

**CINNAMINSON TOWNSHIP  
PUBLIC SCHOOLS  
EMPLOYEE BENEFIT HANDBOOK**

[Please click here to enter](#)

Provided Courtesy of:

**L A N C E  S I A N O**

employee benefit consultants, LLC

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[www.betterbenefitsolutions.com](http://www.betterbenefitsolutions.com)

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## General Information

This handbook has been custom-designed to provide [eligible](#) Cinnaminson Township Public School employees with a single, comprehensive resource summarizing the highlights of your health benefits program. Information contained in this handbook is provided as a convenient reference tool. **Save this website to your Favorites and check in regularly for updates regarding to get the most out of your benefits!**

### ***New!***

[Your Personal Health Advocate](#)

Click here for free personalized assistance with:

- Claim resolution;
- Top medical care provider location;
- Eldercare help for parents and parents-in-law;
- And much more!

[Benefit Updates](#)

Look here for information regarding negotiated plan design modifications, policy amendments and legislative developments that may have a bearing on your benefits.

[Open Enrollment](#)

This references how and when you can make changes to your enrollment in health benefits.

[On-Site Service](#)

Check here for when your carrier representatives will be visiting your work site for one-on-one consultations.

[Did You Know?](#)

Great ideas to help you get the most out of your benefits.

*This website is not intended to replace or supersede the terms of your collective bargaining agreement. Please remember insurance benefits are limited to the terms, conditions, exclusions and limitations of the carrier's policy. Nothing contained on this website shall be deemed to have altered, waived, or extended the coverage provided by the policy.*

## Eligibility

### Employee

**Eligible employees:** Full time staff members working 7 hours/day.

### Dependents

- Dependent children are covered until the end of the calendar year in which age 23 is attained.
- A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, the newborn child must be enrolled within the initial 31 day period.
- To continue coverage for a handicapped child evidence of the child's incapacity and dependency must be provided to the carrier at least 31 days prior to the termination of coverage.

### Waiting Period

- **New employees with a start date on or before September 15<sup>th</sup>:** Coverage becomes effective September 1<sup>st</sup>.
- **New employees with a start date after September 15<sup>th</sup>:** Coverage becomes effective the first of the month following a 30 day waiting period.

### Term of Employment

#### **New employees:**

- **Medical** – Board-paid single medical coverage during the first five years of employment.
- **Dental** – Board-paid family dental coverage up to \$850/year/employee.
- **Prescription** – Board-paid single prescription coverage during the first five years of employment. Eligible employees may elect dependent prescription coverage for which the Board will contribute a percentage of the premium as follows: 40% in 2002-2003; 50% in 2003-2004; 60% in 2004-2005. Additionally, all eligible employees electing prescription coverage through the Board shall pay \$200 per year toward the premium cost of the plan.

#### **Following five years of employment:**

- **Medical** – Board-paid family coverage.
- **Dental** – Board-paid family dental coverage up to \$850/year/employee.
- **Prescription** – Board-paid family coverage. All eligible employees electing prescription coverage through the Board shall pay \$200 per year toward the premium cost of the plan.

### General Enrollment

An eligible individual and any eligible dependents (child(ren)/spouse) may enroll regardless of health status, age, or requirements for health services within 31 days from the eligibility date.

- Newly eligible individual and eligible dependents may enroll within 31 days of the eligibility date (birth/marriage/adoption, etc).
- Eligible individuals or dependents who are eligible for enrollment but do not enroll within the first 31 days following eligibility, may be enrolled during any subsequent [Open Enrollment](#) period.

**For information about Coverage Continuation eligibility:**

[Coverage Continuation](#)

## **NEW!** Your Personal Health Advocate

Your *Personal* Health Advocate provides you and your family, including your *parents* and *parents-in-law*, with toll-free access to a team of highly-trained medical professionals (e.g. registered nurses and medical director) who will assist you with your health-care and insurance issues. No more hassles and/or frustrations for you and your family – just results! This service is made available by Lance Siano Benefits without cost to you and includes all of the following features:

### Product Features

[Advocates of Excellence](#)

[Care Coordination](#)

[Physician Locator](#)

[Claims Assistance](#)

[Fee Negotiation](#)

[Rx Advocate](#)

[Senior Care Navigator](#)

[CareQuest](#)

[Coverage Advantage](#)

<b>Advocates of Excellence</b>	Helps members with rare, serious or complex medical conditions identify top medical institutions, critical illness providers and specialized medical programs across the country. <a href="#">Back to Top</a>
<b>Care Coordination</b>	The Personal Health Advocate helps members coordinate care among physicians and medical institutions in various ways: <ul style="list-style-type: none"> <li>▪ Explain tests, treatments, and medications recommended.</li> <li>▪ Assist members through a complex medical condition.</li> <li>▪ Facilitate transfer of medical records, reports prior to a scheduled appointment with a new physician.</li> <li>▪ Arrange for covered homecare service or equipment.</li> <li>▪ Facilitate review of records/results with another physician for confirmation of diagnosis.</li> <li>▪ Schedule or coordinate appointments for services.</li> <li>▪ Arrange for evaluation for patient participation in a clinical trial.</li> <li>▪ Arrange hospice and other services for terminally ill patients.</li> <li>▪ Facilitate transfer from a community hospital to a tertiary care facility.</li> </ul> <a href="#">Back to Top</a>
<b>Claims Assistance</b>	Personal Health Advocates help sort out and solve claims and related paperwork problems. Examples of other services include: <ul style="list-style-type: none"> <li>▪ Research member's outstanding out-of-pocket responsibilities and resolve errors with providers or health plan.</li> <li>▪ Correct balance-billing problems.</li> <li>▪ Resolve eligibility problems and benefit and claims denials.</li> <li>▪ Resolve issues regarding medical or wellness benefit application.</li> <li>▪ Coordinate benefits between dental, medical, workers comp and disability characters.</li> <li>▪ Resolve incorrect plan procedure interpretations.</li> <li>▪ Resolve incorrect application of provider network status.</li> <li>▪ Correct errors in processing of "blind" network provider discounts.</li> <li>▪ Facilitate information from provider to payor to resolve unpaid claim.</li> <li>▪ Resolve coordination of benefits disputes between multiple carriers.</li> <li>▪ Resolve errors in the application of deductibles and co-payments.</li> </ul> <a href="#">Back to Top</a>
<b>Physician Locator</b>	Helps members identify primary and specialist physicians, hospitals, dentists, and related healthcare providers. Our first focus is on network relationships to help members use their benefits to their best advantage. <a href="#">Back to Top</a>
<b>Fee Negotiation</b>	Health Advocate can attempt to negotiate fees with healthcare providers to lower the member's out-of-pocket costs. <a href="#">Back to Top</a>
<b>Coverage Advantage</b>	If there are questions of coverage for a particular service, or if coverage for clinical care has been denied, the Personal Health Advocate can help members through the review and appeals process. Examples: <ul style="list-style-type: none"> <li>▪ Obtain exceptions for a member to see providers outside of capitation.</li> <li>▪ Coordinate referrals for required services.</li> <li>▪ Obtain transitional care coverage when medically necessary.</li> <li>▪ Resolve incorrect denials of benefits as non-covered, not medically necessary or ineligible.</li> <li>▪ Counsel members regarding current benefit costs and the cost of alternative approaches.</li> <li>▪ Assist members in obtaining coverage for and access to medical equipment, devices, supplies. (e.g. Hearing aids, diabetic supplies, compression stockings)</li> <li>▪ Assist in transition for out-of-network to in-network providers.</li> <li>▪ Assist with preauthorization and predetermination procedures.</li> <li>▪ Locate "hard-to-find" IV drugs or home care services to facilitate hospital charge.</li> <li>▪ Assist employees with disability coverage questions and help them return to work.</li> </ul> <a href="#">Back to Top</a>

	<ul style="list-style-type: none"> <li>▪ Resolve issues involving disabled dependent rules, Family Medical Leave, COBRA, etc.</li> </ul>
<b>Senior Care Navigator</b>	<p style="text-align: right;"><a href="#">Back to Top</a></p> <p>For employees or family members approaching retirement or already retired, we offer access to a wide array of services specifically geared for seniors. Our Personal Health Advocates understand senior members' needs and can help members select the appropriate professionals. Among the kind of issues we have worked on are:</p> <ul style="list-style-type: none"> <li>• Locate alternative care facilities.</li> <li>• Obtain coverage for medical supplies.</li> <li>• Provide information on adult day care programs.</li> <li>• Coordinate coverage for home care services with Medicare and Medicaid.</li> <li>• Assist with transition of insurance coverage and benefits from private insurance to Medicare.</li> <li>• Locate physicians who make house calls.</li> </ul>
<b>CareQuest</b>	<p style="text-align: right;"><a href="#">Back to Top</a></p> <p>Helps locate and makes arrangements for members' special service needs. The individual member is responsible for payment of any specific services arranged on a fee-for-service basis that are not covered by an insurance plan.</p> <p>Examples of these services include:</p> <ul style="list-style-type: none"> <li>• Locate homemaker, day care or rehabilitation services not covered by insurance.</li> <li>• Locate inpatient private duty nursing.</li> <li>• Find a group home for individuals with special needs.</li> <li>• Locate home health aides.</li> <li>• Help complete applications for individual coverage options, including Medicaid and Medicare.</li> </ul>
<b>Rx Advocate</b>	<p style="text-align: right;"><a href="#">Back to Top</a></p> <p>The Personal Health Advocate can provide members with assistance on prescription drug issues including formulary and benefit questions.</p> <ul style="list-style-type: none"> <li>• Provide information on generic drugs.</li> <li>• Locate lower cost sources for prescription drugs that are not covered by health plan.</li> <li>• Assist members in obtaining mail order prescriptions.</li> <li>• Resolve disputes between members and pharmacies regarding formulary rules.</li> <li>• Obtain coverage for medications that require mail order.</li> </ul>

To contact your *Personal* Health Advocate [click here](#).

## Benefit Updates

### Prescription Copay Change

Per the terms of your Collective Bargaining Agreement that takes effect on 7/1/05 your prescription benefits will change.

	Current		Effective July 1, 2005	
	Brand	Generic	Brand	Generic
<b>Retail</b>	\$15 copay (34 days or 100 unit doses, whichever is less)	\$5 copay (34 days or 100 unit doses, whichever is less)	\$15 copay (34 days or 100 unit doses, whichever is less)	<b>\$10 copay</b> (34 days or 100 unit doses, whichever is less)
<b>Mail Order</b>	\$10 copay (30-90 day supply)	\$5 copay (30-90 day supply)	<b>\$15 copay</b> (30-90 day supply)	<b>\$10 copay</b> (30-90 day supply)

## Open Enrollment

Each Spring eligible employees are afforded the opportunity to change their plan selection(s). Changes made during the period become **effective on July 1**.

