

Riverside Township Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna

Who Can Select This Plan?

	All Employees	All Employees	Hired Before 7/1/20	Hired Before 7/1/20
	NJ Educators Health Plan	*Garden State Plan (NJ Network Only)	Aetna QPOS Patriot V	Aetna QPOS Patriot X
In-Network Benefits	In Network	In Network	In Network	In Network
Deductible (Per Calendar Year)	\$0 Individual \$0 Family	\$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	\$4,000 Individual \$8,000 Family
Primary Care	\$10 copay	\$10 copay	\$5 copay	\$10 copay
Specialist	\$15 copay	\$15 copay	\$5 copay	\$15 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	\$125 copay	\$25 copay	\$35 copay
Emergency Transportation	90% covered	90% covered	No Charge	No Charge
Urgent Care	\$15 copay	\$15 copay	\$5 copay	\$15 copay
Durable Medical Equipment	90% covered	90% covered	No Charge	No Charge
Hospital Stay	No Charge	No Charge	No Charge	No Charge
Eye Exams	\$15 Copay (1 exam/calendar year)	\$15 Copay (1 exam/calendar year)	\$5 Copay (1 exam/12 months up to 19; 1 exam/24 months after 19)	\$15 Copay (1 exam/12 months up to 19; 1 exam/24 months after 19)
Vision Hardware Reimbursement	Not Applicable	Not Applicable	\$100 max/24 months	\$70 max/24 months
Out of Network Benefits	Out of Network	Out of Network	Out of Network	Out of Network
Deductible (Per Calendar Year)	\$350 Ind/\$700 Family	\$350 Ind/\$700 Family	\$100 Ind/\$200 Family	\$100 Ind/\$200 Family
Coinsurance	70% after deductible	70% after deductible	70% after deductible	80% after deductible
Out of Pocket Limit (Per Calendar Year)	\$2,000 Ind/\$5,000 Family	\$2,000 Ind/\$5,000 Family	\$2,000 Ind/\$4,000 Family	\$500 Ind/\$1,400 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.

Riverside 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
	Aetna QPOS Premier	Aetna POS II Core	Aetna POS II Buy Up
In-Network Benefits	In Network	In Network	In Network
Deductible (Per Calendar Year)	\$0 Individual \$0 Family	\$1,000 Individual \$2,000 Family	\$500 Individual \$1,000 Family
Out of Pocket Limit (Per Calendar Year)	\$4,000 Individual \$8,000 Family	\$2,000 Individual \$4,000 Family	\$1,000 Individual \$2,000 Family
Primary Care	\$2 copay	\$25 copay	\$20 copay
Specialist	No Charge	\$40 copay	\$30 copay
Preventive	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge	\$40 copay	\$30 copay
Imaging (CT/PET scans, MRIs)	No Charge	\$40 copay	\$30 copay
Outpatient Surgery	No Charge	80% covered	90% covered
Emergency Room	\$15 copay	80% covered after \$100 copay	\$100 copay
Emergency Transportation	No Charge	80% covered	90% covered
Urgent Care	No Charge	\$40 copay	\$30 copay
Durable Medical Equipment	90% covered	80% covered	90% covered
Hospital Stay	No Charge	\$200 copay per, up to 5 days No Charge for Physician/Surgeon	\$100 copay per day, up to 5 days 90% covered for Physician/Surgeon
Eye Exams	\$2 copay (1 exam/12 months up to 19; 1 exam/24 months after 19)	No Charge (1 exam/24 months)	No Charge (1 exam/24 months)
Vision Hardware Reimbursement	\$100 max/24 months	Not Applicable	Not Applicable
Out of Network Benefits	Out of Network	Out of Network	Out of Network
Deductible (Per Calendar Year)	\$1,000 Ind/\$2,000 Family	\$2,500 Ind/\$5,000 Family	\$1,250 Ind/\$2,500 Family
Coinsurance	70% after deductible	60% after deductible	70% after deductible
Out of Pocket Limit (Per Calendar Year)	\$10,000 Ind/\$20,000 Family	\$5,000 Ind/\$10,000 Family	\$2,500 Ind/\$5,000 Family

-*The GSP is a an NJ Network of 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.

Riverside Township Board of Education

Prescription Coverage Selections - Benecard

Who Can Select This Plan?

	All Employees	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20
	NJEHP / GSP	Rx Retail \$5/10	Retail Option A \$5/\$25/\$40	Retail Option B \$10/\$30/\$40
Retail Copays				
Generic	\$5 Copay	\$5 Copay	\$5 copay	\$10 copay
Brand Name Drug (Generic Alternative <u>Not</u> Available)	\$10 Copay	\$10 Copay	\$25 copay	\$30 copay
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference**	\$10 Copay	\$40 copay	\$45 copay
Retail Dispensing Limitation	30 day supply	34 day supply or 100 units	34 day supply or 100 units	34 day supply or 100 units
Mail Order				
Generic	\$10 Copay	\$5 Copay	\$5 copay	\$20 copay
Brand Name Drug (Generic Alternative <u>Not</u> Available)	\$20 Copay	\$5 Copay	\$25 copay	\$60 copay
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference**	\$5 Copay	\$40 copay	\$90 copay
Mail Order Dispensing Limitation	90 day supply	90 day supply	90 day supply	90 day supply
Additional Features				
*Step Therapy	Applies	Not Applicable	Not Applicable	Not Applicable
**Mandatory Generic	Applies	Not Applicable	Not Applicable	Not Applicable
***Mail Order for Specialty Medications	Applies	Applies	Applies	Applies
****Performance Preferred Medication	Applies	Not Applicable	Applies	Applies

***Step Therapy-** Where more than one medication in a certain drug class has been shown to be clinically effective but a varying costs, Step Therapy requires 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.

******Performance Preferred Medications** - The Performance Preferred Medication List is a voluntary guide for selecting clinically and therapeutically appropriate medications. A great majority of brand-name medications and generic medications are included on the Performance Preferred Medication List. In addition, the list also excludes several medications. If purchased, members would be responsible for paying 100% of the medication cost of these excluded medications identified in the Performance Preferred Medication List. Please note, the Performance Preferred Medication List updates throughout the year, and for the most up to date version please refer to Benecard's website: <https://www.benecardpbf.com/PBF/>

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.