Collingswood Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna

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	$15 Copay (1 Exam/Calendar Year)	$15 Copay (1 Exam/Calendar Year)
Vision Hardware Reimbursement	Not Applicable	Not Applicable
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

-Preauthorization may be required for certain services.

- **Garden State Plan is anetwork of NJ providers only. Only true emergencies will be covered outside of NJ.**

-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 remain the same per your collective bargaining agreement.

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Who Can Select This Plan?	Employees Hired Before 7/1/20	Employees Hired Before 7/1/20	Employees Hired Before 7/1/20	Employees Hired Before 7/1/20
	Aetna HMO $15/$25	Aetna HMO $15/$25 (100/200)	Aetna OA $5/$15 (Gold)	Aetna OA $5/$15 (100/200 Gold)
Summary of Benefits	**In Network**	**In Network**	**In Network**	**In Network**
Deductible (Per Calendar Year)	$0 Individual	$100 Individual	$0 Individual	$100 Individual
	$0 Family	$200 Family	$0 Family	$200 Family
Out of Pocket Limit (Per Calendar Year)	$500 Individual	$500 Individual	$500 Individual	$500 Individual
	$1,000 Family	$1,000 Family	$1,000 Family	$1,000 Family
Primary Care	$15 copay	$15 copay	$5 copay	$5 copay
Specialist	$25 copay	$25 copay	$15 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	$250 copay	$250 Copay	No Charge	No Charge
Emergency Room	$50 copay	$50 copay	$50 copay	$50 copay
Emergency Transportation	No Charge	No Charge	No Charge	No Charge
Durable Medical Equipment	No Charge	No Charge	No Charge	No Charge
Urgent Care	$25 copay	$25 copay	$15 copay	$15 copay
Hospital Stay	$500 copay	$500 copay	No Charge	No Charge
Eye Exam	$25 Copay (1 exam/24 months)	$25 Copay (1 exam/24 months)	$15 copay(1 exam/ year)	$15 copay(1 exam/ year)
Out of Network Benefits	**Out of Network**	**Out of Network**	**Out of Network**	**Out of Network**
Deductible (Per Calendar Year)	Coverage for Emergency Services Only	Coverage for Emergency Services Only	$100 Ind/$200 Family	$100 Ind/$200 Family
Coinsurance			80% after deductible	80% after deductible
Out of Pocket Limit (Per Calendar Year)			$2,000 Ind/$4,000 Family	$2,000 Ind/$4,000 Family

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Who Can Select This Plan?	Employees Hired Before 7/1/20	Employees Hired Before 7/1/20	Employees Hired Before 7/1/20
	Aetna QPOS Patriot V (Blue)	**Aetna QPOS Patriot V (100/200 Blue)**	**Aetna QPOS Buy-Up (Bronze)**
Summary of Benefits	**In Network**	**In Network**	**In Network**
Deductible (Per Calendar Year)	$0 Individual	$100 Individual	$200 Individual
	$0 Family	$200 Family	$400 Family
Out of Pocket Limit (Per Calendar Year)	$500 Individual	$500 Individual	$1,000 Individual
	$1,000 Family	$1,000 Family	$2,000 Family
Primary Care	$5 copay	$5 copay	$20 copay
Specialist	$15 copay	$15 copay	$30 copay
Preventive	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge	No Charge	$30 copay
Imaging (CT/PET scans, MRIs)	No Charge	No Charge	$30 copay
Outpatient Surgery	No Charge	No Charge	10% Coinsurance
Emergency Room	$50 copay	$50 copay	$150 copay
Emergency Transportation	No Charge	No Charge	10% Coinsurance
Durable Medical Equipment	No Charge	No Charge	10% Coinsurance
Urgent Care	$15 copay	$15 copay	$30 copay
Hospital Stay	No Charge	No Charge	$100 copay/day, up to 3 days
Eye Exam	$15 copay(1 exam/calendar year)	$15 copay (1 exam/calendar year)	No Charge (1 exam/24 months)
Vision Hardware Reimbursement	$100 max/24 months	$100 max/24 months	Not Applicable
Out of Network Benefits	**Out of Network Benefits**	**Out of Network Benefits**	**Out of Network Benefits**
Deductible (Per Calendar Year)	$100 Ind/$200 Family	$100 Ind/$200 Family	$1,250 Ind/$2,500 Family
Coinsurance	70%	70%	70%
Out of Pocket Limit (Per Calendar Year)	$2,000 Ind/$4,000 Family	$2,000 Ind/$4,000 Family	$2,500 Ind/$5,000 Family