Enrollment/Change forms will be made available through the Business Office and directly from the carrier during the scheduled visits. Enrollment/Change forms are to be returned by June 1<sup>st</sup> to Sharon Rickus in your Business Office.

Lance Siano Benefits will coordinate representatives from Aetna, Horizon Healthcare Dental, and Benecard to be present at your location on the dates and times seen below. These visits provide you with direct assistance from the carriers with any plan selection changes you are considering.

<b>Location</b>	<b>Date</b>	<b>Time</b>
<b>Cinnaminson High School: Wellness Fair</b>	<b>April 29, 2005</b>	<b>8:00 am – 9:00 am</b>
<b>Cinnaminson Administration Building</b>	<b>May 4, 2005</b>	<b>2:00 pm – 4:00 pm</b>

As always, please do not hesitate to [contact us](#) at any time throughout the year should you have any unresolved questions or concerns.

## On-Site Service

These visits provide you with direct responses from the carriers to any questions and/or concerns you may have in regard to your medical, dental and/or prescription drug benefits. Lance Siano Benefits will coordinate representatives from Aetna, Horizon Healthcare Dental, and Benecard to be at your location on the dates and times below.

Location	Date	Time
Cinnaminson High School: Wellness Fair	April 29, 2005	8:00 am – 9:00 am
Cinnaminson Administration Building	May 4, 2005	2:00 pm – 4:00 pm

As always, please do not hesitate to [contact us](#) at any time throughout the year should you have any unresolved questions or concerns.

## Did You Know?

### You have vision benefits.

[Vision One Benefits](#)

In addition to the prescription lens reimbursement available through your medical plan, use Aetna participating providers to cut costs for prescription eyewear, eye exams, mail order contact lenses, LASIK surgery.

### You can easily locate participating providers on the internet.

- Aetna: [www.aetna.com/docfind/](http://www.aetna.com/docfind/) (HINT! Search Aetna Standard Plans)
- Horizon: [www.horizon-bcbsnj.com](http://www.horizon-bcbsnj.com)
- Benecard: [www.benerx.com](http://www.benerx.com)

### You can check the status of your medical claims and more.

[www.aetna.com](http://www.aetna.com)

A few Aetna Navigator features:

- Check the status of a medical or prescription claim.
- Change your Primary Care Physician.
- Review the Aetna Benefit Booklet specific to your group.

### You can submit your copays to Aetna and be reimbursed.

- **Premier and Patriot V:** Submit doctors' office receipts to Aetna for your copayment to be applied to your deductible. Once your deductible is met you will be reimbursed 70% of your copay amount.
- **Patriot X:** Submit you doctors' office and prescription receipts for your copayments to be applied to your deductible. Once your deductible is met you will be reimbursed 80% of your copay amount.

### Your prescription benefits cover medications to treat erectile dysfunction.

Your prescription plan coverage includes coverage of medications for Erectile Dysfunction. Coverage requires a prescription and a statement of medical necessity from your doctor. Coverage includes up to 6 pills, suppositories, or injections per month. Mail order and 90-day supplies are not covered. For details see [prescription](#).

### Your medical benefit offers an alternative to the Flu Shot.

Aetna has decided to cover the nasal-spray flue vaccine, FluMist, during the 2004-2005 flu season. Consistent with FDA-approved indications for FluMist, Aetna will cover the nasal spray for healthy members ages 5 to 49. FluMist coverage is provided according to the terms of the specific benefits plan.

- Medical Preventative Benefits: Physician-administered vaccines such as FluMist are covered within the medical benefits of each plan.

### Precertification is recommended for some Aetna services.

[Aetna Precertification](#)

# Vision One® Discount Program

Eye Care Savings with No Referrals and No Claim Forms

As anyone who wears contact lenses or eyeglasses can tell you, having less-than-perfect vision can be costly. The Vision One discount program\* helps you and your family save on many eye care products, including eyeglasses, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 25% discount on LASIK surgery (the laser vision correction procedure).

The Vision One discount program is available to Aetna members through Cole Managed Vision at no additional cost.



## Here's How It Works

### 1. Find the location nearest you.

**It's simple.** Just log onto [www.aetna.com](http://www.aetna.com), click on DocFind and select Vision One. Or call Vision One Customer Service (1-800-793-8616) to find a participating provider near you. Choose from a wide selection of optical centers nationwide, including Sears, JCPenney, Target, participating Pearle Vision centers and others, as well as through selected independent optometrist and ophthalmologist offices.

### 2. Schedule an eye exam.

**Well-eye exams are an important part of a healthy lifestyle.** If your benefits plan covers eye exams, consult your provider directory or log onto [www.aetna.com](http://www.aetna.com), and click on our DocFind® online provider directory for a list of participating optometrists and ophthalmologists. Your out-of-pocket expenses could be lower if you follow your plan requirements. Covered eye exams are available from most providers at Vision One locations. Check your plan documents for additional coverage and other important details.

*If your benefits plan does not cover eye exams, you can receive an exam at a discounted rate with Vision One. Schedule an appointment with a Vision One provider and pay the discounted exam rate (see schedule on next page for details) for eyeglasses or contact lenses. Most Vision One locations have doctors of optometry practicing on the premises or at a location nearby.*

### 3. Save on eyewear.

**Choose from hundreds of fashionable frames and the latest in lens technology.** Simply show your Aetna ID card, and any applicable services or products you receive will be discounted right at the point of purchase. There are no claim forms to complete and no waiting for reimbursement.

## SPECIAL SAVINGS ON LASIK

You and each member of your family can also receive **up to a 25% discount** off the provider's usual fee for LASIK surgery through the NuVision LASIK Network.\*\* This discounted price includes patient education, an initial screening, the LASIK procedure and follow-up care. Best of all, the initial consultation is always free, even if you elect not to proceed with surgery.

### Three Simple Steps

1. Schedule a free evaluation with a participating LASIK surgeon in your area. Our LASIK information specialists are ready to answer your questions, review the doctors available in your area with you and schedule a consultation with the doctor you choose. So call LASIK Customer Service toll free at 1-800-422-6600 today.
2. At your initial visit, present your Aetna ID card and indicate that you are part of the Vision One discount program.
3. Schedule a surgery date with your provider, and call LASIK Customer Service (1-800-422-6600) to make payment arrangements. You can pay for LASIK surgery with a check or credit card. Qualifying patients can request a low monthly payment plan, with terms ranging from 12 to 60 months or a 6-month same-as-cash program.

\*Vision One is a discount-only program. It is in addition to any vision care plan benefits you may have through your health benefits plan.

\*\*LASIK surgery discounts are offered by Cole Managed Vision. Providers are independent surgeons and are not agents or representatives of Cole Managed Vision, Aetna Health Inc. and/or their affiliates.



Discounted prices on eye care services and eyewear products through Vision One participating providers are listed below. These prices are subject to change.

PRODUCT OR SERVICE	MEMBER COST
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**Eye Exams for Plans That Cover Eye Exams**

Refer to your health benefits plan documents for coverage details.

**Eye Exams for Plans That Do Not Cover Eye Exams**

For eyeglasses	\$38
For standard contact lenses	\$78
For specialty contact lenses (i.e., Toric, Bifocal, Gas Permeable)	\$10 off standard fee

**Lenses per Pair (uncoated plastic)**

Single Vision	\$30
Bifocal	\$49
Trifocal	\$59
Standard Progressive (no-line bifocal)	\$99

**Eyeglass Frames (retail prices)**

Up to \$60.99	\$24
\$61 to \$80.99	\$34
\$81 to \$100.99	\$44
\$101 and up	40% off retail

**Lens Options per Pair (add to lens price above)**

Polycarbonate (includes UV coating and scratch-resistant coating)	\$30
Scratch-resistant coating	\$12
Ultraviolet (UV) coating	\$12
Solid or gradient tint	\$ 8
Glass	\$15
Photochromic glass	\$34
Anti-reflective coating	\$35

**Contact Lenses**

Visit any participating Vision One location and receive a 20% discount off retail prices (10% discount on disposables).

**Mail Order Contact Lens Replacement Program**

Call 1-800-391-LENS (5367) to order replacement contact lenses for additional convenience.

**Additional Vision-related Items**

Visit any participating Vision One location and receive a 20% discount off retail prices.

**LASIK Procedure**

You and your family members can receive up to a 25% discount off the surgeon's fee through the NuVision® LASIK network.

**Mail Order Contact Lens Replacement**

After you purchase your first pair of contact lenses at a Vision One or other eye care location, you can receive additional pairs in two ways:

1. Have your prescription refilled at a participating Vision One location.
2. Order replacement contact lenses through the mail using the Vision One Contact Lens Replacement program. You'll receive the same brand-name lenses your doctor prescribed, but generally at a lower cost. Call 1-800-391-LENS (5367) for more information.

**Questions?**

*Vision One Exam and Eyewear*

Weekdays 9 a.m. – 9 p.m.  
Eastern Time

**1-800-793-8616**

Saturdays 9 a.m. – 5 p.m.

*LASIK Customer Service*

Weekdays 8 a.m. – 9 p.m.  
Eastern Time

**1-800-422-6600**

Saturdays 9 a.m. – 6 p.m.

*Mail Order Contact Lens Replacement*

**1-800-391-LENS (5367)**

[www.aetna.com](http://www.aetna.com)

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the program and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes. The availability of a plan or program may vary by geographic service area. The Vision One discount program is a rate-access program and may be in addition to any plan benefits. Program providers are solely responsible for the products and services provided thereunder. Aetna does not endorse any vendor, product or service associated with this program. Discounts offered hereunder are not insurance. Vision One and the Vision One discount program are registered trademarks of Cole Managed Vision. NuVision is a registered trademark of NuVision, Inc. "Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, which may include: Aetna Health Inc., Aetna Health of the Carolinas Inc., Aetna Health of Illinois Inc., Aetna Health of Washington Inc., Aetna Health Insurance Company of Connecticut, Aetna Health Insurance Company of New York, Corporate Health Insurance Company, Aetna Life Insurance Company and/or Aetna Dental Inc. While this material is believed to be accurate as of the print date, it is subject to change.

For the Commonwealth of Virginia, one or more of the following policy numbers may apply: GR-67603-5; GR-9; GR-29; GR-27; GR-89296; GR-89297; GR-700-W; GR-70-W; GR-96124; GR-96125; HMO/VA COC-1 07/99; CHI/VA SBQNET-1 01/00; HMO/VA SELFREF (10/00); HMO/VA SUPSVSEND-4 01/02; HMO/VA GA-1 01/02; CHI/VA GP-1 04/02; HMO/VA COC-AMEND-3 07/02; HMO/VA NAMEAMEND-1 05/02; HMO/VA AMENDMENT TO GA ELR-1 05/02; HMO/VA SB-1 10/02; CHI/VA INSCT-1- [A-K] (10/01); CHI/VA SBQPOS-1 10/02; HMO/VA RIDER-DEN-1 07/99; HMO/VA RIDER-VIS-1 07/99.

