Long Branch Board of Education

REIMBURSEMENT CLAIM FORM INSTRUCTIONS

The Board of Education has established a supplemental fund to indemnify and reimburse staff members for out-of-pocket expenses where their SEHBP (Horizon) benefit cost share is greater than was the case with Aetna Integrity Health. The parameters of such fund are as follows:

a. The fund will be administered by Gallagher, who will advise the Board's Business Administrator twice monthly on the dollar amount due to eligible employees.

b. No reimbursement will exceed the reimbursement that would have been paid by the prior Aetna Integrity Health Plan.

c. Reimbursement claim forms should be emailed, or mailed to:

   GALLAGHER
   Natalie Fenton
   707 State Road,
   Princeton, NJ 08540
   Natalie_Fenton@aig.com

   Documentation cannot be transmitted to the Board of Education or Personnel Department in order to preserve Protected Health Information (PHI) as defined by HIPAA

d. The fund will be open for dates of service 7/1/22 through 6/30/23, with an additional 6 months beyond 6/30/23 for employees to submit the required documentation to Gallagher, with a final submission deadline of 12/31/23.

e. Employees may appeal an adverse determination by Gallagher to the Board's Business Administrator but would first be required to complete a waiver allowing the Board's Business Administrator to receive and archive their PHI.

Long Branch Board of Education

REIMBURSEMENT CLAIM FORM

For reimbursement for out-of-pocket expenses where your SEHBP (Horizon) benefit cost share (copay, coinsurance, deductible, maximum out-of-pocket) is greater than was with Aetna Integrity Health. Form final submission date is 12/31/23.

Employee Information

Name _____ Telephone _____

Home Address _____ Email _____

_____

Patient _____

Provider Information

Name _____

Address _____

_____

Date(s) of Service _____

Required reimbursement information

I am applying for reimbursement of the following amount: _____

The following documentation must be submitted with this form in order to be considered for reimbursement (please retain originals for your records):

1. **Explanation of Benefits (EOB) from SEHBP (Horizon)**
   Date of service must be between 7/1/22 through 6/30/23

2. **Detailed provider invoice, inclusive of date of service, CPT/treatment code and ICD/Diagnosis code for all services**
   Date of service must be between 7/1/22 through 6/30/23

3. **Proof of payment via bank account statement, credit card statement, or vendor/provider receipt**
   Date of service must be between 7/1/22 through 6/30/23

Long Branch Board of Education

REIMBURSEMENT CLAIM FORM p.2

Certification of employee

I hereby certify that:

a. The full amount of this claim is owed to me, and
b. I have not received, and am not eligible to receive, any type of reimbursement or payment other than the amount shown in the attached documents (if any).

I certify that the foregoing statements are true. I am aware that if any forgoing statements made by me are willfully false, I am subject to punishment.

_____ _____

Signature of Employee Date

Long Branch Board of Education
Medical Plan Comparison
Integrity 10 v. SEHBP Direct 10

