

# 2021 SEHBP Health Plan Options

	NJ DIRECT10	NJ DIRECT15	NEW JERSEY EDUCATORS 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 Maximum (Individual/Family)		\$400/\$1,000	
In-Network Out-of-Pocket Maximum (Individual/Family)	\$400/\$1,000	\$6,840/\$13,420	\$500/\$1,000
Out-of-Network Deductible (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 Maximum (Individual/Family)	\$2,000/\$5,000	\$2,000/ \$5,000	\$2,000/\$5,000
Out-of-Network In Patient Hospital Deductible	Out-of-Network Deductible applies (see above)	Out-of-Network Deductible applies (see above)	Out-of-Network Deductible applies (see above)
Out-of-Network Chiropractic Services	Lesser of \$35/visit or 75% of In-Network cost/visit	Lesser of \$35/visit or 75% of In-Network cost/visit	Lesser of \$35/visit or 75% of In-Network cost/visit
Out-of-Network Acupuncture Services	Lesser of \$60/visit or 75% of In-Network cost/visit	Lesser of \$60/visit or 75% of In-Network cost/visit	Lesser of \$60/visit or 75% of In-Network cost/visit
Out-of-Network Physical Therapy Services	75% of In-Network cost/visit	75% of In-Network cost/visit	75% of In-Network 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



# 2021 BeneCard Prescription Drug Coverage

	NJ Direct 10	NJ Direct 15	BeneCard EHP
<b>Prescription Drug Coinsurance/Copayments</b>			
Retail: Generic Coinsurance/Copayments	<b>ALL CURRENT COPAYS AND BENEFIT DESIGNS WITH EXISTING BENECARD PLANS WILL REMAIN AS PER YOUR CBA</b>		\$5
Retail: Preferred Brand Coinsurance/Copayments			\$10
Retail: Non-Preferred Brand Coinsurance/Copayments			Member pays difference
Mail Order: Generic Coinsurance/Copayments			\$10
Mail Order: Preferred Brand Coinsurance/Copayments			\$20
Mail Order: Non-Preferred Brand Coinsurance/Copayments			Member pays difference
Prescription Drug annual Out-of-Pocket Maximum (Individual/Family)			



# BeneCard EHP Prescription Drug Benefits

## ➤ **Dispensing Limits**

- ❖ Retail – 1 copay for 30-day supply
- ❖ Mail Order – 1 copay for 90-day supply
- ❖ Oral contraceptive drug coverage is available under the medical and prescription drug plans

## ➤ **Mandatory Generic Plan**

- ❖ For brand name drugs with generic equivalents, member pays the difference in cost between the brand name and the generic drug plus brand copay

## ➤ **Closed Formulary** – directs prescriptions to more cost-effective clinically equivalent medications

- ❖ BeneCard utilizes their Performance formulary

