TRENTON BOARD OF EDUCATION
Direct Access (NJ Educators Health Plan equivalent)

Frequently Asked Questions (12/16/2020)

1. If I take the Direct Access Plan, am I correct that I will be covered 100% for preventative tests and hospitalizations?

Preventative Care is covered at 100% In-Network and 70% no deductible for Out-of-Network.

Hospitalizations are covered at 100% In-Network and 70% after deductible for Out-of-Network.

2. What is In-Network Co-Insurance? The new plan looks has 10% and the HMO and PPO plan has 100%. That is a big difference. What does it mean?

The In-Network coinsurance is 100% however, there are certain services such as Ambulance, Durable Medical Equipment and Private Duty Nursing that are covered at 90%. For these services, the plan will pay 90% and the member is responsible for the remaining 10% up to the Maximum Out of Pocket amounts.

3. I have had a great success with the PPO (just had 2 eye surgeries and am in post-op). However, it is a nice chunk of change. I am interested in the new educator's plan. However, I have a lot of doctors in Pennsylvania. For example, my eye surgery was done in NJ and my post-op visits are in PA. I am concern about being treated "out of network" by my PA doctors, which off-sets the cheaper price. Yet, the cost savings cannot be ignored.

Regarding providers, the new Educators plan does offer BlueCard coverage which access the Blue Cross Blue Shield national network of providers. This would aid in seeing providers in another state at the In-Network level of benefits. If the provider unfortunately, does not participate in the Horizon network nor with BlueCard, at that point the member can still see the provider but will have services covered at the Out-of-Network level of benefits.

4. I don't understand the co-insurance of 100% and the in-network out-of-pocket maximum. I've had the teacher's version of BCBS NJ since 2011. I don't pay anything other than my co-payments. Everything is always covered. These numbers are throwing me off. Could you please explain to me?

Coinsurance of 100% means that the plan would pay 100% for the service. The Maximum Out of Pocket (MOOP) amounts are the most that an individual/family would pay for services in a given calendar year (January – December). MOOP is an accumulation of deductibles, copayments or coinsurance that the member would pay for services. With the Educators plan, there is no In-Network deductible that would apply so the method in which an individual would meet their MOOP would be through copayments and coinsurance where applicable. Once the member satisfies their MOOP in a calendar year, the plan will then pay for services at 100% without any member costs like copayments applying.

For Out-of-Network, any balances billed by a non-participating provider will not accumulate to the MOOP.

5. I reached out to all my doctors and they all wanted to know is this plan Employer Specific?

The Educators plan is part of Chapter 44 and would impact all school districts in the state of NJ. Benefits are the same regardless of district. If contacting providers ask if they accept the plan, please state that the plan is a Direct Access as providers may not be aware of marketing names such as Educators Plan, NJEHP, NJEDU, etc.

6. Do I have to go to the doctors in the plan or can I choose my own doctor?

Both. If you utilize providers that accept Direct Access, services will then be paid at the In-Network level of benefits. However, if you would like to utilize an Out-of-Network provider, you can. Out-of-Network providers would be paid based on the Out-of-Network benefits but please note that since the provider is Out-of-Network, they can balance bill you.

7. Is there a list of doctors printed out so I can see if my doctor is on there?

Yes, the list of providers can be found at HorizonBlue.com and by clicking the Find A Doctor icon on the top right of the page. Once there, you will need to fill out the appropriate fields such as Category (Doctors, Hospitals, Other Healthcare Services, Urgent Care Services), Plan (Select Direct Access), Location and Specialty. You can also search by Doctor Affiliations and/or Doctor's Last Name if known.

8. Regarding the Plan Comparison for medical, what does it mean by 30% after Out-of-Network deductible?

That would represent the member's responsibility. The plan would pay 70% for Out-of-Network and the member would be responsible for the Out-of-Network deductible as well as 30% of the allowable charges.

9. Regarding the Plan Comparison for prescription, what does this mean "Member pays difference along with the Brand Name Prescription Copayment?"