## Medical

Aetna is the medical insurance carrier for the Cinnaminson Township Public School employees. The medical program offers eligible employees three plan designs. For your convenient reference, we have provided a detailed summary of each plan's benefits and comparison of the three plan options.

[Premier](#)

[Patriot V](#)

[Patriot X](#)

[Medical Side-by-Side Benefit Comparison](#)

### Related Medical Plan Information

[Eligibility](#)

[Open Enrollment](#)


[Claim Resolution](#)

[Did You Know?](#)

[Aetna Precertification](#)

## Premier

The plan with the lowest office visit copayments. Members choose a Primary Care Physician (PCP). Member is responsible for copay at time of referred services. For non-referred services the member is responsible for the deductible and coinsurance. For services provided by non-participating or out-of-network provider the member is responsible for the deductible, coinsurance and the provider may bill you the unpaid balance of the charges for services.

	<b>Cinnaminson Township Board of Education</b>	
	<b>Aetna Premier</b>	
	<b>Referred</b>	<b>Non-Referred*</b>
<b>FINANCIAL</b>		
Deductible: Single/Family	N/A	\$1,000/\$3,000
Coinsurance	N/A	70%
Coinsurance Limit: Single/Family	N/A	\$10,000/\$30,000
Lifetime maximum Benefit	N/A	\$5,000,000
<b>PRIMARY CARE PHYSICIAN VISITS</b>		
Office Hours	\$2 copay	70% after deductible
After Hours / Home Visits	\$5 copay	70% after deductible
<b>SPECIALTY CARE</b>		
Office Visits	No copay	70% after deductible
Diagnostic Outpatient Testing	No copay	70% after deductible
Physical, Occupational, Speech Therapy	No copay	70% after deductible
<b>OUTPATIENT SURGERY*</b>	No copay	70% after deductible
<b>HOSPITALIZATION*</b>	No copay	70% after deductible
<b>SKILLED NURSING FACILITY*</b>	No copay	70% after deductible
<b>EMERGENCY ROOM**/**</b>	\$15 copay	\$15 copay
<b>HOME CARE*</b>	No copay	70% after deductible, 60 visits
<b>MATERNITY*</b>		
First OB Visit	No copay	70% after deductible
Hospital	No copay	70% after deductible
<b>MENTAL HEALTH*</b>		
Inpatient	No copay, 35 days	70% after deductible
Outpatient	\$10 copay/V, 30 visits	70% after deductible, 30 visits
<b>SUBSTANCE ABUSE*</b>		
Detoxification	No copay	70% after deductible, 7 days
Inpatient Rehabilitation	No copay, 28 days	70% after deductible, 30 days
Outpatient Rehabilitation	No copay, 30 visits	70% after deductible, 30 visits
<b>PREVENTATIVE CARE</b>		
Routine Eye Exam	\$2 copay	Not covered
Routine Physicals	\$2 copay	See insurance certificate
Immunizations	\$2 copay	See insurance certificate
Routine Mammography	No copay	Covered (state-specific guidelines)
Routine GYN Exam	\$2 copay	Not covered
Pediatric Preventive Dental Exam	\$2 copay	Not covered
<b>CHIROPRACTIC CARE*</b>	\$2 copay	70% after deductible, \$500 annual max
<b>PRESCRIPTION LENS REIMBURSEMENT</b>	\$100 every 24 months	
<b>DURABLE MEDICAL EQUIPMENT*</b>	Not covered	70% after deductible

\*Precertification recommended.

\*\*Reimbursed 100% if admitted.

### [Aetna Exclusions, Limitations & Disclaimer](#)

For more information about your Aetna Premier Plan:

[www.aetna.com](http://www.aetna.com)

For a comparison of the medical plan options:

[Medical Side-By-Side Benefit Comparison](#)

**Related Medical Plan Information**

[Eligibility](#)

[Open Enrollment](#)

[Claim Resolution](#)

[Did You Know?](#)

[Aetna Precertification](#)

*Please remember your insurance benefits are limited to the terms, conditions, exclusions and limitations of the insurance carrier's policy. Nothing contained on this website shall be deemed to have altered, waived, or extended the coverage provided by the policy. This overview contains a general description of your medical program for your use as a convenient reference. Complete details of your program appear in the policy, which govern the benefits and operation of your program. The policy supersedes if there should be any inconsistency or difference between its provisions and the information in this overview.*



**AETNA HEALTH INC.® QUALITY POINT-OF-SERVICE<sup>SM</sup> PROGRAM**  
**NJ School Premier / QPOS (1998) Plan**  
**CINNAMINSON TOWNSHIP SCHOOL DISTRICT**

**Exclusions and Limitations**

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.


All medical and hospital services not specifically covered in, or which are limited or excluded in your plan documents; Cosmetic surgery, including breast reduction; Custodial care; Dental care and dental X-rays; Donor egg retrieval; Durable Medical Equipment; Experimental and investigational procedures; Hearing aids; Home births; Implantable drugs and certain injectible drugs including injectible infertility drugs; Immunizations for travel or work; Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents; Long-term rehabilitation therapy; Orthotics; Outpatient Prescription drugs and over-the-counter medications and supplies; Nonmedically necessary services or supplies; Radial keratotomy or related procedures; Reversal of voluntary sterilization; Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling or prescription drugs; Special duty nursing; Therapy or rehabilitation other than those listed as covered; and Treatment of behavioral disorders.

**Disclaimers**

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval of coverage for certain services such as nonemergency inpatient hospital care. Certain benefits like comprehensive infertility and advanced reproduction technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available at the highest copay under plans with an open formulary, or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received upon enrollment) are not covered, and medical exceptions are not available for them. While this material is believed to be accurate as of the print date, it is subject to change.

## Patriot V

This plan offers low office copays and a low deductible for non-referred services. Members choose a Primary Care Physician (PCP). Member is responsible for copay at time of referred services. For non-referred services the member is responsible for the deductible and coinsurance. For services provided by non-participating or out-of-network provider the member is responsible for the deductible, coinsurance and the provider may bill you the unpaid balance of the charges for services.

	Cinnaminson Township Board of Education	
	Aetna Patriot V	
	Referred	Non-Referred*
<b>FINANCIAL</b>		
Deductible: Single/Family	N/A	\$100/\$200
Coinsurance	N/A	70%
Coinsurance Limit: Single/Family	N/A	\$2,000/\$4,000
Lifetime maximum Benefit	N/A	Unlimited
<b>PRIMARY CARE PHYSICIAN VISITS</b>		
Office Hours	\$5 copay	70% after deductible
After Hours / Home Visits	\$10 copay	70% after deductible
<b>SPECIALTY CARE</b>		
Office Visits	\$5 copay	70% after deductible
Diagnostic Outpatient Testing	\$5 copay	70% after deductible
Physical, Occupational, Speech Therapy	\$5 copay	70% after deductible
<b>OUTPATIENT SURGERY*</b>	No copay	70% after deductible
<b>HOSPITALIZATION*</b>	No copay	70% after deductible
<b>SKILLED NURSING FACILITY*</b>	No copay	70% after deductible
<b>EMERGENCY ROOM**/</b>	\$25 copay	\$25 copay
<b>HOME CARE*</b>	No copay	70% after deductible, 60 visits
<b>MATERNITY*</b>		
First OB Visit	\$5 copay	70% after deductible
Hospital	No copay	70% after deductible
<b>MENTAL HEALTH*</b>		
Inpatient	No copay, 35 days	70% after deductible, 60 days
Outpatient	\$5 copay/V, 20 visits	70% after deductible, 30 visits
<b>SUBSTANCE ABUSE*</b>		
Detoxification	No copay	70% after deductible, 7 days
Inpatient Rehabilitation	Not covered	70% after deductible, 30 days
Outpatient Rehabilitation	\$5 copay/V, 60 visits	70% after deductible, 30 visits
<b>PREVENTATIVE CARE</b>		
Routine Eye Exam	\$5 copay	Not covered
Routine Physicals	\$5 copay	See insurance certificate
Immunizations	\$5 copay	See insurance certificate
Routine Mammography	\$5 copay	Covered (state-specific guidelines)
Routine GYN Exam	\$5 copay	Not covered
Pediatric Preventive Dental Exam	\$5 copay	Not covered
<b>CHIROPRACTIC CARE*</b>	\$5 copay, 20 visits	70% after deductible
<b>PRESCRIPTION LENS REIMBURSEMENT</b>	\$70 every 24 months	
<b>DURABLE MEDICAL EQUIPMENT*</b>	No copay	70% after deductible

\*Precertification recommended.

\*\*Reimbursed 100% if admitted.

### [Aetna Exclusions, Limitations & Disclaimer](#)

For more information regarding your Aetna Patriot V Plan:

[www.aetna.com](http://www.aetna.com)

For a comparison of the medical plan options:

[Medical Side-by-Side Benefit Comparison](#)

**Related Medical Plan Information**

[Eligibility](#)

[Open Enrollment](#)

[Claim Resolution](#)

[Did You Know?](#)

[Aetna Precertification](#)

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**AETNA HEALTH INC.® QUALITY POINT-OF-SERVICE<sup>SM</sup> PROGRAM**  
**NJ School Patriot V Flx / QPOS (Cinn BOE) Plan**  
**CINNAMINSON TOWNSHIP SCHOOL DISTRICT**

**Exclusions and Limitations**

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.


All medical and hospital services not specifically covered in, or which are limited or excluded in your plan documents; Cosmetic surgery, including breast reduction; Custodial care; Dental care and dental X-rays; Donor egg retrieval; Durable Medical Equipment; Experimental and investigational procedures; Hearing aids; Home births; Implantable drugs and certain injectible drugs including injectible infertility drugs; Immunizations for travel or work; Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents; Long-term rehabilitation therapy; Orthotics; Outpatient Prescription drugs and over-the-counter medications and supplies; Nonmedically necessary services or supplies; Radial keratotomy or related procedures; Reversal of voluntary sterilization; Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling or prescription drugs; Special duty nursing; Therapy or rehabilitation other than those listed as covered; and Treatment of behavioral disorders.

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## Patriot X

Referrals are recommended, but not required. Members choose a Primary Care Physician (PCP). Member is responsible for copay at time of referred services. For non-referred services the member is responsible for the deductible and coinsurance. For services provided by non-participating or out-of-network provider the member is responsible for the deductible, coinsurance and the provider may bill you the unpaid balance of the charges for services.

