

Lumberton Township Board of Education
Plans Effective July 1, 2021 to June 30, 2022 Medical Coverage
Selections - Schools Health Insurance Fund/Aetna

Who Can Select This Plan?

Who Can Select This Plan?	All Employees		Non-Represented Hired Before 7/1/20		Employees Hired Before 7/1/20	
	NJ Educators Health Plan		Aetna POS \$10		Aetna POS \$15	
Summary of Benefits	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible	\$0 Individual	\$350 Individual	\$0 Individual	\$100 Individual	\$0 Individual	\$100 Individual
	\$0 Family	\$700 Family	\$0 Family	\$250 Family	\$0 Family	\$250 Family
Out of Pocket Limit	\$500 Individual	\$2,000 Individual	\$400 Individual	\$2,000 Individual	\$400 Individual	\$2,000 Individual
	\$1,000 Family	\$5,000 Family	\$800 Family	\$5,000 Family	\$800 Family	\$5,000 Family
Primary Care	\$10 copay	70% after deductible	\$10 copay	80% after deductible	\$15 copay	70% after deductible
Specialist	\$15 copay	70% after deductible	\$10 copay	80% after deductible	\$15 copay	70% after deductible
Preventive	No Charge	Not Covered; 30% Coinsurance for Immunizations, Mammograms, & Gynecological Exams	No Charge	80% after deductible	No Charge	70% after deductible
Diagnostic (x-ray, blood work)	No Charge	70% after deductible	No Charge	80% after deductible	No Charge	70% after deductible
Imaging (CT/PET scans, MRIs)	No Charge	70% after deductible	No Charge	80% after deductible	No Charge	70% after deductible
Outpatient Surgery	No Charge	70% after deductible	No Charge	80% after deductible	No Charge	70% after deductible
Emergency Room	\$125 copay	\$125 Copay	\$25 copay		\$50 copay	
Emergency Transportation	10% Coinsurance	10% Coinsurance	10% Coinsurance	80% after deductible	10% Coinsurance	70% after deductible
Urgent Care	\$15 copay	70% after deductible	\$10 copay	80% after deductible	\$15 copay	70% after deductible
Durable Medical Equipment	10% Coinsurance	70% after deductible	10% Coinsurance	80% after deductible	10% Coinsurance	70% after deductible
Hospital Stay	No Charge	70% after deductible	No Charge	80% after deductible	No Charge	70% after deductible
Eye Exam (1 Exam/Calendar Year INN/OON Combined)	\$15 copay	Not Covered	\$10 copay	\$40 reimbursement	\$10 copay	\$40 reimbursement

-Preauthorization may be required for certain services.

For the NJ Educators Health Plan, the employee's contribution is based on the new salary based contribution schedule. For all other plan options, your employee contribution will follow your collective bargaining agreement and/or Chapter 78.

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	Aetna POS \$15/\$25		Aetna Choice POS \$20/\$30		Aetna Choice POS \$20/\$35	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible	\$0 Individual \$0 Family	\$100 Individual \$250 Family	\$0 Individual \$0 Family	\$200 Individual \$500 Family	\$200 Individual \$400 Family	\$800 Individual \$2,000 Family
Out of Pocket Limit	\$400 Individual \$800 Family	\$2,000 Individual \$5,000 Family	\$800 Individual \$1,600 Family	\$5,000 Individual \$12,500 Family	\$2,000 Individual \$4,000 Family	\$5,000 Individual \$12,500 Family
Primary Care	\$15 copay	70% after deductible	\$20 copay	70% after deductible	\$20 copay	60% after deductible
Specialist	\$25 copay	70% after deductible	\$30 copay	70% after deductible	\$35 copay	60% after deductible
Preventive	No Charge	70% after deductible	No Charge	70% no deductible	No Charge	60% no deductible
Diagnostic (x-ray, blood work)	No Charge	70% after deductible	No Charge	70% after deductible	No charge for office, 20% coinsurance for Ind. Labs or Out Patient Hospital	60% after deductible
Imaging (CT/PET scans, MRIs)	No Charge	70% after deductible	No Charge	70% after deductible	60% after deductible for outpatient hospital	60% after deductible
Outpatient Surgery	No Charge	70% after deductible	No Charge	70% after deductible	80% after deductible	60% after deductible
Emergency Room	\$75 copay		\$100 copay		\$100 copay	
Emergency Transportation	10% Coinsurance	70% after deductible	10% Coinsurance	70% after deductible	80% after deductible	60% after deductible
Urgent Care	\$25 copay	70% after deductible	\$30 copay	70% after deductible	\$35 copay	60% after deductible
Durable Medical Equipment	10% Coinsurance	70% after deductible	10% Coinsurance	70% after deductible	80% after deductible	60% after deductible
Hospital Stay	No Charge	\$200 copay per admission, 90% after deductible for Inpatient Hospital; 70% after deductible for Inpatient Physician Fees	No Charge	\$500 copay per admission, 90% after deductible for Inpatient Hospital; 70% after deductible for Inpatient Physician Fees	80% after deductible	\$500 copay per admission, 60% after deductible for Inpatient Hospital
Eye Exam (1 Exam/Calendar Year INN/OON Combined)	\$10 copay	\$40 reimbursement	\$10 copay	\$40 reimbursement	\$10 copay	\$40 reimbursement

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	Aetna QPOS \$10		Aetna QPOS \$20		Aetna QPOS \$20/\$35	
Summary of Benefits	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible	\$0 Individual	\$500 Individual	\$0 Individual	\$500 Individual	\$0 Individual	\$500 Individual
	\$0 Family	\$1,000 Family	\$0 Family	\$1,000 Family	\$0 Family	\$1,000 Family
Out of Pocket Limit	\$4,000 Individual	\$4,000 Individual	\$4,000 Individual	\$4,000 Individual	\$4,000 Individual	\$4,000 Individual
	\$8,000 Family	\$8,000 Family	\$8,000 Family	\$8,000 Family	\$8,000 Family	\$8,000 Family
Primary Care	\$10 copay	60% after deductible	\$20 copay	60% after deductible	\$20 copay	60% after deductible
Specialist	\$10 copay	60% after deductible	\$20 copay	60% after deductible	\$35 copay	60% after deductible
Preventive	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Diagnostic (x-ray, blood work)	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Imaging (CT/PET scans, MRIs)	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Outpatient Surgery	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Emergency Room	\$35 copay		\$100 copay		\$100 copay	
Emergency Transportation	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Urgent Care	\$10 copay	60% after deductible	\$20 copay	60% after deductible	\$35 copay	60% after deductible
Durable Medical Equipment	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Hospital Stay	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Eye Exam (1 Exam/Calendar Year INN/OON Combined)	\$10 copay	\$40 reimbursement	\$10 copay	\$40 reimbursement	\$10 copay	\$40 reimbursement

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-For the NJ Educators Health Plan, the employee's contribution is based on the new salary based contribution schedule. For all other plan options, your employee contribution will follow your collective bargaining agreement and/or Chapter 78.

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Lumberton Township Board of Education
Plans Effective July 1, 2021 to June 30, 2022 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 Health Plan	Rx Retail \$3/\$10	Rx Retail \$7/\$16/\$35	Rx Retail \$3/\$18/\$46	Rx Retail \$7/\$21
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 Medications	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.

******Performance Preferred Medications** 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 list. 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 Medications list updates throughout the year; for the most up to date version please refer to Benecard's website: <https://www.benecardpbf.com/PBF/>

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