MIDDLESEX COLLEGE

Office of Human Resources

NJ EDUCATORS HEALTH PLAN (NJEHP)
GARDEN STATE HEALTH PLAN (GSHP)
COMPARISON TO HORIZON CHOICE PLANS

ELIGIBILITY	PLAN OPTIONS NJEHP/GSHP Plan All Active Full-Time Employees Eligible for Health Benefits	Horizon Choice AFT, Admin, Confidential Staff, Teamsters	Horizon Choice AFSCME, FOP
HEALTH CARE SERVICES (IN-NETWORK)			
NJEHP Service Area Available	Nationwide (BlueCard PPO)	Horizon Point of Service	Horizon Point of Service
GSHP Service Area Available	State of NJ Providers Only	Horizon Point of Service	Horizon Point of Service
Specialist Referral	No referral required	Referral required	Referral required
Deductible	$0	$0	$0
Coinsurance (On select services)	10%	$0	$0
Coinsurance Out-of-Pocket Maximum			
Individual	$500	$400	$400
Family	$1,000	$800	$800
Primary Care Office Visit	$10	$10	$5
Specialist Office Visit	$15	$10	$5
Chiropractic (30 NJEHP/GSHP combined visits per calendar year)	$15	$10	$5
Physical/Occupational/Speech Therapy	$15	$0	$0
Diagnostic Laboratory/Radiology/Advanced Imaging	$0	$0	$0
EMERGENCY/URGENT MEDICAL SERVICES (IN-NETWORK)			
Urgent Care Center	$15	$20	$20
Emergency Room	$125	$50	$50
Ambulance	10% coinsurance	$0	$0
OTHER SERVICES (IN-NETWORK)			
Inpatient Facility	$0	$0	$0
Outpatient Facility	$0	$0	$0
Outpatient Behavioral Health	$15	$10	$5
OUT-OF-NETWORK (OON) COVERAGE			
Deductible - Individual	$350	$100	$100
Deductible - Family	$700	$200	$200
Coinsurance after Deductible	30%	20%	20%
Out-of-Pocket Coinsurance Maximum - Individual	$2,000	$400	$400
Out-of-Pocket Coinsurance Maximum - Family	$5,000	$800	$800
Out-of-Network Fee Schedule*	200% CMS	90th percentile Fair Health	90th percentile Fair Health
PRESCRIPTION COVERAGE			
Retail Generic Copay	$5	$0	20%
Retail Preferred Brand Copay	$10	$15	20%
Retail Non-Preferred Brand Copay	Member Pays Difference*	$30	20%
Mail Generic Copay	$10	$0	20%
Mail Preferred Brand Copay	$20	$15	20%
Mail Non-Preferred Brand Copay	Members Pays Difference*	$30	20%

*In many instances, 200% of CMS produces lower payment to providers than 90th percentile of Fair Health. This can result in a larger balance billing liability to the patient when utilizing out-of-network services. When a provider bills more than the maximum plan reimbursement, the member is responsible for 100% of the difference between the billed amount and maximum reimbursement. Maximum coinsurance is consolidated. The deductible, coinsurance and copays apply to the Maximum Out-of-Pocket limit. Balances from non-participating providers above plan allowances do not apply towards this limit.

NJEHP/GSHP PRESCRIPTION DRUG COVERAGE AND COPAYMENT(S)	
Retail: Generic	$5 – 30-day supply
Retail: Preferred Brand	$10 – 30-day supply
Retail: Non-Preferred Brand	Member Pays Difference between generic and brand *plus* brand copayment **
Mail: Generic *	$10 – 90-day supply
Mail: Preferred Brand *	$20 – 90-day supply
Mail: Non-Preferred Brand *	Member pays difference between generic and brand *plus* brand copayment **
Prescription Drug Annual Out-of-Pocket Maximum (Individual/Family)	$1,600 single/$3,200 family (Indexed Annually Pursuant to Federal Law)
Formulary	CVS Advanced Control Specialty (copy available on InfoNet announcement)
Step Therapy Rules	Required by plan to try less expensive options before "stepping up" to drugs that cost more

* Mandatory mail is required after one (1) retail fill.

** If a generic is available and Brand is filled, member is responsible for 100% of the cost differential. All multisource brand drugs filled where a generic is available are subject to the brand copay plus the cost differential. Members may appeal to CVS due to medical necessity, and appeals will not be overridden. This cost to the member does not apply to the out-of-pocket maximum.

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