Gloucester Township Board of Education

	AETNA ACPOSII EDUCATORS *or* AMERIHEALTH PPO EDUCATORS	AETNA ACPOSII GARDEN STATE PLAN *or* AMERIHEALTH PPO GARDEN STATE PLAN	AETNA ACPOSII $10 *or* AMERIHEALTH PPO $10	AETNA ACPOSII $15 *or* AMERIHEALTH PPO $15	AETNA ACPOSII $15/$25 *or* AMERIHEALTH PPO $15/$25	AETNA ACPOSII $20/$20 *or* AMERIHEALTH PPO $20/$20	AETNA ACPOSII $20/$35 *or* AMERIHEALTH PPO $20/$35
IN-NETWORK BENEFITS		**New Jersey Providers ONLY**					
Deductible (Calendar Year)							
Individual / Family	None	None	None	None	None	None	$200 / $400
Coinsurance	100%	100%	100%	100%	100%	100%	80%
Maximum Out-of-Pocket							
Individual / Family	$500 / $1,000	$500 / $1,000	$400 / $800	$400 / $800	$400 / $800	$800 / $1,600	$2,500 / $5,000
Primary Care Physician Selection	**Not Required**	**Not Required**	**Not Required**	**Not Required**	**Not Required**	**Not Required**	**Not Required**
Doctor's Office Visits							
Primary Care Office Visit	100% after $10 copay	100% after $10 copay	100% after $10 copay	100% after $15 copay	100% after $15 copay	100% after $20 copay	100% after $20 copay
Specialist Office Visit	100% after $15 copay Referral **not** required	100% after $15 copay Referral **not** required	100% after $10 copay Referral **not** required	100% after $15 copay Referral **not** required	100% after $25 copay Referral **not** required	100% after $20 copay Referral **not** required	100% after $35 copay Referral **not** required
Maternity Visits	100% after $15 copay Applies to 1st visit only	100% after $15 copay Applies to 1st visit only	100% after $10 copay Applies to 1st visit only	100% after $15 copay Applies to 1st visit only	100% after $25 copay Applies to 1st visit only	100% after $20 copay Applies to 1st visit only	100% after $35 copay Applies to 1st visit only
Preventive Care							
Annual Preventive Visits	100%	100%	100%	100%	100%	100%	100%
Well Child Exams	100%	100%	100%	100%	100%	100%	100%
Well Child Immunizations/Lead Screenings	100%	100%	100%	100%	100%	100%	100%
Diagnostics Procedures							
Laboratory	100%	100%	100%	100%	100%	100%	100%
Outpatient X-Ray/Radiology Services	100%	100%	100%	100%	100%	100%	100%
Hospital Care							
Inpatient Admission (including maternity)	100%	100%	100%	100%	100%	100%	80% after deductible
Surgery in Hospital	100%	100%	100%	100%	100%	100%	80% after deductible
Emergency Care							
Emergency Room	100% after $125 copay *	100% after $125 copay *	100% after $25 copay	100% after $100 copay	100% after $100 copay	100% after $100 copay	100% after $100 copay
Ambulance	90%	90%	90%	90%	90%	90%	80%
Outpatient Surgery							
Hospital Outpatient Surgery	100%	100%	100%	100%	100%	100%	80% after deductible
Ambulatory SurgiCenter	100%	100%	100%	100%	100%	100%	80% after deductible
Mental Health/Substance Abuse							
Inpatient	100%	100%	100%	100%	100%	100%	80% after deductible
Outpatient	100%	100%	100%	100%	100%	100%	80% after deductible
Office Setting	100% after $15 copay	100% after $15 copay	100% after $10 copay	100% after $15 copay	100% after $25 copay	100% after $20 copay	100% after $35 copay
Other Services							
Diabetic Supplies	90%	90%	90%	90%	90%	90%	80%
Durable Medical Equipment	90%	90%	90%	90%	90%	90%	80%
Infertility	100% after office copay	100% after office copay	100% after office copay	100% after office copay	100% after office copay	100% after office copay	100% after office copay
Orthotics and Prosthetics	100% after office copay	100% after office copay	100% after office copay	100% after office copay	100% after office copay	100% after office copay	100% after office copay
Short-term Therapies	100% after office copay	100% after office copay	100% after office copay	100% after office copay	100% after office copay	100% after office copay	100% after office copay
Chiropractic Care	100% after office copay 30 visit maximum	100% after office copay 30 visit maximum	100% after office copay 30 visit maximum	100% after office copay 30 visit maximum	100% after office copay 30 visit maximum	100% after office copay 30 visit maximum	100% after office copay 30 visit maximum
Vision - Routine Eye Exam	100% after $15 copay	100% after $15 copay	100% after $10 copay	100% after $15 copay	100% after $25 copay	100% after $20 copay	100% after $35 copay
OUT-OF-NETWORK BENEFITS							
Annual Deductible	$350 / $700	$350 / $700	$100 / $250	$100 / $250	$100 / $250	$200 / $500	$800 / $1,600
Coinsurance (Carrier Pays)	70% after deductible	70% after deductible	80% after deductible	70% after deductible	70% after deductible	70% after deductible	60% after deductible
Out of Pocket Maximum	$2,000 / $5,000	$2,000 / $5,000	$2,000 / $5,000	$2,000 / $5,000	$2,000 / $5,000	$5,000 / $12,500	$5,000 / $10,000
Prescription Drugs	**Express Scripts**	**Express Scripts**	**Express Scripts**	**Express Scripts**	**Express Scripts**	**Express Scripts**	**Express Scripts**
Retail / Mail Order	Retail: $5/$10 Mail Order: $10/$20 Retail/Mail: Mandatory Generics Applies Step Therapy Applies **Non-Preferred Drugs & Specialty: if Generic Drug available, Member pays the Brand Drug copay plus difference between the Brand & the Generic Drug.*	Retail: $5/$10 Mail Order: $10/$20 Retail/Mail: Mandatory Generics Applies Step Therapy Applies **Non-Preferred Drugs & Specialty: if Generic Drug available, Member pays the Brand Drug copay plus difference between the Brand & the Generic Drug.*	Retail: $3/$10 (Generic/Brand) Mail Order: $5/$15 (Generic/Brand)	Retail: $5/$15 (Generic/Brand) Mail Order: $10/$30 (Generic/Brand)	Retail: $7/$16/$35 (Generic/Brand/Non-Preferred) Mail Order: $18/$40/$88 (Generic/Brand/Non- Preferred)	Retail: $3/$18/$46 (Generic/Brand/Non-Preferred) Mail Order: $5/$36/$92 (Generic/Brand/Non- Preferred)	Retail: $7/$21 (Generic/Brand) Mail Order: $18/$52 (Generic/Brand)

