JACKSON BOARD OF EDUCATION

COMPARISON OF HORIZON DIRECT ACCESS 35 vs. HORIZON OMNIA vs. HORIZON Direct Access NJEHP MEDICAL/RX PLANS

	Horizon Direct Access $35		Horizon OMNIA		Horizon Direct Access NJEHP	
	In-Network	Out-of-Network	In-Network Tier 1	In-Network Tier 2	In-Network	Out-of-Network
Service Area	Unrestricted	Unrestricted	New Jersey Limited PA and NY	Unrestricted	Unrestricted	Unrestricted
Hospital In-patient	100%	80% after deductible	100% after $150 copay	80% after deductible	100%	70% after deductible
Skilled Nursing Facility	100%	80% after deductible	100%	80% after deductible	100% 120 days per calendar year.	70% after deductible 60 days per calendar year
	120 days per calendar year		100% after $150 copay 100 days per calendar year			
Hospital Pre-Admission Testing	100%	80% after deductible	100%	80% after deductible	100%	70% after deductible
Physician (Inpatient Surgery)	100%	80% after deductible	100%	80% after deductible	100%	70% after deductible
Primary Care (Office Visits)	100% after 35 copay	80% after deductible	100% after $5 copay	100% after $20 copay	100% after $10 copay	70% after deductible
Specialist (Office Visits)	100% after $35 copay	80% after deductible	100% after $15 copay	100% after $30 copay	100% after $15 copay	70% after deductible
Chiropractic	100% after $35 copay	80% after deductible	100% after $15 copay	100% after $30 copay	100% after $15 copay	70% after deductible
	30 visits per calendar year		25 visits per calendar year		30 visits per calendar year	
Emergency Room	100% after $50 copay	100% after $50 copay	100% after $100 copay	100% after $100 copay	100% after $125 copay	100% after $125 copay
Durable Medical Equipment	80% after deductible	80% after deductible	100%	100%	90%	70% after deductible

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	In-Network	**Out-of-Network**	**In-Network Tier 1**	**In-Network Tier 2**	**In-Network**	**Out-of-Network**
Radiation/Chemotherapy Outpatient	100%	80% after deductible	100% in office 100% after $15 copay in outpatient facility	100% in office 80% after deductible in outpatient facility	100%	70% after deductible
Well-Child Immunizations	100%	80% no deductible	100%	100%	100%	70% no deductible
Routine Adult Physical Exams	100%	80% no deductible	100%	100%	100%	Not Covered
X-Rays/Lab Tests	100%	80% after deductible	100% in office or Lab Corp. 100% after $15 copay in outpatient facility	100% in office or Lab Corp. 80% after deductible in outpatient facility	100%	70% after deductible
Maternity (Physician)	100%, after $35 copay for initial visit	80% after deductible	100% after $15 copay for initial visit	100% after $30 copay for initial visit	100% after $15 copay for initial visit	70% after deductible
Well Child Care	100%	80% no deductible	100%	100%	100%	70% no deductible
Alcohol Abuse (Office visit)	100%	80% after deductible	100% after $15 copay	100% after $30 copay	100% after $15 copay	70% after deductible
Alcohol Abuse (In-patient)	100%	80% after deductible	100%	80% after deductible	100%	70% after deductible
Mental Health (Inpatient)	100%	80% after deductible	100%	80% after deductible	100%	70% after deductible
Mental Health/Alcohol Abuse (Office visit)	100% after $35 copay	80% after deductible	100% after $15 copay	100% after $30 copay	100% after $15 copay	70% after deductible

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	In-Network	**Out-of-Network**	**In-Network Tier 1**	**In-Network Tier 2**	**In-Network**	**Out-of-Network**
Routine Vision Exam	$35 paid at 100% toward cost of exam	80% after deductible, maximum of $35	100% after $15 copay	100% after $30 copay	100% after $15 copay	70% after deductible
	Hardware – Scheduled		Hardware Adults – Not Covered Hardware Children – Up to $125 per year		Hardware – Not Covered	
Physical/Speech Therapy	100%	80% after deductible	100% after $5 copay 100% after $5 copay in outpatient facility	100% after $20 copay 80% after deductible in outpatient facility	100% after $15 copay	70% after deductible, Max per visit $52
	30 visits per calendar year		30 visits per calendar year			
Ambulance	80% after deductible	80% after deductible	100%	100%	90%	70% after deductible
Foot Orthotics	100% after $35 copay	80% after deductible	100% after $5 copay	100% after $20 copay	100% after $15 copay	70% after deductible
Oxygen & Administration	80% after deductible	80% after deductible	100%	100%	90%	70% after deductible
Diabetes Supplies	80% after deductible	80% after deductible	100%	100%	90%	70% after deductible
Home Health Care	100%	80% after deductible Up to 100 visits	100% after $5 copay	100% after $5 copay	100%	70% after deductible Up to 100 visits
Hospice	100%	80% after deductible	100%	100%	100%	70% after deductible

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	In-Network	**Out-of-Network**	**In-Network Tier 1**	**In-Network Tier 2**	**In-Network**	**Out-of-Network**
Prescription Drug	Retail- Generic- $15 copay Brand Name- $30 copay Mail Order- Generic- $15 Copay Brand- $30 copay		Retail- Generic- $15 copay Brand Name- $30 copay Mail Order- Generic- $15 Copay Brand- $30 copay		**Mandatory Generic** **(Member pays the difference between generic and brand name plus brand copay)** **Step Therapy is included** Retail- Generic- $5 copay Brand Name- $10 copay Mail Order- Generic- $10 Copay Brand- $20 copay	
Deductibles (Individual)	$250		N/A	$1,500	$350	
Deductibles (Family Maximum)	$500		N/A	$3,000	$700	
Maximum Out-of-Pocket (Individual)	$1,000		$2,500	$4,500	$500	$2,000
Maximum Out-of-Pocket (Family)	$2,000		$5,000	$9,000	$1,000	$5,000
Maximum Plan Covered Expenses Annual/Lifetime	Unlimited		Unlimited		Unlimited	

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