

Coverage

Your prescription program covers most Medically Necessary, Federal Legend, State Restricted and Compounded Medications which by law may not be dispensed without a prescription. Your pharmacist has online access to see which medications are covered under the benefit guidelines of your program. Alternatively, you can contact Member Services with questions about coverage details. Prescription medication programs do not cover any over-the-counter medications, medical supplies or devices even if purchased at a pharmacy, and even if a prescription order is written. Prior authorization may be required before dispensing certain medications. Your program covers certain diabetic supplies, including insulin. Dispensing of male sexual dysfunction medications is limited to four tablets or six injections per month based on prior approval and appropriate medical diagnosis of non-psychological impotence.

Exclusions

A summary of the exclusions are as follows:

- Medications which do not require a prescription order, even if one is written.
- Medications which are not considered medically necessary for the care and treatment of an injury or sickness.
- Medications which are considered "off-label use" as they are not prescribed in accordance with FDA-approved utilization or are prescribed or dispensed in a manner contrary to normal medical practices.
- Medications administered by a physician or prescriber and those not dispensed at a pharmacy, including medications you receive at your doctor's office, in a hospital, clinic or other care facility.
- Medications for which the cost is recoverable under a government program, Workers' Compensation, occupational disease law, or medications for which no charge is made to you.
- Immunologicals, vaccines, allergy sera, biological sera, blood plasma and charges for the administration or injection of medications.
- Any medication labeled for "Investigational Use" or as experimental.

Therapeutic Categories of medications excluded from your program include:

- Medications prescribed for cosmetic purposes, unless deemed medically necessary
- Growth hormones, unless Prior Authorized
- Legend vitamins, except children's and prenatal
- Weight control
- Smoking cessation or deterrence
- Needles, syringes and injection devices, except with insulin
- Male sexual dysfunction medications are covered with restrictions

This brochure is only a general description of your prescription benefit program and it is not a contract. All benefits described herein are subject to the terms, conditions and limitations of the group master contract and applicable law. All personal health information is kept strictly confidential, as required by the privacy rules of the Health Insurance Portability and Accountability Act.

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7/1/2010

Haddon Township Board of Education

Client ID#: 3233 Group #: 1000 - 1100

Your Co-Payment Schedule

Retail:

- \$10 for a Generic Equivalent Medication
- \$20 for a Brand Name Medication

Mail order:

- \$10 for a Generic Equivalent Medication
- \$20 for a Brand Name Medication



Benecard Member Services

1-877-723-6005

TDD: 1-888-907-0020

24 hours a day, 7 days a week



Benecard SM
Prescription Benefit Facilitator

www.benecardnhi.com

Retail Program

Your ID card provides all the information your pharmacist will need to process your prescription through Benecard PBF.

Your retail co-payment amount will be:

- \$10 for a Generic Equivalent Medication
- \$20 for a Brand Name Medication

You will only pay the actual cost of your prescription if it is less than your co-payment amount. Retail quantities will be dispensed according to the prescription order written by your physician up to a maximum of a 90-day supply; however 1 co-payment will apply per each 30 day supply.

Discounts For Non-Covered Medications

Be sure to present your Benecard PBF ID card at a participating network pharmacy to receive a discount off the retail price of medications that may not be covered under the guidelines of your prescription benefit program.

Pharmacy Network

Your Benecard PBF prescription benefit program provides you with access to an extensive national pharmacy network. To locate a participating pharmacy, visit www.benecardpbf.com or call Benecard Member Services toll-free at 1-877-723-6005 (TDD: 1-888-907-0020).

Direct Reimbursement

If you must pay out-of-pocket for the full price of your medication that should have been covered under the program, manually submit a Direct Member Reimbursement Form, available from your Benefits Office or online at www.benecardpbf.com. You will need to provide an itemized receipt showing: the amount charged, prescription number, name of medication dispensed, manufacturer, dosage form, strength, quantity, and date dispensed. Your pharmacist can assist you if you do not have a detailed receipt. Direct reimbursement is based upon the coverage outlined herein and is reimbursable at the same rate that would have been reimbursed to the pharmacy, less any applicable co-payment amount. This amount may be significantly lower than the retail price you paid; therefore, it is advised that you use a participating network pharmacy to reduce your out-of-pocket costs.

Mail Service Pharmacy

You may wish to consider the convenience and savings offered by Benecard PBF's mail service pharmacy, Benecard Central Fill, if you take maintenance type medications on a long-term basis. Information on how to take advantage of this service is included and available from your Benefits Office or online at www.benecardpbf.com. Up to a 90-day supply may be obtained on a non-emergency basis through mail order. The medication can be shipped directly to your home.

Your mail order co-payment amount required at the time you place your order, will be:

- \$10 for a Generic Equivalent Medication
- \$20 for a Brand Name Medication

Specialty Medications

Specialty pharmaceuticals are typically produced through biotechnology, administered by injection, and/or require special handling and patient monitoring. If your doctor has prescribed a specialty medication, submit your prescription to Benecard Central Fill or your local retail pharmacy. Specialty medications are subject to your program's retail co-payment and at a limited day supply.

