Medical FAQ's:

Where Can I Find Participating Providers?

DocFind provides instructions on using the Aetna Doc Find to locate participating providers.

To search for participating providers in your area Click here

Do I Have Out Of Country Coverage?

In the event of an emergency when traveling overseas, please note Aetna will cover a medical emergency. A medical emergency claim can be sent over to Aetna for processing which will be applied towards your ER benefit. However, there is no coverage for routine and non-emergency visits overseas.

When Should I Choose Urgent Care Over the Emergency Room?

When you are faced with a sudden illness or injury, making an informed choice on where to seek medical care is crucial to your personal and financial well-being.

Benefits Update – LabCorp is now a participating lab provider for Aetna

Members now have more choices for Lab Providers under Aetna. **LabCorp** is now a preferred laboratory services provider for Aetna. Members may also continue to use **Quest Diagnostics** for all diagnostic testing.

To find a facility near you-

LabCorp: https://www.labcorp.com/

Quest Diagnostics: https://www.questdiagnostics.com/home.html

What is Aetna Navigator?

The Aetna Navigator allows you to access your personal benefits information on-line. After you register, under "Select From Your Memberships and Programs" choose the **SHIF.** Once logged in, you will be able to:

- Check the status of a medical claim.
- Change your Primary Care Physician. (When selecting a Primary Care Physician, please make sure to select QPOS as your plan selection. Members who do not select QPOS will have the wrong Provider ID number and will not have the correct PCP listed on their ID card.)
- Request a new or additional ID card

- Review the Aetna Benefit Booklet specific to your group.

It's easy to sign up. Log into **www.aetna.com** and click on register under Member Log-In.

What Is The Health Benefits Mobile Phone App?

Aetna Mobile App- Aetna HMO and Aetna Medicare Plan (HMO) members Connect to Aetna right now from a cell phone, smartphone, or other web-enabled mobile device and access Aetna's most popular online tools from just about anywhere!

When someone goes to **Aetna.com** from their mobile phone's web browser, they can: Find a doctor, dentist, or other facility Access your personal health record, look up a claim, or View your Aetna member ID card. It is safe, quick, and easy. Just type **Aetna.com** in your mobile browser or check your device's App Store for availability.

For additional details visit the **Aetna Mobile information page.**

How Does Coverage For Young Adults to Age 26 Work?

Dependents to age 26 may enroll in the **medical** and **prescription** plans regardless of whether or not they are eligible for coverage through their own employer.

Under the Patient Protection and Affordable Care Act:

A child is defined as an enrollee's child until age 26, regardless of the child's marital, student, or financial dependency status, even if the young adult no longer lives with his or her parents.

Coverage will be extended to eligible children through the end of the month in which they turn age 26 for your Medical and Prescription plans regardless of whether or not they are eligible for coverage through their own employer.

***This applies to your medical and prescription plans only. Dental coverage for dependents remains until the end of the calendar year the dependent turns 23.**

How Do Out Of Network Claims Work?

Members may submit Out of Network claims for reimbursement. Out-of-Network claims are paid at the appropriate coinsurance level (70% or 80%) of Usual and Customary Rate after the deductible has been applied.

What Preventative Care Services Are Available To Me?

Under the **Affordable Care Act**, certain preventive services for your group will be covered 100%, effective 7/1/2011. For these specified preventive services, you won't have to pay anything when:

- Services are received from a doctor or health care provider that is in network (out of network benefits remain the same)
- The main purpose of your visit is to get preventive care. (These services are *not* preventive If you get them as part of a visit to diagnose, monitor or treat an illness or injury. Then copays, coinsurance and deductibles apply.)

Many of these services are covered as part of routine physical exams. These include regular checkups, routine gynecological visits and well-child exams. You won't have to pay out of pocket for these preventive visits, unless you get services not covered under Preventive Care Without Cost Sharing at the same time. For further details and a list of preventive services from Aetna, please **click here**.

Questions About The PPO Core & PPO Buy Up Plans:

How Does the Deductible Work? The deductible is based on the Calendar Year and must be met prior to certain eligible medical expenses being covered. Once you have met your deductible, you are then responsible for your copay or coinsurance listed on the benefit summary. **For many of the Preferred Care (in-network) services, the deductible is waived.** Please see the benefit summaries for further detail.

For Parent/Children and Family Coverage, all members of the family are able to contribute to meeting the family deductible but no one member will contribute more than the individual limit. So once a member of the family reaches the individual limit listed on the benefit summary, they will not pay any more toward the deductible and are just responsible for their copays or coinsurance. The other members of the family will continue to pay towards the deductible until the Family deductible listed is met. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.

Do I Need a Referral for Preferred Care? With the new plan options (PPO Core and PPO Buy Up), the selection of a Primary Care Physician is optional; however members are still encouraged to pick a PCP. Referrals are not needed for Preferred Care but Precertification may be required for certain services and procedures.

What Does the Deductible Apply to? For the PPO Core and PPO Buy Up plans, the deductible is waived for many of the in-network services such as office visits to your Primary Care Physician and Specialists. The deductible is also waived for in-network services such as Preventive Care, Chiropractic Care, Inpatient Hospital Care, and Diagnostic Laboratory and X-Ray services. For other services, such as Outpatient Surgery, Ambulance, Home Health Care, Hospice, Durable Medical Equipment, Family Planning, etc. the deductible does apply. **If you are considering changing plans, it is important to review the complete benefit summaries and see which services you use the most to determine if one of these plans would be a better option for you.**

Which of my out of pocket expenses go towards meeting the deductible and out of pocket maximum? For the PPO Core and PPO Buy Up plans, any service where you have to pay coinsurance goes towards meeting your deductible and out of pocket maximum. Some in-network examples would be outpatient surgery, ambulance services, and home health care. For any out of network services,

coinsurance applies to all benefits. Once your deductible is met, then you are only required to pay your coinsurance amount until you reach your out of pocket maximum. Then services are covered 100% for the remainder of the calendar year. Please note that medical and prescription copays do not apply to the deductible or out of pocket maximum.

