




**POMPTON LAKES BOARD OF EDUCATION COMPARISON
 SCHOOL EMPLOYEES' HEALTH BENEFIT PLAN HORIZON NJ DIRECT 15
 AND
 HORIZON BLUE CROSS BLUE SHIELD DIRECT ACCESS 15**

	SEHBP Horizon NJ Direct 15		Horizon Blue Cross Blue Shield Direct Access 15	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital In-patient	100%	70% after deductible	100%	70% after deductible
Skilled Nursing Facility	100% 120 days per cal. Year	70% after deductible 60 days per cal. Year	100% 120 days per cal. Year	70% after deductible 60 days per cal. Year
Hospital Pre-Admission Testing	100%	70% after deductible	100%	70% after deductible
Ambulatory Surgical Center	100%	70% after deductible	100%	70% after deductible
Physician (Surgery)	100%	70% after deductible	100%	70% after deductible
Primary Care (Office Visits)	100% after \$15 copay	70% after deductible	100% after \$15 copay	70% after deductible


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	SEHBP Horizon NJ Direct 15		Horizon Blue Cross Blue Shield Direct Access 15	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Specialist (Office Visits)	100% after \$15 copay	70% after deductible	100% after \$15 copay	70% after deductible
Chiropractic	100% after \$15 copay	70% after deductible Maximum \$35 per visit*	100% after \$15 copay	70% after deductible
	30 visits per calendar year – Based on medical necessity		30 visits per calendar year – Based on medical necessity	
Emergency Room	100% after \$50 copay		100% after \$50 copay	
Durable Medical Equipment	90%	70% after deductible	90%	70% after deductible
Radiation/ Chemotherapy Outpatient	100%	70% after deductible	100%	70% after deductible
Well-Child Immunizations	100%	Not Covered, except for children under 12 months 70% no deductible	100%	70% no deductible


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	SEHBP Horizon NJ Direct 15		Horizon Blue Cross Blue Shield Direct Access 15	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Adult Immunizations	100%	Not Covered	100%	70% no deductible
Routine Adult Physical Exams	100%	Not Covered	100%	70% no deductible
Routine OB/GYN Exam	100%	70% after deductible	100%	70% no deductible
Routine Eye Exam	100% after \$15 copay	Not Covered	100% after \$15 copay	Not Covered
Imaging Tests (MRIs, MRAs, CAT & PET Scans)	100%	70% after deductible	100%	70% after deductible
X-Rays/Lab Tests	100%	70% after deductible	100%	70% after deductible
Maternity (Physician)	100% after \$15 copay for initial visit	70% after deductible	100% after \$15 copay for initial visit	70% after deductible


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	In-Network	Out-of-Network	In-Network	Out-of-Network
Well Child Care	100%	Not Covered	100%	70% no deductible
Alcohol Abuse (Outpatient)	100%	70% after deductible	100%	70% after deductible
Alcohol Abuse (In-patient)	100%	70% after deductible	100%	70% after deductible
Mental Health (In-patient)	100%	70% after deductible	100%	70% after deductible
Mental Health (Office visit)	100% after \$15 copay	70% after deductible	100% after \$15 copay	70% after deductible
Physical/Speech/ Occupational Therapy	100% after \$15 copay	70% after deductible Maximum of \$52 per visit*	100% after \$15 copay	70% after deductible

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	In-Network	Out-of-Network	In-Network	Out-of-Network
Ambulance	90%	70% after deductible	90%	70% after deductible
Acupuncture	100% after \$15 copay	70% after deductible Maximum of \$60 per visit*	100% after \$15 copay	70% after deductible
Diabetes Supplies	90%	70% after deductible	90%	70% after deductible
Deductibles (Individual)	N/A	\$150	N/A	\$150
Deductibles (Family Maximum)	N/A	\$250	N/A	\$250
Maximum Coinsurance Out-of-Pocket (Individual)	\$400	\$2,000	\$400	\$2,000

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	SEHBP Horizon NJ Direct 15		Horizon Blue Cross Blue Shield Direct Access 15	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Maximum Coinsurance Out-of-Pocket (Family)	\$1,000	\$5,000	\$800	\$5,000
Maximum Out-of-Pocket (Individual) (coinsurance & deductible)	\$400	\$2,000	\$400	\$2,000
Maximum Out-of-Pocket (Family) (coinsurance & deductible)	\$1,000	\$5,000	\$800	\$5,000
Annual/Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Dependent Definitions	Your dependents are your lawful spouse or civil union partner and your dependent children until the <u>end of the year</u> in which they turn age 26.		Your dependents are your lawful spouse or civil union partner and your dependent children until the <u>end of the year</u> in which they turn age 26.	

*** Chiropractic, acupuncture, and physical therapy have a different fee schedule that applies to the SEHBP NJ Direct 15. These dollar caps do not apply to the Horizon Direct Access 15.**


Highlighted fields are better benefits

The network utilized by both the SEHBP NJ Direct 15 and the Horizon Blue Cross Blue Shield Direct Access 15 is the same network.