	Integrity 10		SEHBP Direct Access 10	
	In-Network	Non-Network	In-Network	Non-Network
Annual Deductible				
Individual	$0	$100	$0	$100
Family	$0	$250	$0	$250
Coinsurance	100%; 90% on select services	80% of R&C [1]	100%; 90% on select services	80% of R&C[1]
Annual Out of Pocket Maximum (Includes Coinsurance and Copays)				
Individual	$400	$2,000	$400	$2,000
Family	$1,000	$5,000	$1,000	$5,000
Lifetime Maximum	Unlimited		Unlimited	
Hospital Inpatient Services (room and board; physician visits)	100%	80% after deductible	100%	80% after deductible
Emergency Room	100% after $50 copay waived if admitted	100% after $50 copay waived if admitted	100% after $25 copay waived if admitted	100% after $25 copay waived if admitted
Ambulance	90%; non-emergency condition excluded	90%; non-emergency condition excluded	90%; non-emergency condition excluded	80% after deductible; non-emergency condition excluded
Radiation/Chemotherapy Outpatient	100%	80% after deductible	100%	80% after deductible
X-Ray and Lab Tests	100%	80% after deductible	100%	80% after deductible
Home Health Care	100%	80% after deductible	100%	80% after deductible
	Unlimited		Requires Pre-approval	
Skilled Nursing Facility	100%	80% after deductible	100%	80% after deductible
	120 days per calendar year combined		120 days per calendar year combined	
Private Duty Nursing (outpatient)	90%	80% after deductible	90%	80% after deductible
Hospice	100%	80% after deductible	100%	80% after deductible
	10 days (lifetime max)		Requires Pre-approval	
Surgery/Anesthesia	100%	80% after deductible	100%	80% after deductible
Physician Office Visits [2]	$10 Copay (PCP) $10 Copay (Specialist)	80% after deductible	$10 Copay (PCP) $10 Copay (Specialist)	80% after deductible
Annual Physical Exams	100%	Not Covered	100%	Not Covered
Annual Well Child Care	100%	Not Covered	100%	Not Covered
Immunizations (except if travel or job related)	100%	Not Covered; Well Child immunizations: 80% after deductible (up to age 1)	100%	Not Covered; Well Child immunizations: 80% after deductible (up to age 1)
Annual OB-Gyn Exam	100%	80% after deductible	100%	80% after deductible
Annual Mammogram (baseline and women over age 40)	100%	80% after deductible	100%	80% after deductible
Annual Prostate screening (men over 50)	100%	Not Covered	100%	Not Covered

Long Branch Board of Education
Medical Plan Comparison
Integrity 10 v. SEHBP Direct 10

	Integrity 10		SEHBP Direct Access 10	
	In-Network	Non-Network	In-Network	Non-Network
Maternity (including pre-natal)	$10 copay for 1st prenatal visit, then 100%	80% after deductible	$10 copay for 1st prenatal visit, then 100%	80% after deductible
Infertility services	$10 copay	80% after deductible	$10 copay	80% after deductible
	Subject to limitations set by NJ Mandates		Subject to limitations set by NJ Mandates	
Allergy Testing and Treatment	$10 copay	80% after deductible	$10 copay	80% after deductible
Acupuncture	$10 copay	80% after deductible	$10 copay	80% after deductible, limited to $60/visit
Chiropractic Care	$10 copay	80% after deductible	$10 copay	80% after deductible, limited to $35/visit
	30 visits per calendar year		30 visits per calendar year	
Short Term Therapies (Physical, Cognitive, Occupational, Respiratory, Speech)	$10 copay	80% after deductible	$10 copay	80% after deductible, limited to $52/visit
	Unlimited		Unlimited	
Other Therapies (Chelation, dialysis, Infusion)	100%	80% after deductible	100%	80% after deductible
	Unlimited		Unlimited	
Hearing Aids	100%	80% after deductible	100%	80% after deductible
	One hearing aid for each impaired ear once in a 24-month period, only for members are 19 or younger		One hearing aid for each impaired ear once in a 24-month period, only for members are 15 or younger	
Durable Medical Equipment/Medical Supplies	90%	80% after deductible	90%	80% after deductible
Prosthetics and Orthotics	100%	80% after deductible	90%	80% after deductible
Inpatient Mental Illness/Substance Abuse/Alcohol Treatment [3]	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
Outpatient Mental Illness/Substance Abuse/Alcohol Treatment[3]	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
Routine Vision Exam	$10 copay (one annual exam/year)	Not Covered	$10 copay (one annual exam/year)	Not Covered
Vision Hardware	Covered under Standalone Vision Plan		Not Covered	
Child Dependent Termination age	Children covered to End of Year they turn age 26		Children covered to End of Year they turn age 26	

Comparison is for illustrative purposes only. Written plan documents will supersede any errors on this illustration.

