

# SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

## COMPARISON OF PLANS

| COST | ACTIVE EMPLOYEES         | **                                      |                                         |                                             |
|------|--------------------------|-----------------------------------------|-----------------------------------------|---------------------------------------------|
|      |                          | Direct 10                               | Direct 15                               | NJEHP                                       |
|      | Employee Premium Sharing | Chapter 78 or locally negotiated amount | Chapter 78 or locally negotiated amount | Percent of salary (see chart on other side) |

| IN-NETWORK | NETWORK: National network – NOT limited to NJ doctors and facilities |               |                               |               |
|------------|----------------------------------------------------------------------|---------------|-------------------------------|---------------|
|            | Deductible (Single/Family)                                           | None          | None                          | None          |
|            | In-Network Coinsurance                                               | 10%           | 10%                           | 10%           |
|            | Primary Care Physician Copayment                                     | \$10          | \$15                          | \$10          |
|            | Specialist Copayment                                                 | \$10          | \$15                          | \$15          |
|            | Emergency Room Copayment                                             | \$25          | \$50                          | \$125         |
|            | Total In-Network Coinsurance and Copayment Maximum (Single/Family)   | \$400/\$1,000 | \$6,520/\$13,040 <sup>1</sup> | \$500/\$1,000 |
|            | Inpatient Hospitalization                                            | No charge     | No charge                     | No charge     |

| OUT-OF-NETWORK | Deductible (Single/Family)                                  | \$100/\$250                     | \$100/\$250                     | \$350/\$700                   |
|----------------|-------------------------------------------------------------|---------------------------------|---------------------------------|-------------------------------|
|                | Out-of-Network Coinsurance                                  | 20%                             | 30%                             | 30%                           |
|                | Total Out-of-Network, Out-of-Pocket Maximum (Single/Family) | \$2,000/\$5,000                 | \$2,000/\$5,000                 | \$2,000/\$5,000               |
|                | Inpatient Hospitalization                                   | No charge                       | No charge                       | No charge                     |
|                | Maximum Provider Reimbursement (Reasonable and Customary)   | 90% of Fair Health <sup>2</sup> | 90% of Fair Health <sup>2</sup> | 200% of Medicare <sup>2</sup> |

| PRESCRIPTION DRUG | Retail – Generic                       | \$3  | \$3  | \$5                                     |
|-------------------|----------------------------------------|------|------|-----------------------------------------|
|                   | Retail – Brand w/ No Generic Available | \$10 | \$10 | \$10                                    |
|                   | Retail – Brand w/ Generic Available    | \$10 | \$10 | Member pays the difference <sup>3</sup> |
|                   | Mail – Generic                         | \$5  | \$5  | \$10                                    |
|                   | Mail – Brand w/ No Generic Available   | \$15 | \$15 | \$20                                    |
|                   | Mail – Brand w/ Generic Equivalent     | \$15 | \$15 | Member pays the difference <sup>3</sup> |

<sup>1</sup> Coinsurance is capped at \$400/\$1,000 (Single/Family)

<sup>2</sup> In many instances, 200% of Medicare produces lower payment to providers than 90% of Fair Health. This can result in a larger balance billing liability for the patient when utilizing out-of-network services. When a provider bills more than the maximum reimbursement, the member is responsible for 100% of the difference between the billed amount and the maximum reimbursement. Chiropractic, acupuncture, and physical therapy have a different fee schedule that will apply equally to all plans. Chiropractic: \$35/visit or 75% of the in-network cost per visit, whichever is less. Acupuncture \$60/visit or 75% of the in-network cost per visit, whichever is less. Physical therapy: in-network cost per visit. Currently \$52.

<sup>3</sup> The prescription drug plan will be OptumRx Premium Formulary, which directs prescriptions to more cost-effective, clinically equivalent medications. For brand-name drugs with generic equivalents available, the plan will pay the cost of the generic equivalent. Members who choose to fill the prescription with the brand-name drug will be responsible for the difference in the cost of the prescription. A medical appeal process is available.



