

TOWNSHIP OF EVESHAM  
RESOLUTION NO. 296-2023

RESOLUTION ADOPTING THE COLLECTIVE BARGAINING  
AGREEMENT BETWEEN THE TOWNSHIP OF EVESHAM AND EVESHAM  
TOWNSHIP FRATERNAL ORDER OF POLICE LODGE #143  
COMMENCING ON JANUARY 1, 2023 AND ENDING  
DECEMBER 31, 2027

**WHEREAS**, the Township of Evesham (the "Township")  
is the employer of employees represented by Fraternal  
Order of Police #143 (the "Union"); and

**WHEREAS**, the Township and the Union have engaged  
in good faith negotiations for a successor collective  
bargaining agreement covering the patrolman and  
detectives employed by the Township Police Department;  
and

**WHEREAS**, the Township and the Union reached an  
agreement as to the terms of a successor collective  
bargaining agreement and memorialized that agreement  
in the "Agreement by and between the Township of  
Evesham and the Evesham Township FOP 143 for the  
period from January 1, 2023 through December 31, 2027"  
(attached hereto as Exhibit A); and

**WHEREAS**, the members of the Union have voted to  
ratify the collective bargaining agreement between the  
Township and the Union; and

**WHEREAS**, the Township Manager recommends that the  
Township Council ratify the "Agreement by and between  
the Township of Evesham and the Evesham Township FOP  
143 for the period from January 1, 2023 through  
December 31, 2027";

**NOW, THEREFORE BE IT RESOLVED**, that the Township  
of Evesham Council hereby approves and ratifies the  
"Agreement by and between the Township of Evesham and  
the Evesham Township FOP 143 for the period from  
January 1, 2023 through December 31, 2027" and  
authorizes the Mayor of the Township of Evesham and/or  
her designee to execute same.

I HEREBY CERTIFY that the foregoing Resolution was adopted by the Township Council of the Township of Evesham, County of Burlington, State of New Jersey, at their meeting held in the Meeting Room of the Municipal Complex, 984 Tuckerton Road, Marlton, NJ 08053 on September 13, 2023.

Mary Lou Bergh / per  
Mary Lou Bergh, Township Clerk

| ROLL CALL VOTE |            |          |     |      |         |        |
|----------------|------------|----------|-----|------|---------|--------|
| COUNCIL MEMBER | INTRODUCED | SECONDED | AYE | NAYE | ABSTAIN | ABSENT |
| COOPER         |            |          | ✓   |      |         |        |
| ESPINOZA       |            |          | ✓   |      |         |        |
| FREEMAN        | ✓          |          | ✓   |      |         |        |
| HANSEN         |            | ✓        | ✓   |      |         |        |
| MAYOR          |            |          | ✓   |      |         |        |
| VEASY          |            |          |     |      |         |        |

AGREEMENT  
BETWEEN TOWNSHIP OF EVESHAM



AND  
FRATERNAL ORDER OF POLICE LODGE NO. 143



January 1, 2023 through December 31, 2027

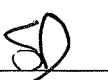
Township: UP

FOP: SD

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Township: 

FOP: 



## PREAMBLE

THIS AGREEMENT, entered into by and between the Township of Evesham in the County of Burlington, State of New Jersey (hereinafter called the "Township") and the Evesham Township Fraternal order of Police Lodge No. 143, (hereinafter called the "FOP") represents the complete and final understanding on all issues between the Township and the FOP that are subject to such negotiations and agreements permitted by the laws of the State of New Jersey

## ARTICLE I

### RECOGNITION

- A. The Township hereby recognizes the Evesham Township Fraternal Order of Police Lodge No. 143 as the exclusive collective bargaining agent for all officers, and officers assigned as detectives being full time paid employees within the Police Department
- B. "Full-time paid employees within the Police Department" includes all officers, and officers assigned as detectives below the rank of Corporal who are full-time Police department personal, excepting clerical and other civilian personnel assigned to the Police Department
- C. The Township shall not negotiate with any organization other than Lodge #143 for the duration of this Agreement

## ARTICLE II

### MAINTENANCE OF OPERATIONS

It shall be the mutual objective of the FOP and the Township to provide for the uninterrupted public safety protection of the general public.

The FOP agrees that during the term of this Agreement, neither the FOP, nor anyone acting on its behalf, will cause, authorize, support, or take part in any strike, work stoppage, slowdown, walkout, or other job action against the Township. The FOP agrees that such action would constitute a material breach of the Agreement. Participation in any of the above shall be deemed grounds for disciplinary action up to and including termination of employment. The FOP will actively discourage any strike, work stoppage, slowdown, walkout or other action that may adversely impact upon the mutual objective as expressed above.

This Agreement shall not be modified in whole or in part by the parties, except by an instrument in writing duly executed by both parties.

Except in Agreement shall hereinafter otherwise provide, all terms and conditions of employment applicable on the effective date of this Agreement to employees as defined under Article One Recognition, as established by the policies of the Township in force shall continue to be applicable during the terms of this Agreement.

The FOP will not dispute the removal of full time police officers from Cherokee High School so long as there are two Class III officers hired to replace the officer and provide full time coverage to Cherokee.

Township: wp

FOP: SD

### ARTICLE III

#### MANAGEMENT RIGHTS

- A.** The Township hereby retains and reserves unto itself without limitations, all powers, rights, authority, duties and responsibilities conferred upon and vested in it prior to the signing of this Agreement by the Laws and Constitution of the State of New Jersey and of the United States, including but without limiting the generality of the foregoing, the following rights:
- 1.** To manage and control administratively the Township government and its properties, facilities and the activities of its employees; and
  - 2.** To hire all employees and, subject to the provisions of the Law, to determine their qualifications and condition for the continued employment or assignment and to promote and transfer employees; and
  - 3.** To suspend, demote, discharge or take other disciplinary action for good and just cause according to law.
- B.** The exercise of the forgoing power, rights authority, duties and responsibilities of the Township, the adoption of the Policies, rules, regulations and practices in furtherance thereof, and the se of judgment and the discretion in the connection therewith shall be limited only by specific and express terms of the Agreement and then only to the extent such specific and express terms hereof are in conformance with the Constitution and laws of the State of New Jersey and the United States.
- C.** The master patrolman position is only for professional development purposes and shall not to be utilized to cover any supervisory position responsibilities. There will be no form of compensation attached to this designation.

### ARTICLE IV

#### HOURS OF WORK, OVERTIME, COURT PREPARTION FEE

**A.** HOURS OF WORK

The normal working week shall consist of an average of (40) hours per week or twenty hundred and eighty (2080) hours annually.

- 1.** Officer working a twelve (12) hour shift shall receive adjustment time in lieu of pay in accordance with Appendix A of this Agreement
- 2.** Adjustment time will be scheduled off at the sole discretion of the Chief of Police in a manner that consistent with Appendix A of this Agreement

**B.** OVERTIME

- 1.** An employee who is requested to work beyond his regularly scheduled duty hours in any day or any week shall be paid overtime at the rate of time and one half. There shall

be established an overtime list which shall be formulated by the Chief of Police or his designee and shall be posted in a conspicuous location.

2. If an employee works overtime that is not a continuation of their scheduled work day they will be compensated with a minimum of 4 hours overtime.

C. COURT PREPARATION FEE

If a member is required to appear in any court of law as a result of the performance of his duties other than during regularly scheduled duty hours, he shall be compensated at a rate of one and half times his normal hourly rate of base pay for the time actually spent in Court or a minimum of four (4) hours at the rate of one and one half (1 1/2) times his normal hourly rate (whichever is greater) this does not apply to member who are in court as a result of litigation they initiated against the township.

Whenever an officer is working overnight shift is scheduled to appear in day court (which begins at 8:00 a.m.) said officer will be paid at the rate of time and one half from the end of his shift until he is released from court. During this period of time (i.e from the end of the officer's shifts until they conclusion of the court appearance), the officer will be considered on duty and subject to assignments as needed.

ARTICLE V

MEAL ALLOWANCE, AND PERSONAL AUTOMOBILE EXPENSE

A. MEAL ALLOWANCE FOR OVERNIGHT TRAINING

Based upon presentation to the Chief of Police, of appropriate vouchers and receipts within ten (10) days, the Township agrees to pay the following for authorized schools, training, conference or seminars for which facilities are not provided:

1. The Township will reimburse a maximum daily rate for meals when the officer is assigned to attend any school, training, seminar, or conference at the rate not to exceed thirty dollars (\$30.00) should the officer be required to stay overnight for which dining facilities are not provided.
2. The Township will reimburse a maximum daily rate for the meals when the officer is assigned to attend any school, training, seminar or conference that requires overnight lodging. The following rates shall apply

|           |                 |
|-----------|-----------------|
| Breakfast | \$5.00 per day  |
| Lunch     | \$10.00 per day |
| Dinner    | \$15.00 per day |

3. The Township will provide any necessary lodging required if facilities are not otherwise provided without cost to the employee.

B. PERSONAL AUTOMOBILE EXPENSE

In the event any member of the FOP is required to use his personal automobile for township business, he shall be reimbursed at the IRS mileage reimbursement rate, upon submitting vouchers and other

Township: wp

FOP: SD

appropriate record to the Chief of Police or such other officer or employee as may be designated by the Township Manager.

## ARTICLE VI

### LEAVE TIME

#### A. VACATION LEAVE

1. Employees covered by this collective bargaining agreement shall earn annual vacation leave with pay which shall be earned on a monthly basis at the following rate:

Step 1 - During the first sixty months next following the date of hire, 180 hours per year.

Step 2 - From the beginning of the sixth year through the tenth year of service, 204 hours per year.

Step 3 - From the beginning of the eleventh year through the nineteenth year of service, 220 hours per year.

Step 4 - From the beginning of the twentieth year through retirement, 260 hours per year.

2. A member can utilize vacation time as of the first of each year but shall reimburse or otherwise make whole the Township for vacation taken but not yet accrued if the member retires, resigns, or is separated from employment.
3. Upon retirement, or separation in good standing, accrued and unused vacation leave may be returned for payment at the employee's current pay rate, with a maximum of 340 hours. Members terminating employment as a result of disciplinary action shall not be entitled to compensation associated with accumulated vacation leave.
4. Only one year's worth of annual vacation leave may be carried into the succeeding year.
5. The Township and the employee concerned may mutually agree to a buy-back by the Township of accrued vacation time earned before December 31<sup>st</sup> of the then current year computed at the employee's then current rate of pay. The provision is permissive; neither party is bound to agree to a buy-back of accrued vacation time.

#### B. HOLIDAYS

1. Previously, (13) Holidays were previously rolled into the base salary. As of 1/1/2023 the Township recognizes (16) holidays. Township recognized holidays are: 1. New Year's Day 2. Martin Luther King Jr. Day 3. President's Day 4. Good Friday 5. Easter Monday 6. Memorial Day 7. Juneteenth 8. Independence Day 9. Labor Day 10. Columbus Day 11. General Election Day 12. Veteran's Day 13. Thanksgiving Day 14. Thanksgiving Friday 15. Christmas Day 16. Day after Christmas
2. In light of the three additional holidays created by the Township, all employees assigned to a twelve-hour shift shall be granted three (3) floating holidays in lieu of additional holiday pay.

Township: wp

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3. All employees assigned to a twelve-hour shift will be granted a floating holiday for any additional holiday recognized by the Township.

## ARTICLE VII

### LEAVE OF ABSENCE

#### A. BEREAVEMENT LEAVE

A regular full-time employee may be excused from work with pay because of a death in his/her immediate family as defined below. The term spouse as used in this Article shall include domestic partners and civil unions as defined by New Jersey law.

1. Six consecutive work days, one of which shall be the day of the funeral or day of death, for death of a spouse, children, stepchildren, parents, step-parents, legally adopted children, brother and, sister. The term spouse as used in this Article shall include domestic partners and civil unions as defined by New Jersey law. If additional bereavement time is desired by the member for any relative listed above, the township will allow the member to utilize any accrued time for the purpose so long as it is contiguous to the bereavement leave.
2. Three consecutive work days, one which shall be the day of the funeral or day of death, for grandparents, grandchildren, step-grandchildren, mother-in-law, father-in-law, brother-in-law and sister-in-law, aunt or uncle.

#### B. FOP DELEGATE LEAVE

An employee covered by this Agreement serving in the position of Delegate of the FOP Lodge 143 shall be entitled to leave to attend the FOP State and National Convention, in accordance with N.J.S.A 40A:14-177.

FOP State Delegate meetings are held four times per year. The Official Trustee of the FOP shall be excused from his/her shift four times per year for the sole purpose of attending the meetings.

#### C. LEAVE OF ABSENCE WITH OR WITHOUT PAY

The Township Manager may grant a request for a leave of absence for periods not to exceed one (1) year when such leave is for a reasonable purpose.

Employees who are granted a leave without pay shall not accumulate seniority credit or benefits of any nature during said leave. The only exception to this rule shall be health benefits in the event an employee's need for leave is covered by either the State or Federal Family Leave Act, and then only in conformance with the State Health Benefits Program guidelines. Upon termination of leave of absence, the Township will reinstate the employee in the capacity in which he left at the rate of pay at which he left.

During a leave of absence under this provision, the employee shall not engage in gainful employment in any industry or attendance a school without the express written approval of the Evesham Township Manager. Failure to comply with this provision shall result in termination of employment and forfeiture of all benefits.

Township: 

FOP: 



When an employee is exercising his right to Family and Medical leave, the Township shall comply with the laws of both the Federal and State of New Jersey, which may supersede the above.

During any approved leave of absence, the employee shall be required to continue making his or her health insurance premium contributions as set forth in Section IX.A.5 of this Agreement

**D. INJURY IN THE LINE OF DUTY**

The Township shall provide Workers' Compensation Insurance coverage to all members. Further, The Township shall comply with N.J.S.A. 35:15-1 et. Seq., which provides a complete and detailed outline of both the employer and employee's responsibilities in the event of a work related injury.

The parties agree to be conclusively bound by the determination of the Township workers' compensation insurance carrier or the Workers' Compensation Court (in a contested matter) with respect to whether an injury occurred while "in the course of employment" pursuant to N.J.S.A 354:15-1 et. Seq. or "in the line of duty;" and, for the purpose of this section, those terms shall be identical.

**1. Township's Duty to Supplement Pay**

The Township's duty to supplement an officer's Workers' Compensation benefits or sustain an officer at regular pay shall terminate as a result of any of the following events:

- a.** Upon the officer's return to work
- b.** If an officer's temporary Workers' Compensations benefits are terminated and the officer refuses or maintain he is unable to return to work, the Township's duty to supplement pay may be terminated only after the Township's physician or his designate (who shall also be a licensed physician) conducts a hearing to determine the officer's fitness to return to work at which time the hearer shall give great weight to medical evidence presented. If the hearer determines the officer fit to return to work, the Township's duty to supplement pay as aforesaid shall terminate. If the hearer determination shall be formally served by mail upon the officer (and if represented, his attorney) whereupon the Township's duty to supplement pay shall terminate within five (5) days except as a prohibited in the following paragraph.
- c.** The determination of the hearer shall be conclusive and both parties agree that no right to appeal exist from such determination.
- d.** If the officer or municipality files and application for disability pension by reason of the officer's inability to return to active police duty, the municipality shall continue to supplement pay or sustain an officers as his regular pay until such application is determined or four (4) months following such application, whichever event first occurs.

- 2.** Notwithstanding the above, the Township will not supplement workers' compensation benefits for a period longer than one (1) year.

Township: wp

FOP: SD

**E. MILITARY LEAVE**

- 1.** An employee who is a member of the National Guard or Naval Militia or of the Military of Naval Forces of the United States and is required to engage in field training therein shall be granted a leave of absence with pay for the period of such field training. This leave shall be in addition to the annual vacation leave. The Township shall pay the difference between military pay and the employee's regular pay.
- 2.** Employees subject to military duty shall be entitled to all rights and privileges in accordance with applicable state and federal statutes and township policy.
- 3.** All members of the military will continue to receive all benefits under the employee contract while on military leave in accordance with state law, federal law, and township policy.

**ARTICLE VIII**

**SICK LEAVE BENEFITS**

**A. SICKLEAVE**

- 1.** Members of the FOP shall be entitled to sick leave totaling 120 hours per year which shall begin accruing on January 1<sup>st</sup> of each year at the rate of 10 hours per month.
- 2.** Sick leave will be cumulative from year to without limit.
- 3.** Members hired after May 21, 2010 shall be compensated for unused leave pursuant to P.L. 2010, c.3 sun-section2, effective May 21, 2010. Members hired before May 21, 2010 who retire shall receive the following retirement benefits:

1 hour through 1000 hours to be paid a 55%

1001 hours through 1600 hours to be paid at 45%

1601 hours and above to be paid as 40%

- 4.** Sick leave payouts for employees covered by this agreement shall be capped at \$35,000 or at the benefit level achieved on December 31, 2020, whichever is greater.