Save With Generics

Generic equivalent medications must meet the same Food and Drug Administration (FDA) standards for purity, strength and safety as brand name medications. They also must have the same active ingredients and identical absorption rate within the body as the brand name version. If you wish to take advantage of this savings opportunity, you should ask your physician to prescribe your medication either generically or as a brand with substitutions permissible. You may also consult with your pharmacist regarding generic medication options that may be available to you.

Eligibility

Your Benefits Office determines who is eligible for benefits under Haddon Township Board of Education prescription benefit program. Eligible dependents may include your spouse or civil union partner and unmarried children who are dependent upon you. Coverage for a dependent will end:

- when your coverage ends,
- on the last day of the benefit month in which the dependent fails to meet the definition of a dependent,
- or, when an unmarried child reaches the last day of the calendar year in which they turn 23, unless dependent qualifies as an overage dependent, NJ only.

You should notify your Benefits Office at 1-856-869-7750, ext. 1107 regarding any eligibility change such as adding or removing a dependent, address or name changes, or other family status change.

ID Cards

If your ID card is lost or you need a duplicate card, promptly notify your Benefits Office to have a new ID card issued. If there is an emergency, and you need a prescription filled, call Benecard PBF Member Service toll-free at 1-877-723-6005 (TDD: 1-888-907-0020) and they will provide your pharmacist with the required information to facilitate processing the claim.

Member Resources at www.benecardpbf.com

Maximize your benefit with our online member resource tools including the network pharmacy finder, mail service, your plan coverage details, comparison pricing tool, as well as view recent personal medication utilization history, including what you have paid and what the plan has paid on your behalf.



Enrollment Form

TODAY'S DATE: _____

CLIENT INFORMATION

HADDON TOWNSHIP BOARD OF EDUCATION

PLAN #3233

CLIENT NAME (PLAN SPONSOR / EMPLOYER)

CLIENT #

GROUP #

CARDMEMBER INFORMATION

FIRST NAME MI LAST NAME ID # SSN#

MAILING ADDRESS CITY STATE ZIP CODE

PHONE NUMBER CELL PHONE EMAIL

COVERAGE TYPE

PLEASE CHECK ONE:

- SINGLE
- CARDMEMBER/SPOUSE
- CARDMEMBER/CHILD
- CARDMEMBER/CHILDREN
- FAMILY

EFFECTIVE DATE: _____

REASON CODE

A	NEW ENROLLMENT
B	REINSTATE MEMBER
C	REINSTATE DEPENDENT / SPOUSE
D	ADD DEPENDENT / SPOUSE
E	TERMINATE COVERAGE
F	TERMINATE DEPENDENT COVERAGE
G	NAME CHANGE
H	ADDRESS CHANGE
I	GROUP CHANGE: FROM _____ TO _____

J	RDS ENROLLMENT, APPLICATION NUMBER IF APPLICABLE: _____
K	ISSUE CARD
L	DO NOT ISSUE ID CARD
M	COBRA ENROLLMENT
N	COBRA TERMINATION
O	STUDENT STATUS UPDATE
P	DISABLED DEPENDENT
Q	OVERAGE DEPENDENT**
R	DEPENDENT ADDRESS DIFFERS FROM CARDMEMBER (INCLUDE ON BACK)

ELIGIBILITY

	LAST NAME	FIRST NAME	MI	GENDER	BIRTHDATE	SSN	HICN	REASON CODES
CARDMEMBER								
02 SPOUSE								
EMAIL/PHONE*								
03 DEPENDENT								
EMAIL/PHONE*								
04 DEPENDENT								
EMAIL/PHONE*								
05 DEPENDENT								
EMAIL/PHONE*								
06 DEPENDENT								
EMAIL/PHONE*								
07 DEPENDENT								
EMAIL/PHONE*								
08 DEPENDENT								
EMAIL/PHONE*								

OPTIONAL, ONLY IF DIFFERENT FROM CARDMEMBER

COORDINATION OF BENEFITS

SECONDARY COVERAGE ID NUMBER INSURANCE COMPANY POLICY / GROUP#

EMPLOYER/PLAN SPONSOR EFFECTIVE DATE

SIGNATURES

CARDMEMBER SIGNATURE CLIENT SIGNATURE

FOR INTERNAL USE ONLY:	DATE ENTERED _____	ENTERED BY _____	LOGGED BY _____
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Back of Enrollment Form

Dependent Address (1)
(if differs from cardmember)

FIRST NAME	MI	LAST NAME	ID #	SSN
MAILING ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER	CELL PHONE		EMAIL	

Dependent Address (2)
(if differs from cardmember)

FIRST NAME	MI	LAST NAME	ID #	SSN
MAILING ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER	CELL PHONE		EMAIL	

Dependent Address (3)
(if differs from cardmember)

FIRST NAME	MI	LAST NAME	ID #	SSN
MAILING ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER	CELL PHONE		EMAIL	

Dependent Address (4)
(if differs from cardmember)

FIRST NAME	MI	LAST NAME	ID #	SSN
MAILING ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER	CELL PHONE		EMAIL	

Dependent Address (5)
(if differs from cardmember)

FIRST NAME	MI	LAST NAME	ID #	SSN
MAILING ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER	CELL PHONE		EMAIL	