## LOCAL EDUCATION ACTIVE GROUP MEDICAL PLAN DESIGN - PLAN YEAR 2021 HORIZON PLANS - MEDICAL COST SHARING

|                                                             | NJ DIRECT10                                                | NJ DIRECT15                                                | NEW JERSEY<br>EDUCATORS<br>HEALTH PLAN                     |
|-------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------|
| <b>Medical Cost Sharing</b>                                 |                                                            |                                                            |                                                            |
| Primary Care Copayment                                      | \$10                                                       | \$15                                                       | \$10                                                       |
| Specialist Care Copayment                                   | \$10                                                       | \$15                                                       | \$15                                                       |
| Emergency Room Copayment                                    | \$25                                                       | \$50                                                       | \$125                                                      |
| In-Network Deductible                                       |                                                            |                                                            |                                                            |
| In-Network Coinsurance                                      | 10% <sup>1</sup>                                           | 10% <sup>1</sup>                                           | 10% <sup>1</sup>                                           |
| In-Network Coinsurance<br>Maximum (Individual/Family)       |                                                            | \$400/\$1,000                                              |                                                            |
| In-Network Out-of-Pocket<br>Maximum (Individual/Family)     | \$400/\$1,000                                              | \$6,840/\$13,680                                           | \$500/\$1,000                                              |
| Out-of-Network Deductible<br>(Individual/Family)            | \$100/\$250                                                | \$100/\$250                                                | \$350/\$700                                                |
| Out-of-Network Coinsurance <sup>2</sup>                     | 20%                                                        | 30%                                                        | 30% <sup>3</sup>                                           |
| Out-of-Network Out-of-Pocket<br>Maximum (Individual/Family) | \$2,000/\$5,000                                            | \$2,000/\$5,000                                            | \$2,000/\$5,000                                            |
| Out-of-Network In Patient<br>Hospital Deductible            | Out-of-Network<br>Deductible applies<br>(see above)        | Out-of-Network<br>Deductible applies<br>(see above)        | Out-of-Network<br>Deductible applies<br>(see above)        |
| Out-of-Network Chiropractic<br>Services                     | Lesser of \$35/visit or<br>75% of In-Network<br>cost/visit | Lesser of \$35/visit or<br>75% of In-Network<br>cost/visit | Lesser of \$35/visit or<br>75% of In-Network<br>cost/visit |
| Out-of-Network Acupuncture<br>Services                      | Lesser of \$60/visit or<br>75% of In-Network<br>cost/visit | Lesser of \$60/visit or<br>75% of In-Network<br>cost/visit | Lesser of \$60/visit or<br>75% of In-Network<br>cost/visit |
| Out-of-Network Physical Therapy<br>Services                 | Lesser of \$52/visit or<br>75% of In-Network<br>cost/visit | Lesser of \$52/visit or<br>75% of In-Network<br>cost/visit | Lesser of \$52/visit or<br>75% of In-Network<br>cost/visit |

<sup>1</sup> On Select Services

<sup>2</sup> After Deductible

<sup>3</sup> Out of Network Allowance is 200% of CMS Fee Schedule



## LOCAL EDUCATION ACTIVE GROUP MEDICAL PLAN DESIGN - PLAN YEAR 2021 HORIZON PLANS - MEDICAL COST SHARING

|                                                                    | NJ DIRECT10     | NJ DIRECT15     | NEW JERSEY<br>EDUCATORS<br>HEALTH PLAN |
|--------------------------------------------------------------------|-----------------|-----------------|----------------------------------------|
| <b>Prescription Drug Copayments*</b>                               |                 |                 |                                        |
| Retail: Generic Copayments                                         | \$3             | \$3             | \$5                                    |
| Retail: Preferred Brand Copayments                                 | \$10            | \$10            | \$10                                   |
| Retail: Non-Preferred Brand Copayments                             | \$10            | \$10            | Member pays difference <sup>4</sup>    |
| Mail: Generic Copayments                                           | \$5             | \$5             | \$10                                   |
| Mail: Preferred Brand Copayments                                   | \$15            | \$15            | \$20                                   |
| Mail: Non-Preferred Brand Copayments                               | \$15            | \$15            | Member pays difference <sup>4</sup>    |
| Prescription Drug annual Out-of-Pocket Maximum (Individual/Family) | \$1,710/\$3,420 | \$1,710/\$3,420 | \$1,600/\$3,200                        |

**Note:** Retail – 30 day supply. Mail – 90 day supply. Oral contraceptive coverage is available under the medical and prescription plans.

\* Local education employers can select from the SEHBP's Prescription Drug Plans, purchase their own prescription drug coverage plan, or receive prescription drug coverage through the SEHBP medical plan. Copayments shown apply to the plans when coverage is through the SEHBP's Prescription Drug Plans. If prescription drug coverage is through the medical plan: for NJ DIRECT10 and NJ DIRECT15, coinsurance is 10%; for NJEHP, copays are the same as if coverage is through the SEHBP's Prescription Drug Plan as shown in the chart above.

<sup>4</sup> You pay the applicable brand copayment as listed above, plus the cost difference between the brand drug and the generic drug.

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