

**Pemberton Township: Plan Design Overview - April 1, 2014**

<b>Pemberton Plan Options - Special Open Enrollment April, 2014</b>				
<u>Plan Name</u>	<u>Platinum Plan</u>	<u>Gold Plan</u>	<u>Silver Plan</u>	<u>Bronze Plan</u>
	Current PBA Plan			
<b><i>In-Network Benefits</i></b>	<i>Calendar Year Plan</i>	<i>Calendar Year Plan</i>	<i>Calendar Year Plan</i>	<i>Calendar Year Plan</i>
<i>Referral required</i>	NO	NO	NO	NO
<i>In-network deductible (calendar year)</i>	\$0 individual/\$0 family	\$250 individual/\$500 family	\$500 individual/\$1,000 family	\$1,500 individual/\$3,000 family
<i>Preventive visits (Adult Physicals, OBGYN, Mammograms etc)</i>	\$0	\$0 copay - Not subject to deductible	\$0 copay - Not subject to deductible	\$0 copay - Not subject to deductible
<i>Primary office visit copay</i>	\$10	\$15	\$20	\$25
<i>Specialist copay</i>	\$15	\$25	\$30	\$40
<i>Outpatient Surgery @ Ambulatory Surgical Facility</i>	\$0	\$200 copay, Not subject to the deductible; plus 10% coinsurance	\$200 copay, Not subject to the deductible; plus 15% coinsurance	\$300 copay, Not subject to the deductible; plus 25% coinsurance
<i>Outpatient Surgery @ Freestanding Surgical Facility</i>	\$0	\$100 copay; Not subject to deductible	\$100 copay; Not subject to deductible	\$200 copay; Not subject to deductible
<i>Hospitalization copay</i>	\$0	\$100 per day; 5 day max per calendar year; Not subject to the deductible	15% coinsurance after deductible	25% coinsurance after deductible
<i>Emergency room copay</i>	\$25 copay; \$100 if Non-emergency	\$50 copay; \$150 if Non-emergency	\$75 copay; \$200 if Non-emergency	\$125 copay; \$200 if Non-emergency
<i>Urgent Care Center</i>	\$10 copay; In Store Clinic: \$10	\$20 copay; In Store Clinic: \$15	\$25 copay; In Store Clinic: \$20	\$40 copay; In Store Clinic: \$40
<i>Ambulance - Emergency Travel</i>	\$0	\$0 copay - Not subject to deductible	\$0 copay - Not subject to deductible	\$0 copay - Not subject to deductible
<i>Chiropractic copay</i>	\$15 copay; 26 visits/calendar year	\$35 copay; 26 visits/calendar year	\$40 copay; 26 visits/calendar year	\$50 copay; 26 visits/calendar year
<i>Diagnostic X-Ray/Lab</i>	Outpatient Hospital 10% coinsurance; Independent Lab \$10	Outpatient Hospital 10% coinsurance; Independent Lab \$25. Not subject to deductible	Outpatient Hospital 15% coinsurance; Independent Lab \$30. Not subject to deductible	Outpatient Hospital 25% coinsurance; Independent Lab \$40. Not subject to deductible
<i>MRI/MRA, PET, CT Scans</i>	Outpatient Hospital 10% coinsurance; Independent Lab \$10	Outpatient Hospital 10% coinsurance; Independent Lab \$50. Not subject to deductible	Outpatient Hospital 15% coinsurance; Independent Lab \$75. Not subject to deductible	Outpatient Hospital 25% coinsurance; Independent Lab \$100. Not subject to deductible
<i>Outpatient Therapy (PT; Speech, Occupational etc)</i>	\$15 copay; 30 visits/calendar year	\$15 copay; 30 visits/calendar year	\$20 copay; 30 visits/calendar year	\$30 copay; 30 visits/calendar year
<i>Prescription copay</i>	\$5/\$10/\$25	\$10/\$15/\$30	\$12/\$20/\$35	\$20/\$35/\$50
<i>Mail order rx (90 day supply)</i>	\$5/\$15/\$35	\$10/\$20/\$40	\$12/\$23/\$45	\$20/\$40/\$60
<i>Vision Hardware</i>	\$100/ 2 Years	\$100/ 2 Years	\$100/ 2 Years	\$100/ 2 Years
<i>Calendar year out of pocket maximum</i>	\$400 individual/\$1,000 family	\$750 individual/\$1,500 family: amounts accumulated between 1/1/14 and 3/31/14 will be credited to this new plan	\$1500 individual/\$3,000 family: amounts accumulated between 1/1/14 and 3/31/14 will be credited to this new plan	\$3500 individual/\$7,000 family: amounts accumulated between 1/1/14 and 3/31/14 will be credited to this new plan
<i>Calendar Year Maximum</i>	Unlimited	Unlimited	Unlimited	Unlimited
<i>Lifetime Maximum</i>	Unlimited	Unlimited	Unlimited	Unlimited
<b><i>Out of Network</i></b>				
<i>Deductible</i>	\$250 individual/\$500 family	\$500 individual/\$1,000 family	\$1,000 individual/\$2,000 family	\$2,000 individual/\$4,000 family
<i>Coinsurance amount</i>	80%	80%	70%	60%
<i>Cal. Yr out of pocket maximum</i>	\$1,000 individual/\$2,000 family	\$1,500 individual/\$3,000 family	\$3,000 individual/\$6,000 family	\$6,000 individual/\$12,000 family
<b>Monthly Premium Rates: Medical, Rx, Dental &amp; Vision</b>		<i>Employee Contribution Discount: -9%</i>	<i>Employee Contribution Discount: -15%</i>	<i>Employee Contribution Discount: -25%</i>
<i>Single</i>	\$1,050.29	\$955.76	\$892.75	\$787.72
<i>Employee/Child(ren)</i>	\$1,680.47	\$1,529.23	\$1,428.40	\$1,260.35
<i>Husband/Wife</i>	\$2,415.68	\$2,198.27	\$2,053.33	\$1,811.76
<i>Family</i>	\$3,045.86	\$2,771.73	\$2,588.98	\$2,284.40
<b>Cost Per Pay:</b>	Based on Annual Salary: Use Contribution Calculator to determine cost per pay amount	Based on Annual Salary: Use Contribution Calculator to determine cost per pay amount	Based on Annual Salary: Use Contribution Calculator to determine cost per pay amount	Based on Annual Salary: Use Contribution Calculator to determine cost per pay amount