1 Out-of-Network providers may bill you for difference between the carrier's Reasonable and Customary (R&C) limit and the provider's actual charges. This amount may be significant. It is important to note that all percentages for out-of-network services are percentages of the carrier's R&C, not the provider's actual charge. You are responsible for any charges in excess of R&C. R&C is 90th percentile of FAIR Health for Integrity 10 and SEHBP Direct 10 plans.

2 Copayments apply to in-network primary care and specialist office visits unless otherwise indicated visit limits.

Long Branch Board of Education
Medical Plan Comparison
Integrity 15 v. SEHBP Direct 15

	Integrity 15		SEHBP Direct Access 15	
	In-Network	Non-Network	In-Network	Non-Network
Annual Deductible				
Individual	$0	$100	$0	$100
Family	$0	$250	$0	$250
Coinsurance	100%; 90% on select services	70% of R&C [1]	100%; 90% on select services	70% of R&C[1]
Annual Out of Pocket Coinsurance Maximum (Includes coinsurance)				
Individual	$400	$2,000	$400	$2,000
Family	$1,000	$5,000	$1,000	$5,000
Overall Annual Out of Pocket Maximum (Includes copay, coinsurance, and deductible)				
Individual	$5,280	$2,000	$6,960	$2,000
Family	$10,560	$5,000	$13,920	$5,000
Lifetime Maximum	Unlimited		Unlimited	
Hospital Inpatient Services (room and board; physician visits)	100%	70% after deductible	100%	70% after deductible
Emergency Room	100% after $50 copay waived if admitted	100% after $50 copay waived if admitted	100% after $50 copay waived if admitted	100% after $50 copay waived if admitted
Ambulance	90%; non-emergency condition excluded	90%; non-emergency condition excluded	90%; non-emergency condition excluded	70%; non-emergency condition excluded
Radiation/Chemotherapy Outpatient	100%	70% after deductible	100%	70% after deductible
X-Ray and Lab Tests	100%	70% after deductible	100%	70% after deductible
Home Health Care	100%	70% after deductible	100%	70% after deductible
	Unlimited		Requires Pre-approval	
Skilled Nursing Facility	100%	70% after deductible	100%	70% after deductible
	120 days per calendar year combined		120 days per calendar year	
Private Duty Nursing (outpatient)	90%	70% after deductible	90%	70% after deductible
Hospice	100%	70% after deductible	100%	70% after deductible
	10 days (lifetime max)		Requires Pre-approval	
Surgery/Anesthesia	100%	70% after deductible	100%	70% after deductible
Physician Office Visits [2]	$15 Copay (PCP) $15 Copay (Specialist)	70% after deductible	$15 Copay (PCP) $15 Copay (Specialist)	70% after deductible
Annual Physical Exams	100%	Not Covered	100%	Not Covered
Annual Well Child Care	100%	Not Covered	100%	Not Covered
Immunizations (except if travel or job related)	100%	Not Covered; Well Child immunizations: 70% after deductible (up to age 1)	100%	Not Covered; Well Child immunizations: 70% after deductible (up to age 1)
Annual OB-Gyn Exam	100%	70% after deductible	100%	70% after deductible
Annual Mammogram (baseline and women over age 40)	100%	70% after deductible	100%	70% after deductible
Annual Prostate screening (men over 50)	100%	Not Covered	100%	Not Covered

Long Branch Board of Education
Medical Plan Comparison
Integrity 15 v. SEHBP Direct 15

