MEDICAL PLANS

AETNA

	NJ EDUCATORS HEALTH PLAN		GARDEN STATE HEALTH PLAN	
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
DEDUCTIBLE (Individual/Family)	$0/$0	$350/$700	$0/$0	$350/$700
OUT-OF-POCKET MAXIMUM (Individual/Family)	$500/$1,000	$2,000/$5,000	$500/$1,000	$2,000/$5,000
PREVENTIVE CARE SERVICES	100% Covered	Not Covered	100% Covered	Not Covered
PRIMARY CARE PHYSICIAN (PCP) REQUIRED?	No	No	No	No
PCP VISIT	$10 copay	70% after deductible	$10 copay	70% after deductible
SPECIALIST VISIT	$15 copay	70% after deductible	$15 copay	70% after deductible
DIAGNOSTIC LABORATORY	100% Covered	70% after deductible	100% Covered	70% after deductible
DIAGNOSTIC X-RAY/IMAGING (MRI, CT-Scan)	100% Covered	70% after deductible	100% Covered	70% after deductible
EMERGENCY ROOM	$125 copay	$125 copay	$125 copay	$125 copay
URGENT CARE CENTER	$15 copay	70% after deductible	$15 copay	70% after deductible
INPATIENT HOSPITAL	100% Covered	70% after deductible	100% Covered	70% after deductible
OUTPATIENT SURGERY	100% Covered	70% after deductible	100% Covered	70% after deductible
HOME HEALTH CARE	100% Covered	70% after deductible	100% Covered	70% after deductible
OUTPATIENT THERAPIES (PT, OT, Chiro)	$15 copay	70% after deductible	$15 copay	70% after deductible
INPATIENT MENTAL HEALTH/SUBSTANCE ABUSE	100% Covered	70% after deductible	100% Covered	70% after deductible
OUTPATIENT MENTAL HEALTH/SUBSTANCE ABUSE	100% Covered	70% after deductible	100% Covered	70% after deductible
MATERNITY CARE	$15 copay	70% after deductible	$15 copay	70% after deductible
DURABLE MEDICAL EQUIPMENT	90%	70% after deductible	90%	70% after deductible
PRESCRIPTION DRUG BENEFITS	**RETAIL**	**MAIL-ORDER**	**RETAIL**	**MAIL-ORDER**
GENERIC	$5 copay	$10 copay	$5 copay	$10 copay
PREFERRED BRAND	$10 copay	$20 copay	$10 copay	$20 copay
NON-PREFERRED BRAND	$10 copay	$20 copay	$10 copay	$20 copay

Embedded Deductible: The single deductible is embedded in the family deductible, so no one family member can contribute more than the individual deductible amount during the plan year. once the member meets their single deductible, they will start paying copays and/or coinsurance until they have reached their out-of-pocket maximum.

Aggregate Deductible: The entire family deductible must be met before the plan pays any benefits. if you cover any dependents under the plan, the full family deductible must be met before the plan pays any benefits. However, once the individual meets the individual out-of-pocket maximum, the plan will begin to pay benefits and that individual has no further liability for the balance of the year. Other members of the family will continue to pay toward the family deductible and out-of-pocket maxium.

NOTES:

- The GSP is an NJ Network of Providers only. Out of state services will not be covered unless it is a true emergency.
- 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.

Please see additional plan notes on page 4.