	<b>Cinnaminson Township Board of Education</b>	
	<b>Aetna Patriot X</b>	
	<b>Referred</b>	<b>Non-Referred*</b>
<b>FINANCIAL</b>		
Deductible: Single/Family	N/A	\$200/\$400
Coinsurance	N/A	80%
Coinsurance Limit: Single/Family	N/A	\$5,000/\$5,000
Lifetime maximum Benefit	N/A	Unlimited
<b>PRIMARY CARE PHYSICIAN VISITS</b>		
Office Hours	\$10 copay	80% after deductible
After Hours / Home Visits	\$15 copay	80% after deductible
<b>SPECIALTY CARE</b>		
Office Visits	\$15 copay	80% after deductible
Diagnostic Outpatient Testing	\$15 copay	100% Covered
Physical, Occupational, Speech Therapy	\$15 copay	100% Covered
<b>OUTPATIENT SURGERY*</b>	No copay	100% Covered
<b>HOSPITALIZATION*</b>	No copay	100% Covered
<b>SKILLED NURSING FACILITY*</b>	No copay	100% Covered
<b>EMERGENCY ROOM**/***</b>	No copay	No copay
<b>HOME CARE*</b>	No copay	100% Covered
<b>MATERNITY*</b>		
First OB Visit	\$15 copay	80% after deductible
Hospital	No copay	100% Covered
<b>MENTAL HEALTH*</b>		
Inpatient	No copay, 35 days	100% Covered, 21 days 80% after deductible, 22-90 days
Outpatient	\$25 copay/V, 20 visits	80% after deductible
<b>SUBSTANCE ABUSE*</b>		
Detoxification	No copay	100% covered, 7 days
Inpatient Rehabilitation	Not covered	100% covered, 30 days
Outpatient Rehabilitation	Not covered	80% after deductible, 30 visits
<b>PREVENTATIVE CARE</b>		
Routine Eye Exam	\$15 copay	Not covered
Routine Physicals	\$10 copay	100% (state-specific guidelines)
Immunizations	\$10 copay	100% (state-specific guidelines)
Routine Mammography	\$15 copay	100% (state-specific guidelines)
Routine GYN Exam	\$15 copay	100% (state-specific guidelines)
Pediatric Preventive Dental Exam	\$15 copay	Not covered
<b>CHIROPRACTIC CARE*</b>	\$15 copay, 20 visits	80% after deductible
<b>PRESCRIPTION LENS REIMBURSEMENT</b>	\$70 every 24 months	
<b>DURABLE MEDICAL EQUIPMENT*</b>	Not covered	80% after deductible

\*Precertification recommended.

\*\*Reimbursed 100% if admitted.

### [Aetna Exclusions, Limitations & Disclaimer](#)

For more information regarding your Aetna Patriot X Plan:

[www.aetna.com](http://www.aetna.com)

For a comparison of the medical plan options:

[Medical Side-by-Side Benefit Comparison](#)

**Related Medical Plan Information**

[Eligibility](#)

[Open Enrollment](#)

[Claim Resolution](#)

[Did You Know?](#)

[Aetna Precertification](#)

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**AETNA HEALTH INC.® QUALITY POINT-OF-SERVICE<sup>SM</sup> PROGRAM**  
**NJ School Premier / QPOS (1998) Plan**  
**CINNAMINSON TOWNSHIP SCHOOL DISTRICT**

**Exclusions and Limitations**

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.


All medical and hospital services not specifically covered in, or which are limited or excluded in your plan documents; Cosmetic surgery, including breast reduction; Custodial care; Dental care and dental X-rays; Donor egg retrieval; Durable Medical Equipment; Experimental and investigational procedures; Hearing aids; Home births; Implantable drugs and certain injectible drugs including injectible infertility drugs; Immunizations for travel or work; Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents; Long-term rehabilitation therapy; Orthotics; Outpatient Prescription drugs and over-the-counter medications and supplies; Nonmedically necessary services or supplies; Radial keratotomy or related procedures; Reversal of voluntary sterilization; Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling or prescription drugs; Special duty nursing; Therapy or rehabilitation other than those listed as covered; and Treatment of behavioral disorders.

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# CINNAMINSON TOWNSHIP BOARD OF EDUCATION TOWNSHIP

## MEDICAL BENEFITS COMPARISON

 <b>FINANCIAL</b>	Aetna Patriot X		Aetna Patriot V		Aetna Premier	
	Referred	Non-Referred*	Referred	Non-Referred*	Referred	Non-Referred*
Deductible: Single/Family	N/A	\$200/\$400	N/A	\$100/\$200	N/A	\$1,000/\$3,000
Coinsurance	N/A	80%	N/A	70%	N/A	70%
Coinsurance Limit: Single/Family	N/A	\$5,000/\$5,000	N/A	\$2,000/\$4,000	N/A	\$10,000/\$30,000
Lifetime maximum Benefit	N/A	Unlimited	N/A	Unlimited	N/A	\$5,000,000
<b>PRIMARY CARE PHYSICIAN VISITS</b>						
Office Hours	\$10 copay	80% after deductible	\$5 copay	70% after deductible	\$2 copay	70% after deductible
After Hours / Home Visits	\$15 copay	80% after deductible	\$10 copay	70% after deductible	\$5 copay	70% after deductible
<b>SPECIALTY CARE</b>						
Office Visits	\$15 copay	80% after deductible	\$5 copay	70% after deductible	No copay	70% after deductible
Diagnostic Outpatient Testing	\$15 copay	100% covered	\$5 copay	70% after deductible	No copay	70% after deductible
Physical, Occupational, Speech Therapy	\$15 copay	100% covered	\$5 copay	70% after deductible	No copay	70% after deductible
<b>OUTPATIENT SURGERY</b>	No copay	100% covered	No copay	70% after deductible	No copay	70% after deductible
<b>HOSPITALIZATION</b>	No copay	100% covered	No copay	70% after deductible	No copay	70% after deductible
<b>SKILLED NURSING FACILITY</b>	No copay	100% covered	No copay	70% after deductible	No copay	70% after deductible
<b>EMERGENCY ROOM**</b>	No copay	No copay	\$25 copay	\$25 copay	\$15 copay	\$15 copay
<b>HOME CARE</b>	100% covered	100% covered	No copay	70% after deductible, 60 visits	No copay	70% after deductible, 60 visits
<b>MATERNITY</b>						
First OB Visit	\$15 copay	80% after deductible	\$5 copay	70% after deductible	No copay	70% after deductible
Hospital	No copay	100% covered	No copay	70% after deductible	No copay	70% after deductible
<b>MENTAL HEALTH</b>						
Inpatient	No copay, 35 days	100% covered, 21 days; 22-90 days D&C	No copay, 35 days	70% after deductible, 60 days	No copay, 35 days	70% after deductible
Outpatient	\$25 copay/V, 20 visits	80% after deductible, 30 visits	\$5 copay/V, 20 visits	70% after deductible, 30 visits	\$10 copay/V, 30 visits	70% after deductible, 30 visits
<b>SUBSTANCE ABUSE</b>						
Detoxification	No copay	100% covered, 7 days	No copay	70% after deductible, 7 days	No copay	70% after deductible, 7 days
Inpatient Rehabilitation	Not covered	100% covered, 30 days	Not covered	70% after deductible, 30 days	No copay, 28 days	70% after deductible, 30 days
Outpatient Rehabilitation	Not covered	80% after deductible, 30 visits	\$5 copay, 60 visits	70% after deductible, 30 visits	No copay, 30 visits	70% after deductible, 30 visits
<b>PREVENTATIVE CARE</b>						
Routine Eye Exam	\$15 copay	Not covered	\$5 copay	Not covered	\$2 copay	Not covered
Routine Physicals	\$10 copay	100% (state-specific guidelines)	\$5 copay	See insurance certificate	\$2 copay	See insurance certificate
Immunizations	\$10 copay	100% (state-specific guidelines)	\$5 copay	See insurance certificate	\$2 copay	See insurance certificate
Routine Mammography	\$15 copay	100% (state-specific guidelines)	\$5 copay	Covered (state-specific guidelines)	No copay	Covered (state-specific guidelines)
Routine GYN Exam	\$15 copay	100% (state-specific guidelines)	\$5 copay	Not covered	\$2 copay	Not covered
Pediatric Preventive Dental Exam	\$15 copay	Not covered	\$5 copay	Not covered	\$2 copay	Not covered
<b>CHIROPRACTIC CARE</b>	\$15 copay, 20 visits	80% after deductible	\$5 copay/V, 20 visits	70% after deductible	\$2 copay	70% after deductible, \$500 annual max
<b>PRESCRIPTION LENS REIMBURSEMENT</b>	\$70 every 24 months		\$70 every 24 months		\$100 every 24 months	
<b>DURABLE MEDICAL EQUIPMENT</b>	Not covered	80% after deductible	No copay	70% after deductible	Not covered	70% after deductible

\*Member precertification required or benefits paid may be substantially reduced

\*\*Reimbursed if admitted.

## Aetna Precertification

Aetna recommends precertification for certain services. Precertification helps to determine if services you seek are covered under your plan, prior to receiving those services. The member is responsible for ensuring that services requiring precertification are, in fact, precertified. There is no penalty if you do not precertify.

Call the telephone number listed on your member identification card to precertify. Call for precertification:

- prior to any planned admission into the hospital;
- within 24 hours after the time of an emergency admission, or as soon thereafter is reasonably possible;
- as soon as possible after the attending physician confirms that you are pregnant;
- within 24 hours of the birth of a child, or as soon thereafter is reasonably possible;
- prior to receiving the following services:

Ambulatory Surgery	Cardiac Rehabilitation – outpatient
Chemotherapy	Chiropractic Care
Durable Medical Equipment (for equipment over \$1,500)	Emergency Services (within 24 hours, or as soon as possible)
Genetic Counseling or Testing	Home Health Services
Hospice Care	Hospital Admission
Injectable Drugs	Laser Assisted Uvulopalatoplasty
Maternity	Non-Biological Mental Health Services – inpatient
MRA	MRI – knee and spine
Occupational Therapy – outpatient	Oral Surgery
Orthotics	Osteoporosis
PET Scan	SPECT Scan
Temporomandibular Joint Disorder Treatment	Transplants
Physical Therapy – outpatient	Private Duty Nursing
Pulmonary Rehabilitation	Radiation Treatment
Respiratory Therapy – outpatient	Skilled Nursing – inpatient and outpatient
Speech Therapy – outpatient	Substance Abuse Services – inpatient and outpatient
Surgery	

For more information please reference your summary plan document.

## Dental

Horizon Healthcare Dental Services is the dental insurance carrier for Cinnaminson Township Public Schools. There are three different dental plans made available. They are outlined below. For a detailed comparison of each plan's benefits please see the [Dental Side-by-Side Benefit Comparison](#).