	Integrity 15		SEHBP Direct Access 15	
	In-Network	Non-Network	In-Network	Non-Network
Maternity (including pre-natal)	$15 copay for 1st prenatal visit, then 100%	70% after deductible	$15 copay for 1st prenatal visit, then 100%	70% after deductible
Infertility services	$15 copay	70% after deductible	$15 copay	70% after deductible
	Subject to limitations set by NJ Mandates		Subject to limitations set by NJ Mandates	
Allergy Testing and Treatment	$15 copay	70% after deductible	$15 copay	70% after deductible
Acupuncture	$15 copay	70% after deductible	$15 copay	70% after deductible, limited to $60/visit
Chiropractic Care	$15 copay	70% after deductible	$15 copay	70% after deductible, limited to $35/visit
	30 visits per calendar year		30 visits per calendar year	
Short Term Therapies (Physical, Cognitive, Occupational, Respiratory, Speech)	$15 copay	70% after deductible	$15 copay	70% after deductible, limited to $52/visit
	Unlimited		Unlimited	
Other Therapies (Chelation, dialysis, Infusion)	100%	70% after deductible	100%	70% after deductible
	Unlimited		Unlimited	
Hearing Aids	100%	70% after deductible	100%	70% after deductible
	One hearing aid for each impaired ear once in a 24-month period, only for members are 19 or younger		One hearing aid for each impaired ear once in a 24-month period, only for members are 15 or younger	
Durable Medical Equipment/Medical Supplies	90%	70% after deductible	90%	70% after deductible
Prosthetics and Orthotics	100%	70% after deductible	90%	70% after deductible
Inpatient Mental Illness/Substance Abuse/Alcohol Treatment [3]	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
Outpatient Mental Illness/Substance Abuse/Alcohol Treatment[3]	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
Routine Vision Exam	$10 copay	Not Covered	$15 copay (one annual exam/year)	Not Covered
Vision Hardware	Covered under Standalone Vision Plan		Not Covered	
Child Dependent Termination age	Children covered to End of Year they turn age 26		Children covered to End of Year they turn age 26	

Comparison is for illustrative purposes only. Written plan documents will supersede any errors on this illustration.

1 Out-of-Network providers may bill you for difference between the carrier's Reasonable and Customary (R&C) limit and the provider's actual charges. This amount may be significant. It is important to note that all percentages for out-of-network services are percentages of the carrier's R&C, not the provider's actual charge. You are responsible for any charges in excess of R&C. R&C is 90th percentile of FAIR Health for Integrity 15 and SEHBP Direct 15 plans.

2 Copayments apply to in-network primary care and specialist office visits unless otherwise indicated

visit limits.

Long Branch Board of Education
Medical Plan Comparison
Integrity Educator Health Plan (EHP) v. SEHBP Educator Health Plan (EHP)

	Integrity Educator Health Plan (EHP)		SEHBP Educator Health Plan (EHP)	
	In-Network	Non-Network	In-Network	Non-Network
Annual Deductible Individual Family	 $0 $0	 $350 $700	 $0 $0	 $350 $700
Coinsurance	100%; 90% on select services	70% of R&C [1]	100%; 90% on select services	70% of R&C [1]
Annual Out of Pocket Coinsurance Maximum (Includes coinsurance) Individual Family	 $500 $1,000	 $2,000 $5,000	 $500 $1,000	 $2,000 $5,000
Overall Annual Out of Pocket Maximum (Includes copay, coinsurance, and deductible) Individual Family	 $500 $1,000	 $2,000 $5,000	 $500 $1,000	 $2,000 $5,000
Lifetime Maximum	Unlimited		Unlimited	
Hospital Inpatient Services (room and board; physician visits)	100%	70% after deductible	100%	70% after deductible
Emergency Room	100% after $125 copay waived if admitted	100% after $125 copay waived if admitted	100% after $125 copay waived if admitted	100% after $125 copay waived if admitted
Ambulance	90%	70% after deductible	90%; non-emergency condition excluded	70% after deductible; non-emergency condition excluded
Radiation/Chemotherapy Outpatient	100%	70% after deductible	100%	70% after deductible
X-Ray and Lab Tests	100%	70% after deductible	100%	70% after deductible
Home Health Care	100%	70% after deductible	100%	70% after deductible
	Unlimited		Requires Pre-approval	
Skilled Nursing Facility	100%	70% after deductible	100%	70% after deductible
	120 days per calendar year combined		120 days per calendar year combined	
Private Duty Nursing (outpatient)	90%	Not Covered	90%	70% after deductible
Hospice	100%	70% after deductible	100%	70% after deductible
	Requires Pre-approval		Requires Pre-approval	
Surgery/Anesthesia	100%	70% after deductible	100%	70% after deductible
Physician Office Visits [2]	$10 Copay (PCP) $15 Copay (Specialist)	70% after deductible	$10 Copay (PCP) $15 Copay (Specialist)	70% after deductible
Annual Physical Exams	100%	Not Covered	100%	Not Covered
Annual Well Child Care	100%	Not Covered	100%	Not Covered
Immunizations (except if travel or job related)	100%	Not Covered; Well Child immunizations: 70% after deductible (up to age 1)	100%	Not Covered; Well Child immunizations: 70% after deductible (up to age 1)
Annual OB-Gyn Exam	100%	70% after deductible	100%	70% after deductible
Annual Mammogram (baseline and women over age 40)	100%	70% after deductible	100%	70% after deductible
Annual Prostate screening (men over 50)	100%	Not Covered	100%	Not Covered

