

Cinnaminson 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 | \$0 Individual \$0 Family | \$0 Individual \$0 Family |
| Out of Pocket Limit | \$500 Individual \$1,000 Family | \$500 Individual \$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 | \$350 Ind/\$700 Family | \$350 Ind/\$700 Family |
| Coinsurance | 70% after deductible | 70% after deductible |
| Out of Pocket Limit | \$2,000 Ind/\$5,000 Family | \$2,000 Ind/\$5,000 Family |

-Preauthorization may be required for certain services.

-GSP is a Network of NJ Providers only. Out of state services will not be covered unless it is a true medical emergency.

-For the NJEHP & GSP, the employee's contribution is based on the new salary based contribution schedule. For all other plans, your employee contribution 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.

Cinnaminson 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 |
|---------------------------------------|---|--|
| | QPOS \$10/\$15 | Minimum Value Plan |
| In-Network Benefits | In Network | In Network |
| Deductible | \$0 Individual \$0 Family | \$3,500 Individual \$7,000 Family |
| Out of Pocket Limit | \$1,500 Individual \$3,000 Family | \$6,000 Individual \$12,000 Family |
| Primary Care | \$10 copay | \$35 copay |
| Specialist | \$15 copay | \$70 copay |
| Preventive | No Charge | No Charge |
| Diagnostic (x-ray, blood work) | No Charge for Lab \$15 copay for X-Ray | \$70 copay |
| Imaging (CT/PET scans, MRIs) | \$15 copay | \$70 copay |
| Outpatient Surgery | No Charge | \$100 copay for Facility No Charge for Physician/Surgeon |
| Emergency Room | \$25 copay | \$150 copay |
| Emergency Transportation | No Charge | 70% covered |
| Urgent Care | \$15 copay | \$70 copay |
| Durable Medical Equipment | No Charge | 70% covered |
| Hospital Stay | No Charge | \$200 copay/day up to 5 days for Facility 70% covered for Physician/Surgeon |
| Eye Exams | \$15 Copay (1 Exam/Calendar Year) | No Charge (1 Exam/24 Months) |
| Vision Hardware Reimbursement | \$70 Maximum/24 Months | Not Applicable |
| Out of Network Benefits | Out of Network | Out of Network |
| Deductible | \$100 Ind/\$200 Family | \$7,000 Ind/\$14,000 Family |
| Coinsurance | 70% after deductible | 50% after deductible |
| Out of Pocket Limit | \$2,000 Ind/\$4,000 Family | \$12,000 Ind/\$24,000 Family |

-Preauthorization may be required for certain services.

-For the NJEHP & GSP, the employee's contribution is based on the new salary based contribution schedule. For all other plans, your employee contribution will remain the same per your collective bargaining agreement.

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Prescription Coverage Selections - Schools Health Insurance Fund/Express Scripts

| Who Can Select This Plan? | All Employees | Hired Before 7/1/20 | Hired Before 7/1/20 |
|---|---|--|--|
| | NJ Educators Health Plan & Garden State Plan | Rx Retail \$10/\$15 Applies to QPOS \$10/\$15 | Retail \$10/\$35/\$50 Applies to Minimum Value Plan |
| Retail Copays | | | \$200 Deductible for Brand Drugs |
| Generic | \$5 Copay | \$10 Copay | \$10 Copay |
| Brand Name Drug (Generic Alternative <u>Not</u> Available) | \$10 Copay | \$15 Copay | \$35 Copay (Preferred) |
| Brand Name Drug (Generic Alternative Available) | Member Pays the Difference** | \$15 Copay | \$50 Copay (Non-Preferred) |
| Retail Dispensing Limitation | 30 day supply | 34 day supply or up to 100 units | 30 day supply |
| Mail Order | | | |
| Generic | \$10 Copay | \$10 Copay | \$20 Copay |
| Brand Name Drug (Generic Alternative <u>Not</u> Available) | \$20 Copay | \$15 Copay | \$70 Copay (Preferred) |
| Brand Name Drug (Generic Alternative Available) | Member Pays the Difference** | \$15 Copay | \$100 Copay (Non-Preferred) |
| Mail Order Dispensing Limitation | 90 day supply | 90 day supply | 90 day supply |
| Additional Features | | | |
| *Step Therapy | Applies | Not Applicable | Not Applicable |
| **Mandatory Generic | Applies | Not Applicable | Not Applicable |
| ***Mail Order for Specialty Drugs | Applies | Applies | Applies |
| ****Closed Formulary | 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.

****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 Accredo. 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/>

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.