"Dental Option Plan" (DOP)	"Dental Choice Plan" (HDC)	"Totalcare" (HTC)
<p><b>(Traditional)</b> Over 5,400 participating dentists, 2,700 of which accepted discounted fees</p>	<p><b>(Managed Plan)</b> Over 250 dentists In-network benefits only <b>Must Select:</b> <b>personal care dentist</b></p>	<p><b>(Managed Plan)</b> 20 multi-practice offices In-network benefits only <b>Must Select:</b> <b>personal care dentist</b></p>
<p>Can go in or out-of-network</p>	<p>No balance billing</p>	<p>No balance billing</p>
<p>No balance billing above usual and customary charges when going in-network</p>	<p>No paperwork No frequency limitations</p>	<p>No paperwork No frequency limitations</p>
<p>Up-front payments are limited to applicable co-payments and deductibles when going to a participating dentist</p>	<p>No deductibles No annual maximum</p>	<p>No deductibles No annual maximum</p>

For more information about your Horizon Healthcare Dental Benefits:

[www.horizon-bcbsnj.com](http://www.horizon-bcbsnj.com)

### Related Dental Plan Information

[Eligibility](#)


[Claims Resolution](#)

[Open Enrollment](#)

[Did You Know?](#)

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## Dental Side-by-Side Benefit Comparison

		Cinnaminson Township Public Schools		
		DOP	HDC	TotalCare
<b>Annual Deductible</b>	Single Family	\$0 \$0	None None	None None
<b>Annual Maximum</b>		\$1,000	None	None
<b>Orthodontia Max</b>		\$1,000	None	None
<b>Visits &amp; Exams</b>	Visit for Oral Examinations Prophylaxis incl. scaling & polishing Fluoride	100%* 100%* 100%*	100% 100% 100%	100% 100% 100%
<b>X-rays</b>	Periapical X-rays Bite-wing x-rays Full mouth series	100%* 100%* 100%*	100% 100% 100%	100% 100% 100%
<b>Endodontics</b>	Pulp Capping Root Canal therapy w/ x-rays & cultures Pulpectomy Apioectomy Molar and/or complex root canal therapy	75%* 75%* 75%* 75%* 75%*	100% 100% 100% 100% 60%	100% 100% 100% 100% 100%
<b>Restorations</b>	Amalgam (silver fillings) Composite Fillings Stainless steel crowns	75%* 75%* 75%*	100% 100% 100%	100% 100% 100%
<b>Periodontics</b>	Scaling and root planning Gingivectomy Correction of occlusion Subgingival curettage Osseous surgery	75%* 75%* 75%* 75%* 75%*	100% 100% 100% 100% 60%	100% 100% 100% 100% 100%
<b>Oral Surgery &amp; Extraction</b>	Uncomplicated extractions Incisions and drainage of abscess Surgical removal of erupted teeth Removal of soft tissue impaction Full or partial bony impaction	75%* 75%* 75%* 75%* 75%*	100% 100% 100% 100% 60%	100% 100% 100% 100% 100%
<b>Prosthodontics &amp; Repairs</b>	Inlays/Onlays Crowns (Freestanding) Full and partial dentures Denture repairs Crowns (abutments to bridgework) Pontics (false teeth) Space Maintainers	75%* 75%* 60%* 75%* 60%* 60%* 100%*	60% 60% 60% 60% 60% 60% 60%	100% 100% 100% 100% 100% 100% 100%
<b>Orthodontia</b>	Orthodontic fee for normal 24 month Banded case	50%*	60%	100%**
<b>Exclusions &amp; Limitations</b>		DOP	HDC	TotalCare

\*Annual Maximum apply. \*\*Totalcare ortho covered for children only to age 19. These services are also subject to Maximum Allowable Charge (MAC) limitations. HDC and TotalCare Dental benefits are available only when services are provided or coordinated by a Horizon TotalCare Dentist or and HDC Dentist. Procedures that require treatment by a specialist must be pre-authorized by Horizon Healthcare Dental Services. Coinsurance rates under the Horizon Dental Option Plan are based upon a percentage of Usual, Customary and Reasonable charges. If you are a dependent or have dental work in progress, you must wait until the work is completed before you enroll in HDC. The above information is provided for illustrative purposes only. Specific benefit levels and dental services are described more completely in the employee benefit books. The extent of insurance for each individual is governed at all times by the complete terms of the master group insurance contract issued by Horizon Blue Cross Blue Shield of New Jersey, Horizon Healthcare Dental Services and Horizon Healthcare Dental.

For more information about your Horizon Healthcare Dental Benefits:

[www.horizon-bcbsnj.com](http://www.horizon-bcbsnj.com)

## Related Dental Plan Information

[Eligibility](#)

[Claim Resolution](#)

[Open Enrollment](#)

[Did You Know?](#)

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**CINNAMINSON TOWNSHIP BOARD OF EDUCATION  
HORIZON HEALTHCARE DENTAL  
DENTAL OPTION PLAN EXCLUSIONS AND LIMITATIONS**

**SECTION 7 COVERAGE LIMITATIONS**

This Policy will cover many of the dental expenses incurred by a Covered Person.

**BENEFIT PROVISIONS**

**Payment Limits**

Horizon limits what it will pay for certain types of charges. See the Schedule of Benefits section for these limits.

**Benefits From Other Plans**

The benefits Horizon will provide may also be affected by benefits available from Medicare and other health benefit plans. Read the Coordination of Benefits section for an explanation of how this works.

**Dental Limitations**

- a. If there are alternative professionally acceptable methods of treating a condition (e.g., varying techniques and appliances) which methods carry different allowances, Horizon shall not make payments in excess of the lesser Allowance, unless a method carrying a greater Allowance is the only adequate treatment and a Treatment Plan for such method has been approved by Horizon.
- b. If a Covered Person transfers from the care of one dentist to that of another dentist during a course of treatment, or if more than one dentist performs services for one dental procedure, Horizon shall not pay more than the amount it would have paid if one dentist performed all the services during each course of treatment.
- c. If the nature or extent of a given service must be Determined, this Determination is entirely up to Horizon. This includes determining whether services are emergency in nature and determining whether a dentist gave services.
- d. Horizon will make payment for services only after they have been completed. If any payment has been pre-certified based on a Treatment Plan, Horizon has the right to change that amount. This change may be necessary because of mathematical error, or because of a change in coverage. If treatment is completed before the time specified in a pre-certified Treatment Plan, Horizon will pay any amount due for Covered Services after notification by the dentist.

**CINNAMINSON TOWNSHIP BOARD OF EDUCATION  
HORIZON HEALTHCARE DENTAL  
DENTAL OPTION PLAN EXCLUSIONS AND LIMITATIONS**

**SECTION 8 EXCLUSIONS**

**The following are not Covered Services and Supplies under this Policy. Horizon will not pay for any charges incurred for, or in connection, with:**

Any charge to the extent it exceeds the Allowance.

Balances for services and supplies after Payment has been made under this Policy.

Completion of claim forms.

Copayments, Deductibles, and the individual's part of any Coinsurance; expenses incurred after any Payment maximum is or would be reached.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise provided in this Policy.

Illness or accidental Injury which occurred on the job or which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Personal comfort and convenience items.

Services or supplies:

- eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his rights to obtain this coverage or payment for these services;
- for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
- furnished by one of the following members of the Covered Person's family, unless otherwise stated in this Policy: Spouse, Child, parent, in-law, brother or sister;
- needed because the Covered Person engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- rendered prior to the Covered Person's Effective Date or after his termination date of coverage under the Policy, unless specified otherwise;
- which are specifically limited or excluded elsewhere in this Policy;

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- which a Covered Person is not legally obligated to pay for.

The following services and materials:

- Any services by a dentist which are not specifically listed as covered under this Policy
- Replacement of tooth structure lost due to attrition, abrasion or erosion
- Educational services, such as oral hygiene or dietary instructions
- Services in connection with plaque control programs, except oral prophylaxis
- Replacement of lost, stolen or broken space maintainers
- Missed or broken dental appointments
- Sterilization fees
- Gold foil restorations
- Inlays
- Services performed by a dental department or clinic of an employer, labor union, or similar group
- Services performed or items furnished strictly for cosmetic purposes. Facings on crowns, or pontics, that are behind the second bicuspid will always be considered cosmetic unless as a result of accidental injuries sustained while a Covered Person
- Periodontal splinting and/or crown and bridgework used in conjunction with periodontal splinting
- Services related to myofunctional therapy
- Services relating to Temporal Mandibular Joint (TMJ) Syndrome
- Implants, related appliances or the surgical removal of an implant

Services if they are performed by any of the following:

1. A Hospital resident, intern or dentist who is paid by a Hospital or other source, or who is permitted to charge for services covered under the Dental Benefits Section of this Policy. Services performed by such persons are excluded whether or not the person is in training.

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2. Anyone who does not qualify as a dentist.

- Services that are usually provided without charge or for which no charge would be made if no dental benefits coverage existed
- Services or supplies provided to the Covered Person prior to the Covered Person's effective date of coverage or after the date the Covered Person is no longer eligible for benefits
- Services with fees payable to a Hospital or other institution; all hospital services; Accidental Injury/Accident or any procedures which are covered under another plan established by the Group which provides group hospital, surgical, or medical benefits, whether or not on an insured basis
- Anesthesia or consultation services performed in connection with any service that is not covered
- Services that do not meet the Necessary Dental Services level of care requirements of this Policy

# CINNAMINSON TOWNSHIP BOARD OF EDUCATION HORIZON HEALTHCARE DENTAL DENTAL CHOICE PLAN EXCLUSIONS AND LIMITATIONS

## DENTAL EXCLUSIONS AND LIMITATIONS

### No Service, procedure or supply is a Covered Service where it:

1.
  - a. is not a Necessary Dental Service,
  - b. does not have uniform professional endorsement,
  - c. is Experimental or Investigational in nature, or
  - d. does not have a favorable prognosis.

Final Determination of dental necessity rests with Horizon.
2. is furnished by a Dentist who is not a Primary Care Dentist or Specialty Care Dentist.
3. is a replacement or modification of a partial or full removable denture, a removable bridge or fixed bridgework, or for adding teeth to any of these, or for a replacement or modification of a crown, inlay or onlay, within 5 years after that denture, bridge, bridgework, crown, inlay or onlay was installed.
4. is:
  - a. an appliance, or modification of one, if an impression for it was made before the person became a Member
  - b. a crown, bridge inlay or onlay, if a tooth was prepared for it before the person became a Member;
  - c. Root canal therapy, if the pulp chamber for it was opened before the person became a Member;
  - d. an inlay, onlay, or crown, unless (i) it is treatment for decay or made necessary by an accidental non-chewing injury and teeth cannot be restored with a filling material; or (ii) it is a primary abutment to a covered bridge.
5. is furnished for cosmetic purposes. Facing on crowns, or pontics, that are posterior to the second bicuspid will always be considered cosmetic. This does not apply if the service is needed as a result of an Accidental Injury sustained while a person is a Member.
6. is in connection with:
  - a. replacement of lost or stolen appliances;
  - b. appliances or restoration needed to alter vertical dimensions or restore occlusion, or for the purpose of splinting or correcting attrition or abrasion or erosion; or
  - c. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint or craniomandibular disorders or its associated structures.
7. is in connection with or for myofunctional therapy infection control, separate charges for acid etch, treatment of jaw fractures, orthognathic surgery, personal supplies, completion of forms, exams by a third party, or professional advice given on the phone.
8. is for implants, insertion of implants or related appliance or surgical removal of implants.
9. is for overdentures and associated procedures, specialized techniques, precision or semi-precision attachments.
10. is for osseous (bone) grafts.
11. is not contained in the Schedule of Services.

