Brown & Brown

Readington Township Board of Education
AmeriHealth Medical Plan Designs - Plan Year 2023-2024*
with Educator Health Plan (EHP)** and Garden State Health Plan (GSHP)**

7/1/23-6/30/24	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	EHP, $5/$10/Mbr Rx [7]	HMO $10, $5/$10/$20 Rx [5]	HMO $20, $3/$18/$46 Rx [5]	HMO $20/$35, $7/$21 Rx [5]	GSHP, $5/$10/Mbr Rx [7, 8]
MONTHLY PREMIUM INCLUSIVE OF RX:**											
Single	$ 1,193.97	$ 1,127.01	$ 1,090.65	$ 1,094.47	$ 1,033.29	$ 891.21	$ 1,094.38	$ 1,186.67	$ 1,049.48	$ 914.10	$ 1,083.24
Parent/Child(ren)	$ 2,029.76	$ 1,915.99	$ 1,854.10	$ 1,860.64	$ 1,756.59	$ 1,515.10	$ 1,860.70	$ 2,017.36	$ 1,784.13	$ 1,554.00	$ 1,841.75
2 Adult	$ 2,387.91	$ 2,254.09	$ 2,181.28	$ 2,189.00	$ 2,066.56	$ 1,782.43	$ 2,188.85	$ 2,373.41	$ 2,098.95	$ 1,828.20	$ 2,166.54
Family	$ 3,223.69	$ 3,042.99	$ 2,944.74	$ 2,955.16	$ 2,789.84	$ 2,406.30	$ 2,955.10	$ 3,204.06	$ 2,833.62	$ 2,468.08	$ 2,925.01
Composite Rate Difference vs. PPO $10		**-6%**	**-9%**	**-8%**	**-13%**	**-25%**	**-8%**	**-1%**	**-12%**	**-23%**	**-9%**
Network	**Value Plus Network: *Inside* NJ, DE, 9 PA Counties - (Northampton, Lehigh, Berks, Lancaster, Bucks, Montgomery, Chester, Delaware, and Philadelphia) Emblem/GHI Network: New York (city and state) ; PHCS Network: National Access *outside* NJ, DE, NY, 9 PA Counties PCP selection not required**							**Value Plus Network - *Inside* NJ, DE, 9 PA Counties- (Northampton, Lehigh, Berks, Lancaster, Bucks, Montgomery, Chester, Delaware, and Philadelphia) Outside NJ- No National Access (emergency only) PCP Selection Required for HMO plans, not required for GSHP**				
Medical Cost Sharing											
Primary Care Copayment	$10	$15	$15	$15	$20	$20	$10	$10	$20	$20	$10
Specialist Care Copayment	$10	$15	$25	$25	$20	$35	$15	$10	$20	$35	$15
Emergency Room Copayment	$25	$50	$75	$75	$100	$100	$125	$35	$100	$100	$125
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]	10% [1]			20% [3]	10% [1]
In-Network Coinsurance Maximum (Individual/Family)		$400/$1,000	$400/$1,000	$400/$1,000	$800/$2,000	$2,000/$5,000	$500/$1,000			$2,000/$4,000	$500/$1,000
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	$500/$1,000	$5,280/$10,560	$5,280/$10,560	$5,280/$10,560	$500/$1,000
Out-of-Network Deductible [2] (Individual/Family)	$100/$250	$100/$250	$100/$250	$100/$250	$200/$500	$800/$2,000	$350/$700				$350/$700
Out-of-Network Coinsurance [2]	20%	30%	30%	30%	30%	40%	30%				30%
Out-of-Network Out-of-Pocket [6] 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	$2,000/$5,000				$2,000/$5,000
Out-of-Network Inpatient Hospital Deductible			No Deductible	No Deductible	No Deductible	No Deductible	Deductible applies				Deductible applies
Prescription Drug Copayments [7]											
Retail (30 day): Generic Copayments	10%	10%	15%	$7.00	15%	20%	$5.00	$5.00	$3.00	$7.00	$5.00
Retail (30 day): Preferred Copayments	10%	10%	15%	$16.00	15%	20%	$10.00	$10.00	$18.00	$21.00	$10.00
Retail (30 day): Non-Preferred Copayments	10%	10%	15%	$35.00	15%	20%	member pays difference	$20.00	$46.00	$21.00	member pays difference
Mail (90 day): Generic Copayments	10%	10%	15%	$7.00	15%	20% [4]	$10.00	$5.00	$3.00	$7.00 [4]	$10.00
Mail (90 day): Preferred Copayments	10%	10%	15%	$16.00	15%	20% [4]	$20.00	$10.00	$18.00	$21.00 [4]	$20.00
Mail (90 day): Non-Preferred Copayments	10%	10%	15%	$35.00	15%	20% [4]	member pays difference	$20.00	$46.00	$21.00	member pays difference

**** Comparison is for illustrative purposes only. Written plan documents will supersede 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.***

***** EHP & GSHP plans subject to change based on Ch. 44 legislation and future guidance issued by controlling legal authority.***

[1] On select services.

[2] After deductible. Out-of-Network providers may bill you for difference between the carrier's Reasonable and Customary (R&C) limit and the provider's actual charge, which is the amount paid by the carrier, 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% Medicare for EHP & GSHP plans, 80% of FAIR Health for all other plans.

[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.

[6] Out-of-Pocket maximum includes deductible, coinsurance and copayments. Charges in excess of Reasonable and Customary do not count toward out-of-pocket maximum.

[7] Under EHP & GSHP Rx, if member fills brand where generic is available, ingredient cost difference does not apply toward out-of-pocket maximum and is member's full responsibility. EHP plan includes mandatory generic/step-therapy/closed formulary

[8] GSP plan is a NJ based network, representative of a smaller network with fewer in-network facilities/providers than other plan/network offerings. Out of state providers are excluded, unless true medical emergency.

3/20/23