Regarding the prescriptions benefit, there is a mandatory generic included in the plan. This means if the member picks up a brand name drug that has a generic alternative, the member would pay the $20 brand drug copayment in addition to the difference in drug cost. For example, if the brand name drug costs $200 and the generic equivalent costs $30; the member would pay the $20 brand name copayment in addition to $170 which is the drug price difference.

10. Are Philadelphia hospitals in network with the new plan?

Yes, there are participating hospitals in Philadelphia. Some examples are Thomas Jefferson University Hospital, University of Pennsylvania Medical Center, Pennsylvania Hospital, The Children's Hospital of Philadelphia Care Network and some others.

11. Why do I have to do submit another benefit waiver again when I did that at the end of last school year? I thought I only do that once a year.

You are correct. Normally, it is once a year. This is a special open enrollment due to a new law, NJ Chapter 44. It requires offering a new plan effective January 1, 2020. Employees are required to document their choice by submitting an affirmation form. Those continuing to waive must include proof of other coverage.

12. If I transfer to the Direct Access Educators medical plan, can I keep my current prescription plan?

No. The Educators Medical plan would have its specific Prescription plan. Both the Educators Medical or Prescription cannot be mixed and matched with any other plan or elected separately.

13. On the Plan Comparison for medical, under PPO, what does $5,000/$10,000 mean for In-Network Out-of-Pocket Maximum (Individual/Family)? I have pre-existing conditions.

The Maximum Out-of-Pocket (MOOP) is an accumulation of Deductible, Coinsurance and Copay amounts that a member would make when seeking care during the plans benefits period. This is the most a member would every pay for medical services during that time period. Regarding pre-existing conditions, there would never be a point where claims would deny due to the condition for treatment being pre-existing. Since the Affordable Care Act (ACA), services for pre-existing conditions cannot be denied as long as all plan procedures are followed.

14. On the Plan Comparison for medical, under PPO, what does $5,000/$10,000 mean for Out-of-Network Out-of-Pocket Maximum (Individual/Family)?

The Maximum Out-of-Pocket (MOOP) is an accumulation of Deductible, Coinsurance and Copay amounts that a member would make when seeking care during the plans benefit period. This is the most a member would every pay for medical services during that time period. However, please note that when seeking Out-of-Network care that a provider can balance bill for services that exceed the allowable reimbursement. Any balance billed amounts would not accumulate to the Out-of-Network MOOP.

15. On the Plan Comparison for prescription, for the Direct Access, please explain the breakdown for $1,600/$3,200 under Prescription Drug annual Out-of-Pocket Maximum (Individual/Family)?

Similar to the Medical plan, the Educators Prescription plan has its own separate Maximum Out-of-Pocket (MOOP). The $1,600 Individual/$3,200 Family Prescription MOOP is an accumulation of Deductible, Coinsurance and Copays that the member would pay based on their benefits. With the Educators Prescription plan, there are only Copayments that would apply and accumulate to the MOOP. Once the MOOP amounts are met, the plan pays at 100% without any responsibility to the member. However, please note that any costs associated with paying the difference for Brand Name drugs would not accumulate to MOOP.

16. Does the new Direct Access Plan include vision coverage?

There is for In-Network Routine Eye Exams only. Vision Hardware is not covered on this plan.

17. If the premium cost sharing formula is changing to a percent of base salary, does the Direct Access Plan include the prescription coverage within that premium cost sharing formula or is there an additional cost for prescription coverage under the Direct Access Plan?

The Educator Medical and Prescription benefits have their own separate premiums and will both apply as percentage of salary.

18. Are all in-Network claims subject to the 10% co-insurance payment, or does this apply to a limited number of benefits?

On the Educator plan, the majority of In-Network services would pay at 100% or 100% after copayment. However, there are some services such as Ambulance, Durable Medical Equipment and Private Duty Nursing that would apply a 10% coinsurance.

19. Is there a plan document that details the expenses that will require a 10% co-insurance payment?

At the moment, we do offer plan highlights that offer a description of the plans benefits. I have reattached the highlights to this email.