### GENERAL EXCLUSIONS:

- A. No benefits will be provided for dental services or supplies which were not prescribed, arranged, coordinated, rendered or approved by the Primary Care Dentist, or by a Specialty Care Dentist, if the services provided by the Specialty Care Dentist were not duly authorized and approved by Horizon; except in the case of a Emergency Services.
- B. No dental benefits will be provided by an Out-of-Network Dentist unless specifically approved or authorized by Horizon.
- C. No dental benefits will be provided that are covered under any government program. No benefits are provided which the Member is eligible to receive under any federal, state, county or municipal law or under the laws of any other county, or for services received in a hospital operated by the United States of America, except for Emergency Services.

**CINNAMINSON TOWNSHIP BOARD OF EDUCATION  
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- D. No benefits will be provided for dental services covered, in whole or in part, under any workers' compensation law, the Federal Employer's Liability Act, the Longshoremen's and Harbor Workers' Compensation Act, the Jones Act, no-fault automobile insurance or similar law, until the Member has exhausted all of the benefits available under these laws. This applies even if (1) the Member does not claim benefits under the above laws or policies, or (2) after any of the above benefits are paid, the Member repays them because he recovered that money in a lawsuit or other proceeding.
- E. No benefits will be provided for prescription and non-prescription drugs and medications.
- F. No benefits will be provided to any person in the armed forces of any government other than for duty of 30 days or less.

**ORTHODONTIC CARE: SERVICES NOT COVERED**

- 1. Services will be discontinued if the person ceases to be covered for any reason under the Policy or this rider.
- 2. Any services for an Orthodontic Procedure if an active appliance for that Orthodontic Procedure has been installed before the first day on which the person becomes covered by this rider.
- 3. Covered Services will not be provided more than for one complete course of orthodontic treatment on a person during that person's lifetime.
- 4. All other benefits and terms of the Policy not changed by this rider remain in force. Attach this rider to the Policy. It is part of the Policy.

# CINNAMINSON TOWNSHIP BOARD OF EDUCATION HORIZON HEALTHCARE DENTAL TOTALCARE PLAN EXCLUSIONS AND LIMITATIONS

## DENTAL EXCLUSIONS AND LIMITATIONS

### No Service, procedure or supply is a Covered Service where it:

1.
  - a. is not a Necessary Dental Service,
  - b. does not have uniform professional endorsement,
  - c. is Experimental or Investigational in nature, or
  - d. does not have a favorable prognosis.

Final Determination of dental necessity rests with Horizon.
2. is furnished by a Dentist who is not a Primary Care Dentist or Specialty Care Dentist.
3. is a replacement or modification of a partial or full removable denture, a removable bridge or fixed bridgework, or for adding teeth to any of these, or for a replacement or modification of a crown, inlay or onlay, within 5 years after that denture, bridge, bridgework, crown, inlay or onlay was installed.
4. is:
  - a. an appliance, or modification of one, if an impression for it was made before the person became a Member
  - b. a crown, bridge inlay or onlay, if a tooth was prepared for it before the person became a Member;
  - c. Root canal therapy, if the pulp chamber for it was opened before the person became a Member;
  - d. an inlay, onlay, or crown, unless (i) it is treatment for decay or made necessary by an accidental non-chewing injury and teeth cannot be restored with a filling material; or (ii) it is a primary abutment to a covered bridge.
5. is furnished for cosmetic purposes. Facing on crowns, or pontics, that are posterior to the second bicuspid will always be considered cosmetic. This does not apply if the service is needed as a result of an Accidental Injury sustained while a person is a Member.
6. is in connection with:
  - a. replacement of lost or stolen appliances;
  - b. appliances or restoration needed to alter vertical dimensions or restore occlusion, or for the purpose of splinting or correcting attrition or abrasion or erosion; or
  - c. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint or craniomandibular disorders or its associated structures.
7. is in connection with or for myofunctional therapy infection control, separate charges for acid etch, treatment of jaw fractures, orthognathic surgery, personal supplies, completion of forms, exams by a third party, or professional advice given on the phone.
8. is for implants, insertion of implants or related appliance or surgical removal of implants.
9. is for overdentures and associated procedures, specialized techniques, precision or semi-precision attachments.
10. is for osseous (bone) grafts.
11. is not contained in the Schedule of Services.

### GENERAL EXCLUSIONS:

- A. No benefits will be provided for dental services or supplies which were not prescribed, arranged, coordinated, rendered or approved by the Primary Care Dentist, or by a Specialty Care Dentist, if the services provided by the Specialty Care Dentist were not duly authorized and approved by Horizon; except in the case of a Emergency Services.
- B. No dental benefits will be provided by an Out-of-Network Dentist unless specifically approved or authorized by Horizon.
- C. No dental benefits will be provided that are covered under any government program. No benefits are provided which the Member is eligible to receive under any federal, state, county or municipal law or under the laws of any other county, or for services received in a hospital operated by the United States of America, except for Emergency Services.

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- D. No benefits will be provided for dental services covered, in whole or in part, under any workers' compensation law, the Federal Employer's Liability Act, the Longshoremen's and Harbor Workers' Compensation Act, the Jones Act, no-fault automobile insurance or similar law, until the Member has exhausted all of the benefits available under these laws. This applies even if (1) the Member does not claim benefits under the above laws or policies, or (2) after any of the above benefits are paid, the Member repays them because he recovered that money in a lawsuit or other proceeding.
- E. No benefits will be provided for prescription and non-prescription drugs and medications.
- F. No benefits will be provided to any person in the armed forces of any government other than for duty of 30 days or less.

## Prescription

The Prescription Drug Carrier is Benecard Services which uses the nationwide network of pharmacies administered by Argus Health Systems.

	Brand	Generic
Retail	<b>\$15 copay</b> (34 days or 100 unit doses, whichever is less)	<b>\$5 copay</b> (34 days or 100 unit doses, whichever is less)
Mail Order	<b>\$10 copay</b> (30-90 day supply)	<b>\$5 copay</b> (30-90 day supply)

\* Please note: Your mail order copay will change effective 7/1/05. Please see [Benefit Updates](#) for details of the changes.

### Covered Medications:

#### 1. Federal Legend Drugs

Any FDA approved medicinal substance which bears the legend "Caution: Federal Law prohibits dispensing without a prescription."

#### 2. State Restricted Drugs

Any medicinal substance which may be dispense by prescription only, according to State Law.

**New Jersey State Law** requires available generic drugs to be dispensed by the pharmacist unless a prescribing physician specifically indicates that only a brand name be dispensed or a patient insists on a brand name. Consequently, unless a brand name prescription drug is stipulated as medically necessary by the prescribing physician, participating providers may require cardholders under this contract who decline a generic alternative to pay any drug costs in excess of the reimbursable generic price. The dispensing pharmacist will be reimbursed based upon the appropriate generic price.

#### 3. Diabetic Supplies

Alcohol Swabs, Lancets, Test Strips and Tablets.

#### 4. Compounded Medications

A compounded medical prescription is an extemporaneously prepared dosage form. The compound must contain at least one federal legend drug in a therapeutic amount; or a combination of ingredients which require a prescription by law when compounded into a specific dosage form for an individual patient at the direction of a prescriber, and which is also in a therapeutic amount.

#### 5. Injectable Imitrex

Dispensing is limited to not more than 48 kits or 96 vials per plan participant within a one year period.

#### 6. Oral Contraceptives

#### 7. Erectile Dysfunction Medication

##### Plan Specifications:

- The member must have a diagnosis of non-psychological impotence;
  - Organic impotence
  - Diabetic impotence
  - Neurogenic impotence
  - Impotence due to venous leakage
  - Impotence due to prostatitis
- Coverage will be for one medication. Therefore, if the member is on Muse or any other medication to correct Male Sexual Dysfunction, he will not be contemporaneously eligible for an oral Male Sexual Dysfunction drug or, Alprostitil or Papaverine.
- A limit of six (6) pills, suppositories or injections will be covered per month.
- A urologist must order the medication and will be responsible for assuring it is prescribed only for an approved diagnosis.
- Oral Male Sexual Dysfunction drugs are not indicated for women and are not covered.

##### Procedure:

- A urologist will write the prescription and send Benecard a letter of medical necessity.
- Group's plan design and provider's diagnosis will be reviewed by professional standards personnel.
- The member will need to use a participating pharmacy to dispense the prescription.

4. No more than six tablets or six suppositories or six injections will be covered per month.
5. If the member has tried a Prescription Drug for Male Sexual Dysfunction without success, the prescribing urologist may submit to Benecard a written request stating that another Prescription Drug is medically necessary to alleviate the Member's Male Sexual Dysfunction. At no time will more than two Prescription Drugs for Male Sexual Dysfunction be covered contemporaneously for any member.
6. Oral male Sexual Dysfunction Drugs are contra-indicated with members on Nitrates and would, therefore, not be covered by the plan.