MEDICAL PLANS

AETNA

	CHOICE POS II $10		CHOICE POS II $15		CHOICE POS II $15/$25		CHOICE POS II $20		CHOICE POS II $20/$35	
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
DEDUCTIBLE (Individual/Family)	$0/$100	$0/$250	$0/$0	$100/$250	$0/$0	$100/$250	$0/$0	$200/$500	$200/$400	$800/$1,600
OUT-OF-POCKET MAXIMUM (Individual/Family)	$400/$800	$2,000/$5,000	$400/$800	$2,000/$5,000	$400/$800	$2,000/$5,000	$800/$1,600	$5,000/$12,500	$2,500/$5,000	$5,000/$10,000
PREVENTIVE CARE SERVICES	100% Covered	80% (no deductible)	100% Covered	70% (no deductible)	100% Covered	70% (no deductible)	100% Covered	70% (no deductible)	100% Covered	60% (no deductible)
PRIMARY CARE PHYSICIAN (PCP) REQUIRED?	No	No	No	No	No	No	No	No	No	No
PCP VISIT	$10 copay	80% after deductible	$15 copay	70% after deductible	$15 copay	70% after deductible	$20 copay	70% after deductible	$20 copay	60% after deductible
SPECIALIST VISIT	$10 copay	80% after deductible	$15 copay	70% after deductible	$25 copay	70% after deductible	$20 copay	70% after deductible	$35 copay	60% after deductible
DIAGNOSTIC LABORATORY	100% Covered	80% after deductible	100% Covered	70% after deductible	100% Covered	70% after deductible	100% Covered	70% after deductible	100% Covered	60% after deductible
DIAGNOSTIC X-RAY/IMAGING (MRI, CT-Scan)	100% Covered	80% after deductible	100% Covered	70% after deductible	100% Covered	70% after deductible	100% Covered	70% after deductible	100% Covered	60% after deductible
EMERGENCY ROOM	$25 copay	$25 copay	$50 copay	$50 copay	$75 copay	$75 copay	$100 copay	$100 copay	$100 copay	$100 copay
URGENT CARE CENTER	$10 copay	80% after deductible	$15 copay	70% after deductible	$25 copay	70% after deductible	$20 copay	70% after deductible	$35 copay	60% after deductible
INPATIENT HOSPITAL	100% Covered	80% after deductible	100% Covered	70% after deductible	100% Covered	70% after deductible and $200 copay	100% Covered	70% after deductible and $500 copay	80% after deductible	60% after deductible and $500 copay
OUTPATIENT SURGERY	100% Covered	80% after deductible	100% Covered	70% after deductible	100% Covered	70% after deductible	100% Covered	70% after deductible	80% after deductible	60% after deductible
HOME HEALTH CARE	100% Covered	80% after deductible	100% Covered	70% after deductible	100% Covered	70% after deductible	100% Covered	70% after deductible	80% after deductible	60% after deductible
OUTPATIENT THERAPIES (PT, OT, Chiro)	$10 copay	80% after deductible	$15 copay	70% after deductible	$15 copay	70% after deductible	$20 copay	70% after deductible	$25 copay	60% after deductible
INPATIENT MENTAL HEALTH/ SUBSTANCE ABUSE	100% Covered	80% after deductible	100% Covered	70% after deductible	100% Covered	70% after deductible and $200 copay	100% Covered	70% after deductible	80% after deductible	$500 copay; 40% you pay
OUTPATIENT MENTAL HEALTH/ SUBSTANCE ABUSE	100% Covered	80% after deductible	100% Covered	70% after deductible	100% Covered	70% after deductible	100% Covered	70% after deductible	100% Covered	60% after deductible
MATERNITY CARE	$10 copay	80% after deductible	$15 copay	70% after deductible	$25 copay	70% after deductible	$20 copay	70% after deductible	$35 copay	60% after deductible
DURABLE MEDICAL EQUIPMENT	90%	80% after deductible	90%	70% after deductible	90%	70% after deductible	90%	70% after deductible	80% after deductible	60% after deductible
PRESCRIPTION DRUG BENEFITS	**RETAIL**	**MAIL-ORDER**	**RETAIL**	**MAIL-ORDER**	**RETAIL**	**MAIL-ORDER**	**RETAIL**	**MAIL-ORDER**	**RETAIL**	**MAIL-ORDER**
GENERIC	$3 copay	$5 copay	$3 copay	$5 copay	$7 copay	$18 copay	$3 copay	$5 copay	$7 copay	$18 copay
PREFERRED BRAND	$10 copay	$15 copay	$10 copay	$15 copay	$16 copay	$40 copay	$18 copay	$36 copay	$21 copay	$52 copay
NON-PREFERRED BRAND	$10 copay	$15 copay	$10 copay	$15 copay	$35 copay	$88 copay	$46 copay	$92 copay	$21 copay	$52 copay

Embedded Deductible: The single deductible is embedded in the family deductible, so no one family member can contribute more than the individual deductible amount during the plan year. once the member meets their single deductible, they will start paying copays and/or coinsurance until they have reached their out-of-pocket maximum.

Aggregate Deductible: The entire family deductible must be met before the plan pays any benefits. if you cover any dependents under the plan, the full family deductible must be met before the plan pays any benefits. However, once the individual meets the individual out-of-pocket maximum, the plan will begin to pay benefits and that individual has no further liability for the balance of the year. Other members of the family will continue to pay toward the family deductible and out-of-pocket maxium.

