 visit ***maximum benefit*** per calendar year	*100% (after $10 copay)	*100% (after $10 copay)
Vision Hardware Limitation: $100 ***maximum benefit*** every 2 years	*100%	*100%
Routine Hearing Exam	*100% (after $10 copay)	70%
Hearing Aids Limitation: $1,000 ***maximum benefit*** every 36 months	*100%	*100%
Mental & Nervous Disorders and Chemical Dependency Care		
Inpatient Services	85%	70%
Partial Confinement	85%	70%
Office Visit	*100% (after $20 copay)	70%
Outpatient Therapy Services		
Physical Therapy Limitation: 30 visits ***maximum benefit*** per calendar year	*100% (after $20 copay)	70%
Speech Therapy Limitation: 30 visits ***maximum benefit*** per calendar year	*100% (after $20 copay)	70%
Occupational Therapy Limitation: 30 visits ***maximum benefit*** per calendar year	*100% (after $20 copay)	70%
All Other Covered Outpatient Therapies	85%	70%

* **Deductible Waived**
One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Private Duty Nursing Limitation: 30 visits ***maximum benefit*** per calendar year	85%	70%
Chiropractic Care Limitation: 26 visits maximum visits per calendar year	*100% (after $30 copay)	70%
Podiatry Office Visit	*100% (after $30 copay)	70%
Diabetic Education	*100% (after $20 copay)	70%
Golden Triangle Specialty Network, LLC. Renal Network	*100%	N/A
All Other Covered Expenses	85%	70%

* **Deductible Waived**
One copay per provider per date of service

Prescription Drug Program	
Pharmacy Option	
Prescription Drug Card	100% after ***copay***
Copay	Flu Shot at a Caremark Pharmacy: $10 ***copay*** Contraceptives: $0 ***copay*** (Generic or with no generic equivalent) Generic: $12 ***copay*** Single Source Brand Name: $20 ***copay*** Multiple Source Brand Name: $35 ***copay***
Limitation: 34 day supply	
Mail Order Option	
Mail Order Prescription	100% after ***copay***
Copay	Contraceptives: $0 ***copay*** (Generic or with no generic equivalent) Generic: $12 ***copay*** Single Source Brand Name: $23 ***copay*** Multiple Source Brand Name: $45 ***copay***
Limitation: 90 day supply	

Received and accepted for Township of Pemberton

By:____________________________________

Title:__________________________________

Date:__________________________________

TOWNSHIP OF PEMBERTON
BRONZE PLAN
SCHEDULE OF BENEFITS
FEBRUARY 1, 2019

Medical Benefits

Maximum Benefit Per Covered Person Per Calendar Year For:	
Outpatient Physical Therapy	30 Visits
Outpatient Speech Therapy	30 Visits
Outpatient Occupational Therapy	30 Visits
Private Duty Nursing	30 Visits
Chiropractic Care	26 Visits
Routine Preventive Care – Nonpreferred Providers Only	$500
Routine Vision Examination	1 Visit
Maximum Benefit Per Covered Person Every Two (2) Years For:	
Vision Hardware	$100
Maximum Benefit Per Covered Person Every Thirty-Six (36) Months For:	
Hearing Aids	$1,000

	Preferred Provider	*Nonpreferred Provider*
Deductible Per Calendar Year:		
Individual (Per Person)	$1,500	$2,000
Family (2 Individuals)	$3,000	$4,000
Out-of-Pocket Expense Limit Per Calendar Year:		
Individual (Per Person)	$3,500	$6,000
Family (2 Individuals)	$7,000	$12,000

Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.

Coinsurance:

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit*, for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance***.

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Inpatient Hospital	75%	60%
Preadmission Testing	100%	60%
Outpatient Surgery Performed at a Hospital – Facility Charges	75% (after $300 copay)	60%
Outpatient Surgery Performed at an Ambulatory/Freestanding Surgical Facility	100% (after $200 copay)	60%
Birthing Center	75%	60%

* **Deductible Waived**
One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Emergency Room Services		
Emergency Care	*100% (after $125 copay)	*100% (after $125 copay)
Non-Emergency Care	*100% (after $200 copay)	Not Covered
Urgent Care Center	*100% (after $40 copay)	60%
In-Store Health Clinic Visit	*100% (after $40 copay)	60%
Ambulance Services	*100%	*100%
Physician Services		
Office Visit		
Primary Care Physician	*100% (after $25 copay)	60%
Specialist Physician	*100% (after $40 copay)	60%
Inpatient Physician Visits		
Primary Care Physician	75%	60%
Specialist Physician	75%	60%
Inpatient Physician Visits at an Extended Care Facility	75%	60%
Inpatient Consultations	75%	60%
Surgery	75%	60%
Allergy Injections/Serum		
Primary Care Physician (if no office visit charge)	*100% (after $25 copay)	60%
Specialist Physician (if no office visit charge)	*100% (after $40 copay)	60%