[Benecard Exclusions, Limitations & Disclaimer](#)

For more information about your Benecard Prescription Benefits:

[www.benerx.com](http://www.benerx.com)

**Related Prescription Plan Information**

[Eligibility](#)

[Claims Resolution](#)

[Open Enrollment](#)

[Did You Know?](#)

*Please remember your insurance benefits are limited to the terms, conditions, exclusions and limitations of the insurance carrier's policy. Nothing contained on this website shall be deemed to have altered, waived, or extended the coverage provided by the policy. This overview contains a general description of your prescription program for your use as a convenient reference. Complete details of your program appear in the policy, which govern the benefits and operation of your program. The policy supersedes if there should be any inconsistency or difference between its provisions and the information in this overview.*

# CINNAMINSON TOWNSHIP BOARD OF EDUCATION

## BENECARD PRESCRIPTION LIMITATIONS

### EXCLUSIONS:

1. Medications administered by a physician or prescriber, or received while an inpatient in a hospital, rest home, nursing facility, sanitarium, or other institution and, any prescription medication administered or consumed in the place where the Prescription Order is written or in a clinical setting. Prescription Drugs administered or dispensed at a physician's office are not covered.
2. Medications for which the cost is recoverable under any other program, government program, insurance policy, or under any Workers Compensation Act, occupational disease law or similar legislation. This exclusion applies whether or not the Member asserts his or her right to obtain this coverage or payment for the medications.
3. Medications furnished by any other drug or medicinal service for which no charge is made to the recipient, or for which the Member would not have been charged if the Member did not have health care coverage.
4. Any drug labeled "Caution - limited by Federal Law to Investigational Use" and any other experimental/investigative drugs, procedures, treatments, equipment, devices or supplies; even though a charge is made to the recipient.
5. Drugs or vitamins which do not by law require a prescription, even if a Prescription Order is written, and over the counter items, except where specifically provided for under the Plan.
6. Devices and medical supplies of any type, including but not limited to: contraceptive devices, condoms, diaphragms, Norplant, jellies, ointment, foams; therapeutic devices, glucometers, non diabetic diagnostics, implants, artificial limbs or orthopedic appliances of any type, even if they require a Prescription Order. Also, support garments or similar non-medical appliances.
7. Nutritional products such as food supplements, special foods, liquid diets and supplements. Performance enhancement medications such as those used to enhance athletic performance, or lifestyle enhancement drugs or supplies.
8. Administration or injection of any drugs or insulin, services of any kind, charges for completion of insurance forms and medications dispensed in bubble pack or other unit doses.
9. Any refill dispensed one year or more after the date of the original Prescription Order.
10. Drugs dispensed by a person other than a pharmacist or a pharmacy, or for services rendered by a pharmacist except where specifically provided for under the Plan specifications. Benefits are not provided for drugs given by a physician or other practitioner.
11. Immunologicals, vaccines, allergy sera or extracts, biological products or treatment, biological or other sera, blood and blood plasma or other derivatives and Rhogam.
12. Drugs and medicines prescribed for injury or sickness resulting from war or any act of war, police actions or riots; or drugs needed because a Member engaged in, or tried to engage in an illegal occupation or committed or tried to commit a felony.
13. Drugs obtained from a federal, state or local public health agency for treatment of tuberculosis, mental disease or communicable diseases. Methadone maintenance. Herbal maintenance. Court ordered treatment which is not medically necessary.
14. Prescription Orders filled through a mail order prescription service which does not have a contract with Claim Processor to provide mail order prescriptions to Members.
15. Any drug prescribed or dispensed in a manner contrary to normal medical practices, or which are not medically necessary, or any drug not prescribed in accordance with FDA approved indications.

## CINNAMINSON TOWNSHIP BOARD OF EDUCATION BENECARD PRESCRIPTION LIMITATIONS

16. Any Prescription Order written before the effective date of this program, or before the effective date of any Member's coverage, or after the termination of a Member's coverage. Refills are permitted for Members during the effective period of coverage if they would otherwise be eligible for payment under this plan.
17. Federal Legend Drugs newly approved by the Federal Drug Administration (FDA) for use subsequent to the inception of this Agreement pending Group's decision to alter or amend its Plan Specifications as provided in Article II.c of this Agreement.
18. Contraceptive drugs, whether oral, injectable, topical or implanted, even when prescribed for other than contraceptive purposes, except where specifically provided for under the Plan.
19. Growth Hormones.
20. Products and drugs for smoking cessation or deterrence.

**DISPENSING LIMITATIONS:** The amount of a drug (including insulin), which may be dispensed and covered through a retail Provider in any one prescription or refill may not exceed a thirty-four (34) day supply or up to 100 units, whichever is less. The amount of a drug (including insulin), which may be dispensed and covered through the Mail Order Pharmacy in any one prescription or refill may not exceed a 90 day supply.

**CO-PAYMENT:** At a retail pharmacy for any one prescription or refill obtained, Members will pay: \$15.00 for a Brand Drug and \$5.00 for each Generic Drug. At the Mail Order Pharmacy for any one prescription or refill obtained, Members will pay: \$10.00 for a Brand Drug and \$5.00 for each Generic Drug.

**NO PREFERRED MEDICATION PROGRAM:** Group has elected not to participate in a Preferred Drug formulary program that would require active promotion of Preferred Drugs through various means such as coverage exclusion of non-preferred medications, higher co-pays for non-preferred medications, or solicitation of plan participants and/or healthcare providers to promote Preferred Drugs.

**GENERIC DRUGS:** Group acknowledges that applicable law may require or permit the prescribing and dispensing of Generic Drugs in substitution for Brand Drugs. Group agrees that consistent with the HIPAA Privacy Rule, Benecard may contact Members about Generic Drugs as treatment alternatives to Brand Drugs. In connection with these services, Benecard also may provide Participating Providers and physicians information messaging and communications about such alternatives and services. Subject to Group's Plan Specifications, the decisions to prescribe and dispense any drug shall remain within the professional judgment of the physician or health care provider and the pharmacist, respectively.

**ADDITIONAL IDENTIFICATION CARDS:** Extra Identification Cards will be issued upon authorization by Group at an additional cost to the Group of \$1.00 per card.

## Coverage Continuation

**Please contact your Business Office should you have a qualifying event and wish to continue your coverage.**

COBRA Under certain circumstances the law prescribes that you and/or your covered dependents may continue coverage, at your own expense, if you have a COBRA qualifying event.

Retirees Retirees of the Cinnaminson Township Public Schools may continue coverage beyond the period of COBRA as prescribed by law. Retirees enrolled in the TPAF or PERS may also have the option of state paid benefits.

## COBRA

Eligible employees and eligible dependents currently enrolled in the Medical, Dental and/or Prescription plan may continue coverage upon a qualifying event in the group plan at your own expense.

### Period of Coverage

- Employees may continue coverage up to a maximum of 18 months.
- Dependents may continue coverage up to a maximum of 36 months.
- Handicapped children incapable of self-support and chiefly dependent upon the employee for support and maintenance may continue coverage until the date the incapacity ends.

### Qualifying Event(s)

#### Employee

As an employee enrolled as a member of the Cinnaminson Township Public Schools' benefit program you may continue coverage at your own expense for yourself and your eligible dependents for the following reasons

- You lose your health coverage because of a reduction in hours; or
- Your employment terminates for reasons other than gross misconduct on your part.

#### Spouse

As a spouse dependent enrolled as a member of the Cinnaminson Township Public Schools' benefit program you may continue coverage for yourself for any of the following reasons:

- Your spouse dies;
- Your spouse's employment terminates for reasons other than gross misconduct, or reduces hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare benefits.

#### Child(ren)

As a dependent child enrolled as a member of the Cinnaminson Township Public Schools' benefit program you may continue coverage for any of the following reasons:

- The death of parent;
- Your parent's employment terminates for reasons other than gross misconduct, or reduces hours of employment;
- Your parents divorce or legally separate;
- Your parent becomes entitled to Medicare; or
- You cease to be an "eligible dependent child" under any/all group coverage.

### Enrollment

Contact the Cinnaminson Township Board of Education Business Office immediately following a COBRA qualifying event.

## Retirees

Any retired employee of the Cinnaminson Township Public Schools may continue coverage through and beyond the period of COBRA at their own expense. Prior to the termination of COBRA eligibility you must notify either the plan administrator or the School Business Office of your desire to continue.

### State Health Benefits Coverage at Retirement

If you fall into one of the categories listed below, you will be offered coverage under the New Jersey State Health Benefits Program (SHBP) into retirement:

- Members who retire with 25 or more years of service credit in the TPAF and school board employees enrolled in PERS, or those on a disability retirement, even if your employer did not participate in the SHBP. This includes members who elected deferred retirement with 25 or more years of service credit. Eligibility is limited to full-time employees as defined by N.J.A.C. 17:9-4. If you fall into this category this coverage is provided without cost to you.
- Members eligible for Medicare who retired from a board of education, vocational/technical school or special services commission not participating in SHBP and do not meet the above criteria, provided you are participating in the health benefits plan of your employer and are enrolled in Medicare Parts A and B. You are required to pay the full cost of the coverage.

### New Jersey Division of Pensions and Benefits

<http://www.state.nj.us/treasury/pensions/>

**TPAF/PERS Retirement Enrollment Packet** (Includes forms and instructions.)

<http://www.state.nj.us/treasury/pensions/epbam/exhibits/pdf/sc0530.pdf>

## Voluntary Benefit Waiver

### Purpose

The purpose of the voluntary benefit waiver option is to encourage eligible employees to waive unnecessary duplicate family coverage. Employees eligible for medical coverage who elect to waive medical coverage for a full year shall receive cash in lieu of coverage.

### How to Waive Medical Coverage

Voluntary waiver forms will be made available by your Business Office by April 1<sup>st</sup> each school year. You must provide documentation certifying coverage through another source in order to waive medical coverage. Waiver forms and certificate of coverage through another source must be returned to your Business Office by June 1<sup>st</sup>.

**Please note:** This waiver is irrevocable during the plan year, except upon a life changing event.

### Payment

Payments will be made on June 30<sup>th</sup> of the school year for which the coverage was waived. Payments will run through payroll as a separate check and be reported as taxable income. Payments made for employees within the first five years of employment will be prorated accordingly.

- Single: \$787
- Parent/Child: \$1,145
- Husband/Wife: \$1,941
- Family: \$2,000

### Re-Enrollment in Benefits

Employees and their dependents may re-enroll or elect health benefits after waiving benefits:

- During [Open Enrollment](#).
- Upon the occurrence of a “life-changing event” during the course of the year.

#### **The following are considered “life-changing events”:**

- Change in legal marital status—marriage, death of spouse, divorce, legal separation or annulment.
- Change in the number of dependents—birth, adoption, placement for adoption or death of a dependent.
- Change in employment status—termination or commencement of employment by the employee, spouse or dependent, a strike or lockout, reduction or increase in hours, or unpaid leave of absence.
- Change in dependent’s status—a dependent satisfies or ceases to satisfy the requirements for coverage due to age, student status or similar circumstances.
- Residence or worksite—a change in the place of residence or work of the employee, spouse or dependent.

## Claim Resolution

Should a benefit issue arise, please use the following guidelines, mutually agreed upon by the Cinnaminson Township Education Association and Administration, to ensure that your issue is resolved in the quickest, most efficient manner possible.

Check the links below for information that may answer your questions.

