Delsea Regional Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna, AmeriHealth Administrators, Horizon Omnia (SHBP)

Who Can Select This Plan?	All Employees	All Employees	Hired Before 7/1/20	Hired Before 7/1/20
	NJ Educators Health Plan	***Garden State Plan (NJ Network)**	**Aetna Patriot V $5**	**Aetna Patriot X $10**
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)	$500 Individual $1,000 Family	$500 Individual $1,000 Family	$5,300 Individual $10,600 Family	$5,300 Individual $10,600 Family
Primary Care	$10 copay	$10 copay	$5 copay	$10 copay
Specialist	$15 copay	$15 copay	$15 copay	$25 copay
Preventive	No Charge	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge	No Charge	No Charge	No Charge for Lab; $25 copay for X-Ray
Imaging (CT/PET scans, MRIs)	No Charge	No Charge	No Charge	$25 copay
Outpatient Surgery	No Charge	No Charge	No Charge	No Charge
Emergency Room	$125 copay	$125 copay	$50 copay	$50 copay
Emergency Transportation	90% covered	90% covered	No Charge	No Charge
Urgent Care	$15 copay	$15 copay	$15 copay	$25 copay
Durable Medical Equipment	90% covered	90% covered	Not Covered	Not Covered
Hospital Stay	No Charge	No Charge	No Charge	No Charge
Eye Exams	$15 Copay (1 exam/calendar year)	$15 Copay (1 exam/calendar year)	$15 Copay (1 exam/12 months up to 19; 1 exam/24 months after 19)	$25 Copay (1 exam/12 months up to 19; 1 exam/24 months after 19)
Vision Hardware Reimbursement	Not Applicable	Not Applicable	$100 max/24 months	$70 max/24 months
Out of Network Benefits	**Out of Network**	**Out of Network**	**Out of Network**	**Out of Network**
Deductible (Per Calendar Year)	$350 Ind/$700 Family	$350 Ind/$700 Family	$100 Ind/$200 Family	$100 Ind/$200 Family
Coinsurance	70% after deductible	70% after deductible	70% after deductible	80% after deductible
Out of Pocket Limit (Per Calendar Year)	$2,000 Ind/$5,000 Family	$2,000 Ind/$5,000 Family	$2,000 Ind/$4,000 Family	$400 Ind/$1,200 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 contributions 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.

Delsea Regional Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna, AmeriHealth Administrators, Horizon Omnia

Who Can Select This Plan?	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20
	Aetna HDHP w/ H.S.A	**Aetna Core $25**	**Aetna Buy Up Plan**
In-Network Benefits	**In Network**	**In Network**	**In Network**
Deductible (Per Calendar Year)	$1,400 Individual	$1,000 Individual	$500 Individual
	$2,800 Family	$2,000 Family	$1,000 Family
Out of Pocket Limit (Per Calendar Year)	$6,250 Individual	$2,000 Individual	$1,000 Individual
	$12,500 Family	$4,000 Family	$2,000 Family
Primary Care	80% covered	$25 copay	$20 copay
Specialist	80% covered	$40 copay	$30 copay
Preventive	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	80% covered	$40 copay	$30 copay
Imaging (CT/PET scans, MRIs)	80% covered	$40 copay	$30 copay
Outpatient Surgery	80% covered	80% covered	90% covered
Emergency Room	80% covered	80% covered after $100 copay	$100 copay
Emergency Transportation	80% covered	80% covered	90% covered
Urgent Care	80% covered	$40 copay	$30 copay
Durable Medical Equipment	80% covered	80% covered	90% covered
Hospital Stay	80% covered	$200 copay/day up to 5 days then No Charge for Facility	$100 copay/day up to 5 days for Facility
Eye Exams	No Charge (1 exam/24 months)	No Charge (1 exam/24 months)	No Charge (1 exam/24 months)
Vision Hardware Reimbursement	Not Applicable	Not Applicable	Not Applicable
Out of Network Benefits	**Out of Network**	**Out of Network**	**Out of Network**
Deductible (Per Calendar Year)	$1,400 Ind/$2,800 Family	$2,500 Ind/$5,000 Family	$1,250 Ind/$2,500 Family
Coinsurance	50% after deductible	60% after deductible	70% after deductible
Out of Pocket Limit (Per Calendar Year)	$6,250 Ind/$12,500 Family	$5,000 Ind/$10,000 Family	$2,500 Ind/$5,000 Family

-Preauthorization may be required for certain services.

