Piscataway Township Board of Education
Medical Plan Comparison
January 1, 2021 - June 30, 2021

COMPARISON IS FOR ILLUSTRATIVE PURPOSE ONLY. PLEASE SEE FOOTNOTES BELOW

Monthly Rates: 1/1/21 - 6/30/21	Traditional (Preferred PPO)	Open Access (PPO)		Educators Health Plan (EHP)**		POS #1		POS #2		High Deductible Plan (HDHP)	
Monthly PREMIUM: Traditional/Open Access/EHP/POS plan rates DO NOT include separate ESI Prescription Drug plan rates; HDHP includes coverage for prescription as part of the medical plan rates.											
Single	$ 882.00	$ 773.00		$ 695.70		$ 658.00		$ 609.00		$ 648.00	
Parent/Child(ren)	$ 1,428.84	$ 1,252.26		$ 1,127.03		$ 1,065.96		$ 986.58		$ 1,049.76	
2 Adult	$ 1,931.58	$ 1,692.87		$ 1,523.58		$ 1,441.02		$ 1,333.71		$ 1,419.12	
Family	$ 2,425.50	$ 2,125.75		$ 1,913.18		$ 1,809.50		$ 1,674.75		$ 1,782.00	
	In or Out of Network	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network [1]**	**Non-Network**	**In-Network [1]**	**Non-Network**	**In-Network**	**Non-Network**
Annual Deductible											
Individual	$200	$0	$200	$0	$350	$0	$100	$0	$500	$2,500	$2,500
Family	$400	$0	$400	$0	$700	$0	$200	$0	$1,000	$5,000 [5]	$5,000 [5]
Coinsurance	100% or 80% of R&C [2]	100%	80% of R&C [2]	90% [6]	70% (200% of Medicare) [2]	100%	70% of R&C [2]	100%	70% of R&C [2]	100%	70% (140% of Medicare)
Annual Out of Pocket Maximum (Includes Deductible)											
Individual	$800	$800 [3]		$500	$2,000	$400	$800	$400	$2,500	$2,500	$5,500
Family	$1,600	$1,600 [3]		$1,000	$5,000	$800	$1,600	$800	$5,000	$5,000	$11,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Hospital Inpatient Services (room and board; physician visits)	100%	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	Deductible then 100%	70% after deductible
Emergency Room	100%	100% after $35 copay waived if admitted	100% after $35 copay waived if admitted	100% after $125 copay waived if admitted	100% after $125 copay waived if admitted	100% after $25 copay waived if admitted	100% after $25 copay waived if admitted	100% after $100 copay waived if admitted	100% after $100 copay waived if admitted	Deductible then 100%	Deductible then 100%
Ambulance	100%	100%	100%	90%	90%	100%	100%	100%	100%	Deductible then 100%	Deductible then 100%
Radiation/Chemotherapy Outpatient	100%	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	Deductible then 100%	70% after deductible
X-Ray and Lab Tests	100%	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	Deductible then 100%	70% after deductible
Home Health Care	100%	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	Deductible then 100%	70% after deductible
	Unlimited	90 visits per calendar year		90 visits per calendar year		Unlimited		Unlimited		60 visit combined calendar year maximum	
Skilled Nursing Facility	100%	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	Deductible then 100%	70% after deductible
	120 days per calendar year	120 days per calendar year		120 days per calendar year		120 days per calendar year		120 days per calendar year		30 day combined calendar year maximum	
Hospice	100%	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	Deductible then 100%	70% after deductible
	Unlimited	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Surgery/Anesthesia	100%	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	Deductible then 100%	70% after deductible
Physician Office Visits	80% after deductible	$10 Copay	80% after deductible	$10 Copay (PCP) $15 Copay (Specialist)	70% after deductible	$5 copay	70% after deductible	$15 PCP/$30 Specialist copay	70% after deductible	Deductible then 100%	70% after deductible
Annual Physical Exams	100%	100%	80% (No deductible)	100%	70% (No deductible)	100%	70% (No deductible)	100%	70% (No deductible)	100%	70% after deductible
Annual Well Child Care	100%	100%	80% (No deductible)	100%	70% (No deductible)	100%	70% (No deductible)	100%	70% (No deductible)	100%	70% (no deductible)
Immunizations (except if travel or job related)	100%	100%	80% (No deductible)	100%	70% (No deductible)	100%	70% (No deductible)	100%	70% (No deductible)	100%	70% (no deductible)
Annual OB-Gyn Exam	100%	100%	80% (No deductible)	100%	70% (No deductible)	100%	70% (No deductible)	100%	70% (No deductible)	100%	70% after deductible
Annual Mammogram (baseline and women over age 40)	100%	100%	80% (No deductible)	100%	70% (No deductible)	100%	70% (No deductible)	100%	70% (No deductible)	100%	70% after deductible
Annual Prostate screening (men over 50)	100%	100%	80% (No deductible)	100%	70% (No deductible)	100%	70% (No deductible)	100%	70% (No deductible)	100%	70% after deductible