NOTE: 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.

Please see additional plan notes on page 4.

MEDICAL PLANS

AETNA

	QPOS $10		QPOS $15/$25		QPOS $20		QPOS $20/$35		HORIZON OMNIA 10	
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**TIER 1**	**TIER 2**
DEDUCTIBLE (Individual/Family)	$0/$0	$500/$1,000	$0/$0	$500/$1,000	$0/$0	$500/$1,000	$200/$400	$500/$1,000	$0/$0	$1,500/$3,000
OUT-OF-POCKET MAXIMUM (Individual/Family)	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000	$4,000/$5,000	$4,000/$5,000	$2,000/$4,000	$5,000/$10,000	$400/$800	$2,000/$4,000
PREVENTIVE CARE SERVICES	100% Covered	60% (no deductible)	100% Covered	60% (no deductible)	100% Covered	60% (no deductible)	100% Covered	60% (no deductible)	100% Covered	100% Covered
PRIMARY CARE PHYSICIAN (PCP) REQUIRED?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
PCP VISIT	$10 copay	60% after deductible	$15 copay	60% after deductible	$20 copay	60% after deductible	$20 copay	60% after deductible	$5 copay	$10 copay
SPECIALIST VISIT	$10 copay	60% after deductible	$25 copay	60% after deductible	$20 copay	60% after deductible	$35 copay	60% after deductible	$5 copay	$10 copay
DIAGNOSTIC LABORATORY	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	100% Covered
DIAGNOSTIC X-RAY/IMAGING (MRI, CT-Scan)	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	100% Covered
EMERGENCY ROOM	$35 copay	$35 copay	$75 copay	$75 copay	$100 copay	$100 copay	$100 copay	$100 copay	$25 copay	$25 copay
URGENT CARE CENTER	$10 copay	60% after deductible	$25 copay	60% after deductible	$20 copay	60% after deductible	$35 copay	60% after deductible	$5 copay	$10 copay
INPATIENT HOSPITAL	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	60% after deductible	80% after deductible	60% after deductible and $500 copay	100% Covered	$150 copay per admission after deductible
OUTPATIENT SURGERY	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	60% after deductible	80% after deductible	60% after deductible	100% Covered	100% after deductible
HOME HEALTH CARE	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	60% after deductible	80% after deductible	60% after deductible	100% Covered	100% Covered
OUTPATIENT THERAPIES (PT, OT, Chiro)	$10 copay	60% after deductible	$15 copay	60% after deductible	$20 copay	60% after deductible	$25 copay	60% after deductible	$5 copay	$10 copay
INPATIENT MENTAL HEALTH/ SUBSTANCE ABUSE	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	60% after deductible	80% after deductible	60% after deductible	100% Covered	$150 copay per admission after deductible
OUTPATIENT MENTAL HEALTH/ SUBSTANCE ABUSE	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	100% after deductible
MATERNITY CARE	$10 copay	60% after deductible	$25 copay	60% after deductible	$20 copay	60% after deductible	$35 copay	60% after deductible	$5 copay	$10 copay
DURABLE MEDICAL EQUIPMENT	100% Covered	60% after deductible	100% Covered	60% after deductible	100% Covered	60% after deductible	80% after deductible	60% after deductible	100% Covered	100% Covered
PRESCRIPTION DRUG BENEFITS	**RETAIL**	**MAIL-ORDER**	**RETAIL**	**MAIL-ORDER**	**RETAIL**	**MAIL-ORDER**	**RETAIL**	**MAIL-ORDER**	**RETAIL**	**MAIL-ORDER**
GENERIC	$3 copay	$5 copay	$7 copay	$18 copay	$3 copay	$5 copay	$7 copay	$18 copay	$3 copay	$5 copay
PREFERRED BRAND	$10 copay	$15 copay	$16 copay	$40 copay	$18 copay	$36 copay	$21 copay	$52 copay	$10 copay	$15 copay
NON-PREFERRED BRAND	$10 copay	$15 copay	$35 copay	$88 copay	$46 copay	$92 copay	$21 copay	$52 copay	$10 copay	$15 copay

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Please see additional plan notes on page 4.

ADDITIONAL PRESCRIPTION PLAN INFORMATION

The following features may apply to your prescription plan:

- **Step Therapy** programs are designed to ensure quality and manage costs. When 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 copayments 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 responssible 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 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: **www.express-scripts.com**