Readington Township Board of Education
AmeriHealth Medical Plan Designs - Plan Year 2020

	PPO $10, 10% MMRx	PPO $15, 10% MMRx	PPO $15/$25, 15% MMRx	PPO $15/$25, $7/$16/$35 Rx	PPO $20/$20, 15% MMRx	PPO $20/$35, 20% MMRx	HMO $10, $5/$10/$20 Rx [5]	HMO $20, $3/$18/$46 Rx [5]	HMO $20/$35, $7/$21 Rx [5]
MONTHLY PREMIUM INCLUSIVE OF RX:**									
Single	$ 1,033.00	$ 975.09	$ 943.65	$ 946.96	$ 894.03	$ 771.16	$ 1,026.36	$ 907.71	$ 790.63
Parent/Child(ren)	$ 1,756.10	$ 1,657.71	$ 1,604.18	$ 1,609.85	$ 1,519.85	$ 1,311.00	$ 1,744.83	$ 1,543.12	$ 1,344.09
2 Adult	$ 2,065.96	$ 1,950.23	$ 1,887.27	$ 1,893.94	$ 1,788.05	$ 1,542.32	$ 2,052.77	$ 1,815.42	$ 1,581.26
Family	$ 2,789.07	$ 2,632.80	$ 2,547.82	$ 2,556.82	$ 2,413.86	$ 2,082.15	$ 2,771.21	$ 2,450.84	$ 2,134.70
Composite Rate Difference vs. PPO $10		**-6%**	**-9%**	**-8%**	**-13%**	**-25%**	**-1%**	**-12%**	**-23%**
Medical Cost Sharing									
Primary Care Copayment	$10	$15	$15	$15	$20	$20	$10	$20	$20
Specialist Care Copayment	$10	$15	$25	$25	$20	$35	$10	$20	$35
Emergency Room Copayment	$25	$50	$75	$75	$100	$100	$35	$100	$100
In-Network Deductible (Individual/Family)						$200/$500	No Deductible	No Deductible	$200/$400
In-Network Coinsurance	10% [1]	10% [1]	10% [1]	10% [1]	10% [1]	20% [3]			20% [3]
In-Network Coinsurance Maximum (Individual/Family)		$400/$1,000	$400/$1,000	$400/$1,000	$800/$2,000	$2,000/$5,000			$2,000/$4,000
In-Network Out-of-Pocket Maximum (Individual/Family)	$400/$1,000	$5,280/$10,560	$5,280/$10,560	$5,280/$10,560	$5,280/$10,560	$5,280/$10,560	$5,280/$10,560	$5,280/$10,560	$5,280/$10,560
Out-of-Network Deductible [2] (Individual/Family)	$100/$250	$100/$250	$100/$250	$100/$250	$200/$500	$800/$2,000			
Out-of-Network Coinsurance [2]	20%	30%	30%	30%	30%	40%			
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	$2,000/$5,000	$2,000/$5,000	$2,000/$5,000	$2,000/$5,000	$5,000/$12,500	$6,500/$13,000			
Out-of-Network Inpatient Hospital Deductible			No Deductible	No Deductible	No Deductible	No Deductible			
Prescription Drug Copayments									
Retail (30 day): Generic Copayments	10%	10%	15%	$7.00	15%	20%	$5.00	$3.00	$7.00
Retail (30 day): Preferred Copayments	10%	10%	15%	$16.00	15%	20%	$10.00	$18.00	$21.00
Retail (30 day): Non-Preferred Copayments	10%	10%	15%	$35.00	15%	20%	$20.00	$46.00	member pays difference
Mail (90 day): Generic Copayments	10%	10%	15%	$7.00	15%	20% [4]	$5.00	$3.00	$7.00 [4]
Mail (90 day): Preferred Copayments	10%	10%	15%	$16.00	15%	20% [4]	$10.00	$18.00	$21.00 [4]
Mail (90 day): Non-Preferred Copayments	10%	10%	15%	$35.00	15%	20% [4]	$20.00	$46.00	member pays difference [4]

** Comparison for illustrative purposes only. Written plan document supersedes any errors on this illustration. Final benefits will be subject to "equal to or better than" letter as submitted by AmeriHealth, and subject to State mandates.*

*** Rates effective 7/1/20-6/30/21. Benefit period is Calendar Year (January - December).*

[1] On select services.

[2] After deductible.

[3] Applies to services that do not require a copayment.

[4] For maintenance prescription drugs, mail order is mandatory under the 2035 plan.

[5] Service areas for AmeriHealth HMO plans are limited to New Jersey, Delaware, and 9 bordering PA counties.