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	Traditional (Preferred PPO)	Open Access (PPO)		Educators Health Plan (EHP)**		POS #1		POS #2		High Deductible Plan	
		In-Network	Non-Network	In-Network	Non-Network	In-Network [1]	Non-Network	In-Network [1]	Non-Network	In-Network	Non-Network
Maternity (including pre-natal)	100%	$10 copay for 1st prenatal visit, then 100%	80% after deductible	$15 copay for 1st prenatal visit, then 100%	70% after deductible	$5 copay for 1st prenatal visit, then 100%	70% after deductible	$15 copay for 1st prenatal visit, then 100%	70% after deductible	Deductible then 100%	70% after deductible
	Includes coverage for child dependents	Includes coverage for child dependents		Includes coverage for child dependents		Includes coverage for child dependents		Includes coverage for child dependents		Does NOT include dependent child pregnancies	
Infertility services	80% after deductible	$10 copay	80% after deductible	$15 copay	70% after deductible	$5 copay	70% after deductible	$15 PCP/$30 Specialist copay	70% after deductible	Deductible then 100%	70% after deductible
	Subject to limitations set by NJ Mandates	Subject to limitations set by NJ Mandates		Subject to limitations set by NJ Mandates		Subject to limitations set by NJ Mandates		Subject to limitations set by NJ Mandates		Subject to limitations set by NJ Mandates	
Allergy Testing and Treatment	80% after deductible	$10 copay	80% after deductible	$15 copay	70% after deductible	$5 copay	70% after deductible	$15 PCP/$30 Specialist copay	70% after deductible	Deductible then 100%	70% after deductible
Acupuncture	80% after deductible	$10 copay	80% after deductible	$15 copay	70% after deductible, limited to $60/visit	$5 copay	70% after deductible	$30 Specialist copay	70% after deductible	Deductible then 100%	70% after deductible
Nutritional Counseling	80% after deductible	$10 copay	80% after deductible	$15 copay	70% after deductible	$5 copay	70% after deductible	$30 Specialist copay	70% after deductible	Deductible then 100%	70% after deductible
	Unlimited	3 visits per calendar year		3 visits per calendar year		3 visits per calendar year		3 visits per calendar year		3 visits per calendar year	
Chiropractic Care	80% after deductible	$10 copay	80% after deductible	$15 copay	70% after deductible, limited to $35/visit	$5 copay	70% after deductible	$30 Specialist copay	70% after deductible	Deductible then 100%	70% after deductible
	Unlimited	30 visits per calendar year		30 visits per calendar year		Unlimited. No referrals.		30 visits per calendar year. No referrals.		Limited to 20 visits per calendar year	
Short Term Therapies (Physical, Cognitive, Occupational, Respiratory, Speech)	80% after deductible	$10 copay	80% after deductible	$15 copay	70% after deductible, limited to $52/visit	$5 copay	70% after deductible	$30 Specialist copay	70% after deductible	Deductible then 100%	70% after deductible
	Unlimited	Unlimited		Unlimited		Unlimited		Unlimited		60 consecutive in-patient days per condition/calendar year; 90 outpatient visits per calendar year	
Other Therapies (Chelation, dialysis, Infusion)	80% after deductible	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	Deductible then 100%	70% after deductible
	Unlimited	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Private Duty Nursing	80% after deductible	100%	80% after deductible	90%	70% after deductible	100%	70% after deductible	100%	70% after deductible	Deductible then 100%	70% after deductible
	30 visits per calendar year	30 visits per calendar year		30 visits per calendar year		Unlimited		Unlimited		Unlimited	