Notes:

-The GSP is a an NJ Network of 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 contributions will remain the same per your collective bargaining agreement.

-The Following Features may apply to your prescription plan:

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. Accredo 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 Accredo. Accredo is the specialty pharmacy for Express Scripts.Specialty pharmaceuticals are typically produced through biotechnology, administered by injection, and/or require special handling and patient

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 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.

Gloucester Township Board of Education

	AETNA QPOS $10 *or* AMERIHEALTH POS $10	AETNA QPOS $15/$25 *or* AMERIHEALTH POS $15/$25	AETNA QPOS $20/$20 *or* AMERIHEALTH POS $20/$20	AETNA QPOS $20/$35 *or* AMERIHEALTH POS $20/$35
IN-NETWORK BENEFITS				
Deductible (Calendar Year)				
Individual / Family	None	None	None	None
Coinsurance	100%	100%	100%	100%
Maximum Out-of-Pocket				
Individual / Family	$4,000 / $8,000	$4,000 / $8,000	$4,000 / $8,000	$4,000 / $8,000
Primary Care Physician Selection	**Required**	**Required**	**Required**	**Required**
Doctor's Office Visits				
Primary Care Office Visit	100% after $10 copay	100% after $15 copay	100% after $20 copay	100% after $20 copay
Specialist Office Visit	100% after $10 copay Referral required	100% after $25 copay Referral required	100% after $20 copay Referral required	100% after $35 copay Referral required
Maternity Visits	100% after $10 copay Applies to 1st visit only	100% after $25 copay Applies to 1st visit only	100% after $20 copay Applies to 1st visit only	100% after $35 copay Applies to 1st visit only
Preventive Care				
Annual Preventive Visits	100%	100%	100%	100%
Well Child Exams	100%	100%	100%	100%
Well Child Immunizations/Lead Screenings	100%	100%	100%	100%
Diagnostics Procedures				
Laboratory	100%	100%	100%	100%
Outpatient X-Ray/Radiology Services	100%	100%	100%	100%
Hospital Care				
Inpatient Admission (including maternity)	100%	100%	100%	100%
Surgery in Hospital	100%	100%	100%	100%
Emergency Care				
Emergency Room	100% after $35 copay	100% after $75 copay	100% after $100 copay	100% after $100 copay
Ambulance	100%	100%	100%	100%
Outpatient Surgery				
Hospital Outpatient Surgery	100%	100%	100%	100%
Ambulatory SurgiCenter	100%	100%	100%	100%
Mental Health/Substance Abuse				
Inpatient	100%	100%	100%	100%
Outpatient	100%	100%	100%	100%
Office Setting	100% after $10 copay	100% after $25 copay	100% after $20 copay	100% after $35 copay
Other Services				
Diabetic Supplies	100%	100%	100%	100%
Durable Medical Equipment	100%	100%	100%	100%
Infertility	100% after office copay	100% after office copay	100% after office copay	100% after office copay
Orthotics and Prosthetics	100% after office copay	100% after office copay	100% after office copay	100% after office copay
Short-term Therapies	100% after office copay	100% after office copay	100% after office copay	100% after office copay
Chiropractic Care	100% after office copay 25 visit maximum	100% after office copay 25 visit maximum	100% after office copay 25 visit maximum	100% after office copay 25 visit maximum
Vision - Routine Eye Exam	100% after $10 copay	100% after $25 copay	100% after $20 copay	100% after $35 copay
OUT-OF-NETWORK BENEFITS				
Annual Deductible	$500 / $1000	$500 / $1000	$500 / $1000	$500 / $1000
Coinsurance (Carrier Pays)	60% after deductible	60% after deductible	60% after deductible	60% after deductible
Out of Pocket Maximum	$4,000 / $8,000	$4,000 / $8,000	$4,000 / $8,000	$4,000 / $8,000
Prescription Drugs	**Express Scripts**	**Express Scripts**	**Express Scripts**	**Express Scripts**
Retail / Mail Order	Retail: $3/$10 (Generic/Brand) Mail Order: $5/$15 (Generic/Brand)	Retail: $7/$16/$35 (Generic/Brand/Non- Preferred) Mail Order: $18/$40/$88 (Generic/Brand/Non-Preferred)	Retail: $3/$18/$46 (Generic/Brand/Non- Preferred) Mail Order: $5/$36/$92 (Generic/Brand/Non-Preferred)	Retail: $7/$21 (Generic/Brand) Mail Order: $18/$52 (Generic/Brand)

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