In the event that the covered employee's sick leave retirement benefit level exceeds the \$35,000 maximum on December 31, 2020, the Township shall certify with each such employee the exact amount of their maximum retirement benefit. This shall remain the employee's maximum cap regardless of sick time use after the cap date, unless the sick time value drops below the maximum capped amount.

There is nothing to preclude the sick leave retirement benefit value from being reduced in the future due to utilization of sick leave.

- 5.** Sick leave payouts for employees hired after 5/21/2010 are capped at \$15,000, utilizing bullet (3) under this article.



6. \_\_\_\_\_ Only members terminating employment as a result of PFRS retirement shall be entitled to compensation associated with the above chart. Members who resign, in good standing, and have 10 years or more of service shall be entitled to 50 percent of the above chart. Members who terminate employment with less than 1- years of service are not entitled to compensation for the accumulated sick leave.
7. \_\_\_\_\_ Any member injured in the line of duty will be bound by the provisions of Article VI, Section (D) of this Agreement and relevant State Statues. Said member will continue to accrue sick leave in accordance with Section "A" above.
8. \_\_\_\_\_ A member's FMLA time will not start until his sick time has been exhausted.
9. \_\_\_\_\_ On January 1 of each year members will be allotted 120 hours of sick time added to their bank of already accrued sick time. A member can utilize these hours as of the first of the year but shall reimburse or otherwise make whole the Township for sick time used but not yet earned if the member retires, resigns, or is separated from employment.

B. MATERNITY LEAVE

Upon notifying the Chief of Police of pregnancy, the pregnant officer shall be given the option to transfer to a modified duty assignment within the department OR, with the approval of the Township Manager, to another appropriate municipal function, for the remainder of the pregnancy or until maternity leave is required. The officer shall be required to supply a note from her physician stating that a member is no longer qualified for full duty as a police officer. During maternity leave, the member may use vacation, sick, personal or comp time without penalty. Once police officer's accrued time has been exhausted, the member will be placed on unpaid medical leave until a physician's note is produced clearing the member to return to full duty. During this unpaid maternity leave the township will agree to pay up to six (6) months of health insurance on behalf of the member.

The purpose of this clause is to take the pregnant officer out of harm's way and to preserve the officer's rights and benefits.

C. FAMILY LEAVE

Members who use FMLA, NJFLA, or State Disability Insurance shall be subject to township policy 301, Updated July 2020. If there is any conflict in language from policy 301 and this contract, the contractual provision shall apply. (See appendix C).

## ARTICLE IX

### HEALTH AND WELFARE

#### A. MEDICAL AND DENTAL INSURANCE

1. During the term of this contract, the Township shall continue to provide health insurance benefits, prescription plan, dental plan and disability income protection benefits to cover employees and their legal dependents. The Township reserves the right to change the insurance carriers provided that equal or better benefits are provided to the plans defined in sub-section (2).
2. Effective January 1, 2015, the standard health insurance plan shall be the Gold Plan (see attached plan design attached hereto as Attachment B) as presented by the Township and discussed in the negotiations resulting in this Agreement. Individuals shall be permitted to select enrollment in the Platinum, Gold Plus, Gold, Silver or Bronze Plan(s) (see Attachment B) provided the individual pays the premium differential and contributes pursuant to the provisions of subsection 4 (below).
3. Employees who volunteer to participate in the Township's "Opt-Out" program will receive the maximum permitted under P.L. 2011, c. 78, whichever is the lesser of 25% of the amount saved or \$5,000.
4. All active employees shall have deducted (pre-tax) via payroll deduction under the Federal Section 125 Plan any amount paid to the Township for their health insurance contribution pursuant to P.L. 2011, Ch.78.
5. The Township will maintain Dental insurance and it will be offered to the employee without contribution from the employee towards the premium.
6. As of 1/1/2024 the Township will fund the HSA account the maximum out of pocket expense per the plan documents for two years and then going forward, 50% of the deductible for any employee who takes the Bronze healthcare plan from the Township at any point throughout this contract term. This is an incentive for members to choose the Bronze plan.
  - The contributions are based on the current policy provisions. As an example, based on the 2023 rates, this equates to \$5,000 for 2 years and then \$1,500 going forward for an employee on the family coverage bronze plan, or \$2,500 for 2 years and then \$750 going forward for an employee on the single coverage bronze plan. Should the maximum out of pocket or deductible amount change for the subsequent years, the amounts will be adjusted.
  - No employee currently employed will have any change in choice of healthcare plans offered by the Township, other than an employee who chooses to take the bronze plan and accepts the increased contribution into their HSA account must remain on the bronze plan for at least 2 years.
  - All employees hired after 1/1/2024 will have the bronze plan as their standard health insurance plan. New employees hired after 1/1/2024 who take the

Township bronze healthcare plan will have their HSA account funded by the Township for the full deductible on the plan at the time of their hiring for the first two years on the plan and then 50% of the deductible going forward. New employees still have the option of selecting a greater plan subject to section 2 above.

B. PRESCRIPTION DRUG INSURANCE Copay shall be as required by the plans offered by the Township. Any changes shall conform to sub-section A (I).

C. VISION REIMBURSEMENT PLAN: The Township shall provide a Vision Reimbursement Plan, which shall cover the employee and dependents (spouse and children under the age of nineteen (19) years old). For each member and qualified dependent up to one-hundred (\$100.00) dollars every twenty-four (24) months reimbursable upon presentation of receipts for eyeglasses.

D. In the event an active employee becomes deceased the employee's immediate family will be offered all health benefits at the cost of 100% of the premium for up to 18 months if not eligible for State Health Benefits.

E. INSURANCE:

1. The Township will continue to provide the present life insurance policy, which provides for group term life insurance for fifty thousand dollars (\$50,000).

2. The Township will pay any reasonable funeral bill up to a maximum of ten thousand (\$10,000) dollars upon presentation of receipts for actual expenditure for any member who shall die while on official duty. Said provision to be effective immediately

3. This payment shall be in addition to the statutory funeral expenses provided by Workers Compensation.

4. The Township shall pay attorney's fees to a licensed attorney selected by the spouse or administrator or executor of an officer's estate to a maximum amount of \$250 for legal services and counseling regarding available insurance and benefits in any case in which a police officer dies in the line of duty.

F. The Township will indemnify and save harmless the members of the FOP 143 from civil liability for false arrest except from punitive damages and legal fees related thereto.

G. Any member who is charged with the commissions of any crime arising from the lawful execution of his/her said duties shall be entitled to full legal representation as outlined below. The Township will pay reasonable amount for the services of legal counsel upon the completion of the such services provided that selected counsel submits an itemized statement to counsel reflecting fees and cost prior to rendering such services and that the Township provides express authorization for the services.

The Township shall not reimburse legal fees for any member who is found guilty of an indictable offense.

Township: ap

FOP: SD

H. \_\_\_\_\_ The Township shall exhibit any and all such policies of insurance to the members of the FOP 143, or their representative, when and if requested.

## ARTICLE X

### CLOTHING, STANDBY COMPENSATION AND EYEWEAR REIMBURSEMENT

#### A. CLOTHING MAINTENANCE

In the event that the Township, in its discretion, utilizes non-uniformed officers during the term of this Agreement, The Township shall pay to each non-uniformed member \$1,650 for 2023, \$1,750 for 2024, \$1,850 for 2025, \$1,950 for 2026, and \$2,050 for 2027 at the first pay period in April for the purpose of deferring the cost of work clothing. For the purpose of this section, "non-uniformed personnel " is defined as those police personnel assigned to the Criminal Bureau that are directed to wear clothing other than the standard issued uniform for police officers. Personnel assigned to the Criminal Bureau after January 1st of any year shall receive a clothing allowance prorated.

The Township will contract directly with a vendor for the purpose of uniform maintenance. Each member shall be entitled to dry cleaning services not to exceed two uniforms or an equivalent number of items per week. In the event that the Township utilizes non-uniformed officers, those officers shall be entitled to cleaning dry service not to exceed two business suits per week or equivalent number of items.

#### B. STANDBY COMPENSATION

Each Detective shall receive annual compensation with respect to standby duty as follows: \$2,000 for 2023, \$2,100 for 2024, \$2,200 for 2025, \$2,300 for 2026, and \$2,400 for 2027

In the event that a Detective should be assigned out of the Criminal Bureau or if a patrolman should be assigned to the Criminal Bureau, standby compensation shall be prorated for the portion of the year that the member was assigned to the Criminal Bureau. Payment for standby compensation shall be made on or about the first pay period in December of each year.

#### C. CANINE STIPEND

Compensation for "At-Home Care" of police canines will be calculated based on 30 minutes per day or 3.5 hours per week. It will be handled by way of schedule adjustment pursuant to the attached Appendix A.

#### D. EYEWEAR REIMBURSEMENT

The Township agrees to provide for the repair or replacement of a member's prescription eyewear, which may become damaged during the performance of on-duty police responsibilities. The Township's liability will not exceed one hundred dollars (\$100.00) In each case, the member must request prior authorization by submitting a signed written request and statement to the Chief of Police describing the damage and the detailed circumstances surrounding the incident, which led to the damage. The Township will not be responsible for normal wear and tear. After authorization for repair is secured, the member must submit receipts to the Township.

Township: WSP

FOP: 



## ARTICLE XI

### SALARIES

#### A. ANNUAL WAGE INCREASES

1. Effective January 1, 2023, all employees covered under this Agreement shall be paid in accordance the following wage guides:

| Step    | 2022         | 2023          | 2024          | 2025          | 2026          | 2027          |
|---------|--------------|---------------|---------------|---------------|---------------|---------------|
| Recruit | \$ 35,000.00 | \$ 35,875.00  | \$ 35,875.00  | \$ 35,875.00  | \$ 35,875.00  | \$ 35,875.00  |
| 1       | \$ 51,945.00 | \$ 53,244.00  | \$ 53,244.00  | \$ 53,244.00  | \$ 53,244.00  | \$ 53,244.00  |
| 2       | \$ 57,536.00 | \$ 58,974.00  | \$ 58,974.00  | \$ 58,974.00  | \$ 58,974.00  | \$ 58,974.00  |
| 3       | \$ 63,127.00 | \$ 64,705.00  | \$ 64,705.00  | \$ 64,705.00  | \$ 64,705.00  | \$ 64,705.00  |
| 4       | \$ 68,719.00 | \$ 70,437.00  | \$ 70,437.00  | \$ 70,437.00  | \$ 70,437.00  | \$ 70,437.00  |
| 5       | \$ 74,310.00 | \$ 76,168.00  | \$ 76,168.00  | \$ 76,168.00  | \$ 76,168.00  | \$ 76,168.00  |
| 6       | \$ 79,901.00 | \$ 81,899.00  | \$ 81,899.00  | \$ 81,899.00  | \$ 81,899.00  | \$ 81,899.00  |
| 7       | \$ 85,492.00 | \$ 87,629.00  | \$ 87,629.00  | \$ 87,629.00  | \$ 87,629.00  | \$ 87,629.00  |
| 8       | \$ 91,084.00 | \$ 93,361.00  | \$ 93,361.00  | \$ 93,361.00  | \$ 93,361.00  | \$ 93,361.00  |
| 9       | \$ 96,675.00 | \$ 99,092.00  | \$ 99,092.00  | \$ 99,092.00  | \$ 99,092.00  | \$ 99,092.00  |
| 10      | \$102,266.00 | \$ 104,823.00 | \$ 104,823.00 | \$ 104,823.00 | \$ 104,823.00 | \$ 104,823.00 |
| 11      | \$107,858.00 | \$ 111,094.00 | \$ 111,094.00 | \$ 111,094.00 | \$ 111,094.00 | \$ 111,094.00 |
| 12      | \$117,364.00 | \$ 120,885.00 | \$ 124,209.00 | \$ 124,209.00 | \$ 124,209.00 | \$ 124,209.00 |
| 13      | \$126,869.00 | \$ 130,675.00 | \$ 134,269.00 | \$ 137,961.00 | \$ 137,961.00 | \$ 137,961.00 |
| 14      |              | \$ 134,595.00 | \$ 138,296.00 | \$ 142,099.00 | \$ 145,651.00 | \$ 145,651.00 |
| 15      |              |               | \$ 142,099.00 | \$ 146,007.00 | \$ 149,657.00 | \$ 153,024.00 |

2. Employees' hourly rates of pay will be determined by dividing the annual base salary by 2080 hours.
3. On January 1st of each subsequent year employees will advance one step on the wage guide until top step is reached.
4. All new hires (except recruit officers, if applicable) shall be placed at Step 1 and thereafter, the employee will move to the next step depending upon whether they are hired prior to or after July 1<sup>st</sup> of any year. For those employees hired prior to July 1<sup>st</sup>, they will advance one step on the wage guide on January 1<sup>st</sup> of the next year. For those employees hired on or after July 1<sup>st</sup>, they will not advance to the next step until January 1<sup>st</sup> one year removed.

[Ex. 1: Hired 1/1/23 through 6/30/23 will advance to next step on 1/1/24]

[Ex. 2: Hired 7/1/23 through 12/31/23 will advance to next step on 1/1/25]



**B.**      **RECRUIT**

There is a rate of pay for recruit officers reflected in the wage guide. It is a rate that will be for members who have not yet graduated the academy nor received a PTC certification. The following shall apply with regard to Recruits.

- 1.**      Upon completion of the academy and PTC certification the member will advance to step "1" of the wage guide.
- 2.**      However, for purposes of advancement through the steps in the wage guide, the employee's date of hire will determine such movement, and not the employee's graduation from the police academy. For purposes of this provision, the employee's date of hire shall be the employee's first day in the police academy.
- 3.**      Recruit salary shall only apply to officers attending the police academy on a full-time basis.
- 4.**      For the purposes of future collective bargaining negotiations, when determining the unit- based annual percentage cost of living increases, if any, Recruits should be treated as Step 1 employees.

**C.**      **PROBATION**

The probation period for all new hires will be for a period of one year or more in accordance with State Statutes.

**D.**      **DETECTIVES**

Patrolman and detectives are equal in rank. Assignments in and out of the Investigative Bureau will be made by the Chief of Police. Any member assigned to the Investigative Bureau as a Detective will be compensated in accordance with the wage guide at the next higher step over his current pay rate. Further, once assigned by the Chief of Police to the Investigative Bureau as a Detective, the employee will remain at the advanced wage step even if the Chief reassigns the employee out of the Investigative Bureau. As with all other covered employees, step advancement will be one step every January 1st until top step is reached.

Detectives assigned a take home vehicle shall receive no additional compensation and shall not be required to reimburse the Township for any expenses related to the vehicle.

**E.**      **PAY PERIOD**

Members shall be considered salaried employees. Annual salaries will be distributed over the course of the year on a bi-weekly basis. Payday shall remain Friday and shall occur every other Friday. This will typically result in 26 paydays and officers will receive 1/26th of their annual salary on each payday. In the event that a given year will have 27 paydays, management and the unit will meet to discuss a mutually agreed upon method for the distribution of the annual salary that is compatible with the Township's payroll program/system

- F.**      The Township reserves the right to hire a patrol officer at any step not to exceed Step 3 based on qualifications and experience.

G.     SHIFT DIFFERENTIAL

1.     Rotating monthly shift

In the event the Township institutes a rotating shift schedule requiring members to work alternating shifts based on a 28-day schedule cycle, there shall be an annual flat shift differential payment to every officer assigned to the 28-day schedule cycle in the amount of \$2,800 for 2023, \$2,900 for 2024, \$3,000 for 2025, \$3,100 for 2026, and \$3,200 for 2027.

2.     Fixed Shift

In the event the Township utilizes 8.5 hours shift intervals, a shift differential will be paid at the following rates: six percent (6%) for the evening shift (i.e. the 2:00pm to 10:30pm), or any part thereof Eight percent (8%) for the overnight shift (i.e., 10:00pm to 6:30pm shift), or any part thereof.

3.     Shift Differential shall be paid in the first paycheck of December each year

ARTICLE XII

EDUCATION

A.     Upon prior approval of the Chief of Police, the Township will pay, on a reimbursement basis, the tuition and book expense of any member furthering his education by taking police courses. Educational reimbursement shall be based on the less of 1) actual tuition cost; or 2) the established undergraduate tuition rate (per credit) for a New Jersey resident attending a college or university with the New Jersey State System. Police courses are defined as college level courses directly associated with a degree program in police science or criminal justice at an accredited college.

