Lumberton Township Board of Education
Special Open Enrollment - Rates Effective January 1, 2021 to June 30, 2021

Medical Coverage Selections - Schools Health Insurance Fund/Aetna

Summary of Benefits	NJ Educators Health Plan		Aetna POS $10		Aetna POS $15		Aetna POS $15/$25	
	In Network	Out of Network	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 Individual	$100 Individual
	$0 Family	$700 Family	$0 Family	$250 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	$400 Individual	$2,000 Individual
	$1,000 Family	$5,000 Family	$800 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	$15 copay	70% after deductible
Specialist	$15 copay	70% after deductible	$10 copay	80% after deductible	$15 copay	70% after deductible	$25 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	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	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	No Charge	70% after deductible
Outpatient Surgery	No Charge	70% after deductible	No Charge	80% after deductible	No Charge	70% after deductible	No Charge	70% after deductible
Emergency Room	$125 copay	$125 Copay	$25 copay		$50 copay		$75 copay	
Emergency Transportation	10% Coinsurance	10% Coinsurance	10% Coinsurance	80% after deductible	10% Coinsurance	70% after deductible	10% Coinsurance	70% after deductible
Urgent Care	$15 copay	70% after deductible	$10 copay	80% after deductible	$15 copay	70% after deductible	$25 copay	70% after deductible
Durable Medical Equipment	10% Coinsurance	70% after deductible	10% Coinsurance	80% after deductible	10% Coinsurance	70% after deductible	10% Coinsurance	70% after deductible
Hospital Stay	No Charge	70% after deductible	No Charge	80% after deductible	No Charge	70% after deductible	No Charge	$200 copay per admission, 10% coinsurance for Inpatient
Eye Exam	$15 copay (1 exam/calendar year)	Not Covered	$10 copay (1 exam/calendar year)	$40 reimbursement (1 exam/calendar year)	$10 copay (1 exam/calendar year)	$40 reimbursement (1 exam/calendar year)	$10 copay (1 exam/calendar year)	$40 reimbursement (1 exam/calendar year)
Vision Hardware Reimbursement	Not Applicable		Please Refer to Vision Gold Plan Summary		Please Refer to Vision Gold Plan Summary		Please Refer to Vision Gold Plan Summary	
•Preauthorization may be required for certain services.	***NJ Educators Health Plan** Single $776.00 Parent/Child(ren) $1,444.00 Employee/Spouse $1,552.00 Family $2,220.00		**POS $10** Single $833.00 Parent/Child(ren) $1,549.00 Employee/Spouse $1,666.00 Family $2,383.00		**POS $15** Single $792.00 Parent/Child(ren) $1,475.00 Employee/Spouse $1,586.00 Family $2,268.00		**POS $15/$25** Single $769.00 Parent/Child(ren) $1,432.00 Employee/Spouse $1,539.00 Family $2,201.00	

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Lumberton Township Board of Education
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Medical Coverage Selections - Schools Health Insurance Fund/Aetna

Summary of Benefits	NJ Educators Health Plan		Aetna Choice POS DA $20/$30		Aetna Choice POS DA $20/$35	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible	$0 Individual	$350 Individual	$0 Individual	$200 Individual	$200 Individual	$800 Individual
	$0 Family	$700 Family	$0 Family	$500 Family	$400 Family	$2,000 Family
Out of Pocket Limit	$500 Individual	$2,000 Individual	$800 Individual	$5,000 Individual	$2,000 Individual	$5,000 Individual
	$1,000 Family	$5,000 Family	$1,600 Family	$12,500 Family	$4,000 Family	$12,500 Family
Primary Care	$10 copay	70% after deductible	$20 copay	70% after deductible	$20 copay	60% after deductible
Specialist	$15 copay	70% after deductible	$30 copay	70% after deductible	$35 copay	60% after deductible
Preventive	No Charge	Not Covered; 30% Coinsurance for Immunizations, Mammograms, & Gynecological Exams	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	$125 copay	$125 Copay	$100 copay		$100 copay	
Emergency Transportation	10% Coinsurance	10% Coinsurance	10% Coinsurance	70% after deductible	80% after deductible	60% after deductible
Urgent Care	$15 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	70% after deductible	No Charge	$500 copay per admission, then 90% after deductible for inpatient; 70% after deductible for physician fees and outpatient	80% after deductible	$500 copay per admission, then 60% after deductible for Inpatient
Vision Hardware Reimbursement	$15 copay (1 exam/calendar year)	Not Covered	$10 copay (1 exam/calendar year)	$40 reimbursement (1 exam/calendar year)	$10 copay (1 exam/calendar year)	$40 reimbursement (1 exam/calendar year)
Eye Exam	Not Applicable		Please Refer to Vision Gold Plan Summary		Please Refer to Vision Gold Plan Summary	
●Preauthorization may be required for certain services.	***NJ Educators Health Plan** Single $776.00 Parent/Child(ren) $1,444.00 Employee/Spouse $1,552.00 Family $2,220.00		**Direct Access $20/$30** Single $723.00 Parent/Child(ren) $1,346.00 Employee/Spouse $1,447.00 Family $2,069.00		**Direct Access $20/$35** Single $622.00 Parent/Child(ren) $1,158.00 Employee/Spouse $1,245.00 Family $1,780.00	

