South Harrison Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna

Who Can Select This Plan?	All Employees	All Employees
	NJ Educators Health Plan	***Garden State Plan (NJ Network Only)**
In-Network Benefits	**In Network**	**In Network**
Deductible	$0 Individual	$0 Individual
	$0 Family	$0 Family
Out of Pocket Limit	$500 Individual	$500 Individual
	$1,000 Family	$1,000 Family
Primary Care	$10 copay	$10 copay
Specialist	$15 copay	$15 copay
Preventive	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge	No Charge
Imaging (CT/PET scans, MRIs)	No Charge	No Charge
Outpatient Surgery	No Charge	No Charge
Emergency Room	$125 copay	$125 copay
Emergency Transportation	90% covered	90% covered
Urgent Care	$15 copay	$15 copay
Durable Medical Equipment	90% covered	90% covered
Hospital Stay	No Charge	No Charge
Eye Exams (1 Exam/Calendar Year)	$15 Copay	$15 Copay
Vision Hardware Reimbursement	Not Applicable	Not Applicable
Out of Network Benefits	**Out of Network**	**Out of Network**
Deductible	$350 Ind/$700 Family	$350 Ind/$700 Family
Coinsurance	70% after deductible	70% after deductible
Out of Pocket Limit	$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

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

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Who Can Select This Plan?	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20
	Patriot V $10 Gold	**Patriot V $10 Silver**	**Open Access Bronze $20**
In-Network Benefits	**In Network**	**In Network**	**In Network**
Deductible	$0 Individual $0 Family	$0 Individual $0 Family	$500 Individual $1,000 Family
Out of Pocket Limit	$5,300 Individual $10,600 Family	$5,300 Individual $10,600 Family	$1,000 Individual $2,000 Family
Primary Care	$10 copay	$10 copay	$20 copay
Specialist	$15 copay	$15 copay	$30 copay
Preventive	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge for Lab $15 copay for X-Rays	No Charge for Lab $15 copay for X-Rays	$30 copay
Imaging (CT/PET scans, MRIs)	$15 copay	$15 copay	$30 copay
Outpatient Surgery	No Charge	No Charge	10% coinsurance
Emergency Room	$50 copay	$50 copay	$100 copay
Emergency Transportation	No Charge	No Charge	10% coinsurance
Urgent Care	$15 copay	$15 copay	$30 copay
Durable Medical Equipment	70% Covered After OON Deductible	70% Covered After OON Deductible	90% covered
Hospital Stay	No Charge	No Charge	$100 copay/day up to 5 days, then No Charge for Facility. 90% covered for Physician/Surgeon Fees
Eye Exams	$15 copay 1 exam/calendar year	$15 copay 1 exam/calendar year	No Charge 1 exam/24 months
Vision Hardware Reimbursement	$100 Maximum/24 Months	$100 Maximum/24 Months	Not Applicable
Out of Network Benefits	**Out of Network**	**Out of Network**	**Out of Network**
Deductible	$100 Ind/$200 Family	$100 Ind/$200 Family	$1,250 Ind/$2,500 Family
Coinsurance	70% after deductible	70% after deductible	70% after deductible
Out of Pocket Limit	$2,000 Ind/$4,000 Family	$2,000 Ind/$4,000 Family	$2,500 Ind/$5,000 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.

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South Harrison 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	
	HDHP $1350/$2700	**Horizon Omnia**	
In-Network Benefits	**In Network**	**Tier 1**	**Tier 2**
Deductible	$1,350 Individual	$0 Individual	$1,500 Individual
	$2,700 Family	$0 Family	$3,000 Family
Out of Pocket Limit	$6,250 Individual	$2,500 Individual	$4,500 Individual
	$12,500 Family	$5,000 Family	$9,000 Family
Primary Care	20% coinsurance	$5 copay	$20 copay
Specialist	20% coinsurance	$15 copay	$30 copay
Preventive	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	20% coinsurance	No Charge for Office/Independent Lab $15 copay for Outpatient Hosptial	No Charge for Office/Independent Lab 20% coinsurance for Outpatient Hosptial
Imaging (CT/PET scans, MRIs)	20% coinsurance	$15 copay for Outpatient Hosptial	20% coinsurance for Outpatient Hospital
Outpatient Surgery	20% coinsurance	$150 copay for Facility No Charge for Physician/Surgeon Fees	20% coinsurance
Emergency Room	20% coinsurance	$100 copay for Outpatient Hospital	$100 copay & 20% coinsurance for Outpatient Hospital
Emergency Transportation	20% coinsurance	No Charge	Deductible Applies
Urgent Care	20% coinsurance	$15 copay	$30 copay
Durable Medical Equipment	20% coinsurance	No Charge	No Charge
Hospital Stay	20% coinsurance	$150 copay for Facility No Charge for Physician/Surgeon Fees	20% coinsurance
Eye Exams	No Charge 1 exam/24 months	$15 copay 1 exam/calendar year	$30 copay 1 exam/calendar year
Vision Hardware Reimbursement	Not Applicable	$125 Maximum/12 Months	$125 Maximum/12 Months
Out of Network Benefits	**Out of Network**	**Out of Network**	**Out of Network**
Deductible	$1,350 Ind/$2,700 Family	No Coverage for OON Services Unless it is a True Medical Emergency	
Coinsurance	50% after deductible		
Out of Pocket Limit	$6,250 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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Prescription Coverage Selections - 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
	Rx Retail $5/$10 NJEHP & GSP	**Retail Rx $5/$10 Patriot V Gold Plan**	**Retail $10/$20/$30 Patriot V Silver Plan**	**Retail $15/$30/$45 Bronze/Omnia**	**20% Coinsurance HDHP**
Retail Copays (30 Day Supply)					
Generic	$5 Copay	$5 Copay	$10 Copay	$15 Copay	20% Coinsurance
Brand Name Drug (Generic Alternative Not Available)	$10 Copay	$10 Copay	$20 Copay	$30 Copay	20% Coinsurance
Non- Preferred Brand Name Drug (or Generic Alternative Available)	Member Pays the Difference*	$10 Copay	$30 Copay	$45 Copay	20% Coinsurance
Retail Dispensing Limitation	30 day supply	34 day supply or 100 units	30 day supply	30 day supply	30 day supply
Mail Order (90 Day Supply)					
Generic	$10 Copay	$0 Copay	$5 Copay	$15 Copay	20% Coinsurance
Brand Name Drug (Generic Alternative Not Available)	$20 Copay	$0 Copay	$10 Copay	$30 Copay	20% Coinsurance
Non-Preferred Brand Name Drug (or Generic Alternative Available)	Member Pays the Difference**	$0 Copay	$10 Copay	$45 Copay	20% Coinsurance
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/

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