LEAP Academy University Charter 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 (Calendar Year)	$2,000 Ind/$5,000 Family	$2,000 Ind/$5,000 Family

-Preauthorization may be required for certain services.

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

-For the NJEHP & GSP, the employee's contribution is based on the new salary based contribution schedule. For all other plans, your employee contribution 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.

LEAP Academy University Charter School

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 Patriot XV (Low)	**Aetna Patriot XV (High)**	**Aetna Patriot X**
In-Network 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)	$1,500 Individual	$6,350 Individual	$6,350 Individual
	$3,000 Family	$12,700 Family	$12,700 Family
Primary Care	$10 copay	$10 copay	$15 copay
Specialist	$15 copay	$30 copay	$30 copay
Preventive	No Charge	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge for Lab $15 copay for X-Ray	No Charge	No Charge for Lab $30 copay for X-Ray
Imaging (CT/PET scans, MRIs)	$15 copay	No Charge	$30 copay
Outpatient Surgery	$15 copay for Facility	$30 copay for Facility	$30 copay for Facility
Emergency Room	$150 copay	$150 copay	$150 copay
Emergency Transportation	No Charge	No Charge	No Charge
Urgent Care	$15 copay	$30 copay	$30 copay
Durable Medical Equipment	50% covered	No Charge	No Charge
Hospital Stay	No Charge	No Charge	No Charge
Eye Exams	No Charge (1 Exam/24 Months)	No Charge (1 Exam/24 Months)	$30 Copay (1 Exam/24 Months)
Vision Hardware Reimbursement	$35 Maximum/24 Months	$100 Maximum/24 Months	700 Maximum/24 Months
Out of Network Benefits	**Out of Network**	**Out of Network**	**Out of Network**
Deductible (Per Calendar Year)	$5,000 Ind/$15,000 Family	$3,000 Ind/$6,000 Family	$300 Ind/$600 Family
Coinsurance	50% after deductible	60% after deductible	70% after deductible
Out of Pocket Limit (Calendar Year)	$10,000 Ind/$30,000 Family	$2,500 Ind/$5,000 Family	$400 Ind/$1,200 Family

-Preauthorization may be required for certain services.

For the NJEHP & GSP, the employee's contribution is based on the new salary based contribution schedule. For al lother plans offered by the district, your employee contribution will remain the same per your collective bargaining agreement and/or Chapter 78.

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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Prescription Coverage Selections - Express Scripts

Who Can Select This Plan?	All Employees	Hired Before 7/1/20
	NJEHP/GSP	Rx Retail $3/$10/$15
Retail Copays		
Generic	$5 Copay	$3 Copay
Brand Name Drug (Generic Alternative Not Available)	$10 Copay	$10 Copay
Non-Preferred Brand or Generic Alternative Available	Member Pays the Difference**	$15 Copay
Retail Dispensing Limitation	30 day supply	30 day supply
Mail Order		
Generic	$10 Copay	$3 Copay
Brand Name Drug (Generic Alternative Not Available)	$20 Copay	$10 Copay
Non-Preferred Brand or Generic Alternative Available	Member Pays the Difference**	$15 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
****Closed Formulary	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 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.