

Lumberton Township Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna

Who Can Select This Plan?

	All Employees	All Employees	Non-Represented Before 7/1/20
	NJ Educators Health Plan	*Garden State Plan (NJ Network Only)	POS \$10
In-Network Benefits	In Network	In Network	In Network
Deductible (Per Calendar Year)	\$0 Individual \$0 Family	\$0 Individual \$0 Family	\$0 Individual \$0 Family
Out of Pocket Limit (Per Calendar Year)	\$500 Individual \$1,000 Family	\$500 Individual \$1,000 Family	\$400 Individual \$800 Family
Primary Care	\$10 copay	\$10 copay	\$10 copay
Specialist	\$15 copay	\$15 copay	\$10 copay
Preventive	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge	No Charge	No Charge
Imaging (CT/PET scans, MRIs)	No Charge	No Charge	No Charge
Outpatient Surgery	No Charge	No Charge	No Charge
Emergency Room	\$125 copay	\$125 copay	\$25 copay
Emergency Transportation	90% covered	90% covered	90% covered
Urgent Care	\$15 copay	\$15 copay	\$10 copay
Durable Medical Equipment	90% covered	90% covered	90% covered
Hospital Stay	No Charge	No Charge	No Charge
Eye Exams	\$15 Copay 1 exam/calendar year	\$15 Copay 1 exam/calendar year	\$10 Copay 1 exam/calendar year
Out of Network Benefits	Out of Network	Out of Network	Out of Network
Deductible (Per Calendar Year)	\$350 Ind/\$700 Family	\$350 Ind/\$700 Family	\$100 Ind/\$250 Family
Coinsurance	70% after deductible	70% after deductible	60% after deductible
Out of Pocket Limit (Per Calendar Year)	\$2,000 Ind/\$5,000 Family	\$2,000 Ind/\$5,000 Family	\$2,000 Ind/\$5,000 Family

-*The GSP is a network of NJ providers only. Out of state services will not be covered unless it is a true medical emergency.

-Preauthorization may be required for certain services.

-For the NJEHP & GSP, the employee's contribution is based on new salary based contribution schedules. For all other plans, your employee contributions will remain the same per your collective bargaining agreement.

This overview is being provided as a convenient reference tool and is not a complete overview of the benefits being offered through your medical plans. Some plan limitations may apply. Please refer to the plan documents provided by your carriers for detailed plan information. If there is any discrepancy between the descriptions of the program elements in this overview and the official plan documents, the language of the official plan documents shall prevail as accurate.

Lumberton Township Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna

Who Can Select This Plan?	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20
	POS \$15	POS \$15/\$25	POS \$20/\$30	POS \$20/\$35
In-Network Benefits	In Network	In Network	In Network	In Network
Deductible (Per Calendar Year)	\$0 Individual	\$0 Individual	\$0 Individual	\$200 Individual
	\$0 Family	\$0 Family	\$0 Family	\$400 Family
Out of Pocket Limit (Per Calendar Year)	\$400 Individual	\$400 Individual	\$800 Individual	\$2,000 Individual
	\$800 Familly	\$800 Family	\$1,600 Family	\$4,000 Family
Primary Care	\$15 copay	\$15 copay	\$20 copay	\$20 copay
Specialist	\$15 copay	\$25 Charge	\$30 copay	\$35 copay
Preventive	No Charge	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge	No Charge	No Charge	No charge for office, 20% coinsurance for Ind. Labs or Out Patient Hospital
Imaging (CT/PET scans, MRIs)	No Charge	No Charge	No Charge	60% after deductible for outpatient hospital
Outpatient Surgery	No Charge	No Charge	No Charge	80% covered
Emergency Room	\$50 copay	\$75 copay	\$100 copay	\$100 copay & 20% coinsurance for Outpatient Hospital
Emergency Transportation	90% covered	90% covered	90% covered	80% covered
Urgent Care	\$15 copay	\$25 copay	\$30 copay	\$35 copay
Durable Medical Equipment	90% covered	90% covered	90% covered	80% covered
Hospital Stay	No Charge	No Charge	No Charge	80% covered
Eye Exams	\$10 Copay 1 exam/calendar year	\$10 Copay 1 exam/calendar year	\$10 Copay 1 exam/calendar year	\$10 Copay 1 exam/calendar year
Out of Network Benefits	Out of Network	Out of Network	Out of Network	Out of Network
Deductible (Per Calendar Year)	\$100 Ind/\$250 Family	\$100 Ind/\$250 Family	\$200 Ind/\$500 Family	\$800 Ind/\$2,000 Family
	70% after deductible	70% after deductible	70% after deductible	60% after deductible
Out of Pocket Limit (Per Calendar Year)	\$2,000 Ind/\$5,000 Family	\$2,000 Ind/\$5,000 Family	\$5,000 Ind/\$12,500 Family	\$5,000 Ind/\$12,500 Family

-*The GSP is a network of NJ providers only. Out of state services will not be covered unless it is a true medical emergency.

-Preauthorization may be required for certain services.

-For the NJEHP & GSP, the employee's contribution is based on new salary based contribution schedules. For all other plans, your employee contributions will remain the same per your collective bargaining agreement.

This overview is being provided as a convenient reference tool and is not a complete overview of the benefits being offered through your medical plans. Some plan limitations may apply. Please refer to the plan documents provided by your carriers for detailed plan information. If there is any discrepancy between the descriptions of the program elements in this overview and the official plan documents, the language of the official plan documents shall prevail as accurate.