Wigs (if needed due to specific diagnosis like Chemo)	80% after deductible up to $1500 maximum	100% to $1500 maximum		100% to $1500 maximum		100% to $1500 maximum		100% to $1500 maximum		Deductible then 100%	70% after deductible
										$1500 maximum per benefit period	
Hearing Aids	80% after deductible	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	Deductible then 100%	70% after deductible
	$5,000 per hearing aid per 24 month, no age restriction	$5,000 per hearing aid per 24 month, no age restriction		$5,000 per hearing aid per 24 month, no age restriction		$5,000 per hearing aid per 24 month, no age restriction		$5,000 per hearing aid per 24 month, no age restriction		$5,000 per hearing aid per 24 month, no age restriction	
Durable Medical Equipment/Medical Supplies	80% after deductible	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	Deductible then 100%	70% after deductible
Prosthetics and Orthotics	80% after deductible	100%	80% after deductible	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	Deductible then 100%	70% after deductible
Inpatient Mental Illness/Substance Abuse/Alcohol Treatment [4]	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
Outpatient Mental Illness/Substance Abuse/Alcohol Treatment [4]	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness	Covered as any other illness
Routine Vision Exam	Not covered	Covered under Vision Plan		$15 copay	Not Covered	Covered under Vision Plan		Covered under Vision Plan		Not covered	
Vision Hardware	Not covered	Covered under Vision Plan		Not Covered		Covered under Vision Plan		Covered under Vision Plan		Not covered	
Prescription Drug Benefit	Covered under separate RX carrier with separate premium rates	Covered under separate RX carrier with separate premium rates		Covered under separate RX carrier with separate premium rates Must take the EHP Rx with the EHP Medical		Covered under separate RX carrier with separate premium rates		Covered under separate RX carrier with separate premium rates		Tier 1-$10 copay; Tier 2-$25 copay Tier 3-$50 copay Mail Order - 2x retail Pharmacy claims are subject to the in-network deductible. After deductible satisfied, then applicable copay will apply.	Not covered at non-participating pharmacy
Child Dependent Termination age	Children covered to End of month they turn age 26	Children covered to End of month they turn age 26		Children covered to End of month they turn age 26		Children covered to End of month they turn age 26		Children covered to End of month they turn age 26		Children covered to End of month they turn age 26	
PRE-ADMISSION REVIEW	No preadmission review	No preadmission review		No preadmission review		Required for in and out of network hospitals.		Required for in and out of network hospitals.		Required on all surgeries/admissions/x-rays and extensive diagnostic tests	

Comparison is for illustrative purposes only. Written plan documents will supersede any errors on this illustration.

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

1 Under the POS Plan, in order for services to be considered in-network, you must be seen by your Primary Care Physician, or have services referred by your Primary Care Physician.

2 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 plan, 140% Medicare for the HDHP and 90th percentile of FAIR Health for all other plans.

3 In-network out-of-pocket expenses apply to out-of-network out of pocket expenses.

4 Mental health conditions and Alcohol/Substance Abuse treatment are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visit limits.

5 If you have a family contract, the entire $5,000 family deductible must be satisfied before any payment is made under this plan, except for routine physicals.

6 On select services.