B.     Members hired after March 18, 1986 will be limited to a four-year bachelor's level degree, with respect to the above. The Township will reimburse the member for tuition and book expenses only after completion of course work, the submission of receipts, and proof of the attainment of a final grade of "C" or better. The Township will only provide compensation, which in conjunction with financial aid or compensation received from other sources, will defray tuition and book expenses. The Township will not, in conjunction with financial aid and compensation received from other sources, provide compensation when such combined payments would exceed actual tuition and book expenses

Township: cap

FOP: S

**ARTICLE XIII**  
**GRIEVANCE PROCEDURE**

**A. STATEMENT OF PURPOSE**

**1. Grievance Resolution**

The purpose of the grievance mechanism is to resolve, at the lowest possible level, any problem arising from the terms and conditions of this contract and in the employment relationship of all members covered by this Agreement.

**2. Informal Resolution**

Nothing herein shall limit or infringe the right of any employee freely and informally to discuss any grievance with a Superior.

**B. EXCLUSIVE REMEDY**

The procedures hereinafter set forth are the sole and exclusive means of resolving grievances between the parties.

**C. DEFINITIONS**

**1. Grievance**

Any controversy arising over the interpretation, application, or violation of policies, agreements, and administrative decisions affecting the terms and conditions of employees covered under this Agreement and may be raised by an individual, the FOP, or at the request and on behalf of an individual or group of individuals, or the Township.

**2. Grievance Committee**

For the purposes of this Agreement, "Grievance Committee", shall mean that group of members of the FOP, duly appointed by the FOP to resolve the member's grievances.

**3. Superior Officer**

For the purposes of this Agreement, "Superior Officer" shall mean the Chief of Police, his designee, or in their absence a Captain

**D. INITIATION OF GRIEVANCES**

**1. Written Complaint:** All grievances shall be in writing, signed by the aggrieved party, and shall clearly set forth the allegations upon which it is based.

**2. Service:** All grievances shall be personally delivered to the Superior Officer and a Grievance Committee member within twenty calendar (20) days of the occurrence from which the grievance arose.

**3. Representation:** Any aggrieved party may either present his own case, designate an FOP member to present his case or to employ legal counsel for his representation. Should the member choose to employ legal counsel, he shall do so at his own or the FOP's expense.



4. Waiver: Failure to serve a written complaint citing a grievance within twenty calendar (20) days of its occurrence shall constitute a waiver of any and all rights to pursue said grievance.

5. Extension of Time: Any extension of time requirements contained in the grievance article may only be extended by the written consent of the Township Manager or the Chief of Police (or his designee) and the aggrieved party.

6. Attendance: Any member whose attendance may be necessary to resolve a grievance shall attend any meeting or hearing during working hours without loss of pay or other benefits.

7. Disciplinary Action: No disciplinary action shall be commenced without just cause.

E. DETERMINATION BY THE CHIEF OF POLICE

1. Referral of the Chief of Police

If the grievance is not settled by the Superior Officer to the member's satisfaction within seven (7) calendar days and such grievance concerns the interpretation, application, or alleged violation of this contract only, the aggrieved party may make written request within five (5) calendar days to the Chief of Police for review.

2. Decision by Chief of Police

The Chief of Police shall render a written decision clearly setting forth his decision and the basis for said decision within five (5) calendar days of receipt of the complaint to both the FOP and to the complainant.

F. DETERMINATION BY THE TOWNSHIP MANAGER

1. Appeal to Township Manager

In the event the aggrieved party be unsatisfied with the determination by the Chief of Police, the complainant or the FOP may serve a copy of the original complaint upon the Township Manager within five (5) calendar days of the decision by the Chief of Police

2. Decision by Township Manager

The Township Manager shall render a written copy of his/her decision to both the FOP and the complainant within twenty (20) calendar days of receipt of the complaint.

G. DETERMINATION BY ARBITRATION

1. Request for Arbitration

In the event the aggrieved party is unsatisfied with the determination of the Township Manager, the grievant shall petition the FOP for arbitration. Only the FOP Lodge #143 shall be allowed to move a grievance to arbitration. The Executive of the Lodge shall advise the Township Manager in writing that a grievance shall be moved to Arbitration.



2. Determination for Arbitration shall be made through the Offices of the Public Employment Relation Commission (PERC)

3. Choice of Arbitrator

Upon receipt of the list of arbitrators from PERC, the aggrieved party and the Township shall mutually agree on the selection of an arbitrator.

4. Cost of Arbitration

- a. In the event the aggrieved party is a member of the FOP at the time of the occurrence of the action complained of then costs of the arbitration shall be shared equally by the Township and the FOP.
- b. In the event the aggrieved party not be an FOP member at the time of the occurrence of the action complained of, the FOP shall bear no responsibility for arbitration costs and the grievant shall pay half of costs.
- c. Any other expenses incurred by the parties beyond the cost of the arbitrator shall be the respective party's responsibility.
- d. In the event the arbitrator should determine a party to have prosecuted a claim so clearly lacking any merit or sufficiency so as to be deemed frivolous, the arbitrator may, in his sole discretion, assess reasonable counsel fees to costs upon said party.

5. Effect of Arbitration

The decision of the arbitrator shall be binding upon both parties

**ARTICLE XIV**

**MISCELLANEOUS UNION RIGHTS**

The FOP shall have the right to install at its own expense a bulletin board and file cabinet on the Township's premises for the posting and filing of notices/correspondence relating to the FOP meetings and official business only. Location of the bulletin board and file cabinet will be approved by the Chief of Police. No other notice shall be posted until it has been submitted to and approved by the Township Manager or his designee. Such approval shall not be unreasonably withheld.

1. Nothing contained herein shall be construed to deny or restrict to any officer such rights as he may have under New Jersey Laws or other applicable Laws and Regulations. The rights granted to Officers and Lodge shall be deemed to be in addition to those provided elsewhere.
2. All discipline proceedings affecting any officer by any authorized agent of the Township shall not be made public and shall be confined to within the Department or Township.
3. Any dismissal or suspension shall be considered a discipline action and be subject to the grievance procedure subject to applicable statute.

Township: up

FOP: SD

4. The Executive member of the Lodge shall be furnished all information within the public domain pertaining to collective negotiations with the Township and any or all information in the processing of a grievance pursuant to Article 12 of this Agreement.

5. Nothing in this Article shall prohibit the Township from seeking information as required by law or rule.

#### ARTICLE XV

#### TERM AND RENEWAL

This Agreement shall be in full force and effect as of January 1, 2023 and shall remain in effect up to and including December 31, 2027, but nothing herein shall be deemed to terminate the provisions of this Agreement prior to the parties hereto executing a new Agreement at the expiration date hereof.

#### ARTICLE XVI

#### RETROACTIVITY

Unless otherwise specified, the terms and conditions contained herein shall be given retroactive effect, as though the Agreement were commenced on January 1, 2023.

#### ARTICLE XVII

#### REDUCTION OF BENEFITS

It is expressly understood by both parties that reduction or elimination of any benefits shall only be by written agreement.

#### ARTICLE XVIII

#### FULLY BARGAINED PROVISION

This Agreement represents and incorporates the complete and final understanding and settlement by the parties on all bargain able issues, which were or could have been the subject of negotiations. During the term of this Agreement, neither party will be required to negotiate with respect to any such matter, whether or not covered by this Agreement, and whether or not within the knowledge or contemplation of either or both of the parties at the time they negotiated or signed this Agreement. Renegotiating may commence only upon the written request of both parties hereto.

IN WITNESS WHEREOF, the parties hereto have hereunto set their hand and seals at Evesham Township, New Jersey, on the date and year below written.

TOWNSHIP OF EVESHAM

FOP 143

  
Mayor  
  
Township Manager 15 SEP 23

  
FOP 143

FOP 143 Attest

  
FOP 143 Attest

Dated: 9/20/23

Dated: 9/13/2023

Township: 

FOP: 

## APPENDIX A ADJUSTMENT TIME

**WHEREAS**, generally and subject to the modifications stated herein, the police force of the Township of Evesham currently works a schedule commonly known as the "Pitman". A Pitman schedule is a schedule to utilizes a 28-day work cycle where employees are scheduled to work two-on, two-off, three-on, two-off, two-on, three-off, two-on, two-off, three-on, two-off two-on, three-off and repeat that schedule throughout the year. Each officer working a Pitman works 13 twenty-eight day cycles annually. The working of a Pitman schedule results in approximately 2184 working hours per year whereas the working of a set 8-hour workday/40-hour work week would result in 2080 hours worked per year by any given officer. A 2080 hour work year corresponds with the FLSA standard work year; and

**WHEREAS**, the police officers of the Township of Evesham covered under this Agreement are assigned to patrol work in two separate groups or "sides", with one side being off while the other side is working, and vice versa; and

**WHEREAS**, in addition to the 2184 scheduled working hours created by working a Pitman Schedule, said officers of the Township of Evesham are required to spend 16 hours annually at the range and receiving additional mandatory training, resulting in a 2200 scheduled working hour year annually, an amount which exceeds the 2080 hour FLSA standard work year by 120 hours. Officers working the extra 16 hours of mandatory annual range training shall be compensated for the extra hours with 16 hours of unscheduled time off (Compensatory Time) thereby reducing the hours imbalance by 16 hours resulting in an adjusted total of 104 hours; and

**WHEREAS**, the 13 twenty-eight day cycles worked by patrol will consume 364 days of a standard (non-leap) calendar year, resulting in an "extra work day" of 12 hours which will be scheduled to be worked by one "side" annually, meaning that one "side" will be scheduled to work 2196 hours annually, exceeding the 2080 hour FLSA standard work year by 116 hours annually. These officers scheduled to work the "extra day" will be given 12 hours of additional unscheduled time off (Compensatory Time) as compensation for the extra hours, thereby reducing the hours imbalance by 12 hours and resulting in an adjusted total of 104 hours; and

**WHEREAS**, the remaining 104 "extra hours" scheduled to be worked by said officers assigned to patrol will result in scheduled time off (known as "adjustment time") in order to balance out the remaining discrepancy between a typical 2080 hour work year and the work year created by working a Pitman schedule; and

**WHEREAS**, Canine Officers of the Evesham Township Police Department covered under this Agreement work 286.5 hours beyond the 2080 FLSA standard when considering the 104 extra hours scheduled to be worked due to a Pitman schedule, together with the 182.5 hours annually for which Canine Officers are compensated for their "at home" care of their canine partners. To accommodate for the discrepancy between the 2080 FLSA standard and the 2366.5 hours worked as described above, each Canine Officer will work a ten (10) hour shift when on Night Watch Shift (i.e. 6:00 p.m. to 4:00 a.m.), thereby reducing the hours imbalance by 182 hours and resulting in an adjusted total of 104.5 hours. Additionally, 8 hour (as opposed to the standard 11 hour) canine training days are factored in further reducing the annual

Township: wp

FOP: SD



imbalance of hours by 36 hours resulting in an adjusted total of 68.5 hours. Therefore, in order to meet the 2080 FLSA standard work year, 68.5 hours annually must be scheduled as Township FOP: "adjustment time" for each Canine Officer; and

**WHEREAS**, Canine Officers assigned to work the "extra calendar day" are given an additional 12 hours of Compensator; Time for that year and

**WHEREAS**, the parties negotiated this issue and agreed to record the negotiated terms by and through this Appendix A in order to provide record notice of the agreement which the parties have achieved:

**NOW, THEREFORE**, the parties do hereby agree as follows:

1. "Adjustment Time" - in order to comply with the 2080 hour FLSA standard work year, and after factoring in the above described awarding of Compensatory Time and other schedule adjustments, officers covered under this Agreement assigned to patrol will require an additional 104 hours of Adjustment Time to correct the imbalance between scheduled hours of work under the Pitman schedule and the FLSA standard work year of 2080 hours. Similarly, Canine Officers assigned to the Pitman schedule will require an additional 68.5 hours of Adjustment Time to correct the imbalance in their schedule.
2. Effective for the term of this Agreement, the Chief of Police shall manage the aforementioned additional Adjustment Time as follows:
  - a. Patrol Adjustment Time shall be assigned to the schedule in 12 hour blocks of time.
  - b. The Chief of Police, in his sole discretion, shall schedule the 12 hour blocks of Adjustment Time on officers' scheduled days of work, Sunday through Thursday, throughout the calendar year. There will be no scheduled Adjustment Time on Fridays or Saturdays.
  - c. After scheduling full 12 hour blocks of Adjustment Time, any remaining hours balance of Adjustment Time owed to an officer will be awarded to the officer as unscheduled time off (Compensatory Time).
  - d. If for any reason the chief of police determines that it is necessary for the efficient delivery of law enforcement service to the Township to modify and or revise the terms of this Appendix A, the Chief of Police shall articulate the necessity to modify the terms and agrees to meet and negotiate with the FOP in good faith to reach a mutual resolution.



Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                                                                                                                                                                    | Platinum Plan                 |                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|------------------------------|
|                                                                                                                                                                                                                                             | Participating                 | Non-Participating            |
|                                                                                                                                                                                                                                             |                               |                              |
| <b>*In-Network Services (Participating)</b>                                                                                                                                                                                                 |                               |                              |
| Allowables are based on the Negotiated Rate established in a contractual arrangement with a Provider and/or Facility.                                                                                                                       |                               |                              |
| <b>*Out-of-Network Services (Non-Participating) - Payments are subject to the "Maximum Allowable Charge"</b>                                                                                                                                |                               |                              |
| "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan.                                                                                                                           |                               |                              |
| Maximum Allowable Charge(s) may be the lesser of:                                                                                                                                                                                           |                               |                              |
| 1. The Usual and Customary amount;                                                                                                                                                                                                          |                               |                              |
| 2. The allowable charge specified under the terms of the Plan;                                                                                                                                                                              |                               |                              |
| 3. 125% of the Medicare Reimbursement Rate; or                                                                                                                                                                                              |                               |                              |
| 4. The actual billed charges for the covered services.                                                                                                                                                                                      |                               |                              |
| The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount.                                                                                                                                         |                               |                              |
| The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.                                                                                                 |                               |                              |
| The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.                                                        |                               |                              |
| <b>Please see pre-cert services at the end of the schedule of benefits.</b>                                                                                                                                                                 |                               |                              |
| Lifetime Maximum                                                                                                                                                                                                                            | Unlimited                     | Unlimited                    |
| Plan Year Maximum                                                                                                                                                                                                                           | Unlimited                     | Unlimited                    |
| Deductible (Per Calendar Year)                                                                                                                                                                                                              |                               |                              |
| Individual                                                                                                                                                                                                                                  | None                          | \$100                        |
| Per Family Unit                                                                                                                                                                                                                             | None                          | \$250                        |
| Charges tracking to the deductible in the last quarter of the year are applied to the following year deductible.                                                                                                                            |                               |                              |
| Out of Pocket Maximum                                                                                                                                                                                                                       |                               |                              |
| Individual                                                                                                                                                                                                                                  | \$400                         | \$2,000                      |
| Family Unit                                                                                                                                                                                                                                 | \$1,000                       | \$5,000                      |
| Out-of-network expenses are applied to the in-network out-of-pocket maximum.                                                                                                                                                                |                               |                              |
| The plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered charges for the rest of the Calendar Year unless otherwise stated. |                               |                              |
| Deductible, Coinsurance, and Copayments are included in the Out of Pocket Maximum.                                                                                                                                                          |                               |                              |
| Cost containment penalties do not apply toward the out-of-pocket maximum and are never paid at 100%.                                                                                                                                        |                               |                              |
| Co-Payments                                                                                                                                                                                                                                 |                               |                              |
| Teladoc Consultation                                                                                                                                                                                                                        | Covered 100%                  | N/A                          |
| Teladoc Specialist Consultation                                                                                                                                                                                                             | Covered 100% after \$10 copay | N/A                          |
| Physician Visits                                                                                                                                                                                                                            | Covered 100% after \$10 copay | Covered 80% after deductible |
| Specialist Visits                                                                                                                                                                                                                           | Covered 100% after \$10 copay | Covered 80% after deductible |
| Urgent Care Visits                                                                                                                                                                                                                          | Covered 100% after \$10 copay | Covered 80% after deductible |
| Emergency Services                                                                                                                                                                                                                          |                               |                              |
| Ambulance Service (For Emergency Transportation Only)                                                                                                                                                                                       | Covered 90%                   |                              |
| Emergency Room Services (copay waived if admitted)                                                                                                                                                                                          | Covered 100% after \$75 copay |                              |
| The utilization review administrator must be notified within 48 hours of the admission (please refer to your ID card) even if the patient is discharged within 48 hours of the admission.                                                   |                               | within 48                    |





Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                                               | Platinum Plan                                                                             |                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
|                                                                                                                        | Participating                                                                             | Non-Participating                                                                                       |
| <b>Covered Services</b>                                                                                                |                                                                                           |                                                                                                         |
| Acupuncture for Pain Management Only                                                                                   | Covered 100%                                                                              | Covered 80% after deductible                                                                            |
| Allergy Injections/Testing                                                                                             | Covered 100% after \$10 copay                                                             | Covered 80% after deductible                                                                            |
| Biofeedback                                                                                                            | Covered 100%                                                                              | Covered 80% after deductible                                                                            |
| Chiropractic Care (Limit of 30 visits per Calendar Year, Combined in and out-of-network)                               | Covered 100% after \$10 copay                                                             | Covered 80% after deductible                                                                            |
| Diabetic Self-Management Education (4 visits per year)                                                                 | Covered 100%                                                                              | Not Covered                                                                                             |
| Dialysis Treatment (Outpatient)                                                                                        | Covered 100%                                                                              | Covered 80% after deductible                                                                            |
| <i>Outpatient-100% after the Maximum Allowable Charge after all applicable deductibles and coinsurance</i>             |                                                                                           |                                                                                                         |
| Durable Medical Equipment                                                                                              | Covered 90%                                                                               | Covered 80% after deductible                                                                            |
| Hearing Aids (children under age 16 only, one per ear in 24 months)                                                    | Covered 100%                                                                              | Not Covered                                                                                             |
| Home Health Care (Nursing Home Care or Custodial Care is Not Covered)                                                  | Covered 100%                                                                              | Covered 80% after deductible                                                                            |
| Hospice Care Outpatient & Facility                                                                                     | Covered 100%                                                                              | Covered 80% after deductible                                                                            |
| Hospital Inpatient Care                                                                                                |                                                                                           |                                                                                                         |
| Hospital Inpatient Care                                                                                                | Covered 100%                                                                              | Covered 80% after separate \$200 deductible per hospital stay                                           |
| Inpatient Physician Services                                                                                           | Covered 100%                                                                              | Covered 80% after deductible                                                                            |
| Infertility Services                                                                                                   | Diagnosis covered after \$10 copay; Treatment covered, with limitations, after \$10 copay | Diagnosis covered at 80% after deductible; Treatment covered, with limitations, at 80% after deductible |
| Insulin Pump and Supplies                                                                                              | Covered 100%                                                                              | Covered 80% after deductible                                                                            |
| Maternity Benefits                                                                                                     |                                                                                           |                                                                                                         |
| Inpatient Hospital Charges                                                                                             | Covered 100%                                                                              | Covered 80% after separate \$200 deductible per hospital stay                                           |
| Obstetric Care/Physician Charges                                                                                       | Covered 100% after \$10 copay for first visit                                             | Covered 80% after deductible                                                                            |
| Ultrasound                                                                                                             | Covered 100%                                                                              | Covered 80% after deductible                                                                            |
| Mental Health/Alcohol and Drug Abuse/Applied Behavioral Analysis (ABA)                                                 |                                                                                           |                                                                                                         |
| Inpatient                                                                                                              | Covered 100%                                                                              | Covered 80% after separate \$200 deductible per hospital stay                                           |
| Outpatient                                                                                                             | Covered 100% after \$10 copay                                                             | Covered 80% after deductible                                                                            |
| ABA Only Home                                                                                                          | Covered 100%                                                                              | Covered 80% after deductible                                                                            |
| Orthotics (Limited to one pair per Calendar Year. \$600 maximum per Calendar Year)                                     | Covered 90%                                                                               | Covered 80% after deductible                                                                            |
| Prosthetic Devices                                                                                                     | Covered 90%                                                                               | Covered 80% after deductible                                                                            |
| Scalp Hair Prostheses (benefit max of \$500 in a 24 month period)                                                      | Covered 90%                                                                               | Covered 80% after deductible                                                                            |
| <i>Only for the treatment of disease by radiation or chemicals, Alopecia Universalis (totalis), or Alopecia Areata</i> |                                                                                           |                                                                                                         |
| Skilled Nursing Facility                                                                                               | Covered 100% (For up to 120 Days per Calendar Year; combined in and out-of-network)       | Covered 80% after deductible (For up to 60 Days per Calendar Year; combined in and out-of-network)      |





Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

3

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                            | Platinum Plan                           |                                                                    |
|-----------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------|
|                                                                                                     | Participating                           | Non-Participating                                                  |
| <b>Preventive Well Care as defined by PPACA</b>                                                     |                                         |                                                                    |
| Breastfeeding Support, Supplies & Counseling                                                        | Covered 100%                            | Covered 80% after deductible                                       |
| Colonoscopy & Colorectal Screening                                                                  | Covered 100%                            | Not Covered                                                        |
| Contraceptive Methods & Counseling                                                                  | Covered 100%                            | Covered 80% after deductible                                       |
| GYN/PAP                                                                                             | Covered 100%                            | Covered 80% after deductible                                       |
| Immunizations (Except for Travel and/or Job Related)                                                | Covered 100%                            | Covered for children under 12 months: Covered 80% after deductible |
| Mammograms (Includes 3D mammograms)                                                                 | Covered 100%                            | Covered 80% after deductible                                       |
| Prostate Cancer Screening                                                                           | Covered 100%                            | Not Covered                                                        |
| Routine Adult Physicals                                                                             | Covered 100%                            | Not Covered                                                        |
| Well Child Exams                                                                                    | Covered 100%                            | Not Covered                                                        |
| <b>Surgical Benefits</b>                                                                            |                                         |                                                                    |
| Ambulatory Surgical Center/Free Standing Facility                                                   | Covered 100%                            | Covered 80% after deductible                                       |
| Anesthesia at Ambulatory Surgical Center/Free Standing Facility                                     | Covered 100%                            | Covered 80% after deductible                                       |
| Physician Services at Ambulatory Surgical Center/Free Standing Facility                             | Covered 100%                            | Covered 80% after deductible                                       |
| Physician Office                                                                                    | Covered 100% under office visit benefit | Covered 80% after deductible                                       |
| Hospital Inpatient Surgery                                                                          | Covered 100%                            | Covered 80% after deductible                                       |
| Anesthesia Hospital Inpatient                                                                       | Covered 100%                            | Covered 80% after deductible                                       |
| Physician Services Hospital Inpatient                                                               | Covered 100%                            | Covered 80% after deductible                                       |
| Hospital Outpatient Surgery                                                                         | Covered 100%                            | Covered 80% after deductible                                       |
| Anesthesia Hospital Outpatient                                                                      | Covered 100%                            | Covered 80% after deductible                                       |
| Physician Services Hospital Outpatient                                                              | Covered 100%                            | Covered 80% after deductible                                       |
| Bariatric Surgery                                                                                   | Covered 100%                            | Covered 80% after deductible                                       |
| <b>X-Rays, Ultrasound and Lab Tests - Charge By Place of Service</b>                                |                                         |                                                                    |
| Physicians Office Testing                                                                           | Covered 100%                            | Covered 80% after deductible                                       |
| Independent Facility Testing                                                                        | Covered 100%                            | Covered 80% after deductible                                       |
| Hospital - Outpatient Testing                                                                       | Covered 100%                            | Covered 80% after deductible                                       |
| <b>Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.) - Charge By Place of Service</b> |                                         |                                                                    |
| Physicians Office Testing                                                                           | Covered 100%                            | Covered 80% after deductible                                       |
| Independent Facility Testing                                                                        | Covered 100%                            | Covered 80% after deductible                                       |
| Hospital - Outpatient Testing                                                                       | Covered 100%                            | Covered 80% after deductible                                       |
| <b>Therapy Services</b>                                                                             |                                         |                                                                    |
| Chemotherapy                                                                                        | Covered 100%                            | Covered 80% after deductible                                       |
| Radiation                                                                                           | Covered 100%                            | Covered 80% after deductible                                       |
| Infusion (Limited to a \$250 out-of-pocket maximum per incident)                                    | Covered 100% after \$10 copay per visit | Covered 80% after deductible                                       |







Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                                       | Platinum Plan                                |                              |
|----------------------------------------------------------------------------------------------------------------|----------------------------------------------|------------------------------|
|                                                                                                                | Participating                                | Non-Participating            |
| <b>Occupational</b> (Limited to a \$250 out-of-pocket maximum per incident) (includes the diagnosis of autism) | Covered 100% after \$10 copay per visit      | Covered 80% after deductible |
| <b>Outpatient Cardiac Rehabilitation</b> (Limited to a \$250 out-of-pocket maximum per incident)               | Covered 100% after \$10 copay per visit      | Covered 80% after deductible |
| <b>Physical</b> (Limited to a \$250 out-of-pocket maximum per incident) (includes the diagnosis of autism)     | Covered 100% after \$10 copay per visit      | Covered 80% after deductible |
| <b>Speech</b> (Limited to a \$250 out-of-pocket maximum per incident) (includes the diagnosis of autism)       | Covered 100% after \$10 copay per visit      | Covered 80% after deductible |
| <b>Vision Care Benefits</b>                                                                                    |                                              |                              |
| <b>Routine Annual Eye Examinations</b>                                                                         | Covered 100%                                 | Not Covered                  |
| <b>Wellness &amp; Nutritional Coach On-Site Benefits</b>                                                       |                                              |                              |
| <b>Wellness Coaching On-Site Visits</b>                                                                        | Covered 100%                                 | Not Covered                  |
| <b>*Nutritional Counseling On-Site Visits</b>                                                                  | Covered 100%                                 | Not Covered                  |
| <b>*Nutritional Counseling</b>                                                                                 | Covered 100%                                 | Not Covered                  |
| <i>*Nutritional Counseling is a combined benefit and benefit limit is 3 visits per year.</i>                   |                                              |                              |
| <b>Prescription Drug Benefit</b>                                                                               |                                              |                              |
| <b>Out of Pocket Maximum (Rx Only)</b>                                                                         | Individual                                   | \$1,430                      |
|                                                                                                                | Family Unit                                  | \$2,860                      |
| <b>Retail 30-Day Supply</b>                                                                                    | Tier 1                                       | \$3                          |
|                                                                                                                | Tier 2                                       | \$10                         |
|                                                                                                                | Tier 3                                       | \$10                         |
|                                                                                                                | Preventative Medications as defined by PPACA | \$0                          |
| <b>Mail Order 90-Day Supply</b>                                                                                | Tier 1                                       | \$5                          |
|                                                                                                                | Tier 2                                       | \$15                         |
|                                                                                                                | Tier 3                                       | \$15                         |
|                                                                                                                | Preventative Medications as defined by PPACA | \$0                          |

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Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Precertification List**

**The following services require Precertification**

Inpatient hospitalization  
Home Health Services  
Inpatient Mental/Nervous facility based programs  
Inpatient Substance Abuse facility based programs  
Adenoidectomy  
Breast Surgery (non-diagnostic, excluding needle biopsy/aspirations or lumpectomies)  
Skilled Nursing Facility stays  
Infusion services  
Obesity Surgery  
Foot Surgery  
Gallbladder Surgery  
Gastric Bypass Surgery (Covered under the Platinum Plan only)  
Infertility Services  
Heart Surgery (excluding cardiac cauterization or PTCA)  
Hysterectomy  
Joint Surgery (excluding arthroscopy for diagnostic use)  
Joint Replacement Surgery  
Laminectomy  
Nasal Surgery (excluding sinus surgery, i.e. submucous resection, ethmoidectomy, polyp removal)  
Prostatectomy (excluding TURP (transurethral prostatectomy))  
Spinal Fusion  
Tonsillectomy  
Lithotripsy after three  
Prosthetic Devices

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Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                                                                                                                                                                    | Gold Plus Plan                |                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|------------------------------|
|                                                                                                                                                                                                                                             | Participating                 | Non-Participating            |
|                                                                                                                                                                                                                                             |                               |                              |
| <b>*In-Network Services (Participating)</b>                                                                                                                                                                                                 |                               |                              |
| Allowables are based on the Negotiated Rate established in a contractual arrangement with a Provider and/or Facility.                                                                                                                       |                               |                              |
| <b>*Out-of-Network Services (Non-Participating) - Payments are subject to the "Maximum Allowable Charge"</b>                                                                                                                                |                               |                              |
| "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan.                                                                                                                           |                               |                              |
| Maximum Allowable Charge(s) may be the lesser of:                                                                                                                                                                                           |                               |                              |
| 1. The Usual and Customary amount;                                                                                                                                                                                                          |                               |                              |
| 2. The allowable charge specified under the terms of the Plan;                                                                                                                                                                              |                               |                              |
| 3. 125% of the Medicare Reimbursement Rate; or                                                                                                                                                                                              |                               |                              |
| 4. The actual billed charges for the covered services.                                                                                                                                                                                      |                               |                              |
| The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount.                                                                                                                                         |                               |                              |
| The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.                                                                                                 |                               |                              |
| The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.                                                        |                               |                              |
| <b>Please see pre-certed services at the end of the schedule of benefits.</b>                                                                                                                                                               |                               |                              |
| Lifetime Maximum                                                                                                                                                                                                                            | Unlimited                     | Unlimited                    |
| Plan Year Maximum                                                                                                                                                                                                                           | Unlimited                     | Unlimited                    |
| Deductible (Per Calendar Year)                                                                                                                                                                                                              |                               |                              |
| Individual                                                                                                                                                                                                                                  | \$250                         | \$500                        |
| Per Family Unit                                                                                                                                                                                                                             | \$500                         | \$1,000                      |
| Charges tracking to the deductible in the last quarter of the year are applied to the following year deductible.                                                                                                                            |                               |                              |
| Out of Pocket Maximum                                                                                                                                                                                                                       |                               |                              |
| Individual                                                                                                                                                                                                                                  | \$2,000                       | \$4,000                      |
| Family Unit                                                                                                                                                                                                                                 | \$4,000                       | \$8,000                      |
| Out-of-network expenses are applied to the in-network deductible and out-of-pocket maximum.                                                                                                                                                 |                               |                              |
| The plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered charges for the rest of the Calendar Year unless otherwise stated. |                               |                              |
| Deductible, Coinsurance, and Copayments are included in the Out of Pocket Maximum.                                                                                                                                                          |                               |                              |
| Cost containment penalties do not apply toward the out-of-pocket maximum and are never paid at 100%.                                                                                                                                        |                               |                              |
| <b>Co-Payments</b>                                                                                                                                                                                                                          |                               |                              |
| Teladoc Consultation                                                                                                                                                                                                                        | Covered 100%                  | N/A                          |
| Teladoc Specialist Consultation                                                                                                                                                                                                             | Covered 100% after \$10 copay | N/A                          |
| Physician Visits                                                                                                                                                                                                                            | Covered 100% after \$10 copay | Covered 80% after deductible |
| Specialist Visits                                                                                                                                                                                                                           | Covered 100% after \$10 copay | Covered 80% after deductible |
| Urgent Care Visits                                                                                                                                                                                                                          | Covered 100% after \$10 copay | Covered 80% after deductible |
| <b>Emergency Services</b>                                                                                                                                                                                                                   |                               |                              |
| Ambulance Service (For Emergency Transportation Only)                                                                                                                                                                                       | Covered 90% after deductible  |                              |
| Emergency Room Services (copay waived if admitted)                                                                                                                                                                                          | Covered 100% after \$75 copay |                              |
| The utilization review administrator must be notified within 48 hours of the admission (please refer to your ID card) even if the patient is discharged within 48 hours of the admission.                                                   |                               |                              |







Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                                               | Gold Plus Plan                                                                                      |                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
|                                                                                                                        | Participating                                                                                       | Non-Participating                                                                                         |
| <b>Covered Services</b>                                                                                                |                                                                                                     |                                                                                                           |
| <b>Acupuncture For Pain Management Only</b>                                                                            | Covered 100% after \$10 copay per visit                                                             | Not Covered                                                                                               |
| <b>Allergy Injections/Testing</b>                                                                                      | Covered 100% after \$10 copay                                                                       | Covered 80% after deductible                                                                              |
| <b>Biofeedback</b>                                                                                                     | Covered 100% after \$10 copay per visit                                                             | Covered 80% after deductible                                                                              |
| <b>Chiropractic Care</b> <i>(Limit of 30 visits per Calendar Year, Combined in and out-of-network)</i>                 | Covered 100% after \$10 copay                                                                       | Covered 80% after deductible                                                                              |
| <b>Diabetic Self-Management Education</b><br><i>(4 visits per year)</i>                                                | Covered 100%                                                                                        | Not Covered                                                                                               |
| <b>Dialysis Treatment</b> <i>(Outpatient)</i>                                                                          | Covered 100% after deductible                                                                       | Covered 80% after deductible                                                                              |
| <i>Outpatient-100% after the Maximum Allowable Charge after all applicable deductibles and coinsurance</i>             |                                                                                                     |                                                                                                           |
| <b>Durable Medical Equipment</b>                                                                                       | Covered 90% after deductible                                                                        | Covered 80% after deductible                                                                              |
| <b>Hearing Aids</b> <i>(children under age 16 only, one per ear in 24 months)</i>                                      | Covered 90% after deductible                                                                        | Not Covered                                                                                               |
| <b>Home Health Care</b> <i>(Nursing Home Care or Custodial Care is Not Covered)</i>                                    | Covered 100% after deductible                                                                       | Covered 80% after deductible                                                                              |
| <b>Hospice Care Outpatient &amp; Facility</b>                                                                          | Covered 100% after deductible                                                                       | Covered 80% after deductible                                                                              |
| <b>Hospital Inpatient Care</b>                                                                                         |                                                                                                     |                                                                                                           |
| Hospital Inpatient Care                                                                                                | Covered 100% after deductible                                                                       | Covered 80% after separate \$200 deductible per hospital stay                                             |
| Inpatient Physician Services                                                                                           | Covered 100% after deductible                                                                       | Covered 80% after deductible                                                                              |
| <b>Infertility Services</b>                                                                                            | Diagnosis covered 100% after deductible: Treatment covered, with limitations, 100% after deductible | Diagnosis covered at 80% after deductible: Treatment covered, with limitations, at 80% after deductible   |
| <b>Insulin Pump and Supplies</b>                                                                                       | Covered 100%                                                                                        | Covered 80% after deductible                                                                              |
| <b>Maternity Benefits</b>                                                                                              |                                                                                                     |                                                                                                           |
| Inpatient Hospital Charges                                                                                             | Covered 100% after deductible                                                                       | Covered 80% after separate \$200 deductible per hospital stay                                             |
| Obstetric Care/Physician Charges                                                                                       | Covered 100% after \$10 copay for first visit                                                       | Covered 80% after deductible                                                                              |
| Ultrasound                                                                                                             | Covered 100%                                                                                        | Covered 80% after deductible                                                                              |
| <b>Mental Health/Alcohol and Drug Abuse/Applied Behavioral Analysis (ABA)</b>                                          |                                                                                                     |                                                                                                           |
| Inpatient                                                                                                              | Covered 100% after deductible                                                                       | Covered 80% after separate \$200 deductible per hospital stay                                             |
| Outpatient                                                                                                             | Covered 100% after \$10 copay                                                                       | Covered 80% after deductible                                                                              |
| ABA Only Home                                                                                                          | Covered 100% after deductible                                                                       | Covered 80% after deductible                                                                              |
| <b>Orthotics</b> <i>(Limited to one pair per Calendar Year. \$600 maximum per Calendar Year)</i>                       | Covered 90% after deductible                                                                        | Covered 80% after deductible                                                                              |
| <b>Prosthetic Devices</b>                                                                                              | Covered 90% after deductible                                                                        | Covered 80% after deductible                                                                              |
| <b>Scalp Hair Protheses</b> <i>(benefit max of \$500 in a 24 month period)</i>                                         | Covered 90% after deductible                                                                        | Covered 80% after deductible                                                                              |
| <i>Only for the treatment of disease by radiation or chemicals, Alopecia Universalis (totalis), or Alopecia Areata</i> |                                                                                                     |                                                                                                           |
| <b>Skilled Nursing Facility</b>                                                                                        | Covered 100% <i>(For up to 120 Days per Calendar Year; combined in and out-of-network)</i>          | Covered 80% after deductible <i>(For up to 60 Days per Calendar Year; combined in and out-of-network)</i> |

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Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

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**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                            | Gold Plus Plan                          |                                                                    |
|-----------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------|
|                                                                                                     | Participating                           | Non-Participating                                                  |
| <b>Preventive Well Care as defined by PPACA</b>                                                     |                                         |                                                                    |
| Breastfeeding Support, Supplies & Counseling                                                        | Covered 100%                            | Covered 80% after deductible                                       |
| Colonoscopy & Colorectal Screening                                                                  | Covered 100%                            | Not Covered                                                        |
| Contraceptive Methods & Counseling                                                                  | Covered 100%                            | Covered 80% after deductible                                       |
| GYN/PAP                                                                                             | Covered 100%                            | Covered 80% after deductible                                       |
| Immunizations <i>(Except for Travel and/or Job Related)</i>                                         | Covered 100%                            | Covered for children under 12 months: Covered 80% after deductible |
| Mammograms <i>(Includes 3D mammograms)</i>                                                          | Covered 100%                            | Covered 80% after deductible                                       |
| Prostate Cancer Screening                                                                           | Covered 100%                            | Not Covered                                                        |
| Routine Adult Physicals                                                                             | Covered 100%                            | Not Covered                                                        |
| Well Child Exams                                                                                    | Covered 100%                            | Not Covered                                                        |
| <b>Surgical Benefits</b>                                                                            |                                         |                                                                    |
| Ambulatory Surgical Center/Free Standing Facility                                                   | Covered 100% after deductible           | Covered 80% after deductible                                       |
| Anesthesia at Ambulatory Surgical Center/Free Standing Facility                                     | Covered 100% after deductible           | Covered 80% after deductible                                       |
| Physician Services at Ambulatory Surgical Center/Free Standing Facility                             | Covered 100% after deductible           | Covered 80% after deductible                                       |
| Physician Office                                                                                    | Covered 100% under office visit benefit | Covered 80% after deductible                                       |
| Hospital Inpatient Surgery                                                                          | Covered 100% after deductible           | Covered 80% after deductible                                       |
| Anesthesia Hospital Inpatient                                                                       | Covered 100% after deductible           | Covered 80% after deductible                                       |
| Physician Services Hospital Inpatient                                                               | Covered 100% after deductible           | Covered 80% after deductible                                       |
| Hospital Outpatient Surgery                                                                         | Covered 100% after deductible           | Covered 80% after deductible                                       |
| Anesthesia Hospital Outpatient                                                                      | Covered 100% after deductible           | Covered 80% after deductible                                       |
| Physician Services Hospital Outpatient                                                              | Covered 100% after deductible           | Covered 80% after deductible                                       |
| Bariatric Surgery                                                                                   | Not Covered                             | Not Covered                                                        |
| <b>X-Rays, Ultrasound and Lab Tests - Charge By Place of Service</b>                                |                                         |                                                                    |
| Physicians Office Testing                                                                           | Covered 100% after deductible           | Covered 80% after deductible                                       |
| Independent Facility Testing                                                                        | Covered 100% after deductible           | Covered 80% after deductible                                       |
| Hospital - Outpatient Testing                                                                       | Covered 100% after deductible           | Covered 80% after deductible                                       |
| <b>Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.) - Charge By Place of Service</b> |                                         |                                                                    |
| Physicians Office Testing                                                                           | Covered 100% after deductible           | Covered 80% after deductible                                       |
| Independent Facility Testing                                                                        | Covered 100% after deductible           | Covered 80% after deductible                                       |
| Hospital - Outpatient Testing                                                                       | Covered 100% after deductible           | Covered 80% after deductible                                       |



Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                                   | Gold Plus Plan                               |                              |
|------------------------------------------------------------------------------------------------------------|----------------------------------------------|------------------------------|
|                                                                                                            | Participating                                | Non-Participating            |
| <b>Therapy Services</b>                                                                                    |                                              |                              |
| <b>Chemotherapy</b>                                                                                        | Covered 100% after deductible                | Covered 80% after deductible |
| <b>Radiation Therapy</b>                                                                                   | Covered 100% after deductible                | Covered 80% after deductible |
| <b>Infusion</b> (Limited to a \$250 out-of-pocket maximum per incident)                                    | Covered 100% after \$10 copay per visit      | Covered 80% after deductible |
| <b>Occupational</b> (Limited to a \$250 out-of-pocket maximum per incident) (includes diagnosis of autism) | Covered 100% after \$10 copay per visit      | Covered 80% after deductible |
| <b>Outpatient Cardiac Rehabilitation</b> (Limited to a \$250 out-of-pocket maximum per incident)           | Covered 100% after \$10 copay per visit      | Covered 80% after deductible |
| <b>Physical</b> (Limited to a \$250 out-of-pocket maximum per incident) (includes diagnosis of autism)     | Covered 100% after \$10 copay per visit      | Covered 80% after deductible |
| <b>Speech</b> (Limited to a \$250 out-of-pocket maximum per incident) (includes diagnosis of autism)       | Covered 100% after \$10 copay per visit      | Covered 80% after deductible |
| <b>Vision Care Benefits</b>                                                                                |                                              |                              |
| <b>Routine Annual Eye Examinations</b>                                                                     | Covered 100%                                 | Not Covered                  |
| <b>Wellness Program Work Site Benefits</b>                                                                 |                                              |                              |
| <b>Wellness Coach On-Site Visits</b>                                                                       | Covered 100%                                 | N/A                          |
| <b>*Nutritional Counseling On-Site Visits</b>                                                              | Covered 100%                                 | N/A                          |
| <b>*Nutritional Counseling</b>                                                                             | Covered 100% after \$10 copay per visit      | Covered 80% after deductible |
| <i>*Nutritional Counseling is a combined benefit and benefit limit is 3 visits per year.</i>               |                                              |                              |
| <b>Prescription Drug Benefit</b>                                                                           |                                              |                              |
| <b>Out of Pocket Maximum (Rx Only)</b>                                                                     | Individual                                   | \$1,430                      |
|                                                                                                            | Family Unit                                  | \$2,860                      |
| <b>Retail 30-Day Supply</b>                                                                                | Tier 1                                       | \$3                          |
|                                                                                                            | Tier 2                                       | \$10                         |
|                                                                                                            | Tier 3                                       | \$10                         |
|                                                                                                            | Preventative Medications as defined by PPACA | \$0                          |
|                                                                                                            |                                              |                              |
| <b>Mail Order 90-Day Supply</b>                                                                            | Tier 1                                       | \$5                          |
|                                                                                                            | Tier 2                                       | \$15                         |
|                                                                                                            | Tier 3                                       | \$15                         |
|                                                                                                            | Preventative Medications as defined by PPACA | \$0                          |
|                                                                                                            |                                              |                              |

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Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

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**Precertification List**

**The following services require Precertification**

Inpatient hospitalization  
Home Health Services  
Inpatient Mental/Nervous facility based programs  
Inpatient Substance Abuse facility based programs  
Adenoidectomy  
Breast Surgery (non-diagnostic, excluding needle biopsy/aspirations or lumpectomies)  
Skilled Nursing Facility stays  
Infusion services  
Obesity Surgery  
Foot Surgery  
Gallbladder Surgery  
Infertility Services  
Heart Surgery (excluding cardiac catheterization or PTCA)  
Hysterectomy  
Joint Surgery (excluding arthroscopy for diagnostic use)  
Joint Replacement Surgery  
Laminectomy  
Nasal Surgery (excluding sinus surgery, i.e. submucous resection, ethmoidectomy, polyp removal)  
Prostatectomy (excluding TURP (transurethral prostatectomy))  
Spinal Fusion  
Tonsillectomy  
Lithotripsy after three  
Prosthetic Devices





Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                                                                                                                                                                    | Gold Plan                               |                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------------------------|
|                                                                                                                                                                                                                                             | Participating                           | Non-Participating            |
|                                                                                                                                                                                                                                             |                                         |                              |
| <b>*In-Network Services (Participating)</b>                                                                                                                                                                                                 |                                         |                              |
| Allowables are based on the Negotiated Rate established in a contractual arrangement with a Provider and/or Facility.                                                                                                                       |                                         |                              |
| <b>*Out-of-Network Services (Non-Participating) - Payments are subject to the "Maximum Allowable Charge"</b>                                                                                                                                |                                         |                              |
| "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan.                                                                                                                           |                                         |                              |
| Maximum Allowable Charge(s) may be the lesser of:                                                                                                                                                                                           |                                         |                              |
| 1. The Usual and Customary amount;                                                                                                                                                                                                          |                                         |                              |
| 2. The allowable charge specified under the terms of the Plan;                                                                                                                                                                              |                                         |                              |
| 3. 125% of the Medicare Reimbursement Rate; or                                                                                                                                                                                              |                                         |                              |
| 4. The actual billed charges for the covered services.                                                                                                                                                                                      |                                         |                              |
| The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount.                                                                                                                                         |                                         |                              |
| The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.                                                                                                 |                                         |                              |
| The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.                                                        |                                         |                              |
| Please see pre-certed services at the end of the schedule of benefits.                                                                                                                                                                      |                                         |                              |
| Lifetime Maximum                                                                                                                                                                                                                            | Unlimited                               | Unlimited                    |
| Plan Year Maximum                                                                                                                                                                                                                           | Unlimited                               | Unlimited                    |
| Deductible (Per Calendar Year)                                                                                                                                                                                                              |                                         |                              |
| Individual                                                                                                                                                                                                                                  | \$250                                   | \$1,000                      |
| Per Family Unit                                                                                                                                                                                                                             | \$500                                   | \$2,000                      |
| Charges tracking to the deductible in the last quarter of the year are applied to the following year deductible.                                                                                                                            |                                         |                              |
| Out of Pocket Maximum                                                                                                                                                                                                                       |                                         |                              |
| Individual                                                                                                                                                                                                                                  | \$2,500                                 | \$10,000                     |
| Family Unit                                                                                                                                                                                                                                 | \$5,000                                 | \$20,000                     |
| Out-of-network expenses are applied to the in-network deductible and out-of-pocket maximum.                                                                                                                                                 |                                         |                              |
| The plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered charges for the rest of the Calendar Year unless otherwise stated. |                                         |                              |
| Deductible, Coinsurance, and Copayments are included in the Out of Pocket Maximum.                                                                                                                                                          |                                         |                              |
| Cost containment penalties do not apply toward the out-of-pocket maximum and are never paid at 100%.                                                                                                                                        |                                         |                              |
| Co-Payments                                                                                                                                                                                                                                 |                                         |                              |
| Teladoc Consultation                                                                                                                                                                                                                        | Covered 100%                            | N/A                          |
| Teladoc Specialist Consultation                                                                                                                                                                                                             | Covered 100% after \$45 copay           | N/A                          |
| Physician Visits                                                                                                                                                                                                                            | Covered 100% after \$25 copay           | Covered 80% after deductible |
| Specialist Visits                                                                                                                                                                                                                           | Covered 100% after \$45 copay           | Covered 80% after deductible |
| Urgent Care Visits                                                                                                                                                                                                                          | Covered 100% after \$25 copay           | Covered 80% after deductible |
| Emergency Services                                                                                                                                                                                                                          |                                         |                              |
| Ambulance Service (For Emergency Transportation Only)                                                                                                                                                                                       | Covered 90% after deductible            |                              |
| Emergency Room Services (copay waived if admitted)                                                                                                                                                                                          | Covered 100% after \$100 copay          |                              |
| The utilization review administrator must be notified within 48 hours of the admission (please refer to your ID card) even if the patient is discharged within 48 hours of the admission.                                                   |                                         |                              |
| Covered Services                                                                                                                                                                                                                            |                                         |                              |
| Acupuncture For Pain Management Only                                                                                                                                                                                                        | Covered 100% after \$25 copay per visit | Covered 80% after deductible |
| Allergy Injections/Testing                                                                                                                                                                                                                  | Covered 100% after \$25 copay           | Covered 80% after deductible |





Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                                 | Gold Plan                                                                                              |                                                                                                           |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
|                                                                                                          | Participating                                                                                          | Non-Participating                                                                                         |
| <b>Biofeedback</b>                                                                                       | Covered 100% after \$25 copay per visit                                                                | Covered 80% after deductible                                                                              |
| <b>Chiropractic Care</b> <i>(Limit of 30 visits per Calendar Year, Combined in and out-of-network)</i>   | Covered 100% after \$25 copay                                                                          | Covered 80% after deductible                                                                              |
| <b>Diabetic Self-Management Education</b><br><i>(4 visits per year)</i>                                  | Covered 100%                                                                                           | Not Covered                                                                                               |
| <b>Dialysis Treatment (Outpatient)</b>                                                                   | Covered 100% after deductible                                                                          | Covered 80% after deductible                                                                              |
| <i>Outpatient- 100% of the Maximum Allowable Charge after all applicable deductibles and coinsurance</i> |                                                                                                        |                                                                                                           |
| <b>Durable Medical Equipment</b>                                                                         | Covered 90% after deductible                                                                           | Covered 80% after deductible                                                                              |
| <b>Hearing Aids</b> <i>(children under age 16 only, one per ear in 24 months)</i>                        | Covered 90% after deductible                                                                           | Not Covered                                                                                               |
| <b>Home Health Care</b> <i>(Nursing Home Care or Custodial Care is Not Covered)</i>                      | Covered 100% after deductible                                                                          | Covered 80% after deductible                                                                              |
| <b>Hospice Care -Outpatient &amp; Facility</b>                                                           | Covered 100% after deductible                                                                          | Covered 80% after deductible                                                                              |
| <b>Hospital Inpatient Care</b>                                                                           | Inpatient Admission                                                                                    | Covered 80% after separate \$200 deductible per hospital stay                                             |
|                                                                                                          | Inpatient Physician Services                                                                           | Covered 80% after deductible                                                                              |
| <b>Infertility Services</b>                                                                              | Diagnosis covered 100% after deductible;<br>Treatment covered, with limitations, 100% after deductible | Diagnosis covered at 80% after deductible; Treatment covered, with limitations, at 80% after deductible   |
| <b>Insulin Pump and Supplies</b>                                                                         | Covered 100%                                                                                           | Covered 80% after deductible                                                                              |
| <b>Maternity Benefits</b>                                                                                | Inpatient Hospital Charges                                                                             | Covered 80% after separate \$200 deductible per hospital stay                                             |
|                                                                                                          | Obstetric Care/Physician Charges                                                                       | Covered 80% after deductible                                                                              |
|                                                                                                          | Ultrasound                                                                                             | Covered 80% after deductible                                                                              |
| <b>Mental Health/Alcohol and Drug Abuse/Applied Behavioral Analysis (ABA)</b>                            |                                                                                                        | Covered 80% after separate \$200 deductible per hospital stay                                             |
|                                                                                                          | Inpatient                                                                                              | Covered 100% after deductible                                                                             |
|                                                                                                          | Outpatient                                                                                             | Covered 80% after deductible                                                                              |
|                                                                                                          | ABA Only Home                                                                                          | Covered 80% after deductible                                                                              |
| <b>Orthotics</b> <i>(Limited to one pair per Calendar Year. \$600 maximum per Calendar Year)</i>         | Covered 90% after deductible                                                                           | Covered 80% after deductible                                                                              |
| <b>Prosthetic Devices</b>                                                                                | Covered 90% after deductible                                                                           | Covered 80% after deductible                                                                              |
| <b>Scalp Hair Prostheses</b><br><i>(benefit max of \$500 in a 24 month period)</i>                       | Covered 90%                                                                                            | Covered 80% after deductible                                                                              |
| <b>Skilled Nursing Facility</b>                                                                          | Covered 100% <i>(For up to 120 Days per Calendar Year; combined in and out-of-network)</i>             | Covered 80% after deductible <i>(For up to 60 Days per Calendar Year; combined in and out-of-network)</i> |









Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

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**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                     |                                              | Gold Plan                                                      |                   |
|----------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------------------------------------------|-------------------|
|                                                                                              |                                              | Participating                                                  | Non-Participating |
| <b>Vision Care Benefits</b>                                                                  |                                              |                                                                |                   |
| Routine Annual Eye Examinations                                                              |                                              | Covered 100%                                                   | Not Covered       |
| <b>Wellness &amp; Nutritional Coach On-Site Benefits</b>                                     |                                              |                                                                |                   |
| Wellness Coach On-Site Visits                                                                |                                              | 100%                                                           | N/A               |
| * Nutritional Counseling On-Site Visits                                                      |                                              | 100%                                                           | N/A               |
| *Nutritional Counseling                                                                      |                                              | Covered 100% after \$25 copay per visit                        | Not Covered       |
| <i>*Nutritional Counseling is a combined benefit and benefit limit is 3 visits per year.</i> |                                              |                                                                |                   |
| <b>Prescription Drug Benefit</b>                                                             |                                              |                                                                |                   |
| Out of Pocket Maximum (Rx Only)                                                              |                                              |                                                                |                   |
|                                                                                              | Individual                                   | \$1,430                                                        | N/A               |
|                                                                                              | Family                                       | \$2,860                                                        | N/A               |
| Retail 30-Day Supply                                                                         |                                              |                                                                |                   |
|                                                                                              | Tier 1                                       | \$5                                                            | N/A               |
|                                                                                              | Tier 2                                       | \$25 if generic is not available.\$35 if generic is available  |                   |
|                                                                                              | Tier 3                                       | \$25 if generic is not available.\$35 if generic is available  |                   |
|                                                                                              | Preventative Medications as defined by PPACA | \$0 copay                                                      |                   |
| Mail Order 90-Day Supply                                                                     |                                              |                                                                |                   |
|                                                                                              | Tier 1                                       | \$5                                                            | N/A               |
|                                                                                              | Tier 2                                       | \$25 if generic is not available. \$35 if generic is available |                   |
|                                                                                              | Tier 3                                       | \$25 if generic is not available.\$35 if generic is available  |                   |
|                                                                                              | Preventative Medications as defined by PPACA | \$0 copay                                                      |                   |





Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

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**Precertification List**

**The following services require Precertification**

Inpatient hospitalization  
Home Health Services  
Inpatient Mental/Nervous facility based programs  
Inpatient Substance Abuse facility based programs  
Adenoidectomy  
Breast Surgery (non-diagnostic, excluding needle biopsy/aspirations or lumpectomies)  
Skilled Nursing Facility stays  
Infusion services  
Obesity Surgery  
Foot Surgery  
Gallbladder Surgery  
Infertility Services  
Heart Surgery (excluding cardiac catheterization or PTCA)  
Hysterectomy  
Joint Surgery (excluding arthroscopy for diagnostic use)  
Joint Replacement Surgery  
Laminectomy  
Nasal Surgery (excluding sinus surgery, i.e. submucous resection, ethmoidectomy, polyp removal)  
Prostatectomy (excluding TURP (transurethral prostatectomy))  
Spinal Fusion  
Tonsillectomy  
Lithotripsy after three





Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                                                                                                                                                                    | Silver Plan                            |                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------|
|                                                                                                                                                                                                                                             | Participating                          | Non-Participating            |
| *In-Network Services (Participating)                                                                                                                                                                                                        |                                        |                              |
| Allowables are based on the Negotiated Rate established in a contractual arrangement with a Provider and/or Facility.                                                                                                                       |                                        |                              |
| *Out-of-Network Services (Non-Participating) - Payments are subject to the "Maximum Allowable Charge"                                                                                                                                       |                                        |                              |
| "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan.                                                                                                                           |                                        |                              |
| Maximum Allowable Charge(s) may be the lesser of:                                                                                                                                                                                           |                                        |                              |
| 1. The Usual and Customary amount;                                                                                                                                                                                                          |                                        |                              |
| 2. The allowable charge specified under the terms of the Plan;                                                                                                                                                                              |                                        |                              |
| 3. 125% of the Medicare Reimbursement Rate; or                                                                                                                                                                                              |                                        |                              |
| 4. The actual billed charges for the covered services.                                                                                                                                                                                      |                                        |                              |
| The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount.                                                                                                                                         |                                        |                              |
| The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.                                                                                                 |                                        |                              |
| The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.                                                        |                                        |                              |
| Please see pre-certed services at the end of the schedule of benefits.                                                                                                                                                                      |                                        |                              |
| Lifetime Maximum                                                                                                                                                                                                                            | Unlimited                              | Unlimited                    |
| Plan Year Maximum                                                                                                                                                                                                                           | Unlimited                              | Unlimited                    |
| Deductible (Per Calendar Year)                                                                                                                                                                                                              |                                        |                              |
| Individual                                                                                                                                                                                                                                  | \$500                                  | \$1,000                      |
| Per Family Unit                                                                                                                                                                                                                             | \$1,000                                | \$2,000                      |
| Charges tracking to the deductible in the last quarter of the year are applied to the following year deductible.                                                                                                                            |                                        |                              |
| Out of Pocket Maximum                                                                                                                                                                                                                       |                                        |                              |
| Individual                                                                                                                                                                                                                                  | \$5,000                                | \$10,000                     |
| Family Unit                                                                                                                                                                                                                                 | \$10,000                               | \$20,000                     |
| Out-of-network expenses are applied to the in-network deductible and out-of-pocket maximum.                                                                                                                                                 |                                        |                              |
| The plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered charges for the rest of the Calendar Year unless otherwise stated. |                                        |                              |
| Deductible, Coinsurance, and Copayments are included in the Out of Pocket Maximum.                                                                                                                                                          |                                        |                              |
| Cost containment penalties do not apply toward the out-of-pocket maximum and are never paid at 100%.                                                                                                                                        |                                        |                              |
| Co-Payments                                                                                                                                                                                                                                 |                                        |                              |
| Teladoc Consultation                                                                                                                                                                                                                        | Covered 100%                           | N/A                          |
| Teladoc Specialist Consultation                                                                                                                                                                                                             | Covered 90% after \$45 copay           | N/A                          |
| Physician Visits                                                                                                                                                                                                                            | Covered 90% after \$25 copay           | Covered 80% after deductible |
| Specialist Visits                                                                                                                                                                                                                           | Covered 90% after \$45 copay           | Covered 80% after deductible |
| Urgent Care Visits                                                                                                                                                                                                                          | Covered 90% after \$25 copay           | Covered 80% after deductible |
| Emergency Services                                                                                                                                                                                                                          |                                        |                              |
| Ambulance Service (For Emergency Transportation Only)                                                                                                                                                                                       | Covered 80% after deductible           |                              |
| Emergency Room Services (copay waived if admitted)                                                                                                                                                                                          | Covered 100% after \$100 copay         |                              |
| The utilization review administrator must be notified within 48 hours of the admission (please refer to your ID card) even if the patient is discharged within 48 hours of the admission.                                                   |                                        |                              |
| Covered Services                                                                                                                                                                                                                            |                                        |                              |
| Acupuncture for Pain Management Only                                                                                                                                                                                                        | Covered 90% after \$25 copay per visit | Covered 80% after deductible |
| Allergy Injections/Testing                                                                                                                                                                                                                  | Covered 90% after deductible           | Covered 80% after deductible |







Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                                  | Silver Plan                                                                                       |                                                                                                         |
|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
|                                                                                                           | Participating                                                                                     | Non-Participating                                                                                       |
| <b>Biofeedback</b>                                                                                        | Covered 90% after \$25 copay per visit                                                            | Covered 80% after deductible                                                                            |
| <b>Chiropractic Care</b> (Limit of 30 visits per Calendar Year, Combined in and out-of-network)           | Covered 90% after \$25 copay                                                                      | Covered 80% after deductible                                                                            |
| <b>Diabetic Self-Management Education</b><br>(4 visits per year)                                          | Covered 100%                                                                                      | Not Covered                                                                                             |
| <b>Dialysis</b> (Outpatient)                                                                              | Covered 90% after deductible                                                                      | Covered 80% after deductible                                                                            |
| <i>Outpatient--100% of the Maximum Allowable Charge after all applicable deductibles and coinsurance.</i> |                                                                                                   |                                                                                                         |
| <b>Durable Medical Equipment</b>                                                                          | Covered 90% after deductible                                                                      | Covered 80% after deductible                                                                            |
| <b>Hearing Aids</b> (children under age 16 only, one per ear in 24 months)                                | Covered 90% after deductible                                                                      | Not Covered                                                                                             |
| <b>Home Health Care</b> (Nursing Home Care or Custodial Care is Not Covered)                              | Covered 90% after deductible                                                                      | Covered 80% after deductible                                                                            |
| <b>Hospice Care Outpatient &amp; Facility</b>                                                             | Covered 90% after deductible                                                                      | Covered 80% after deductible                                                                            |
| <b>Hospital Inpatient Care</b>                                                                            | Hospital Inpatient Care<br>Covered 90% after deductible                                           | Covered 80% after separate \$200 deductible per hospital stay                                           |
|                                                                                                           | Inpatient Physician Services<br>Covered 90% after deductible                                      | Covered 80% after deductible                                                                            |
| <b>Infertility Services</b>                                                                               | Diagnosis covered 90% after deductible: Treatment covered, with limitations, 90% after deductible | Diagnosis covered at 80% after deductible: Treatment covered, with limitations, at 80% after deductible |
| <b>Insulin Pump and Supplies</b>                                                                          | Not Covered                                                                                       | Not Covered                                                                                             |
| <b>Maternity Benefits</b>                                                                                 | Inpatient Hospital Charges<br>Covered 90% after deductible                                        | Covered 80% after separate \$200 deductible per hospital stay                                           |
|                                                                                                           | Obstetric Care/Physician Charges<br>Covered 100% after \$25 copay for first visit                 | Covered 80% after deductible                                                                            |
|                                                                                                           | Ultrasound<br>Covered 100%                                                                        | Covered 80% after deductible                                                                            |
| <b>Mental Health/Alcohol and Drug Abuse/Applied Behavioral Analysis (ABA)</b>                             | Inpatient<br>Covered 90% after deductible                                                         | Covered 80% after separate \$200 deductible per hospital stay                                           |
|                                                                                                           | Outpatient<br>Covered 90% after \$45 copay                                                        | Covered 80% after deductible                                                                            |
|                                                                                                           | ABA Only Home<br>Covered 90% after deductible                                                     | Covered 80% after deductible                                                                            |
| <b>Orthotics</b> (Limited to one pair per Calendar Year. \$600 maximum per Calendar Year)                 | Covered 90% after deductible                                                                      | Covered 80% after deductible                                                                            |
| <b>Prosthetic Devices</b>                                                                                 | Covered 90% after deductible                                                                      | Covered 80% after deductible                                                                            |
| <b>Scalp Hair Prostheses</b><br>(benefit max of \$500 in a 24 month period)                               | Covered 90%                                                                                       | Covered 80% after deductible                                                                            |
| <b>Skilled Nursing Facility</b>                                                                           | Covered 100% (For up to 120 Days per Calendar Year; combined in and out-of-network)               | 80% after deductible (For up to 60 Days per Calendar Year; combined in and out-of-network)              |





Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                            | Silver Plan                            |                                                                    |
|-----------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------------------------------------|
|                                                                                                     | Participating                          | Non-Participating                                                  |
| <b>Preventive Well Care as defined by PPACA</b>                                                     |                                        |                                                                    |
| Breastfeeding Support, Supplies & Counseling                                                        | Covered 100%                           | Covered 80% after deductible                                       |
| Colonoscopy & Colorectal Screening                                                                  | Covered 100%                           | Not Covered                                                        |
| Contraceptive Methods & Counseling                                                                  | Covered 100%                           | Covered 80% after deductible                                       |
| GYN/PAP                                                                                             | Covered 100%                           | Covered 80% after deductible                                       |
| Immunizations (Except for Travel and/or Job Related)                                                | Covered 100%                           | Covered for children under 12 months: Covered 80% after deductible |
| Mammograms (Includes 3D mammograms)                                                                 | Covered 100%                           | Covered 80% after deductible                                       |
| Prostate Cancer Screening                                                                           | Covered 100%                           | Not Covered                                                        |
| Routine Adult Physicals                                                                             | Covered 100%                           | Not Covered                                                        |
| Well Child Exams                                                                                    | Covered 100%                           | Not Covered                                                        |
| <b>Surgical Benefits</b>                                                                            |                                        |                                                                    |
| Ambulatory Surgical Center/Free Standing Facility                                                   | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Anesthesia at Ambulatory Surgical Center/Free Standing Facility                                     | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Physician Services at Ambulatory Surgical Center/Free Standing Facility                             | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Physician Office                                                                                    | Covered 90%                            | Covered 80% after deductible                                       |
| Hospital Inpatient Surgery                                                                          | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Anesthesia Hospital Inpatient                                                                       | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Physician Services Hospital Inpatient                                                               | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Hospital Outpatient Surgery                                                                         | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Anesthesia Hospital Outpatient                                                                      | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Physician Services Hospital Outpatient                                                              | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Bariatric Surgery                                                                                   | Not Covered                            | Not Covered                                                        |
| <b>X-Rays, Ultrasound and Lab Tests - Charge By Place of Service</b>                                |                                        |                                                                    |
| Physicians Office Testing                                                                           | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Independent Facility Testing                                                                        | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Hospital - Outpatient Testing                                                                       | Covered 90% after deductible           | Covered 80% after deductible                                       |
| <b>Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.) - Charge By Place of Service</b> |                                        |                                                                    |
| Physicians Office Testing                                                                           | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Independent Facility Testing                                                                        | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Hospital - Outpatient Testing                                                                       | Covered 90% after deductible           | Covered 80% after deductible                                       |
| <b>Therapy Services</b>                                                                             |                                        |                                                                    |
| Chemotherapy                                                                                        | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Radiation Therapy                                                                                   | Covered 90% after deductible           | Covered 80% after deductible                                       |
| Infusion (Limited to a \$250 out-of-pocket maximum per incident)                                    | Covered 90% after \$25 copay per visit | Covered 80% after deductible                                       |
| Occupational (Limited to a \$250 out-of-pocket maximum per incident) (includes diagnosis of autism) | Covered 90% after \$25 copay per visit | Covered 80% after deductible                                       |
| Outpatient Cardiac Rehabilitation (Limited to a \$250 out-of-pocket maximum per incident)           | Covered 90% after \$25 copay per visit | Covered 80% after deductible                                       |







Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

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**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                               |                                              | Silver Plan                                                   |                              |
|--------------------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------|------------------------------|
|                                                                                                        |                                              | Participating                                                 | Non-Participating            |
| <b>Physical</b> (Limited to a \$250 out-of-pocket maximum per incident) (includes diagnosis of autism) |                                              | Covered 90% after \$25 copay per visit                        | Covered 80% after deductible |
| <b>Speech</b> (Limited to a \$250 out-of-pocket maximum per incident) (includes diagnosis of autism)   |                                              | Covered 90% after \$25 copay per visit                        | Covered 80% after deductible |
| <b>Vision Care Benefits</b>                                                                            |                                              |                                                               |                              |
| Routine Annual Eye Examinations                                                                        |                                              | Covered 100%                                                  | Not Covered                  |
| <b>Wellness Program Work Site Benefits</b>                                                             |                                              |                                                               |                              |
| Wellness Coach On-Site Visits                                                                          |                                              | Covered 100%                                                  | N/A                          |
| Nutritional Counseling On-Site Visits                                                                  |                                              | Covered 100%                                                  | N/A                          |
| Nutritional Counseling                                                                                 |                                              | Covered 90% after \$25 copay per visit                        | Not Covered                  |
| <i>*Nutritional Counseling is a combined benefit and benefit limit is 3 visits per year.</i>           |                                              |                                                               |                              |
| <b>Prescription Drug Benefit</b>                                                                       |                                              |                                                               |                              |
| Out of Pocket Maximum                                                                                  | Individual                                   | \$1,430                                                       | N/A                          |
|                                                                                                        | Family Unit                                  | \$2,860                                                       | N/A                          |
| Retail 30-Day Supply                                                                                   | Tier 1                                       | \$5                                                           | N/A                          |
|                                                                                                        | Tier 2                                       | \$25 if generic is not available.\$35 if generic is available |                              |
|                                                                                                        | Tier 3                                       | \$25 if generic is not available.\$35 if generic is available |                              |
|                                                                                                        | Preventative Medications as defined by PPACA | \$0                                                           |                              |
| Mail Order 90-Day Supply                                                                               | Tier 1                                       | \$5                                                           | N/A                          |
|                                                                                                        | Tier 2                                       | \$25 if generic is not available.\$35 if generic is available |                              |
|                                                                                                        | Tier 3                                       | \$25 if generic is not available.\$35 if generic is available |                              |
|                                                                                                        | Preventative Medications as defined by PPACA | \$0                                                           |                              |

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Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

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**Precertification List**

**The following services require Precertification**

Inpatient hospitalization  
Home Health Services  
Inpatient Mental/Nervous facility based programs  
Inpatient Substance Abuse facility based programs  
Adenoidectomy  
Breast Surgery (non-diagnostic, excluding needle biopsy/aspirations or lumpectomies)  
Skilled Nursing Facility stays  
Infusion services  
Obesity Surgery  
Foot Surgery  
Gallbladder Surgery  
Infertility Services  
Heart Surgery (excluding cardiac catheterization or PTCA)  
Hysterectomy  
Joint Surgery (excluding arthroscopy for diagnostic use)  
Joint Replacement Surgery  
Laminectomy  
Nasal Surgery (excluding sinus surgery, i.e. submucous resection, ethmoidectomy, polyp removal)  
Prostatectomy (excluding TURP (transurethral prostatectomy))  
Spinal Fusion  
Tonsillectomy  
Lithotripsy after three  
Prosthetic Devices





Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                                                                                                                                                                        |  | Bronze Plan - HSA Option     |                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------|------------------------------|
|                                                                                                                                                                                                                                                 |  | Participating                | Non-Participating            |
|                                                                                                                                                                                                                                                 |  |                              |                              |
| <b>*In-Network Services (Participating)</b>                                                                                                                                                                                                     |  |                              |                              |
| Allowables are based on the Negotiated Rate established in a contractual arrangement with a Provider and/or Facility.                                                                                                                           |  |                              |                              |
| <b>*Out-of-Network Services (Non-Participating) - Payments are subject to the "Maximum Allowable Charge"</b>                                                                                                                                    |  |                              |                              |
| "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan.                                                                                                                               |  |                              |                              |
| 1. The Usual and Customary amount;                                                                                                                                                                                                              |  |                              |                              |
| 2. The allowable charge specified under the terms of the Plan;                                                                                                                                                                                  |  |                              |                              |
| 3. 125% of the Medicare Reimbursement Rate; or                                                                                                                                                                                                  |  |                              |                              |
| 4. The actual billed charges for the covered services.                                                                                                                                                                                          |  |                              |                              |
| The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service. |  |                              |                              |
| The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.                                                            |  |                              |                              |
| <b>Please see pre-certed services at the end of the schedule of benefits.</b>                                                                                                                                                                   |  |                              |                              |
| Lifetime Maximum                                                                                                                                                                                                                                |  | Unlimited                    | Unlimited                    |
| Plan Year Maximum                                                                                                                                                                                                                               |  | Unlimited                    | Unlimited                    |
| Deductible (Per Calendar Year)                                                                                                                                                                                                                  |  |                              |                              |
| Single Coverage                                                                                                                                                                                                                                 |  | \$1,500                      | \$1,500                      |
| Family Coverage                                                                                                                                                                                                                                 |  | \$3,000                      | \$3,000                      |
| Out of Pocket Maximum (Combined with Rx)                                                                                                                                                                                                        |  |                              |                              |
| Single Coverage                                                                                                                                                                                                                                 |  | \$2,500                      | \$3,500                      |
| Family Coverage                                                                                                                                                                                                                                 |  | \$5,000                      | \$7,000                      |
| Out-of-network expenses are applied to the in-network deductible and out-of-pocket maximum.                                                                                                                                                     |  |                              |                              |
| The plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered charges for the rest of the Calendar Year unless otherwise stated.     |  |                              |                              |
| Deductible and Coinsurance are applied to the Out of Pocket Maximum. There is no deductible carry over provision for this plan.                                                                                                                 |  |                              |                              |
| Cost Containment penalties do not apply toward the out-of-pocket maximum and are never paid at 100% .                                                                                                                                           |  |                              |                              |
| Employer HSA Funding                                                                                                                                                                                                                            |  | \$500 Annually               |                              |
| Coinsurance                                                                                                                                                                                                                                     |  |                              |                              |
| Teladoc Consultation                                                                                                                                                                                                                            |  | Covered 80% after deductible | N/A                          |
| Teladoc Specialist Consultation                                                                                                                                                                                                                 |  | Covered 80% after deductible | N/A                          |
| Physician Office Visits                                                                                                                                                                                                                         |  | Covered 80% after deductible | Covered 60% after deductible |
| Specialist Office Visits                                                                                                                                                                                                                        |  | Covered 80% after deductible | Covered 60% after deductible |
| Urgent Care Visits                                                                                                                                                                                                                              |  | Covered 80% after deductible | Covered 60% after deductible |
| Emergency Services                                                                                                                                                                                                                              |  |                              |                              |
| Ambulance Service (For Emergency Transportation Only)                                                                                                                                                                                           |  | Covered 80% after deductible |                              |
| Emergency Room Services                                                                                                                                                                                                                         |  | Covered 80% after deductible |                              |
| The utilization review administrator must be notified within 48 hours of the admission (please refer to your ID card), even if the patient is discharged within 48 hours of the admission.                                                      |  |                              |                              |
| Covered Services                                                                                                                                                                                                                                |  |                              |                              |
| Acupuncture For Pain Management Only                                                                                                                                                                                                            |  | Covered 80% after deductible | Covered 60% after deductible |
| Allergy Injections/Testing                                                                                                                                                                                                                      |  | Covered 80% after deductible | Covered 60% after deductible |





Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                                               | Bronze Plan - HSA Option                                                                            |                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
|                                                                                                                        | Participating                                                                                       | Non-Participating                                                                                  |
| <b>Biofeedback</b>                                                                                                     | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <b>Chiropractic Care</b> (Limit of 30 visits per Calendar Year, Combined in and out-of-network)                        | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <b>Diabetic Self-Management Education</b><br>(4 visits per year)                                                       | Covered 100%                                                                                        | Not Covered                                                                                        |
| <b>Dialysis Treatment (Outpatient)</b>                                                                                 | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <i>Outpatient--100% of the Maximum Allowable Charge after all applicable deductibles and coinsurance.</i>              |                                                                                                     |                                                                                                    |
| <b>Durable Medical Equipment</b>                                                                                       | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <b>Hearing Aids</b> (children under age 16 only, one per ear in 24 months)                                             | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <b>Home Health Care</b> (Nursing Home Care or Custodial Care is Not Covered)                                           | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <b>Hospice Care -Outpatient &amp; Facility</b>                                                                         | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <b>Hospital Inpatient Care</b>                                                                                         |                                                                                                     |                                                                                                    |
| Inpatient Admission                                                                                                    | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| Inpatient Physician Services                                                                                           | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <b>Infertility Services</b>                                                                                            | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <b>Insulin Pump and Supplies</b>                                                                                       | Not Covered                                                                                         | Not Covered                                                                                        |
| <b>Maternity/PreNatal Care</b>                                                                                         |                                                                                                     |                                                                                                    |
| Inpatient Hospital Charges                                                                                             | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| Obstetric Care/Physician Charges                                                                                       | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| Ultrasound                                                                                                             | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <b>Mental Health/Alcohol and Drug Abuse/Applied Behavioral Analysis (ABA)</b>                                          |                                                                                                     |                                                                                                    |
| Inpatient                                                                                                              | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| Outpatient                                                                                                             | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| ABA Only Home                                                                                                          | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <b>Orthotics</b> (Limited to one pair per Calendar Year. \$600 maximum per Calendar Year)                              | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <b>Prosthetic Devices</b>                                                                                              | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <b>Scalp Hair Protheses</b> (benefit max of \$500 in a 24 month period)                                                | Covered 80% after deductible                                                                        | Covered 60% after deductible                                                                       |
| <i>Only for the treatment of disease by radiation or chemicals, Alopecia Universalis (totalis), or Alopecia Areata</i> |                                                                                                     |                                                                                                    |
| <b>Skilled Nursing Facility</b>                                                                                        | Covered 80% after deductible (For up to 120 Days per Calendar Year; combined in and out-of-network) | Covered 60% after deductible (For up to 60 Days per Calendar Year; combined in and out-of-network) |







Powerful Solutions Real Savings From IAA, Your Employee Benefit Experts

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**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                            | Bronze Plan - HSA Option     |                                                                    |
|-----------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------|
|                                                                                                     | Participating                | Non-Participating                                                  |
| <b>Preventive Well Care as defined by PPACA</b>                                                     |                              |                                                                    |
| Breastfeeding Support, Supplies & Counseling                                                        | Covered 100%                 | Covered 60% after deductible                                       |
| Colonoscopy & Colorectal Screening                                                                  | Covered 100%                 | Not Covered                                                        |
| Contraceptive Methods & Counseling                                                                  | Covered 100%                 | Covered 60% after deductible                                       |
| GYN/PAP                                                                                             | Covered 100%                 | Covered 60% after deductible                                       |
| Immunizations (Except for Travel and/or Job Related)                                                | Covered 100%                 | Covered for children under 12 months: Covered 80% after deductible |
| Mammograms (Includes 3D mammograms)                                                                 | Covered 100%                 | Covered 60% after deductible                                       |
| Prostate Cancer Screening                                                                           | Covered 100%                 | Not Covered                                                        |
| Routine Adult Physicals                                                                             | Covered 100%                 | Not Covered                                                        |
| Well Child Exams                                                                                    | Covered 100%                 | Not Covered                                                        |
| <b>Surgical Benefits</b>                                                                            |                              |                                                                    |
| Ambulatory Surgical Center/Free Standing Facility                                                   | Covered 80% after deductible | Covered 60% after deductible                                       |
| Anesthesia at Ambulatory Surgical Center/Free Standing Facility                                     | Covered 80% after deductible | Covered 60% after deductible                                       |
| Physician Services at Ambulatory Surgical Center/Free Standing Facility                             | Covered 80% after deductible | Covered 60% after deductible                                       |
| Physician Office                                                                                    | Covered 80% after deductible | Covered 60% after deductible                                       |
| Hospital Inpatient Surgery                                                                          | Covered 80% after deductible | Covered 60% after deductible                                       |
| Anesthesia Hospital Inpatient                                                                       | Covered 80% after deductible | Covered 60% after deductible                                       |
| Physician Services Hospital Inpatient                                                               | Covered 80% after deductible | Covered 60% after deductible                                       |
| Hospital Outpatient Surgery                                                                         | Covered 80% after deductible | Covered 60% after deductible                                       |
| Anesthesia Hospital Outpatient                                                                      | Covered 80% after deductible | Covered 60% after deductible                                       |
| Physician Services Hospital Outpatient                                                              | Covered 80% after deductible | Covered 60% after deductible                                       |
| Bariatric Surgery                                                                                   | Not Covered                  | Not Covered                                                        |
| <b>X-Rays, Ultrasound and Lab Tests - Charge By Place of Service</b>                                |                              |                                                                    |
| Physicians Office Testing                                                                           | Covered 80% after deductible | Covered 60% after deductible                                       |
| Independent Facility Testing                                                                        | Covered 80% after deductible | Covered 60% after deductible                                       |
| Hospital - Outpatient Testing                                                                       | Covered 80% after deductible | Covered 60% after deductible                                       |
| <b>Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.) - Charge By Place of Service</b> |                              |                                                                    |
| Physicians Office Testing                                                                           | Covered 80% after deductible | Covered 60% after deductible                                       |
| Independent Facility Testing                                                                        | Covered 80% after deductible | Covered 60% after deductible                                       |
| Hospital - Outpatient Testing                                                                       | Covered 80% after deductible | Covered 60% after deductible                                       |
| <b>Therapy Services</b>                                                                             |                              |                                                                    |
| Chemotherapy                                                                                        | Covered 80% after deductible | Covered 60% after deductible                                       |
| Radiation Therapy                                                                                   | Covered 80% after deductible | Covered 60% after deductible                                       |
| Infusion (Limited to a \$250 out-of-pocket maximum per incident)                                    | Covered 80% after deductible | Covered 60% after deductible                                       |





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**Evesham Township  
Schedule of Benefits  
January 1, 2023  
Non-Grandfathered Plan**

| Benefits                                                                                                   | Bronze Plan - HSA Option     |                              |
|------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------|
|                                                                                                            | Participating                | Non-Participating            |
| <b>Occupational</b> (Limited to a \$250 out-of-pocket maximum per incident) (includes diagnosis of autism) | Covered 80% after deductible | Covered 60% after deductible |
| <b>Outpatient Cardiac Rehabilitation</b> (Limited to a \$250 out-of-pocket maximum per incident)           | Covered 80% after deductible | Covered 60% after deductible |
| <b>Physical</b> (Limited to a \$250 out-of-pocket maximum per incident) (includes diagnosis of autism)     | Covered 80% after deductible | Covered 60% after deductible |
| <b>Speech</b> (Limited to a \$250 out-of-pocket maximum per incident) (includes diagnosis of autism)       | Covered 80% after deductible | Covered 60% after deductible |
| <b>Vision Care Benefits</b>                                                                                |                              |                              |
| <b>Routine Annual Eye Examinations</b>                                                                     | Covered 100%                 | Not Covered                  |
| <b>Wellness &amp; Nutritional Coach On-Site Benefits</b>                                                   |                              |                              |
| <b>Wellness Coach On-Site Visits</b>                                                                       | Covered 100%                 | N/A                          |
| <b>* Nutritional Counseling On-Site Visits</b>                                                             | Covered 100%                 | N/A                          |
| <b>*Nutritional Counseling</b>                                                                             | Covered 80% after deductible | Not Covered                  |
| <i>*Nutritional Counseling is a combined benefit and benefit limit is 3 visits per year.</i>               |                              |                              |
| <b>Prescription Drug Benefit</b>                                                                           |                              |                              |
| <b>Rx Out of Pocket Maximum: Combined with Medical</b>                                                     |                              |                              |
| <b>Rx Benefit</b>                                                                                          | Covered 80% after deductible | Not Covered                  |
| <b>Preventive Medications as defined by PPACA are covered at 100%</b>                                      |                              |                              |

| Precertification List                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| The following services require Precertification                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |
| Inpatient hospitalization<br>Home Health Services<br>Inpatient Mental/Nervous facility based programs<br>Inpatient Substance Abuse facility based programs<br>Adenoidectomy<br>Breast Surgery (non-diagnostic, excluding needle biopsy/aspirations or lumpectomies)<br>Skilled Nursing Facility stays<br>Infusion services<br>Obesity Surgery<br>Foot Surgery<br>Gallbladder Surgery<br>Infertility Services<br>Heart Surgery (excluding cardiac catheterization or PTCA)<br>Hysterectomy<br>Joint Surgery (excluding arthroscopy for diagnostic use)<br>Joint Replacement Surgery<br>Laminectomy<br>Nasal Surgery (excluding sinus surgery, i.e. submucous resection, ethmoidectomy, polyp removal)<br>Prostatectomy (excluding TURP (transurethral prostatectomy))<br>Spinal Fusion<br>Tonsillectomy<br>Lithotripsy after three<br>Prosthetic Devices |  |





# Township of Evesham

|                                   |                                  |
|-----------------------------------|----------------------------------|
| Policy:<br>Leave of Absence       | Manual:<br>Human Resources       |
| Effective Date:<br>September 2000 | Policy No.:<br>301               |
| Last Review Date:<br>July 2020    | Distribution:<br>All Departments |

## I. POLICY

It is the policy of the Township of Evesham to provide eligible employees with leaves of absence in the event of certain family or medical circumstances. The provisions of the leave shall be consistent with the provisions of the Federal Family and Medical Leave Act (FMLA), the New Jersey Family Leave Act (NJFLA), the Township of Evesham Code §22-9 and all appropriate Collective Negotiations Agreements. The Township will not interfere with, restrain, or deny the exercise of any right provided by this law. The Township will not discharge or discriminate against any individual for opposing any practice, or because of involvement in any proceeding, related to FMLA or NJFLA. The employee may be eligible for NJ State Temporary Disability benefits during this time, dependent upon the rules of the Temporary Disability program.