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Medical Coverage Selections - Schools Health Insurance Fund/Aetna

Summary of Benefits	NJ Educators Health Plan		Aetna QPOS $10		Aetna QPOS $20		Aetna QPOS $20/$35	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible	$0 Individual	$350 Individual	$0 Individual	$500 Individual	$0 Individual	$500 Individual	$0 Individual	$500 Individual
	$0 Family	$700 Family	$0 Family	$1,000 Family	$0 Family	$1,000 Family	$0 Family	$1,000 Family
Out of Pocket Limit	$500 Individual	$2,000 Individual	$4,000 Individual	$4,000 Individual	$4,000 Individual	$4,000 Individual	$4,000 Individual	$4,000 Individual
	$1,000 Family	$5,000 Family	$8,000 Family	$8,000 Family	$8,000 Family	$8,000 Family	$8,000 Family	$8,000 Family
Primary Care	$10 copay	70% after deductible	$10 copay	60% after deductible	$20 copay	60% after deductible	$20 copay	60% after deductible
Specialist	$15 copay	70% after deductible	$10 copay	60% after deductible	$20 copay	60% after deductible	$35 copay	60% after deductible
Preventive	No Charge	Not Covered; 30% Coinsurance for Immunizations, Mammograms, & Gynecological Exams	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Diagnostic (x-ray, blood work)	No Charge	70% after deductible	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Imaging (CT/PET scans, MRIs)	No Charge	70% after deductible	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Outpatient Surgery	No Charge	70% after deductible	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Emergency Room	$125 copay	$125 Copay	$35 copay		$100 copay		$100 copay	
Emergency Transportation	10% Coinsurance	10% Coinsurance	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Urgent Care	$15 copay	70% after deductible	$10 copay	60% after deductible	$20 copay	60% after deductible	$35 copay	60% after deductible
Durable Medical Equipment	10% Coinsurance	70% after deductible	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Hospital Stay	No Charge	70% after deductible	No Charge	60% after deductible	No Charge	60% after deductible	No Charge	60% after deductible
Eye Exam	$15 copay (1 exam/calendar year)	Not Covered	$10 copay (1 exam/calendar year)	$40 reimbursement (1 exam/calendar year)	$10 copay (1 exam/calendar	$40 reimbursement (1 exam/calendar year)	$10 copay (1 exam/calendar	$40 reimbursement (1 exam/calendar
Vision Hardware Reimbursement	Not Applicable		Please Refer to Vision Gold Plan Summary		Please Refer to Vision Gold Plan Summary		Please Refer to Vision Gold Plan Summary	
•Preauthorization may be required for certain services.	***NJ Educators Health Plan** Single $776.00 Parent/Child(ren) $1,444.00 Employee/Spouse $1,552.00 Family $2,220.00		**QPOS $10** Single $764.00 Parent/Child(ren) $1,406.00 Employee/Spouse $1,528.00 Family $2,185.00		**QPOS $20** Single $663.00 Parent/Child(ren) $1,234.00 Employee/Spouse $1,327.00 Family $1,897.00		**QPOS $20/$35** Single $570.00 Parent/Child(ren) $1,062.00 Employee/Spouse $1,142.00 Family $1,632.00	

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Lumberton Township Board of Education
Special Open Enrollment - Rates Effective January 1, 2021 to June 30, 2021
Prescription Coverage Selections - Benecard

Prescription Coverage -	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 Not Available)	$10 Copay	$10 Copay	$16 Copay (preferred)	$18 Copay (preferred)	$21 Copay
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference	10 Copay	$35 Copay (non-preferred)	$46 Copay (non-preferred)	$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 (preferred)	$36 Copay (preferred)	$52 Copay
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference	$15 Copay	$88 Copay (non-preferred)	$92 Copay (non-preferred)	$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	Not Applicable	Not Applicable	Not Applicable	Not Applicable
****Performance Preferred Medications	Applies	Not Applicable	Applies	Applies	Not Applicable
Prescription Monthly Rates					
Single	$211.02	$245.64	$222.79	$215.91	$204.05
Parent/Child(ren)	$355.45	$456.88	$367.60	$421.72	$379.54
Employee/Spouse	$429.06	$491.26	$467.85	$453.42	$428.51
Family	$611.89	$702.52	$637.17	$648.44	$489.72

***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 all 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.

This overview is being provided as a convenient reference tool and is not a complete overview of the benefits being offered through your prescription plan. Some plan limitations may apply. Please refer to the carrier plan documents 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.