How is Preventive Care Covered Under the New Plans? Preventive Care is covered 100% when you visit an in-network (participating) provider. The deductible does not apply to Preventive Care.

Reimbursements: Medical and Prescription Copay Reimbursements and Vision Eyewear Please note that these benefits, Medical and Prescription Copay Reimbursement and Vision Eyewear allowance, do not apply to the new plans.

How Do I Search for a Participating Providers for the New Plans?

Go to www.aetna.com and click on **Find a Doctor**.

- Select a Plan: **Aetna Open Access® Plans**
- Select: **Aetna Choice® POS II (Open Access)**

Dental FAQ's:

How Do I Reach Delta Dental's Customer Service Department?

Call **800-452-9310** or Email Delta Dental at **service@deltadentalnj.com**

Delta Dental Benefits Connection- Your connection to your Delta Dental benefits, eligibility, and claim information.

- Determine your dental maximum and deductible balances
- Check the status of your claims
- Print a copy of your ID card.
- Available 24 hours a day, seven days a week

Registration is easy. For more information about your Delta Dental Benefits: http://www.deltadentalnj.com

To review your dental options, please refer to the Dental Plan section of your group's BenePortal site.

Prescription FAQ's:

What Prescription Plans Are offered To Me?

To review your prescription plan options, please refer to the Rx Plan comparison chart located on the Prescription Plan section of your group's BenePortal site.

What Is The Difference Between Preferred and Non-Preferred Brands?

The prescription plan options refer to Preferred and Non-Preferred Brand drugs. The Preferred Medication List identifies the cost effective medications in each drug category. Preferred Medications are effective treatments that tend to be either unique or less expensive when compared to other drugs in their class. The most current list can be viewed on the Benecard website at http://www.benecardpbf.com/ once you sign in. Non Preferred Brands are available at a higher copayment. It is important to note that the list may be modified from time to time usually on a quarterly basis.

What Is Specialty Medications Benefit Enhancement?

A new benefit enhancement has been added to your prescription plan for specialty medications. All specialty medications are now ordered through the **Benecard Central Fill** Program. Specialty medications require special handling, careful administration, and ongoing patient care management.

The features of the specialty pharmacy program, **Benecard Central Fill**, are designed to provide support to members. Benefits include:

- Personal support and individual education
- Improved overall health and results from medication therapy
- Elimination of gaps and delays in modification of medication dose or type when necessary due to health changes, drug to drug interactions, side effects, etc.
- Convenience of home delivery, saving the patient a trip to the pharmacist for each medication fill.

Specialty medications that are refrigerated come through overnight delivery in a refrigerated pack, which keeps the medication cold. Members can have their specialty medications delivered to their home or work address, whichever is preferred.

How can a patient start filling a specialty medication with Benecard Central Fill? Either the patient or the prescriber can call **Benecard Central Fill at 1-888-907-0090** to begin the process.

Did you know that using the mail order service to fill prescriptions is easy to do, very convenient, and provides savings to you?

For new prescriptions, members will need to complete the mail order form and mail it in along with their prescription. Members will receive a new mail service order form and envelope with each shipment.

Members can also have their physician fax their prescription to Benecard at 1-888-907-0040. The physician must include the cardholder name, ID number, shipping address and date of birth. Only prescriptions faxed from a doctor's office will be accepted via fax.

Need to request a refill? There are currently 3 different ways members can requests refills through the mail order system:

- **Internet:** Visit www.benecardpbf.com. If you have not yet registered, click on Register. If you are a registered user, log in and select Mail Order.
- **Phone:** Call Member Services toll-free, 1-877-723-6005 24 hours a day, 7 days a week and use the prompts to order your refills. Have your identification number and credit card information ready.
- **Mail:** Send the Refill Request Order Form provided with your last shipment back to Benecard Central Fill mail service in the pre-addressed envelope.

For more information regarding Mail Orders, please refer to the documents provided in the Prescription Plan section of your group's BenePortal site.

Which Medications Are Covered?

1. *Federal Legend Drugs*

Any FDA approved medicinal substance which bears the legend Caution: Federal Law prohibits dispensing without a prescription.

2. State Restricted Drugs

Any medicinal substance which may be dispense by prescription only, according to State Law.

New Jersey State Law requires available generic drugs to be dispensed by the pharmacist unless a prescribing physician specifically indicates that only a brand name be dispensed or a patient insists on a brand name. Consequently, unless a brand name prescription drug is stipulated as medically necessary by the prescribing physician, participating providers may require cardholders under this contract who decline a generic alternative to pay any drug costs in excess of the reimbursable generic price. The dispensing pharmacist will be reimbursed based upon the appropriate generic price.

3. Compounded Medications

A compounded medical prescription is an extemporaneously prepared dosage form. The compound must contain at least one federal legend drug in a therapeutic amount; or a combination of ingredients which require a prescription by law when compounded into a specific dosage form for an individual patient at the direction of a prescriber, and which is also in a therapeutic amount.

4. Diabetic Supplies

Insulin; disposable insulin needles/syringes; disposable blood/urine glucose/acetone testing agents (e.g. Clinitest tables, Chemstrips. Diastix Strips and test-tape); blood glucose monitors; and lancets.

5. Contraceptive Devices

Any drug or device used for contraception by a female which is approved by the FDA for that purpose.