

Voorhees Township Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna & AmeriHealth Administrators

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 (Per Calendar Year)	\$0 Individual	\$0 Individual
	\$0 Family	\$0 Family
Out of Pocket Limit (Per Calendar Year)	\$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 (1 Exam/Calendar Year)
Out of Network Benefits	Out of Network	Out of Network
Deductible (Per Calendar Year)	\$350 Ind/\$700 Family	\$350 Ind/\$700 Family
Coinsurance	70% after deductible	70% after deductible
Out of Pocket Limit (Per Calendar Year)	\$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

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Voorhees Township Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna & AmeriHealth Administrators

Who Can Select This Plan?	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20
	POS/PPO \$10	POS/PPO \$15	POS/PPO \$15/\$25	POS/PPO \$20/\$20
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)	\$400 Individual \$1,000 Family	Coinsurance: \$400 Indiv/\$1,000 Family; Copays: \$5,320 Indiv/\$10,440 Family	Coinsurance: \$400 Indiv/\$1,000 Family; Copays: \$5,039 Indiv/\$9,878 Family	Coinsurance: \$800 Indiv/\$2,000 Family; Copays: \$4,920 Indiv/\$9,440 Family
Primary Care	\$10 copay	\$15 copay	\$15 copay	\$20 copay
Specialist	\$10 copay	\$15 copay	\$25 Charge	\$20 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	\$25 copay	\$50 copay	\$75 copay	\$125 copay
Emergency Transportation	90% covered	90% covered	90% covered	90% covered
Urgent Care	\$10 copay	\$15 copay	\$25 copay	\$20 copay
Durable Medical Equipment	90% covered	90% covered	90% covered	90% covered
Hospital Stay	No Charge	No Charge	No Charge	No Charge
Eye Exams (1 Exam/Calendar Year)	\$10 Copay	\$15 copay	\$25 copay	\$20 copay
Out of Network Benefits	Out of Network	Out of Network	Out of Network	Out of Network
Deductible (Per Calendar Year)	\$100 Ind/\$250 Family	\$100 Ind/\$250 Family	\$100 Ind/\$250 Family	\$200 Ind/\$500 Family
Coinsurance	80% after deductible	70% after deductible	70% after deductible \$200 Facility Fee	70% after deductible & \$500 Facility Fee
Out of Pocket Limit (Per Calendar Year)	\$2,000 Ind/\$5,000 Family	\$2,000 Ind/\$5,000 Family	\$2,000 Ind/\$5,000 Family	\$5,000 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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Voorhees Township Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna & AmeriHealth Administrators

Who Can Select This Plan?

Hired Before 7/1/20

Hired Before 7/1/20

	POS/PPO \$20/\$35	HNO/EPO \$20/\$35
In-Network Benefits	In Network	In Network
Deductible (Per Calendar Year)	\$200 Individual \$500 Family	\$200 Individual \$500 Family
Out of Pocket Limit (Per Calendar Year)	Coinsurance: \$2,000 Indiv/\$5,000 Family; Copays: \$3,720 Indiv/\$6,440 Family	Copays: \$5,720 Indiv/\$11,440 Family
Primary Care	\$20 copay	\$20 copay
Specialist	\$35 copay	\$35 copay
Preventive	No Charge	No Charge
Diagnostic (x-ray, blood work)	80% after deductible	80% after deductible
Imaging (CT/PET scans, MRIs)	80% after deductible	80% after deductible
Outpatient Surgery	80% after deductible	80% after deductible
Emergency Room	\$300 copay	\$300 copay
Emergency Transportation	80% after deductible	80% after deductible
Urgent Care	\$35 copay	\$35 copay
Durable Medical Equipment	80% after deductible	80% after deductible
Hospital Stay	80% after deductible	80% after deductible
Eye Exams	\$35 copay (1 exam/calendar year)	\$35 Copay (1 exam/12 months)
Out of Network Benefits	Out of Network	Out of Network
Deductible (Per Calendar Year)	\$800 Ind/\$2,000 Family	Covered for Emergency Services Only
Coinsurance	60% after deductible & \$600 Facility Fee	
Out of Pocket Limit (Per Calendar Year)	\$6,500 Ind/\$13,000 Family	

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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
	NJEHP & GSP	Retail \$3/\$10	Retail \$7/\$16/\$35	Retail \$3/\$18/\$46	Retail \$7/\$21/diff
Retail Copays (30 Day Supply)					
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
Non- Preferred Brand Name Drug (or Generic Alternative Available)	Member Pays the Difference**	\$10 Copay	\$35 Copay	\$46 Copay	Member Pays the Difference between \$21 and cost of drug
Retail Dispensing Limitation	30 day supply	30 day supply	30 day supply	30 day supply	30 day supply
Mail Order (90 Day Supply)					
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
Non-Preferred Brand Name Drug (or Generic Alternative Available)	Member Pays the Difference**	\$15 Copay	\$88 Copay	\$92 Copay	Member Pays the Difference between \$52 and cost of drug
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	Not Applicable	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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