[Eligibility](#)

[Benefit Updates](#)

[FAQ](#)

[Did You Know?](#)

### Step 1

Your first step should be to call the insurance carrier directly:

Coverage	Carrier	Website	Phone
Medical Coverage	Aetna	<a href="http://www.aetna.com">www.aetna.com</a>	800-333-9227
Dental Coverage	Horizon Healthcare Dental	<a href="http://www.horizon-bcbsnj.com">www.horizon-bcbsnj.com</a>	800-433-6825
Prescription Coverage	Benecard	<a href="http://www.benerx.com">www.benerx.com</a>	800-479-0031

**\*Please note the name and phone number of the person you speak with at the carrier.**

The majority of your questions should be satisfactorily addressed by the carrier. However, if you are in any way dissatisfied please proceed to [Step 2](#)

**NEW!** Step 2



**Contact Your *Personal* Health Advocate:**

<p><b>Toll-free Claim Resolution Hotline</b> 1-866-695-8622</p> <p>or Email: <a href="mailto:answers@HealthAdvocate.com">answers@HealthAdvocate.com</a></p>	<p><b>Notice:</b> Complete your authorization form to release your private health information and fax to 610-941-4200.</p> <p><a href="#">Authorization for Use and Disclosure of Private Health Information</a></p>
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Learn more about your *Personal* Health Advocate:

[Personal Health Advocate](#)

If you are in any way dissatisfied please proceed to [Step 3](#)

 <p><b>HEALTH Advocate™</b></p>	<p>450 SENTRY PARKWAY SUITE 102 BLUE BELL, PA 19422 FAX: 610-941-4200 <a href="http://www.HealthAdvocate.com">www.HealthAdvocate.com</a></p>			
<b>AUTHORIZATION FOR USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION</b>				

**DESCRIPTION OF PHI TO BE RELEASED TO HEALTH ADVOCATE:**

I hereby authorize my health plan(s), my healthcare providers and their applicable business associates to disclose the following Private Health Information ("PHI") pertaining to me: enrollment, claims, payment and managed care information to Health Advocate, Inc. for the purpose of assisting me in my quest to obtain health care services and/or approval or payment for health care services.

Unless otherwise indicated, my authorization includes the release of the following: *(Please strike through those you wish to exclude, if any.)*

- Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency
- Diagnosis and/or treatment regarding mental health issues
- HIV antibody test results and/or diagnosis and treatment
- Genetic test results and/or related treatment

Identification of person authorizing release: *(Please complete all items.)*

Name of Member/Participant: \_\_\_\_\_  
Last First MI

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Subscriber: \_\_\_\_\_

Address: \_\_\_\_\_  
Street ( Apt #) City State Zip

Subscriber Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Subscriber's Sponsor Name: *(eg: Employer, Health & Welfare Fund):* \_\_\_\_\_

Health Insurance Carrier 1: \_\_\_\_\_ Health Insurance Carrier 2: \_\_\_\_\_

Carrier 1 – Coverage Type:  HMO  POS  PPO  Indemnity  Medicare ID#: \_\_\_\_\_

Carrier 2 – Coverage Type:  HMO  POS  PPO  Indemnity  Medicare ID#: \_\_\_\_\_

Unless otherwise revoked, this authorization will commence on the date indicated below and will expire on the following date, event or circumstance: \_\_\_\_\_. If I fail to specify, this authorization will expire in twelve months.

- I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization at any time by giving written notice of my revocation to Health Advocate's Privacy Officer at the above address. I understand that revocation of this authorization will not affect any action Health Advocate or other parties took in reliance on this authorization before it received my written notice of revocation.
- I understand that Health Advocate provides administrative and informational services only and does not provide health insurance or medical services nor does it recommend treatment. Consequently, independent health care practitioners, who are not employees or agents of Health Advocate, will provide all my medical services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative (Include a description of such authority to act for the patient.)

You are not required to authorize Health Advocate to have access to your "PHI" and the provision of treatment, payment, enrollment or eligibility for benefits does not depend on whether you sign this authorization. You should keep a signed copy of this authorization for your records, however, a copy of this signed authorization will be provided upon your request.

### Step 3

Contact your Benefit Services Representative at Lance Siano Employee Benefit Consultants, LLC:

<p><b>Claim Resolution Hotline</b> 856-797-3500</p> <p>or Email: <a href="mailto:help@lancesianobenefits.com">help@lancesianobenefits.com</a></p>	<p><b>Notice:</b> To comply with <a href="#">HIPAA</a> you must complete our authorization form for us to assist you with claims. Please fax your completed authorization and any relevant claim information to 856-797-6230.</p> <p><a href="#">Authorization for Disclosure of Protected Health Information</a></p>
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**Our Quality Assurance Promise:** All claim inquiries brought to the attention of Lance Siano Benefits will receive the utmost professional care and active intervention until a final disposition, consistent with the carrier's contractual obligation, is determined and communicated to the staff member.

LANCE  SIANO  
employee benefit consultants, LLC

**Authorization for Disclosure of Protected Health Information**

My protected health information is information about me, including information such as my name, address, Social Security number, date of birth and/or medical information. The information was used or created when I received health care or when payment was received for my health care. The information may include my past, present or future physical or mental health or condition.

Name: \_\_\_\_\_ Member ID/SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ DOB: \_\_\_\_\_  
\_\_\_\_\_  
Telephone: \_\_\_\_\_  
\_\_\_\_\_  
Email: \_\_\_\_\_

I hereby authorize Lance Siano Employee Benefit Consultants, LLC (located at 12000 Lincoln Drive West, Suite 111, Marlton, NJ 08053), and its affiliates to disclose and/or received confidential information pertaining to the member/insured named above.

This release is for (please complete):

Carrier/Provider Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This release is for the purpose of (please check all that apply):

- Coordination of benefits
- Claim resolution
- Payment resolution
- Other: \_\_\_\_\_

Lance Siano Benefits agrees to maintain my protected health information in accordance with its privacy policy practices.

This authorization will expire on \_\_\_\_\_ or on occurrence of the following event \_\_\_\_\_, which relates to the purpose of the use and/or disclosure being authorized. If no date is specified, this authorization will automatically expire in six (6) months from the date originated.

You may revoke this authorization at any time by providing written notification to Lance Siano Benefits. Your revocation of this authorization will not affect any action we have taken before we receive your notice of revocation.

Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Date: \_\_\_\_\_  
Authorized Representative/Guardian (if under 18): \_\_\_\_\_

## FAQ

### Do I have vision benefits?

In addition to the prescription lens reimbursement available through your medical plan, use Aetna participating providers to cut costs for prescription eyewear, eye exams, mail order contact lenses, and LASIK surgery.

### How do I locate participating providers?

- Aetna: [www.aetna.com/docfind/](http://www.aetna.com/docfind/) (HINT! Search Aetna Standard Plans)
- Horizon: [www.horizon-bcbsnj.com](http://www.horizon-bcbsnj.com)
- Benecard: [www.benex.com](http://www.benex.com)

### Are composite (white) fillings covered under my Horizon Dental plan?

Composite fillings are covered at two different levels depending on which tooth it is. For anterior (front) teeth, composite fillings are covered at the same coinsurance level as amalgam (silver) fillings. For posterior (back) teeth, composite fillings are covered up to the maximum allowable charge for amalgam fillings. (Please note that amalgam fillings are considerably less expensive and you, the member, are responsible for the balance of the bill to your dentist if you choose composite fillings for your posterior teeth.)

### What copays can I submit to Aetna for reimbursement?

- **Premier and Patriot V:** Submit doctors' office receipts to Aetna for your copayment to be applied to your deductible. Once your deductible is met you will be reimbursed 70% of your copay amount.
- **Patriot X:** Submit you doctors' office and prescription receipts for your copayments to be applied to your deductible. Once your deductible is met you will be reimbursed 80% of your copay amount.

### When does my child's coverage begin/terminate?

[Eligibility](#)

- A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, the newborn child must be enrolled within the initial 31 day period.
- Children are covered until the end of the year in which age 23 is attained.
- Newly eligible dependents (due to marriage, adoption, etc.) may enroll within 31 days of the eligibility date (date of marriage, adoption, etc.).
- Eligible dependents who are eligible for enrollment, but do not enroll within the first 31 days following eligibility, may be enrolled during any subsequent.
- [Open Enrollment](#) period.

### Do my prescription benefits cover medications to treat erectile dysfunction?

Your prescription plan coverage includes coverage of medications for Erectile Dysfunction. Coverage requires a prescription and a statement of medical necessity from your doctor. Coverage includes up to 6 pills, suppositories, or injections per month. Mail order and 90-day supplies are not covered. For details see [prescription](#).

### Do I have to have a precertification for medical services?

[Aetna Precertification](#)

Precertification of certain medical services is recommended by Aetna, but precertification is not required. Precertification of your medical services helps determine if the services you seek are covered under your plan, prior to receiving the services.

## Privacy Policy

This notice is provided to you pursuant to the [Health Insurance Portability and Accountability Act \(HIPAA\)](#) and is designed to inform you of how we may use or disclose your protected health information (PHI). Lance Siano Benefits is fully compliant with all statutes in maintaining the privacy of your PHI. PHI includes any data that is unique to you, for example your Social Security number, and any health information that is nonpublic that we obtain to help you.

### How We Protect Your PHI

Lance Siano Benefits will not sell or license your PHI under any circumstances. We may transmit or disclose your PHI as allowable by law when:

- a) expressly authorized by you.
- b) necessary to enable us to perform certain administrative functions.

Please note, for your convenience we have provided links to other companies' websites. Lance Siano Benefits is not responsible for the privacy practices of companies that are not owned or controlled by us.

### Why We Obtain Your PHI

- For claim resolution: With your written consent our client services department may access your PHI – as well as communicate with your insurance company and/or your providers to advocate on your behalf to resolve claim issues.
- Pre-enrollment/Enrollment and Benefit Administration: Without consent the law allows us to use your PHI to administer your group's benefits, administer COBRA/Retiree benefits (when applicable), solicit competitive quotes for your group, as well as for personal health advocacy enrollment/administration (when applicable).

### For More Information

For more detailed information about the laws governing the protection of your PHI visit the United States Department of Health and Human Services website at <http://www.hhs.gov/news/facts/privacy.html>.

We welcome the opportunity to answer any questions you may have about this statement. You may email us [info@lsebc.com](mailto:info@lsebc.com) or call 856-797-3500.

## Health Insurance Portability and Accountability Act (HIPAA)

The first-ever federal privacy standards to protect individuals' health information. Developed by the Department of Health and Human Services (HHS), these standards provide people with access to their medical records as well as more control over how their personal health information is used and disclosed. These laws represent a uniform, federal floor of privacy protections for consumers across the country. State laws providing additional protections to consumers are not affected by these new rules.

For more detailed information about the laws governing the protection of your protected health information visit the United States Department of Health and Human Services website at <http://www.hhs.gov/news/facts/privacy.html>.

## Contact Us

We welcome your feedback and questions. You may contact us by:

**Email:** [help@lancesianobenefits.com](mailto:help@lancesianobenefits.com)

**Website:** [www.betterbenefitsolutions.com](http://www.betterbenefitsolutions.com)

**Local phone:** (856) 797-3500

**Fax:** (856) 797-7230

**Mail:** Lance Siano Employee Benefit Consultants, LLC  
12000 Lincoln Drive West, Suite 111  
Marlton, NJ 08053

**Out-of-Area phone:** (800) 642-6089