TOMS RIVER BOE EMPLOYEES' HEALTH BENEFITS PROGRAM
COMPARISON OF PLANS CY 2021

PLAN	ACTIVE EMPLOYEES	TRBOE PPO-A	TRBOE PPO-B	TRS EHP *1
IN-NETWORK	Deductible (Single/Family)	$200 / $400	$0	Not Applicable
	Coinsurance	20% *2	No Charge	10% *3
	Primary Care Physician Copayment	$10	$5	$10
	Specialist Copayment	$10	$5	$15
	Emergency Room Copayment	No Charge (OON 20% Coinsurance)	$25 Copay / visit (OON 30% Coinsurance)	$125
	Out-of-Pocket Maximum (Single/Family)	$400 / $800	$400 / $1,000	$500/$1,000
	Inpatient Hospitalization	No Charge	No Charge	No Charge
	PHC Access	YES	YES	YES
OUT-OF-NETWORK	Deductible (Single/Family)	$200 / $400	$300 / $600	$350/$700
	Out-of-Network Coinsurance	20% Coinsurance	30%	30%
	Out-of-Pocket Maximum (Single/Family)	$400 / $800	$2,000 / $5,000	$2,000/$5,000
	Inpatient Hospitalization	20% Coinsurance	30% Coinsurance	30%
	Maximum Provider Reimbursement	Usual and Customary (80% of FAIR Health)	Usual and Customary (80% of FAIR Health)	200% of CMS - Medicare
PRESCRIPTION DRUG	Out-of-pocket limit (Single/Family)	$6,450 / $12,700	$6,450 / $12,700	$1,600 / $3,200
	Retail – Generic	$3.00 (30 day supply) $6.00 (60 day supply) $9.00 (90 day supply)	$5	$5 (30 day supply)
	Retail – Brand w/ No Generic Available	$10.00 (30 day supply) $20.00 (60 day supply) $30.00 (90 day supply)	$10	$10 (30 day supply)
	Retail – Brand w/ Generic Available	n/a - no mandatory generic	n/a - no mandatory generic	Member pays the difference *4
	Mail – Generic	$5	$0	$10 (90 day supply)
	Mail – Brand w/ No Generic Available	$15	$0	$20 (90 day supply)
	Mail – Brand w/ Generic Equivalent	n/a - no mandatory generic	n/a - no mandatory generic	Member pays the difference *4
ADDITIONAL BENEFITS COVERAGE INFORMATION	Physical Therapy / Outpatient Short-Term Rehabilitation	$10 Copay / Visit (OON 20% Coinsurance)	$5 Copay / visit (OON 30% Coinsurance)	$15 copay (OON Lesser of $52/visit or 75% of in network cost/visit)
	Physical Therapy / Habilitation Services	$10 Copay / Visit (OON 20% Coinsurance)	$5 Copay / visit (OON 30% Coinsurance)	$15 copay (OON Lesser of $52/visit or 75% of in network cost/visit)
	Chiropractic Care	$10 Copay, then 100% Deductible waived (OON 80% Coinsurance) (*Some bargaining units subject to annual cap*)	$5 Copay, then 100% Deductible waived (OON 70% Coinsurance) (*Some bargaining units subject to annual cap*)	$15 Copay (OON $35/visit or 75% of the in-network cost per visit, whichever is less.)
	Acupuncture	$10 Copay, then 100% Deductible waived (OON 80% Coinsurance) *(Some bargaining units subject to annual cap)*	100% Covered (OON 70% Coinsurance) *(Some bargaining units subject to annual cap)*	$15 Copay (OON Lesser of $60/visit or 75% of in network cost/visit)
	Routine Lab: Diagnostic test (x-ray, blood work); Imaging (CT/PET scans, MRIs)	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)
	Preventive care / screening / immunization	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON Not Covered)
	If you have outpatient surgery: Facility fee (e.g. ambulatory surgery center)	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)
	If you have outpatient surgery: Physician / surgeon fees	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)

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	If you need immediate medical attention: Emergency medical transportation	20% Coinsurance (emergency services and non-emergency services)	No Charge (emergency services and non-emergency services)	10% Coinsurance (OON 30% Coinsurance)
	If you need immediate medical attention: Urgent Care	$10 Copay / visit (OON 20% Coinsurance)	$5 Copay / visit (OON 30% Coinsurance)	$15 Copayment per visit (OON 30% Coinsurance)
	If you need mental health, behavioral health, or substance abuse services: Outpatient services	$10 Copay / visit (office visit) / No Charge (all other outpatient) (OON 20% Coinsurance)	$5 Copay / visit (office visit) / No Charge (all other outpatient) (OON 30% Coinsurance)	No Charge for Outpatient Hospital or Substance Abuse Office Visit. $15 Copay / visit for Mental Health and Behavioral Health. (OON 30% Coinsurance for Outpatient Hospital.
	If you need mental health, behavioral health, or substance abuse services: Inpatient services	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge for Inpatient Hospital. (OON 30% Coinsurance)
	If you are pregnant: Office Visits	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	$10.00 Copayment per visit for Office. $15.00 Copayment per visit for Office; Specialist. (OON 30% Coinsurance)
	If you are pregnant: Childbirth/delivery professional services	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)
	If you are pregnant: Childbirth/delivery facility services	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)
	If you need help recovering or have other special health needs: Home health care	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)
	If you need help recovering or have other special health needs: Rehabilitation services	$10 Copay / visit (OON 20% Coinsurance)	$5 Copay / visit (OON 30% Coinsurance)	No Charge for Inpatient and Outpatient Facility $15 Copay / Office visit (OON 30% Coinsurance)
	If you need help recovering or have other special health needs: Habilitation services	$10 Copay / visit (OON 20% Coinsurance)	$5 Copay / visit (OON 30% Coinsurance)	No Charge for Inpatient and Outpatient Facility $15 Copay / Office visit (OON 30% Coinsurance)
	If you need help recovering or have other special health needs: Skilled nursing care	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance) Limited to 120 days in-network and 60 out-of-network facility days for a combined maximum of 120 days per calendar year.
	If you need help recovering or have other special health needs: Durable medical equipment	20% Coinsurance	No Charge (OON 30% Coinsurance)	10% Coinsurance (OON 30% Coinsurance)
	If you need help recovering or have other special health needs: Hospice services	No Charge (OON 20% Coinsurance)	No Charge (OON 30% Coinsurance)	No Charge (OON 30% Coinsurance)
	Children's Eye Exam	Not Covered	Not Covered	$15 Copay / visit (OON Not Covered)

*1 - Identical to NJEHP Plan Design; Pending Negotiations

*2 - Member is responsible for 20% of eligible charges after applicable Deductibles are met specific to: Ambulance Services (both Emergency and Non-Emergency Medical Condition or Medically Necessary Transfer); Diabetic Education and Supplies; Durable Medical Equipment; Foot Orthotics; Hearing Aids and Related Supplies (up to age 16); Private Duty Nursing (Outpatient); and All Other Eligible Medical Expenses

*3 - Member is responsible for 10% of eligible charges after applicable Deductibles are met specific to: Ambulance Services (Emergency Medical transportation limited to local emergency transport to the nearest facility equipped to treat the emergency condition); and Durable Medical Equipment

*4 - Member pays difference in cost between generic and brand, plus brand copayment.