CJHIF- Brick Township- $10/$20

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.town.com or by calling **800-282-2881.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Not applicable**	Prescription benefits ONLY outlined in this document
Are there other deductibles for specific services?	**Not applicable**	Not applicable
Is there an out-of-pocket limit on my expenses?	There is a prescription out of pocket max. It is **$3,000 per individual/ $6,000 per family**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Not Applicable	Not applicable
Is there an overall annual limit on what the plan pays?	No.t applicable	Not applicable
Does this plan use a network of providers?	Yes	The CJHIF utilizes the Express Scripts *Prime Network.* For information regarding pharmacies participating in your network call **800-282-2881**
Do I need a referral to see a specialist?	Not applicable	Not applicable
Are there services this plan doesn't cover?	Yes.	Certain medications are not covered. Reach out to Express Scripts at **800-282-2881** for a full listing.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**NOT APPLICABLE**		
	Specialist visit			
	Other practitioner office visit			
	Preventive care / screening / immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition. *** Prescription Drugs are covered through Express Scripts and are excluded through the medical plan** **More information about prescription drug coverage is available at www.express-scripts.com**	Generic drugs	$10 copay mail order or retail	Not Covered	34 days or 100 units retail 90 days mail order Certain medications may require prior authorization.
	Preferred brand drugs	$20 copay mail order or retail	Not Covered	
	Non-preferred brand drugs	$20 copay mail order or retail	Not Covered	
	Specialty drugs	$10/$20 Copay Accredo Mail Order	Not Covered	Certain specialty medications may be limited to 30 day supply. **Prior Authorization required.** For more information regarding your specialty medication call Accredo Specialty Pharmacy at 877-222-7336
	Prescription drugs	Deductible does not apply	Not Covered	Not Applicable

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	NOT APPLICABLE		
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services			
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health Outpatient services			
	Mental/Behavioral health Inpatient services			
	Substance use disorder Outpatient services			
	Substance use disorder Inpatient services			
If you are pregnant	Prenatal and postnatal care			
	Delivery and all inpatient services			
If you need help recovering or have other special health needs	Home health care	NOT APPLICABLE		
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice service			
If your child needs dental or eye care	Eye exam			
	Glasses			
	Dental check-up			

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Over the counter equivalents
- Alternative medications
- Cosmetics
- IV Medications
- Smoking Cessation Products
- Medical Supplies

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Federal Legend Drugs • Male Sexual Dysfunction	• Diabetic Supplies • Needles & Syringes (Insulin Only)	• Compound Medications- Prior Authorization required • Hair Growth- Prior Authorization required

Your Rights to Continue Coverage:

For more information on your rights to continue coverage upon termination of benefits, contact your health benefits coordinator at 732-262-1055. You may also contact your state insurance department, US Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877-267-2323 or www.cciio.cms.gov

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the plan sponsor at 866-834-0022.