**POMPTON LAKES BOARD OF EDUCATION COMPARISON
SCHOOL EMPLOYEES' HEALTH BENEFIT PLAN HORIZON NJEHP
AND
HORIZON BLUE CROSS BLUE SHIELD NJEHP**

	SEHBP Horizon NJEHP		Horizon Blue Cross Blue Shield NJEHP	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Hospital In-patient	100%	70% after deductible	100%	70% after deductible
Skilled Nursing Facility	100% 120 days per cal. Year	70% after deductible 60 days per cal. Year	100% 120 days per cal. Year	70% after deductible 60 days per cal. Year
Hospital Pre-Admission Testing	100%	70% after deductible	100%	70% after deductible
Ambulatory Surgical Center	100%	70% after deductible	100%	70% after deductible
Physician (Surgery)	100%	70% after deductible	100%	70% after deductible
Primary Care (Office Visits)	100% after \$10 copay	70% after deductible	100% after \$10 copay	70% after deductible
Specialist (Office Visits)	100% after \$15 copay	70% after deductible	100% after \$15 copay	70% after deductible


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	SEHBP Horizon NJEHP		Horizon Blue Cross Blue Shield NJEHP	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Chiropractic	100% after \$15 copay	Lesser of \$35/visit or 75% of In-Network cost/visit after deductible	100% after \$15 copay	70% after deductible
	30 visits per cal. year – Based on medical necessity		30 visits per cal. year – Based on medical necessity	
Emergency Room	100% after \$125 copay		100% after \$125 copay	
Durable Medical Equipment	90%	70% after deductible	90%	70% after deductible
Radiation/ Chemotherapy Outpatient	100%	70% after deductible	100%	70% after deductible
Well-Child Immunizations	100%	70% after deductible for children under 12 months of age only	100%	70% no deductible
Adult Immunizations	100%	Not Covered	100%	70% no deductible


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	SEHBP Horizon NJEHP		Horizon Blue Cross Blue Shield NJEHP	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Routine Adult Physical Exams	100%	Not Covered	100%	70% no deductible
Routine OB/GYN Exam	100%	70% after deductible	100%	70% no deductible
Routine Eye Exam	100% after \$15 copay	Not Covered	100% after \$15 copay	Not Covered
Imaging Tests (MRIs, MRAs, CAT & PET Scans)	100%	70% after deductible	100%	70% after deductible
X-Rays/Lab Tests	100%	70% after deductible	100%	70% after deductible
Maternity (Physician)	100% after \$15 copay for initial visit	70% after deductible	100% after \$15 copay for initial visit	70% after deductible
Well Child Care	100%	Not Covered	100%	70% no deductible


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	SEHBP Horizon NJEHP		Horizon Blue Cross Blue Shield NJEHP	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Alcohol Abuse (Outpatient)	100%	70% after deductible	100%	70% after deductible
Alcohol Abuse (In-patient)	100%	70% after deductible	100%	70% after deductible
Mental Health (In-patient)	100%	70% after deductible	100%	70% after deductible
Mental Health (Office visit)	100% after \$15 copay	70% after deductible	100% after \$15 copay	70% after deductible
Physical Therapy	100% after \$15 copay	75% of In-Network cost/visit currently \$52 after deductible	100% after \$15 copay	75% of In-Network cost/visit currently \$52 after deductible
Ambulance	90%	70% after deductible	90%	70% after deductible
Acupuncture	100% after \$15 copay	Lesser of \$60/visit or 75% of In-Network cost/visit after deductible	100% after \$15 copay	Lesser of \$60/visit or 75% of In-Network cost/visit after deductible

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	SEHBP Horizon NJEHP		Horizon Blue Cross Blue Shield NJEHP	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Diabetes Supplies	90%	70% after deductible	90%	70% after deductible
Deductibles (Individual)	N/A	\$350	N/A	\$350
Deductibles (Family Maximum)	N/A	\$700	N/A	\$700
Maximum Coinsurance Out-of-Pocket (Individual)	\$500	\$2,000	\$500	\$2,000
Maximum Coinsurance Out-of-Pocket (Family)	\$1,000	\$5,000	\$1,000	\$5,000
Maximum Out-of-Pocket (Individual) (copays, coinsurance & deductible)	\$500	\$2,000	\$500	\$2,000
Maximum Out-of-Pocket (Family) (copays, coinsurance & deductible)	\$1,000	\$5,000	\$1,000	\$5,000
Annual/Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited

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	SEHBP Horizon NJEHP		Horizon Blue Cross Blue Shield NJEHP	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Dependent Definitions	Your dependents are your lawful spouse or civil union partner and your dependent children until the <u>end of the year</u> in which they turn age 26.		Your dependents are your lawful spouse or civil union partner and your dependent children until the <u>end of the year</u> in which they turn age 26.	

***The Out of Network Fee Schedule is 200% CMS on both the SEHBP NJEHP & HBCBS NJEHP**

*** Out of Network Chiropractic, acupuncture, and physical therapy have a different fee schedule that applies to the SEHBP NJEHP. Only acupuncture and physical therapy have a different fee schedule that applies to the Horizon Blue Cross Blue Shield NJEHP.**

Highlighted Fields are better benefits.

The network, utilized by both the SEHBP NJEHP and the Horizon Blue Cross Blue Shield NJEHP, is the same network.