Lumberton Township Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna

Who Can Select This Plan?	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20
	QPOS \$10	QPOS \$20	QPOS \$20/\$35
In-Network Benefits	In Network	In Network	In Network
Deductible (Per Calendar Year)	\$0 Individual \$0 Family	\$0 Individual \$0 Family	\$0 Individual \$0 Family
Out of Pocket Limit (Per Calendar Year)	\$4,000 Individual \$8,000 Family	\$4,000 Individual \$8,000 Family	\$4,000 Individual \$8,000 Family
Primary Care	\$10 copay	\$20 copay	\$20 copay
Specialist	\$10 copay	\$20 copay	\$35 copay
Preventive	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge	No Charge	No Charge
Imaging (CT/PET scans, MRIs)	No Charge	No Charge	No Charge
Outpatient Surgery	No Charge	No Charge	No Charge
Emergency Room	\$35 copay	\$100 copay	\$100 copay
Emergency Transportation	No Charge	No Charge	No Charge
Urgent Care	\$10 copay	\$20 copay	\$35 copay
Durable Medical Equipment	No Charge	No Charge	No Charge
Hospital Stay	No Charge	No Charge	No Charge
Eye Exams	\$10 Copay 1 exam/calendar year	\$10 copay (1 Exam/12 Months)	\$10 copay (1 Exam/12 Months)
Out of Network Benefits	Out of Network	Out of Network	Out of Network
Deductible (Per Calendar Year)	\$500 Ind/\$1,000 Family	\$500 Ind/\$1,000 Family	\$500 Ind/\$1,000 Family
Coinsurance	60% after deductible	60% after deductible	60% after deductible
Out of Pocket Limit (Per Calendar Year)	\$4,000 Ind/\$8,000 Family	\$4,000 Ind/\$8,000 Family	\$4,000 Ind/\$8,000 Family

-Preauthorization may be required for certain services.

-For the NJEHP & GSP, the employee's contribution is based on new salary based contribution schedules. For all other plans, your employee contributions will remain the same per your collective bargaining agreement.

This overview is being provided as a convenient reference tool and is not a complete overview of the benefits being offered through your medical plans. Some plan limitations may apply. Please refer to the plan documents provided by your carriers for detailed plan information. If there is any discrepancy between the descriptions of the program elements in this overview and the official plan documents, the language of the official plan documents shall prevail as accurate.

Lumberton Township Board of Education
Prescription Coverage Selections - Benecard/Rx Alliance

Who Can Select This Plan?	All Employees	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20
	NJ Educators Plan / Garden State Plan	Retail \$3/\$10/\$10 POS \$10, POS \$15, QPOS \$10	Retail \$7/\$16/\$35 POS \$15/\$25	Retail \$3/\$18/\$46 POS \$20/\$30, QPOS \$20	Retail \$7/\$21 POS/QPOS \$20/\$35
Retail Copays					
Generic	\$5 Copay	\$3 Copay	\$7 Copay	\$3 Copay	\$7 Copay
Brand Name Drug (Generic Alternative <u>Not</u> Available)	\$10 Copay	\$10 Copay	\$16 Copay	\$18 Copay	\$21 Copay
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference**	\$10 Copay	\$35 Copay	\$46 Copay	\$21 Copay
Retail Dispensing Limitation	30 day supply	30 day supply	30 day supply	30 day supply	30 day supply
Mail Order					
Generic	\$10 Copay	\$5 Copay	\$18 Copay	\$5 Copay	\$18 Copay
Brand Name Drug (Generic Alternative <u>Not</u> Available)	\$20 Copay	\$15 Copay	\$40 Copay	\$36 Copay	\$52 Copay
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference**	\$15 Copay	\$88 Copay	\$92 Copay	\$52 Copay
Mail Order Dispensing Limitation	90 day supply	90 day supply	90 day supply	90 day supply	90 day supply
Additional Features					
*Step Therapy	Applies	Not Applicable	Not Applicable	Not Applicable	Not Applicable
**Mandatory Generic	Applies	Not Applicable	Not Applicable	Not Applicable	Not Applicable
***Mail Order for Specialty Drugs	Applies	Applies	Applies	Applies	Applies
****Performance Preferred Medications	Applies	Not Applicable	Applies	Applies	Not Applicable

***Step Therapy** programs are designed to ensure quality and manage costs. Where more than one medication in certain drug classes has been shown to be clinically effective but at varying costs, Step Therapy programs require a trial with the lower cost medication before approval of the higher cost medication, where clinically appropriate. If the member purchases the higher cost medication without a prior approval, there will be no coverage for the higher cost medication. Benecard employs Step Therapy in each of the following drug categories: Proton Pump Inhibitors (Ulcer/Reflux medications), SSRI/SSNRI (Antidepressants), Osteoporosis, Nasal Steroids, Hypnotics, Triptans (Migraine), ARBs (High Blood Pressure/Hypertension). Standard co-payments apply for prescription medications approved under the Step Therapy program.

****Mandatory Generics**- The pharmacist must dispense the generic equivalent medication when one is available. If the member fills the brand name drug instead, they will be responsible for the brand copay plus the difference in cost between the generic and brand name drug.

*****Mail Order for Specialty Medications** - Requires that specialty pharmaceutical medications be obtained through Benecard Central Fill Specialty. Specialty pharmaceuticals are typically produced through biotechnology, administered by injection, and/or require special handling and patient monitoring.

******Closed Formulary** - Certain medications are excluded from the covered drug list. A great majority of brand-name medications and generic medications are included in the formulary. All conditions with excluded medications have covered clinically equivalent medications. Please note, the formulary list updates throughout the year; for the most up to date version of the formulary please refer to the Express Scripts website: <https://www.express-scripts.com/>

This overview is being provided as a convenient reference tool and is not a complete overview of the benefits being offered through your prescription program. Some plan limitations may apply. If there is any discrepancy between the descriptions of the program elements in this overview and the official plan documents, the language of the official plan documents shall prevail as accurate.