* **Deductible Waived**
One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Pathology		
Primary Care Physician (if no office visit charge)	*100% (after $40 copay)	60%
Specialist Physician (if no office visit charge)	*100% (after $40 copay)	60%
Anesthesiology	75%	60%
Radiology		
Primary Care Physician (if no office visit charge)	*100% (after $40 copay)	60%
Specialist Physician (if no office visit charge)	*100% (after $40 copay)	60%
Telemedicine Visit *(from Teladoc)*	$0 ***Copay***	
Telemedicine Behavioral Health Visit *(from Teladoc)*		
Initial psychiatric evaluation	$25 ***Copay***	
Subsequent consults with a psychiatrist	$25 ***Copay***	
Consults with a therapist other than a psychiatrist	$25 ***Copay***	
Diagnostic Services and Supplies		
Inpatient Facility Charges	75%	60%
Outpatient Facility Charges	75%	60%
Independent Laboratory	*100% (after $40 copay)	60%
Independent MRI/MRA, Pet Scan, CT Scan Facility	*100% (after $100 copay)	60%
Second Surgical Opinion	*100%	60%
Extended Care Facility	75%	60%
Home Health Care	75%	60%
Hospice Care Limitation: 15 visits ***maximum benefit*** for family bereavement counseling within 6 months of death of ***covered person***	75%	60%

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One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Durable Medical Equipment	75%	60%
Prostheses/Orthotics	75%	60%
Routine Preventive Care Limitation: $500 ***maximum benefit*** per calendar year nonpreferred providers only	*100%	60%
Routine Colorectal Screenings	*100%	60%
Women's Preventive Services	*100%	60%
Routine Vision Limitation: 1 visit ***maximum benefit*** per calendar year	*100% (after $10 copay)	*100% (after $10 copay)
Vision Hardware Limitation: $100 ***maximum benefit*** every 2 years	*100%	*100%
Routine Hearing Exam	*100% (after $10 copay)	60%
Hearing Aids Limitation: $1,000 ***maximum benefit*** every 36 months	*100%	*100%
Mental & Nervous Disorders and Chemical Dependency Care		
Inpatient Services	75%	60%
Partial Confinement	75%	60%
Office Visit	*100% (after $25 copay)	60%
Outpatient Therapy Services		
Physical Therapy Limitation: 30 visits ***maximum benefit*** per calendar year	*100% (after $30 copay)	60%
Speech Therapy Limitation: 30 visits ***maximum benefit*** per calendar year	*100% (after $30 copay)	60%
Occupational Therapy Limitation: 30 visits ***maximum benefit*** per calendar year	*100% (after $30 copay)	60%
All Other Covered Outpatient Therapies	75%	60%

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One copay per provider per date of service

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Private Duty Nursing Limitation: 30 visits ***maximum benefit*** per calendar year	75%	60%
Chiropractic Care Limitation: 26 visits maximum visits per calendar year	*100% (after $40 copay)	60%
Podiatry Office Visit	*100% (after $40 copay)	60%
Diabetic Education	*100% (after $25 copay)	60%
Golden Triangle Specialty Network, LLC. Renal Network	*100%	N/A
All Other Covered Expenses	75%	60%

* **Deductible Waived**
One copay per provider per date of service

Prescription Drug Program	
Deductible Per Calendar Year Per Person	$3,100 Individual / $6,200 Family
Pharmacy Option	
Prescription Drug Card	100% after ***copay***
Copay	Flu Shot at a Caremark Pharmacy: $10 ***copay***
	Contraceptives: $0 ***copay*** (Generic or with no generic equivalent)
	Generic: $20 ***copay***
	Single Source Brand Name: $35 ***copay***
	Multiple Source Brand Name: $50 ***copay***
Limitation: 34 day supply	
Mail Order Option	
Mail Order Prescription	100% after ***copay***
Copay	Contraceptives: $0 ***copay*** (Generic or with no generic equivalent)
	Generic: $20 ***copay***
	Single Source Brand Name: $40 ***copay***
	Multiple Source Brand Name: $60 ***copay***
Limitation: 90 day supply	

Received and accepted for Township of Pemberton

By:______________________________________

Title:_____________________________________

Date:_____________________________________