20. In-Network, out of pocket, co-insurance/copay maximum is $500 (Individual)/$1,000 (Family), I go to all In-Network hospital and doctors only. I have no problem to fulfill the $500 max for individual and $1,000 max for the family. Once I reach that $1,000 mark, whole family will not have to pay anything for the whole year.

- Am I right?

  Correct. Once the Maximum Out of Pocket is met, all applicable services are paid at 100% for the remainder of the plan year.

- Is there anything that will not be covered?

  No, services will continue to pay accordingly as long as all plan policies and procedures are followed.

21. Suppose I go to an In-Network hospital and end up staying overnight, taking a MRI and CAT scan. Hospital charges me a total of $8,000. By this one visit, I have reached the maximum for the family (I pay only $1,000). After that, for the whole family everything will be free for the year or not?

In the event that you are admitted into an In-Network Hospital, services are paid at 100%. You would not be responsible for paying the $1,000 Maximum Out of Pocket (MOOP) as the MOOP is an accumulation of Deductibles, Coinsurance and Copayments. The MOOP is not accumulated by billed amounts.

22. Are referrals required to see Specialists?

No, referrals are not required to see Specialists.

23. On the Medical Plan Comparison, under In-Network Coinsurance, the row reads 100% for HMO, 100% for PPO and 10% for the Direct Access Educator plans. So people won't be confused, could it be noted that 100% covered; 100% covered; and 90% covered/10% employee responsibility?

The medical plan comparison can always be altered as this is just a reference document. When referencing the plan, the plan highlights should be the documents used.

24. Under Trenton BOE (Other Contract Units), Pre-existing Conditions and Grandfathered are listed as "Not Applicable." Please provide additional information for Pre-Existing conditions ie. Waiting period, etc.

Pre-existing conditions do not apply per the Affordable Care Act. As for waiting periods, the new hire waiting period is 1st of the month following date of employment.

25. When I spoke with a Horizon rep last week about the breakdown of the new plan, the rep mentioned a TRUE FAMILY phrase. I am wondering if deductibles are for true family, meaning the $1,000 for the family would include all plan members counting towards the $1,000 maximum deductible or would each family member have to reach $1,000 individually?

The Medical Maximum Out of Pocket (MOOP) of $1,000 is an aggregate accumulation. This means that any combinations of family members can contribute up to $1,000 but, that no one member in the family will exceed the Individual MOOP of $500.

26. Where can I find more information to find out fertility coverage with the direct plan?

Fertility services are covered and include Assisted Reproductive Technologies such as In-Vitro Fertilization.

27. If we switch and the plan goes into effect in January, will we be receiving new insurance cards before the end of the year, or are the ones we have now good for the new plan and just going to be updated with the new plan information?

New ID cards will be sent for the Educators plan. Depending on when the enrollment information is received, this will determine if enough time is allotted to allow ID cards to be received before the end of the year. However, in the event that ID cards are not received by January 1st, a virtual ID card can be printed from the Member Portal at HorizonBlue.com or accessed via the Horizon app on your smartphone.

28. I noticed in the TBOE 2021 comparison chart that the In-Network co-insurance was listed as 100% for traditional HMO and PPO plans. Healthcare.gov defines co-insurance as "The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible." By this definition, if the co-insurance is 100% then, the amount of the service that would be paid for by the insured would be the total cost of the service and the insurance plan would be 0 dollars. Did you mean 0% in-network co-insurance for traditional HMO and PPO plans?

0% In-Network can cause confusion as individuals may interpret it as no coverage. The best reference document to utilize is the plan highlights as it touches on more services and includes the coverage levels for In and Out of Network.

29. Does the new Direct Access Plan include vision coverage?

There is for In-Network Routine Eye Exams only. Vision Hardware is not covered on this plan.

30. I currently have a handicapped adult daughter on my plan. Will I need to provide documentation for her to remain on my insurance or will she transfer over as well?

That may depend on the overage dependent documentation that was previously submitted. If the overage dependent is currently covered and deemed permanently disabled, the documentation would not be needed. However, if the documentation is currently being sent on a yearly basis and permanent disability has not be established; documentation may be needed. This can be taken offline and reviewed separately for a specific response.

