CONNER STRONG & BUCKELEW

Winslow Township 2025 Benefit Comparison

In-Network Benefits

In-Network Benefits		Winslow Township PPO 2	Winslow Township PPO 3	Winslow Township PPO 4
What is the overall deductible?		N/A	N/A	N/A
Preventive Services		Covered 100%	Covered 100%	Covered 100%
Are there other deductibles for specific services?		No	No	No
What is the out-of-pocket limit for this plan?		$250 individual $500 family	$250 individual $500 family	In-network coinsurance limit: $400 individual/$1000 family In-network coinsurance/copay limit: $6,520 individual/$13,040 family
Do you need a referral to see a specialist?		No	No	No
Common Medical Event	**Services You May Need**			
If you visit a heath care provider's office or clinic	Primary care visit to treat and injury or illness	$5 copay	$15 copay	$15 copay
	Specialist visit	$10 copay Chiropractor: limited to 30 combined in-network and out-of-network visits per calendar year.	$25 copay Chiropractor: limited to 30 combined in-network and out-of-network visits per calendar year.	$15 copay Chiropractor: limited to 30 combined in-network and out-of-network visits per calendar year.
	Preventative care/screening/immunization	No charge.	No charge	No charge.
If you have a test	Diagnostic test (x-ray, blood work)	Outpatient Hospital: 10% coinsurance. Freestanding or doctor's office: No charge.	Outpatient Hospital: 10% coinsurance. Freestanding or doctor's office: No charge.	No charge.
	Imaging (CT/PET scan, MRI)	Outpatient Hospital: 10% coinsurance. Freestanding or doctor's office: No charge.	Outpatient Hospital: 10% coinsurance. Freestanding or doctor's office: No charge.	No charge.
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	10% coinsurance for SP Facility. No charge for Freestanding or Doctor's office.	10% coinsurance for SP Facility. No charge for Freestanding or Doctor's office.	No charge.
	Physician/surgeon fees	10% coinsurance for SP Facility. No charge for Freestanding or Doctor's office.	10% coinsurance for SP Facility. No charge for Freestanding or Doctor's office.	No charge.
If you need immediate medical attention	Emergency room care**	$25 copay Waived if admitted.	$125 copay Waived if admitted	$100 copay per visit for outpatient hospital $50 copay/visit for physician referrals or pediatric (under age 19) ER visits. Waived if admitted.
	Emergency medical transportation**	No charge.	No charge	10% coinsurance
	Urgent care	$5 copay	$50 copay	$15 copay

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Winslow Township 2025
Benefit Comparison

If you have a hospital stay	Facility fee (e.g. hospital room)	No charge.	No charge	No charge.
	Physician/surgeon fees	No charge.	No charge	No charge.
If you need mental, behavioral health, or substance abuse services	Outpatient services	$10 copay	$25 copay	No charge for Outpatient Hospital. $15 copay per office visit for Mental Health and Behavioral Health. No charge for substance abuse Office visit.
	Inpatient services	No charge.	No charge	No charge.
If you are pregnant	Office visits	$5 copay	$25 copay	$15 copay initial visit only
	Childbirth/delivery professional services	No charge.	No charge	No charge.
	Childbirth/delivery facility services	No charge.	No charge	No charge.
If you need help recovering or have other special health needs	Home health care	No charge. Limited to 100 combined in-network and out-of-network visits per year.	No charge. Limited to 100 combined in-network and out-of-network visits per year.	No charge.
	Rehabilitation services	$10 copay Maximum of 60 combined visits per calendar year.	$25 copay Maximum of 60 combined visits per calendar year.	No charge for Inpatient and Outpatient Facility. $15 copay per visit for Office.
	Habilitation services			
	Skilled nursing care	No charge. Limited to 60 combined in-network and out-of-network visits per calendar year.	No charge. Limited to 60 combined in-network and out-of-network visits per calendar year.	No charge. Limited to 120 days of in-network and 60 days of out-of-network facility days for a combined maximum of 120 days per calendar year.
	Durable medical equipment	No charge.	No charge	10% coinsurance
	Hospice services	No charge.	No charge	No charge.
If your child needs dental or eye care*	Children's eye exam	Covered via rider	Covered via rider	Covered via rider
	Children's glasses	Covered via rider	Covered via rider	Covered via rider
	Children's dental check-up	Not covered under the AHA medical plan	Not covered under the AHA medical plan	Not covered under the AHA medical plan

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Winslow Township 2025 Benefit Comparison

