Berlin Borough Board of Education

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

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

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Who Can Select This Plan?	Hired Before 7/1/20	Hired Before 7/1/20	Hired Before 7/1/20
	QPOS $15	**HMO $2**	**ACPOS $35/$70 MEC**
In-Network Benefits	**In Network**	**In Network**	**In Network**
Deductible (Per Calendar Year)	$0 Individual	$0 Individual	$3,500 Individual
	$0 Family	$0 Family	$7,000 Family
Out of Pocket Limit (Per Calendar Year)	$5,300 Individual	$1,500 Individual	$6,000 Individual
	$10,600 Family	$3,000 Family	$12,000 Family
Primary Care	$15 copay	$2 copay	$35 copay
Specialist	$15 copay	No Charge	$70 copay
Preventive	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge	No Charge	$70 copay
Imaging (CT/PET scans, MRIs)	No Charge	No Charge	$70 copay
Outpatient Surgery	No Charge	No Charge	$100 Facility Fee No Charge for Physician/Surgeon Fees
Emergency Room	$75 copay	$15 copay	$150 copay
Emergency Transportation	No Charge	No Charge	70% Covered
Urgent Care	$15 copay	No Charge	$70 copay
Durable Medical Equipment	70% Covered After OON Deductible	Not Covered	70% covered
Hospital Stay	No Charge	No Charge	$200 copay/day up to 5 days, then No Charge for Facility. No Charge for Physician/Surgeon Fees
Eye Exams	No Charge 1 exam/12 months up to age 19; 1 exam/24 months for ages 19+	No Charge 1 exam/12 months up to age 19; 1 exam/24 months for ages 19+	No Charge 1 exam/24 months
Vision Hardware Reimbursement	$100 Maximum/24 Months	$100 Maximum/24 Months	Not Applicable
Out of Network Benefits	**Out of Network**	**Out of Network**	**Out of Network**
Deductible (Per Calendar Year)	$100 Ind/$200 Family	No Coverage for OON Services Unless it is a True Medical Emergency	$7,000 Ind/$14,000 Family
Coinsurance	70% after deductible		50% after deductible
Out of Pocket Limit (Per Calendar Year)	$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 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.

Berlin Borough Board of Education

Prescription Coverage Selections - Express Scripts

Who Can Select This Plan?	All Employees	Hired Before 7/1/20	Hired Before 7/1/20
	Rx Retail $5/$10 Applies to NJEHP & GSP	**Retail Rx $15/$30/$30 Applies to HMO & QPOS Plans**	**Retail $20/$35/$50 Applies to MEC Plan**
Retail Copays (30 Day Supply)			
Generic	$5 Copay	$15 Copay	$20 Copay
Brand Name Drug (Generic Alternative Not Available)	$10 Copay	$30 Copay	$35 Copay
Non- Preferred Brand Name Drug (or Generic Alternative Available)	Member Pays the Difference*	$30 Copay	$50 Copay
Retail Dispensing Limitation	30 day supply	30 day supply	30 day supply
Mail Order (90 Day Supply)			
Generic	$10 Copay	$15 Copay	$20 Copay
Brand Name Drug (Generic Alternative Not Available)	$20 Copay	$30 Copay	$35 Copay
Non-Preferred Brand Name Drug (or Generic Alternative Available)	Member Pays the Difference**	$30 Copay	$50 Copay

The Below Additional Features May Apply to Your Prescription Benefits Coverage:

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.