

**TOWNSHIP OF PEMBERTON
SCHEDULE OF BENEFITS
JANUARY 1, 2014**

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

	<i>Preferred Provider</i>	<i>Nonpreferred Provider</i>
Deductible Per Calendar Year:		
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.

Amounts applied toward satisfaction of the *preferred provider* out-of-pocket expense limit may also be applied toward satisfaction of the *nonpreferred provider* out-of-pocket expense limit and vice versa.

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	<i>Preferred Provider</i> (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)	<i>Nonpreferred Provider</i> (% 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
Urgent Care Center	100% (after \$10 copay)	80%
In-Store Health Clinic Visit	100% (after \$10 copay)	80%
Ambulance Services	100%	100%

* Deductible Waived

One copay per provider per date of service

BENEFIT DESCRIPTION	<i>Preferred Provider</i> (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)	<i>Nonpreferred Provider</i> (% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)
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% (after \$15 copay)	80%
Inpatient Physician Visits at an Extended Care Facility		
	100% (after \$15 copay)	80%
Inpatient Consultations		
	100% (after \$15 copay)	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%
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%

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

* Deductible Waived

BENEFIT DESCRIPTION	<i>Preferred Provider</i> (% of <i>negotiated rate</i> , if applicable, otherwise % of <i>customary and reasonable amount</i>)	<i>Nonpreferred Provider</i> (% of <i>customary and reasonable amount</i> , if applicable, otherwise % of <i>negotiated rate</i>)
Outpatient Therapy Services		
Physical Therapy Limitation: 30 visits <i>maximum benefit</i> per calendar year	100% (after \$15 copay)	80%
Speech Therapy Limitation: 30 visits <i>maximum benefit</i> per calendar year	100% (after \$15 copay)	80%
Occupational Therapy Limitation: 30 visits <i>maximum benefit</i> per calendar year	100% (after \$15 copay)	80%
All Other Covered Outpatient Therapies	100%	80%
Private Duty Nursing Limitation: 30 visits <i>maximum benefit</i> 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%
Diabetic Education	100% (after \$10 copay)	80%
Golden Triangle Specialty Network, LLC. Renal Network	100%	N/A
All Other Covered Expenses	100%	80%

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: \$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

Dental Benefits

Maximum Benefit Per Covered Person For:	
Preventive, Basic and Major Dental services per calendar year (other than Orthodontics)	\$2,000
Orthodontic services while covered by this <i>Plan</i>	\$2,500
Percentage of Customary and Reasonable Amount Payable For:	
Class I - Diagnostic & Preventive Dental Services	100%
Class II - Basic Dental Services	80%
Class III - Major Dental Services	
Denture Replacement	50%
All Other Major Dental Services	70%
Class IV - Orthodontic Services	70%