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Medical Coverage Selections - Schools Health Insurance Fund/Aetna

Who Can Select This Plan?	Employees Hired Before 7/1/20	Employees Hired Before 7/1/20	Employees Hired Before 7/1/20
	Aetna PPO Core	**Aetna PPO Buy-Up**	**Aetna PPO MEC**
Summary of Benefits	**In Network**	**In Network**	**In Network**
Deductible (Per Calendar Year)	$1,000 Individual	$500 Individual	$4,000 Individual
	$2,000 Family	$1,000 Family	$8,000 Family
Out of Pocket Limit (Per Calendar Year)	$2,000 Individual	$1,000 Individual	$6,000 Individual
	$4,000 Family	$2,000 Family	$12,000 Family
Primary Care	$25 copay	$20 copay	$40 copay
Specialist	$40 copay	$30 copay	$80 copay
Preventive	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	$40 copay	$30 copay	$80 copay
Imaging (CT/PET scans, MRIs)	$40 copay	$30 copay	$80 copay
Outpatient Surgery	20% Coinsurance	10% Coinsurance	20% Coinsurance
Emergency Room	20% Coinsurance after $100 Copay	$100 copay	$150 copay
Emergency Transportation	20% Coinsurance	10% Coinsurance	20% Coinsurance
Durable Medical Equipment	20% Coinsurance	10% Coinsurance	20% Coinsurance
Urgent Care	$40 copay	$30 copay	$80 copay
Hospital Stay	$200 copay/day up to 5 days	$100 copay/day up to 5 days	$100 copay/day, up to 5 days
Eye Exam	No Charge (1 exam/24 months)	No Charge (1 exam/24 months)	No Charge (1 exam/24 months)
Out of Network Benefits	**Out of Network Benefits**	**Out of Network Benefits**	**Out of Network Benefits**
Deductible (Per Calendar Year)	$2,500 Ind/$5,000 Family	$1,250 Ind/$$2,500 Family	$8,000 Ind/$16,000 Family
Coinsurance	60%	70%	60%
Out of Pocket Limit (Per Calendar Year)	$5,000 Indv/$10,000 Family	$2,500 Ind/$5,000 Family	$10,050 Ind/$21,000 Family

-Preauthorization may be required for certain services.

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Prescription Coverage Selections - Benecard/Rx Alliance

Who Can Select This Plan?	All Employees	Employees Hired Before 7/1/20	Employees Hired Before 7/1/20
	NJ Educators Health Plan/GSP	Rx Retail $15/$25	Rx Retail $15/$25/$50
Retail Copays			
Generic	$5 Copay	$15 Copay	$15 Copay
Brand Name Drug (Generic Alternative Not Available)	$10 Copay	$25 Copay	$25 Copay (Preferred)
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference**	$25 Copay	$50 Copay (Non-preferred)
Retail Dispensing Limitation	30 day supply	34 day supply or 100 units	34 day supply or 100 units
Mail Order			
Generic	$10 Copay	$10 Copay	$15 Copay
Brand Name Drug (Generic Alternative Not Available)	$20 Copay	$10 Copay	$25 Copay (Preferred)
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference**	$10 Copay	$50 Copay (Non-Preferred)
Mail Order Dispensing Limitation	90 day supply	90 day supply	34 day supply or 100 units
Additional Features			
*Step Therapy	Applies	Not Applicable	Not Applicable
**Mandatory Generic	Applies	Not Applicable	Not Applicable
***Mail Order for Specialty Medications	Applies	Applies	Applies
****Performance Preferred Medication	Applies	Applies	Applies

***Step Therapy-** 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** - 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 formulary list updates throughout the year, and for the most up to date version please refer to Benecard's site: https://www.benecardpbf.com/PBF/

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