Out-Of-Network Benefits

Out-of-Network Benefits		Winslow Township PPO 2	Winslow Township PPO 3	Winslow Township PPO 4
What is the overall deductible?		$100 individual/$200 family	$100 individual/$200 family	$100 individual/$250 family Benefits not available until deductible is met***
What is the out-of-pocket limit for this plan?		$500 individual $1000 family	$500 individual $1000 family	$2,000 individual/$5,000 family
Common Medical Event	**Services You May Need**			
If you visit a heath care provider's office or clinic	Primary care visit to treat and injury or illness	20% coinsurance	20% coinsurance	30% coinsurance
	Specialist visit	20% coinsurance Chiropractor: limited to 30 combined in-network and out-of-network visits per calendar year.	20% coinsurance Chiropractor: limited to 30 combined in-network and out-of-network visits per calendar year.	30% coinsurance Out-of-network coverage for chiropractic, physical therapy and acupuncture services is limited to no more than $35/visit for chiropractor, $52/visit physical therapy and $60/visit for acupuncture, or 75% of the in-network cost per visit, whichever is less. Chiropractor: limited to 30 combined in-network and out-of-network visits per calendar year.
	Preventative care/screening/immunization	20% coinsurance	20% coinsurance	Not covered.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	30% coinsurance
	Imaging (CT/PET scan, MRI)	20% coinsurance	20% coinsurance	30% coinsurance
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	20% coinsurance	20% coinsurance	30% coinsurance
	Physician/surgeon fees	20% coinsurance	20% coinsurance	30% coinsurance
If you need immediate medical attention	Emergency room care**	$35 copay Waived if admitted.	$125 copay	$100 copay per visit for Outpatient Hospital. Deductible does not apply. $50 copay/visit for physician referrals or pediatric (under age 19) ER visits. Waived if admitted.
	Emergency medical transportation	100% of the allowed amount and subject to balance billing	100% of the allowed amount and subject to balance billing	30% coinsurance
	Urgent care	20% coinsurance	$50 copay	30% coinsurance

CONNER STRONG & BUCKELEW

Winslow Township 2025 Benefit Comparison

If you have a hospital stay	Facility fee (e.g. hospital room)	20% coinsurance	20% coinsurance	30% coinsurance There is a separate $200 deductible for inpatient stay for out-of-network facilities.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	30% coinsurance
If you need mental, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	30% coinsurance
	Inpatient services	20% coinsurance	20% coinsurance	30% coinsurance
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	30% coinsurance
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	30% coinsurance
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	30% coinsurance There is a separate $200 deductible for inpatient stay for out-of-network facilities.
Common Medical Event	**Services You May Need**	**Winslow Township PPO 2**	**Winslow Township PPO 3**	**Winslow Township PPO 4**
If you need help recovering or have other special health needs	Home health care	20% coinsurance Limited to 100 combined in-network and out-of-network visits per calendar year.	20% coinsurance Limited to 100 combined in-network and out-of-network visits per calendar year.	30% coinsurance
	Rehabilitation services	20% coinsurance. Maximum of 60 combined in-network and out-of-network visits per calendar year.	20% coinsurance. Maximum of 60 combined in-network and out-of-network visits per calendar year.	30% coinsurance. Out-of-network coverage for physical therapy services is limited to no more than $52/visit, or 75% of the in-network cost per visit, whichever is less. There is a separate $200 deductible for inpatient stay for out-of-network facilities.
	Habilitation services			
	Skilled nursing care	20% coinsurance. Limited to 60 combined in-network and out-of-network visits per calendar year.	20% coinsurance. Limited to 60 combined in-network and out-of-network visits per calendar year.	30% coinsurance Limited to 120 days of in-network and 60 days of out-of-network facility days for a combined maximum of 120 days per calendar year. There is a separate $200 deductible per inpatient stay for out-of-network facilities.
	Durable medical equipment	20% coinsurance	20% coinsurance	30% coinsurance
	Hospice services	20% coinsurance	20% coinsurance	30% coinsurance. There is a separate $200 deductible for inpatient stay for out-of-network facilities.

***Routine eye exam.**

****Payment at in-network level applies only to true medical accidental injury emergencies.**

*****Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family member meets the overall family deductible.**

This comparison does not include clinical management differences such as services or prescription drugs requiring prior authorization, prescription drug formulary, etc.

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Winslow Township 2025
Benefit Comparison

Prescription Drug Benefits

Prescription Drug		Winslow Township PPO 2	Winslow Township PPO 3	Winslow Township PPO 4
Prescription Drug Copayments	Generic drugs	$5 copay retail. No charge for mail order.	$10 copay retail. $20 copay mail order.	$3 copay retail. No charge for mail order.
	Preferred brand drugs	$10 copay retail. $5 copay mail order.	$25 copay retail. $50 copay mail order.	$10 copay retail. $15 copay mail order
	Non-preferred brand drugs	$10 copay retail. $5 copay mail order.	$50 copay retail. $100 copay mail order	$10 copay retail. $15 copay mail order
	Specialty drugs	Generic: $5 copay. Preferred brand: $10 copay. Non-Preferred: $10 copay.	Generic: $10 copay. Preferred: $20 copay. Non-preferred: $35 copay	Same as mail order copay
Prescription Drug Clinical Management Programs	Prior Authorization	Yes	Yes	Yes
	Dose Optimization	No	No	Yes
	Drug Quantity Management	Yes	Yes	Yes
	Step Therapy	Yes	Yes	Yes
	Open/Closed Formulary	Open	Open	Closed
	Management for sexual dysfunction medications	Yes	Yes	Yes

This comparison does not include clinical management differences such as services or prescription drugs requiring prior authorization, prescription drug formulary, etc.