31. What benefits does the Direct Access Plan cover regarding CPAP equipment and supplies?

CPAP equipment and supplies are covered as these are accepted Durable Medical Equipment.

- What expense out of pocket will I be required to pay?

  The Maximum Out-of-Pocket (MOOP) on the Educators Plan is $500 Individual/$1,000 Family for In-Network and $2,000 Individual/$5,000 Family Out-of-Network. These amounts are the most a member would pay for medical services during the benefit period. However, please note that when utilizing Out-of-Network services that any amounts that the provider balance bills would not contribute to the Out-of-Network MOOP.

- How does it compare to our current PPO plan?

  The Educators Plan covers Durable Medical Equipment services at 90% In-Network and 70% after the $350 Individual/$700 Family Deductible for Out-of-Network. The PPO plan currently covers Durable Medical Equipment at 80% after the $100 In-Network/$200 Family Deductible.

32. If doctors are not on the find a doctor site but I use them now without a problem, it should not be a problem with direct access?

If the doctor is not on the Find a Doctor, that would indicate that the provider is Out-of-Network. You can continue to see the provider however, the Out-of-Network benefits would apply to the service and there is a possibility that the provider can balance bill for any amounts above the allowed amounts.

33. What would be the co-pay of a brand name prescription if there is no generic version of the prescription available? (The PPO has a mandatory generic option in place)

The co-payments for Brand drugs are $10 Retail/$20 Mail Order.

34. For prescription benefits, if I decide to switch to the Educators plan, if the medicine does not carry a generic, do we still have to pay out-of-pocket the full price on the Educators plan.

If there is no generic equivalent for the brand name drug, only the brand name co-payment would apply.

35. If you are allergic to the generic brand of prescription, do you still have to pay the higher co-pay and the difference between the generic and the brand name drug?

Typically, when an individual is unable to take a generic drug; the physician prescribing the drug would select or indicate to dispense the drug as written. When the prescription is not indicated to be dispensed as written and a generic is available, the generic would be dispensed. At that moment, if the brand name drug is requested then the appropriate copayment would be applied along with the drug cost difference.

36. Where can you go to get your blood work done, does it have to be at lab corp locations only?

The preferred labs are Lab Corp and Quest Diagnostics. However, services can also be rendered in an office setting or in an outpatient facility setting.

37. If I was to go to the doctor in NY that is out of network, what percentage would be covered and what percentage would be out of pocket?

If you go see an Out-of-Network provider regardless of state, an office visit would pay at 70% after deductible. This means that the member would need to first satisfy their Out-of-Network deductible of $350 Individual/$700 Family and would then be responsible for 30% of the allowable charges. Since this would be an Out-of-Network provider, the provider can choose to balance bill the difference between the allowed amount and the charged amount.

38. I just found out that my son needs his wisdom teeth out, and they cannot complete the surgery until January. But his referral stands now.

1. Will he need a new one? **No referrals are needed on this plan.**
2. And how can I tell if this will be covered under the new insurance? **Horizon HMO will cover 100% of the surgery with copay. The surgical removal of boney impacted teeth is covered on the NJ Direct Access Plan. Depending on where the service is rendered, services would be covered either at 100% or 100% after an office visit copayment when rendered In-Network.**
3. Is there a way to check ahead of time? **Yes, the physician can submit a pre-service treatment plan ahead of time to confirm the specific service that will be performed.**

39. Is it true that specialists are not covered until we reach a $3,000 deductible? Like a cardiologist or an orthopedic surgeon?

The Direct Access plan does not have a $3,000 deductible. In-Network Specialists are covered at 100% after a $15 copayment plan in which a referral is not required. Out-of-Network Specialists are covered at 70% after the Out-of-Network Deductible of $350 Individual/$700 Family is met.

40. I have elected to choose the new medical and RX plans that goes into effect on January 1, 2021. I was just wondering who will be the new mail order provider for medicine. I currently have Alliance.

The prescription benefit is covered by Horizon and powered by Prime Therapeutics. For mail orders, we partner with AllianceRX Walgreens Prime to have drugs mailed to the members.

(Note to employees: A mail order form will be added to the HR Department's website.)