West Deptford Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna & AmeriHealth Administrators

Who Can Select This Plan?	All Employees	All Employees	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20
	NJ Educators Health Plan	*Garden State Plan NJ Network Only	POS/PPO $10	POS/PPO $15	POS/PPO $15/$25
In-Network Benefits	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**
Deductible	$0 Individual	$0 Individual	$0 Individual	$0 Individual	$0 Individual
	$0 Family	$0 Family	$0 Family	$0 Family	$0 Family
Out of Pocket Limit	$500 Individual	$500 Individual	$400 Individual	Coinsurance: $400 Indiv/$1,000 Family; Copays: $5,039 Indiv/$9,878 Family	Coinsurance: $400 Indiv/$1,000 Family; Copays: $5,039 Indiv/$9,878 Family
	$1,000 Family	$1,000 Family	$1,000 Family		
Primary Care	$10 copay	$10 copay	$10 copay	$15 copay	$15 copay
Specialist	$15 copay	$15 copay	$10 copay	$15 copay	$25 Charge
Preventive	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge	No Charge	No Charge	No Charge	No Charge
Imaging (CT/PET scans, MRIs)	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient Surgery	No Charge	No Charge	No Charge	No Charge	No Charge
Emergency Room	$125 copay	$125 copay	$25 copay	$50 copay	$75 copay
Emergency Transportation	90% covered	90% covered	90% covered	90% covered	90% covered
Urgent Care	$15 copay	$15 copay	$10 copay	$15 copay	$25 copay
Durable Medical Equipment	90% covered	90% covered	90% covered	90% covered	90% covered
Hospital Stay	No Charge	No Charge	No Charge	No Charge	No Charge
Eye Exams (1 Exam/Calendar Year)	$15 Copay	$15 Copay	$10 Copay	$15 copay	$25 copay
Out of Network Benefits	**Out of Network**	**Out of Network**	**Out of Network**	**Out of Network**	**Out of Network**
Deductible	$350 Ind/$700 Family	$350 Ind/$700 Family	$100 Ind/$250 Family	$100 Ind/$250 Family	$100 Ind/$250 Family
Coinsurance	70% after deductible	70% after deductible	80% after deductible	70% after deductible	70% after deductible $200 Facility Fee
Out of Pocket Limit	$2,000 Ind/$5,000 Family	$2,000 Ind/$5,000 Family	$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.

West Deptford Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna & AmeriHealth Administrators

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/PPO $20/$30	**HMO/EPO $10**	**HMO $15/$25**	**HMO/EPO $20/$30**
In-Network Benefits	**In Network**	**In Network**	**In Network**	**In Network**
Deductible	$0 Individual	$0 Individual	$0 Individual	$0 Individual
	$0 Family	$0 Family	$0 Family	$0 Family
Out of Pocket Limit	Coinsurance: $800 Indiv/$2,000	$5,439 Individual	$5,439 Individual	$5,439 Individual
	Family; Copays: $4,639 Indiv/$8,878	$10,878 Family	$10,878 Family	$10,878 Family
Primary Care	$20 copay	$10 copay	$15 copay	$20 copay
Specialist	$20 copay	$10 copay	$25 copay	$20 copay
Preventive	No Charge	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge	No Charge	No Charge	No Charge
Imaging (CT/PET scans, MRIs)	No Charge	No Charge	No Charge	No Charge
Outpatient Surgery	No Charge	No Charge	No Charge	No Charge
Emergency Room	$125 copay	$35 copay	$75 copay	$125 copay
Emergency Transportation	90% covered	No Charge	No Charge	No Charge
Urgent Care	$20 copay	$10 copay	$25 copay	$20 copay
Durable Medical Equipment	90% covered	100% covered after $100 Ded.	100% covered after $100 ded.	100% covered after $100 ded.
Hospital Stay	No Charge	No Charge	No Charge	No Charge
Eye Exams	$20 copay (1 Exam/Calendar Year)	$10 copay (1 Exam/12 Months)	$25 copay (1 Exam/12 Months)	$20 copay (1 Exam/12 Months)
Out of Network Benefits	**Out of Network**	**Out of Network**	**Out of Network**	**Out of Network**
Deductible	$200 Ind/$500 Family	Covered for Emergency Services Only	Covered for Emergency Services Only	Covered for Emergency Services Only
Coinsurance	70% after deductible & $500 Facility Fee			
Out of Pocket Limit	$5,000 Ind/$12,500 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.

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West Deptford Board of Education

Prescription Coverage Selections - Schools Health Insurance Fund/Express Scripts

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, HMO $10	**Retail $7/$16/$35** POS $15/$25	**Retail $3/$18/$46** POS $20/$30, HMO $20/$30	**Retail $15/$35/$50** HMO $15/$25
Retail Copays					
Generic	$5 Copay	$3 Copay	$7 Copay	$3 Copay	$7 Copay
Brand Name Drug (Generic Alternative Not Available)	$10 Copay	$10 Copay	$16 Copay	$18 Copay	$21 Copay
Non-Preferred Brand Name Drug or (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 Not Available)	$20 Copay	$15 Copay	$40 Copay	$36 Copay	$52 Copay
Non-Preferred Brand Name Drug or (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
****Closed Formulary	Applies	Applies	Applies	Applies	Applies

*__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.