Long Branch Board of Education
Medical Plan Comparison
Integrity Educator Health Plan (EHP) v. SEHBP Educator Health Plan (EHP)

	Integrity Educator Health Plan (EHP)		SEHBP Educator Health Plan (EHP)	
	In-Network	Non-Network	In-Network	Non-Network
Maternity (including pre-natal)	$15 copay for 1st prenatal visit, then 100%	70% after deductible	$15 copay for 1st prenatal visit, then 100%	70% after deductible
Infertility services	$15 copay	70% after deductible	$15 copay	70% after deductible
	Subject to limitations set by NJ Mandates		Subject to limitations set by NJ Mandates	
Allergy Testing and Treatment	$15 copay	70% after deductible	$15 copay	70% after deductible
Acupuncture	$15 copay	Lesser of $60 or 75% of negotiated charge	$15 copay	70% after deductible, limited to $60/visit
Chiropractic Care	$15 copay	Lesser of $35 or 75% of negotiated charge	$15 copay	70% after deductible, limited to $35/visit
	30 visits per calendar year		30 visits per calendar year	
Short Term Therapies (Physical, Cognitive, Occupational, Respiratory, Speech)	$15 copay	Lesser of $52 or 75% of negotiated charge	$15 copay	70% after deductible, limited to $52/visit
	Unlimited		Unlimited	
Other Therapies (Chelation, dialysis, Infusion)	100%	70% after deductible	100%	70% after deductible
	Unlimited		Unlimited	
Hearing Aids	100%	70% after deductible	100%	70% after deductible
	One hearing aid for each impaired ear once in a 24-month period, only for members are 15 or younger		One hearing aid for each impaired ear once in a 24-month period, only for members are 15 or younger	
Durable Medical Equipment/Medical Supplies	90%	70% after deductible	90%	70% after deductible
Prosthetics and Orthotics	$15 copay	70% after deductible	90%	70% after deductible
Inpatient Mental Illness/Substance Abuse/Alcohol Treatment [3]	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
Outpatient Mental Illness/Substance Abuse/Alcohol Treatment[3]	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
Routine Vision Exam	$15 copay (one annual exam/year)	Not Covered	$15 copay (one annual exam/year)	Not Covered
Vision Hardware	Not Covered		Not Covered	
Child Dependent Termination age	Children covered to End of Year they turn age 26		Children covered to End of Year they turn age 26	

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1 Out-of-Network providers may bill you for difference between the carrier's Reasonable and Customary (R&C) limit and the provider's actual charges. This amount may be significant. It is important to note that all percentages for out-of-network services are percentages of the carrier's R&C, not the provider's actual charge. You are responsible for any charges in excess of R&C. R&C is 200% CMS for Integrity EHP and SEHBP EHP plans.

2 Copayments apply to in-network primary care and specialist office visits unless otherwise indicated

visit limits.