Rancocas Valley Regional High School

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 (1 Exam/Calendar Year)	$15 Copay	$15 Copay
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

-*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.

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Who Can Select This Plan?	Employees Before 7/1/20	Employees Before 7/1/20	Employees Before 7/1/20
	Aetna Patriot V $10 (High)	**Aetna Patriot V $10 (Low)**	**Aetna Patriot X $15**
Summary of Benefits	**In Network**	**In Network**	**In Network**
Deductible (Per Calendar Year)	$0 Individual	$0 Individual	$0 Individual
	$0 Family	$0 Family	$0 Family
Out of Pocket Limit (Per Calendar Year)	$5,300 Individual	$1,500 Individual	$5,300 Individual
	$10,600 Family	$3,000 Family	$10,600 Family
Primary Care	$10 copay	$10 copay	$15 copay
Specialist	$15 copay	$15 copay	$25 copay
Preventive	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge for Lab; $10 copay for X-Ray	No Charge for Lab; $15 copay for X-Ray	No Charge for Lab; $25 copay for X-Ray
Imaging (CT/PET scans, MRIs)	$10 copay	$15 copay	$25 copay
Outpatient Surgery	No Charge	No Charge	No Charge
Emergency Room	$35 copay	$35 copay	$35 copay
Emergency Transportation	No Charge	No Charge	No Charge
Durable Medical Equipment	No Charge	No Charge	No Charge
Urgent Care	$15 copay	$15 copay	$25 copay
Hospital Stay	No Charge	No Charge	No Charge
Eye Exam **1 Exam/12 Months up to 19;** **1 Exam/24 Months after 19**	$15 copay	$15 copay	$25 copay
Vision Hardware Reimbursement	$100 max/24 months	Not Applicable	$70 max/24 months
Out of Network Benefits	**Out of Network**	**Out of Network**	**Out of Network**
Deductible (Per Calendar Year)	$100 Ind/$200 Family	$5,000 Ind/$15,000 Family	$100 Ind/$200 Family
Coinsurance	70% after deductible	50% after deductible	80% after deductible
Out of Pocket Limit (Per Calendar Year)	$2,000 Ind/$4,000 Family	$10,000 Ind/$30,000 Family	$400 Ind/$1,200 Family

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Medical Coverage Selections - Schools Health Insurance Fund/Aetna

Who Can Select This Plan?	Employees Before 7/1/20	Employees Before 7/1/20
	Aetna Buy Up	**Aetna Core**
Summary of Benefits	**In Network**	**In Network**
Deductible (Per Calendar Year)	$500 Individual	$1,000 Individual
	$1,000 Family	$2,000 Family
Out of Pocket Limit (Per Calendar Year)	$1,000 Individual	$2,000 Individual
	$2,000 Family	$4,000 Family
Primary Care	$20 copay	$25 copay
Specialist	$30 copay	$40 copay
Preventive	No Charge	No Charge
Diagnostic (x-ray, blood work)	$30 copay	$40 copay
Imaging (CT/PET scans, MRIs)	$30 copay	$40 copay
Outpatient Surgery	10% Coinsurance	20% Coinsurance
Emergency Room	$100 copay	20% Coinsurance after $100 copay
Emergency Transportation	10% Coinsurance	20% Coinsurance
Durable Medical Equipment	10% Coinsurance	20% Coinsurance
Urgent Care	$30 copay	$40 copay
Hospital Stay	$100 copay/day up to 5 days	$200 copay/day up to 5 days
Eye Exam (1 Exam/24 Months)	No Charge	No Charge
Vision Hardware Reimbursement	Not Applicable	Not Applicable
Out of Network Benefits	**Out of Network**	**Out of Network**
Deductible (Per Calendar Year)	$1,250 Ind/$2,500 Family	$2,500 Ind/$5,000 Family
Coinsurance	70% after deductible	60% after deductible
Out of Pocket Limit (Per Calendar Year)	$2,500 Ind/$5,000 Family	$5,000 Ind/$10,000 Family

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Who Can Select This Plan? **Employees Before 7/1/20**

	Aetna 3-Tier (Virtua)		
Summary of Benefits	**Virtua In Network**	**Aenta In Network**	**Aetna Out of Network**
Deductible (Per Calendar Year)	$0 Individual	$1,500 Individual	$3,000 Individual
	$0 Family	$3,000 Family	$6,000 Family
Out of Pocket Limit (Per Calendar Year)	$1,000 Individual	$4,000 Individual	$6,000 Individual
	$2,000 Family	$8,000 Family	$12,000 Family
Primary Care	$10 copay	20% Coinsurance	60% after deductible
Specialist	$10 copay	20% Coinsurance	60% after deductible
Preventive	No Charge	No Charge	60% after deductible
Diagnostic (x-ray, blood work)	No Charge	20% Coinsurance	60% after deductible
Imaging (CT/PET scans, MRIs)	No Charge	20% Coinsurance	60% after deductible
Outpatient Surgery	No Charge	20% Coinsurance	60% after deductible
Emergency Room	$100 copay	$100 copay	$100 copay
Emergency Transportation	No Charge	20% Coinsurance	20% Coinsurance
Durable Medical Equipment	No Charge	20% Coinsurance	60% after deductible
Urgent Care	$10 copay	20% Coinsurance	60% after deductible
Hospital Stay	No Charge	20% Coinsurance	60% after deductible
Eye Exam (1 Exam/12 Months)	$10 copay	20% Coinsurance	60% after deductible
Vision Hardware Reimbursement	Not Applicable	Not Applicable	Not Applicable

-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.

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Prescription Coverage Selections - Benecard

Who Can Select This Plan?	All Employees	Employees Before 7/1/20
	NJEHP / GSP	**Rx Retail $7.50/$25**
Retail Copays		
Generic	$5 Copay	$7.50 Copay
Brand Name Drug (Generic Alternative Not Available)	$10 Copay	$25 Copay
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference**	$25 Copay
Retail Dispensing Limitation	30 day supply	34 day supply or 100 units
Mail Order		
Generic	$10 Copay	$7.50 Copay
Brand Name Drug (Generic Alternative Not Available)	$20 Copay	$25 Copay
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference**	$25 Copay
Mail Order Dispensing Limitation	90 day supply	90 day supply
Additional Features		
*Step Therapy	Applies	Not Applicable
**Mandatory Generic	Applies	Not Applicable
***Mail Order for Specialty Medications	Applies	Applies
****Performance Preferred Medication	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 Performance Preferred Medications List may update throughout the year; for the most up to date version please refer to Benecard's website: https://www.benecardpbf.com/PBF/

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