Southampton Board of Education

Plans Effective July 1, 2022 to June 30, 2023

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	$0 Individual	$0 Individual
	$0 Family	$0 Family
Out of Pocket Limit	$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	$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

-*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.

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Medical Coverage Selections - Schools Health Insurance Fund/Aetna

Who Can Select This Plan?	Hired Before 9/1/18	Hired Before 9/1/18
	Aetna Patriot V $10	**Aetna Patriot X $15**
In-Network Benefits	**In Network**	**In Network**
Deductible	$0 Individual $0 Family	$0 Individual $0 Family
Out of Pocket Limit	$5,300 Individual $10,600 Family	$5,300 Individual $10,600 Family
Primary Care	$10 copay	$15 copay
Specialist	$10 copay	$20 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	$50 copay	$50 copay
Emergency Transportation	No Charge	No Charge
Urgent Care	$10 copay	$20 copay
Durable Medical Equipment	No Charge	No Charge
Hospital Stay	No Charge	No Charge
Eye Exams	$10 Copay (1 exam/12 months)	$20 Copay (1 exam/12 months)
Vision Hardware Reimbursement	$100 max/24 months	$70 Maximum/24 Months
Out of Network Benefits	**Out of Network**	**Out of Network**
Deductible	$100 Ind/$200 Family	$100 Ind/$200 Family
Coinsurance	70% after deductible	80% after deductible
Out of Pocket Limit	$2,000 Ind/$4,000 Family	$400 Ind/$1,200 Family

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Medical Coverage Selections - Schools Health Insurance Fund/Aetna

Who Can Select This Plan?	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20
	Aetna EPO $15/$25	Aetna PPO Core	Aetna HDHP $1350/$2700
In-Network Benefits	**In Network**	**In Network**	**In Network**
Deductible	$0 Individual $0 Family	$1,000 Individual $2,000 Family	$1,350 Individual $2,700 Family
Out of Pocket Limit	$4,000 Individual $8,000 Family	$2,000 Individual $4,000 Family	$6,250 Individual $12,500 Family
Primary Care	$15 copay	$25 copay	80% covered
Specialist	$25 copay	$40 copay	80% covered
Preventive	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge for Lab $25 copay for X-Ray	$40 copay	80% covered
Imaging (CT/PET scans, MRIs)	$25 copay	$40 copay	80% covered
Outpatient Surgery	No Charge	80% Covered	80% covered
Emergency Room	$100 copay	80% Covered after $100 copay	80% covered
Emergency Transportation	No Charge	80% Covered	80% covered
Urgent Care	$15 copay	$40 copay	80% covered
Durable Medical Equipment	No Charge	80% covered	80% covered
Hospital Stay	$50 copay/day, up to 5 days for Facility No Charge for Physician/Surgeon	$200 copay/day up to 5 days	80% covered
Eye Exams	No Charge (1 exam/12 months)	No Charge (1 exam/24 months)	No Charge (1 exam/24 months)
Vision Hardware Reimbursement	$200 max/24 months	Not Applicable	Not Applicable
Out of Network Benefits	**Out of Network**	**Out of Network**	**Out of Network**
Deductible	Emergency Services Covered Only	$2,500 Ind/$5,000 Family	$1,350 Ind/$2,700 Family
Coinsurance		60% after deductible	50% after deductible
Out of Pocket Limit		$5,000 Ind/$10,000 Family	$6,250 Ind/$12,500 Family

-Preauthorization may be required for certain services.

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Southampton Board of Education
Plans Effective July 1, 2022 to June 30, 2023
Prescription Coverage Selections - Express Scripts

Who Can Select This Plan?	All Employees	Hired Before 9/1/18	Teachers After 9/1/18, Cust., Sec., Admin. Staff
	NJ Educators Health Plan & Garden State Plan	**Retail $10/$25/$50**	**Retrail $10/$25/$50 (Step Therapy)**
Retail Copays			
Generic	$5 Copay	$10 Copay	$10 Copay
Brand Name Drug (Generic Alternative Not Available)	$10 Copay	$25 Copay	$25 Copay
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference**	$50 Copay	$50 Copay
Retail Dispensing Limitation	30 day supply	34 day supply	30 day supply
Mail Order			
Generic	$10 Copay	$20 Copay	$20 Copay
Brand Name Drug (Generic Alternative Not Available)	$20 Copay	$50 Copay	$50 Copay
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference**	$100 Copay	$100 Copay
Mail Order Dispensing Limitation	90 day supply	90 day supply	90 day supply
Additional Features			
*Step Therapy	Applies	Not Applicable	Applies
**Mandatory Generic	Applies	Not Applicable	Not Applicable
***Mail Order for Specialty Medications	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. 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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