Employees who are not eligible for leave under the FMLA or NJFLA may be eligible for a General Leave of Absence at the discretion of the Township, or as required by their respective Collective Negotiations Agreements. Employees should contact the Human Resources Office for more specific information if they have questions.

## II. DEFINITION OF TERMS

For purposes of this Policy, a leave of absence shall be defined as a pre-arranged period during which an employee is authorized to be absent from duty. Leaves may be considered either FMLA and/or NJFLA leaves of absence or General Leaves of Absence. Leaves may be either with pay through the use of accrued Sick time and/or accrued Vacation time, or without pay in the absence of sufficient Sick or Vacation time as allowable by law. Whether paid time off is used or not, where appropriate, leave may be counted against an employee's entitlement under the FMLA and/or the NJFLA.

## III. EMPLOYEE ELIGIBILITY

Employees shall be eligible for a leave of absence under the FMLA if they have worked for the Township for at least 12 months (does not need to be consecutive) and at least 1250 hours in the 12-month period immediately preceding the commencement of the leave.

Employees shall be eligible for a leave of absence under the NJFLA if they have worked for the Township for at least 12 months (need not be consecutive) and at least 1000 hours in the 12-month period immediately preceding the commencement of leave. (This 1000 hours includes time out on workers' compensation leave and military service).

Employees not meeting the above eligibility requirements may be eligible for a General Leave of Absence at the discretion of the Township or as required by their respective Collective Negotiations Agreement or law.





#### IV. REASONS FOR LEAVE

A. Leaves of Absence may be granted for the following reasons:

1. The birth of a child, or the placement of a child with the employee for adoption or foster care, and/or to care for the child (referred to as Family Leave under the FMLA and NJFLA);
2. To care for an employee's child, spouse or parent, with a serious health condition (referred to as Family Leave under the FMLA and NJFLA);
3. To care for an employee's parent-in-law, domestic or civil union partner with a serious health condition (referred to as Family Leave under the NJFLA only);
4. For the employee's own serious health condition, including pregnancy or on-the-job illness or injury that makes the employee unable to perform at least one of his/her essential job functions (referred to as Medical Leave under the FMLA only);
5. Because of any qualifying exigency arising out of the fact that the spouse or a son, daughter, or parent of the employee is on active duty (or has been notified of an impending call order to active duty) in the Armed Forces in support of a contingency operation (referred to as Service Member Exigency Leave under the FMLA only);
6. To care for the spouse, son, daughter, parent or next of kin who is a covered service member who needs medical treatment, recuperation or therapy, is otherwise in out-patient status or is otherwise on the temporary disability retired list for a serious illness or injury incurred in the line of duty (referred to as Military Caregiver Medical Leave under the FMLA only).

Where leave is covered under both the FMLA and the NJFLA and the employee is eligible for leave under both laws, time out shall run concurrently against an employee's entitlement under both laws.

In the sole discretion of the Township Manager, leaves of absence may be granted for other purposes as deemed in the best interests of the Township or as otherwise required by law or provided by Collective Negotiations Agreement. Leaves granted to employees who are not eligible for FMLA and/or NJFLA, or for purposes not covered by the FMLA and/or NJFLA shall not be deducted from an employee's FMLA and/or NJFLA entitlement. When these leaves are approved and paid, all benefits will remain intact.

#### V. NOTICE REQUIREMENTS

Where the need for leave is foreseeable, the employee must provide at least 30 days' advance notice (15 days advance notice for a serious health condition of a family member). If such advance notice is not possible, the employee must provide as much notice as is possible. Employees can provide notice to the Township on **Leave Request Forms** (Attachment A) that can be obtained in the Human Resources Office. If the employee does not provide sufficient advance notice, leave may be delayed until proper notice is given, or if leave has already begun, leave may be deemed unauthorized.

Once an employee provides notice of the need for leave, an employee shall be provided with a **Leave Designation/Employee Acknowledgement of Obligations Form** (Attachment B) which the employee should review and return to the Human Resources Office.

In the case of FMLA/NJFLA leave resulting from the serious health condition of the employee or an employee's family member, the employee shall submit a completed **Health Care Provider Certification Form** as soon as possible after the request for leave. Employees must provide the



completed form to Human Resources no later than 15 calendar days from the date the Township provides the form to the employee. Failure to provide the completed Health Care Provider Certification Form in a timely manner may result in delay of requested leave, or if leave has already begun, leave being deemed unauthorized. (The Township maintains separate Health Care Provider Certification Forms for the serious health condition of the employee and the serious health condition of the family member).

The Human Resources Office may contact an employee's (or family member's) health care provider with prior approval of the patient or family member to authenticate or clarify information provided on the Health Care Provider Certification Form. In the event that the Health Care Provider Certification Form is not deemed sufficient, the employee shall be provided with written notice of such deficiency and shall be provided with 7 days to cure the deficiency. Failure to cure the deficiency may result in the denial of leave or the request of a second opinion.

In the event the Township reasonably doubts the validity of the medical certification, the Township may, at its own expense, require the employee to secure a second opinion by a health care provider selected by the Township. If the two opinions differ, the Township may, at its own expense, require a third opinion, by a jointly designated or approved health care provider, which opinion shall be binding on both the Township and the employee.

The Township of Evesham may request recertification of a serious health condition every 30 days or as frequently as required by the initial Health Care Provider Certification. The employer may also request recertification if the circumstances described in the former certification change substantially, or if the Township reasonably doubts the validity of leave.

Employees requesting leave for the birth, adoption or foster care placement of a child may be required to provide proof of birth, adoption or foster care placement.

Employees requesting leave due for Service Member Exigency Leave or Military Caregiver Leave shall also be required to complete forms obtained from Human Resources (Attachments D and E).

## **VI. LENGTH AND TYPES OF LEAVE**

### **A. FMLA**

Eligible employees are entitled to a maximum of 12 work-weeks of leave in a rolling 12-month period. Employees needing Military Caregiver Leave are entitled to a maximum of 26 weeks of leave in a 12-month period. This 26-weeks shall include all FMLA time taken in the 12-month period. The 12-month period begins on the first day an employee begins FMLA leave. FMLA leave is not cumulative and unused FMLA leave cannot be carried over to a future 12-month period.

### **B. NJFLA**

Eligible employees are entitled to a maximum of 12 work-weeks of leave in a 24-month period. The 24-month period begins on the first day an employee begins NJFLA leave. NJFLA leave is not cumulative and unused NJFLA leave cannot be carried over.

### **C. TYPES OF LEAVE**

Employees may take FMLA/NJFLA leave on a continuous, intermittent or reduced leave basis as described below:



1. Continuous Leave is leave which is taken in a single block of time up to the employee's maximum leave entitlement;
2. Intermittent Leave is leave taken in separate blocks of time. The use of intermittent leave must be deemed medically necessary and may be used only for the employee's own serious health condition, the serious health condition of a family member, Service Member Exigency Leave or Military Caregiver Leave. Intermittent leave cannot be used for the birth, adoption or foster care placement of a child.
3. Reduced Schedule Leave is leave which reduces the usual number of working hours or days per week the employee works, must be deemed medically necessary and may be used only for the employee's own serious health condition, the serious health condition of a family member, Service Member Exigency Leave or Military Caregiver Leave. Reduced Schedule leave cannot be used for the birth, adoption or foster care placement of a child.

Employees taking intermittent or reduced schedule leave must attempt to schedule leave so as not to disrupt Township operations. In order to accommodate an intermittent or reduced leave schedule, the Township may transfer an employee to an alternative position with equivalent pay and benefits for the duration of the leave.

#### D. USE OF ACCRUED PAID TIME OFF

Employees taking leave for the care of a newborn child or a seriously ill family member, or for the adoption or placement of a child, must exhaust all accrued paid vacation and sick time unless the employee is also taking paid leave as provided under New Jersey's Paid Family Leave Law. If an employee is taking paid leave as part of FMLA/NJFLA, the employee shall be required to use 2 weeks of paid vacation until the employee has exhausted his/her 12 weeks' entitlement of NJ Paid Leave (see Section below on NJ's Paid Family Leave Law). Thereafter, the employee shall be required to use his/her accrued remaining vacation and sick time for the remainder of the FMLA/NJFLA period.

Employees taking leave for their own serious health condition must exhaust all accrued paid sick and vacation time as part of the leave period. If employees are also receiving other partial pay supplementation, the use of paid time shall be used as a supplement. The remainder of the leave will be unpaid.

An employee who is on a General Leave of Absence may be required to use all accrued Sick and Vacation time. Donated Leave may be requested and will count towards "paid leave."

In all cases, up to 5 days accrued vacation may be reserved for use upon return to work.

#### E. EFFECT OF LEAVE ON SENIORITY AND PAY ANNIVERSARY DATE

An employee who is on leave status will retain all seniority rights and the leave shall not serve as a break in service. However, an employee shall not continue to accrue additional benefits while on unpaid leave.





An employee who is on leave will not be given a performance review until the employee returns from leave. The performance review date shall thereafter be changed to reflect completion of 12 months of service.

Employees shall be entitled to any and all salary increases to which they would have been entitled to but for the taking of leave; for example, non-merit based across-the-board increases.

## **VII. BENEFIT CONTINUATION**

### **A. BENEFIT ACCRUAL**

Although a leave under the FMLA/NJFLA shall not constitute a break in service, employees shall not accrue additional benefits while on an unpaid leave. Employees utilizing vacation or sick time as part of the leave period shall continue to accrue benefits in accordance with Township policy.

### **B. INSURANCE BENEFITS**

Health, Prescription, Dental, and Life Insurance coverage shall be continued while an employee is on an approved leave or as may otherwise be required by applicable Collective Negotiations Agreements. Employees using paid time off concurrently with a leave described herein shall also have his/her benefits continued for the duration of the use of paid leave.

Employees on FMLA leave are responsible for paying their employee share of health insurance premiums, as well as any voluntary contributions they wish to maintain. If employees are using accrued paid leave as part of the FMLA leave period, the employee's premium share will be deducted from paid leave wages. If an employee is on unpaid FMLA leave, the employee shall be required to submit payments to the Township's Human Resources office, on or before dates set by the Township, for his/her regular premium share.

In the event of the failure of the employee to make timely payments, the Township may terminate coverage if the payment is more than 30 days late. The employer will provide written notification 15 days prior to the loss of coverage.

Once FMLA leave has expired, unless an employee is on an approved leave with pay, the employee's paid benefits shall stop and the employee will be responsible for the entire premium for health, prescription and dental coverage. Such employees shall be provided with appropriate COBRA notifications.

Group Term Life Insurance benefits shall continue at Township expense during approved leaves of absence for up to six months of leave.

## **VIII. RETURN FROM LEAVE**

- A. Upon return from approved FMLA/NJFLA leave, an employee shall be reinstated to the same or an equivalent position to that the employee held prior to the leave, unless the employee would not otherwise have been employed at the time of reinstatement; i.e., if the employee would have been laid-off or terminated for performance reasons. Return from a General Leave of Absence may not be guaranteed, and an employee may not be returned to the same or an equivalent position unless

otherwise required by law or applicable Collective Negotiations Agreement. Employees who are deemed "key employees" may also be denied reinstatement. Employees deemed "key" shall be so notified at the beginning of their leave and shall be advised in writing of their status and its impact on reinstatement rights.

- B. Employees must give at least 2 business days' notice of return from leave, if such return date is different from the return date approved in the original leave request. Employees needing an extension of leave must provide as much advance notice as possible of the need for additional leave. The failure to give advance notice may be deemed reason to deny continued leave or deem continued leave unauthorized.
- C. An employee returning to work because of the employee's own serious health condition is required to provide a return to work note from his/her Health Care Provider stating that the employee is able to perform the essential functions of his/her position with or without accommodation. If an accommodation is needed, the Health Care Provider must indicate the type of accommodation needed and the duration of the needed accommodation. If the employee is in need of accommodation to perform his/her duties, the Township shall determine whether such requested accommodations are reasonable and if reinstatement can be made without undue hardship. The Township shall provide the employee with a copy of his/her job description or the essential functions of the position. An employee shall not be returned to work without a medical return to work release.
- D. An employee requesting an extension of leave must provide appropriate documentation to justify the need for the extension. If the employee has FMLA/NJFLA leave available, leave extension requests shall be as required by the FMLA/NJFLA. If FMLA/NJFLA leave entitlements have been exhausted, leave requests shall be made in the discretion of the Township or as may be required by Collective Negotiations Agreement or by law.
- E. An employee who fails to return to work as scheduled and does not request a timely extension or such extension is denied, shall be deemed to have resigned his/her position with the Township. Employees will be deemed to have resigned in good standing only if they provide notice to the Township and cannot return to work due to a documented serious health condition and/or other reason beyond their control.
- F. An employee who fails to return to work at the end of an approved leave, may be required to repay any insurance premiums paid by the Township on the employee's behalf during the period of leave. This requirement will be waived if the employee cannot return to work due to the onset or continuation of a serious health condition or other circumstances beyond the employee's control.

## **IX. WORKERS' COMPENSATION**

An employee's FMLA leave may run concurrently with an employee's workers' compensation leave provided that the underlying workers' compensation injury constitutes a serious health condition under FMLA. An employee's right to Workers' Compensation benefits shall not add to or detract from rights under the FMLA/NJFLA

## **X. DISCIPLINE**

An employee who intentionally furnishes incorrect information in order to obtain FMLA/NJFLA leave, is not protected by the FMLA's or NJFLA's job restoration benefit. He/she is not protected by the FMLA's maintenance of health benefits provisions and will be subject to appropriate disciplinary action, up to and including termination.



## **XI. NEW JERSEY PAID FAMILY LEAVE**

Eligible employees may take up to 12 weeks (56 days if intermittent) of paid family leave to: care for a child, spouse, parent, or domestic partner, as well as parents-in-law, siblings, grandparents, grandchildren, any blood relative, and anyone who is the equivalent of family – their loved ones. Employees may also claim benefits to take time off to bond with a new foster care placement. Victims of domestic or sexual violence and their family caregivers are also eligible. Time out as paid family leave shall run concurrently with leave under the NJFLA and/or FMLA where appropriate.

Employees should contact Human Resources for additional information.

## **XII. EFFECT ON THIS POLICY**

Effective with the implementation of this policy, its provisions shall supersede all previous or contradictory policies.

## **XIII. APPROVALS**

Approved by:

  
\_\_\_\_\_  
Township Manager

15 SEP 23  
Date