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Delsea Regional Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna, AmeriHealth Administrators, Horizon Omnia (SHBP)

Who Can Select This Plan?	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20	
	AHA EPO $15/$25	**AHA PPO $15/$25**	**Horizon Omnia 2-Tier Plan**	
In-Network Benefits	**In Network**	**In Network**	**Omnia Network (Tier 1)**	**Direct Access Network (Tier 2)**
Deductible (Per Calendar Year)	$500 for infertility services only	$1,000 for infertility services only	$0 Individual $0 Family	$1,500 Individual $3,000 Family
Out of Pocket Limit (Per Calendar Year)	$4,000 Individual $8,000 Family	$2,000 Individual $5,000 Family	$2,500 Individual $5,000 Family	$4,500 Individual $9,000 Family
Primary Care	$15 copay	$15 copay	$5 copay	$20 copay
Specialist	$25 copay	$25 copay	$15 copay	$30 copay
Preventive	No Charge	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	$25 copay for X-Ray; No charge for blood work	$25 copay for X-Ray; No charge for blood work	No Charge	80% covered for Outpatient Hospital; No Charge for Office & Ind. Lab
Imaging (CT/PET scans, MRIs)	$25 copay	$25 copay	$15 copay	80% covered
Outpatient Surgery	No Charge	No Charge	$150 copay for outpatient hospital, ambulatory surgical center	80% covered
Emergency Room	$50 copay	$50 copay	$100 copay	$100 copay
Emergency Transportation	No Charge	No Charge	No Charge	No Charge, Deductible Applies
Urgent Care	$25 copay	$25 copay	$15 copay	$30 copay
Durable Medical Equipment	90% covered	90% covered	No Charge	80% covered
Hospital Stay	$50 copay/day up to 5 days & $500 in copays per benefit period	No Charge	$150 copay/day for Facility; No Charge for Physician/Surgeon	80% covered
Eye Exams	No Charge (1 exam/12 months)	No Charge (1 exam/12 months)	No Charge - 1 exam/12 months Limited to Children Only Administered by Davis Vision	No Charge - 1 exam/12 months Limited to Children Only Administered by Davis Vision
Vision Hardware Reimbursement	$100 max/24 months	$100 max/24 Months	$150 max/non-collection frames every 12 months Limited to Children Only	$150 max/non-collection frames every 12 months Limited to Children Only
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	$500 Ind/$1,000 Family	Coverage for Emergency Services Only	
Coinsurance		70% after deductible		
Out of Pocket Limit (Per Calendar Year)		$4,000 Ind/$8,000 Family		

-Preauthorization may be required for certain services.

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Delsea Regional Board of Education

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	**Retail $10/$20/$35 Applies to Patriot, AHA, Omnia Plans**	**Retail $15/$35/$50 Applies to Core & Buy Up**
Retail Copays			
Generic	$5 Copay	$10 Copay	$15 Copay
Brand Name Drug (Generic Alternative Not Available)	$10 Copay	$20 Copay	$35 Copay
Non- Preferred Brand Name Drug (or Generic Alternative Available)	Member Pays the Difference**	$35 Copay	$50 Copay
Retail Dispensing Limitation	30 day supply	30 day supply	34 day supply
Mail Order			
Generic	$10 Copay	$30 Copay	$45 Copay
Brand Name Drug (Generic Alternative Not Available)	$20 Copay	$60 Copay	$105 Copay
Non-Preferred Brand Name Drug (or Generic Alternative Available)	Member Pays the Difference**	$105 Copay	$150 Copay
Mail Order Dispensing Limitation	90 day supply	90 day supply	90 day supply
Additional Features			
*Step Therapy	Applies	Applies	Applies
**Mandatory Generic	Applies	Not Applicable	Not Applicable
***Mail Order for Specialty Drugs	Applies	Applies	Applies
****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 Pharmacy. Specialty pharmaceuticals are typically produced through biotechnology, administered by injection, and/or require special handling and patient monitoring.

******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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