CCESC

Current Horizon PPO v. SEHBP NJ Direct10 & NJ Direct15

Yellow Shaded Boxes Reflect Reduction in Benefits

Green Shaded Boxes Reflect Enhancement in Benefits

	Current Horizon PPO		SEHBP NJ DIRECT10		SEHBP NJ DIRECT15	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Benefit Period	Calendar Year		Calendar Year		Calendar Year	
Provider Network	NJ: Horizon PPO / Out-of-State: Blue Card PPO	Does not apply	NJ: Horizon Direct Access / Out-of-State: Blue Card PPO	Does not apply	NJ: Horizon Direct Access / Out-of-State: Blue Card PPO	Does not apply
Service Area	Nationwide	Unrestricted	Nationwide	Unrestricted	Nationwide	Unrestricted
Primary Care Physician	No	Does not apply	No	Does not apply	No	Does not apply
Specialist Referral Requirement	No	Does not apply	No	Does not apply	No	Does not apply
Coordination of Benefits	Yes	Yes	D15 & HMO's	D15 & HMO's	D10 & HMO's	D10 & HMO'sy
Hospital Inpatient	100%	80% after deductible	100%	80% after Deductible	100%; no copayment	70% after Deductible
Skilled Nursing Facility	100% 120 days per benefit period following a 3 or more day prior hospital stay	80% after deductible 120 days per benefit period following a 3 or more day prior hospital stay	100%; no copayment; for up to120 days per calendar year; combined in-network and out-of-network	80% after deductible; up to 60 days per calendar year; combined in-network and out-of-network	100%; no copayment; for up to120 days per calendar year; combined in-network and out-of-network	70% after deductible; up to 60 days per calendar year; combined in-network and out-of-network
Physician (Surgery)	100%	80% after deductible	100%	80% after deductible	100%	70% after deductible
Physician (Office Visits)	100% after $20 copayment	80% after deductible	100% after $10 copayment per visit	80% after deductible, No coverage for wellness care	100% after $15 copayment per visit	70% after deductible, No coverage for wellness care
Allergy Testing	100% after $20 copayment	80% after deductible	100% after $10 copayment per visit	80% after deductible	100% after $15 copayment per visit	70% after Deductible
Chiropractic (Therapeutic Manipulations)	100% after $20 copayment; 30 visits per benefit period; combined in and out of network	80% after deductible; 30 visits per benefit period; combined in and out of network	100% after $10 per visit copayment; 30 visits per calendar year; combined in and out of network	80% after deductible for up to 30 visits per calendar year combined in & out of network	100% after $15 per visit copayment; 30 visits per calendar year; combined in and out of network	70% after deductible for up to 30 visits per calendar year combined in & out of network
Hospital Emergency Room	100% after $50 copayment (copayment waived if admitted)	100% after $50 copayment (copayment waived if admitted)	100% after $25 copayment; copayment waived if admitted	100% after $25 copayment; copayment waived if admitted	100% after $50 copayment if reported within 48 hours; copayment waived if admitted	100% after $50 copayment if reported within 48 hours; copayment waived if admitted
Durable Medical Equipment	80% after deductible	80% after deductible	90%; no copayment	80% after deductible	90%; no copayment	70% after deductible
Ambulance (For Emergency Transportation Only)	80% after deductible	80% after deductible	90%; no copayment	80% after deductible	90%; no copayment	70% after deductible
Immunizations	100% after $20 copayment	80% (no deductible)	100% after $10 copayment per visit (except for travel and/or job related)	Not covered except for children under 12 months; 80% after deductible	100% after $15 copayment per visit (except for travel and/or job related)	Not covered except for children under 12 months; 70% after deductible
Maternity	100% after $20 copayment	80% after deductible	$10 copayment for first prenatal office visit then 100% covered	80% after deductible	$15 copayment for first prenatal office visit than 100% covered	70% after deductible
Physical Exams	100% after $20 copayment - One routine physical exam per year.	80% (no deductible) One routine physical exam per year.	100% after $10 copayment per visit	Not covered	100% after $15 copayment per visit	Not covered
Annual Routine OBGYN Exams	100% after $20 copayment - One routine ob/gyn exam per year. One pap smear per calendar year.	80% after deductible - One routine ob/gyn exam per year. One pap smear per calendar year.	100% after $10 copayment per visit	80% after deductible	100% after $15 copayment per visit	70% after deductible
Annual Routine Mammogram	100% after $20 copayment - One baseline mammography between ages 35 and 40; annual mammography over age 40.	80% no deductible - One baseline mammography between ages 35 and 40; annual mammography over age 40.	100% after $10 copayment per visit	80% after deductible	100% after $15 copayment per visit	70% after deductible
Prostate Screening	100% after $20 copayment - One routine prostate screen per calendar year	80% no deductible - One routine prostate screen per calendar year	100% after $10 copayment per visit	Not covered	100% after $15 copayment per visit	Not covered
Well Baby	100% after $20 copayment, $300 maximum per calendar year combined in and out of network	80% after deductible, $300 maximum per calendar year combined in and out of network	100% after $10 copayment per visit	Not covered	100% after $15 copayment per visit	Not covered
Radiation/Chemo-therapy Outpatient	100%	80% after deductible	100%; no copayment	80% after deductible	100%; no copayment	70% after deductible
Hospice Care	100%	80% after deductible	100%; no copayment	80% after deductible	100%; no copayment	70% after deductible
Outpatient Therapy - Physical, Speech and Occupational Therapy	100% There is a maximum of 30 visits for each therapy per benefit period, combined in and out of network	80% after deductible - There is a maximum of 30 visits for each therapy per benefit period, combined in and out of network	100% after $10 co-payment per visit	80% after deductible	100% after $15 co-payment	70% after deductible
X-Rays and Lab Tests (outpatient)	100%	80% after deductible	100%; no copayment	80% after deductible	100%; no copayment	70% after deductible
Routine Vision Exam	Not Covered	Not Covered	100% after $10 copayment; one exam per calendar year	Not covered	100% after $15 copayment; one exam per calendar year	None
Alcohol Abuse (Inpatient)	Same as any other illness	Same as any other illness	Same as any other illness	Same as any other illness	Same as any other illness	Same as any other illness
Drug Abuse (Inpatient)	100% - 30 days maximum per benefit period, combined in and out of network and combined with Mental Health	80% after deductible - 30 days maximum per benefit period, combined in and out of network and combined with Mental Health	Same as any other illness	Same as any other illness	Same as any other illness	Same as any other illness
Alcohol Abuse (Outpatient)	Same as any other illness	Same as any other illness	100%, no visit limit	80% after deductible	100%; no copayment; no visit limit	70% after deductible

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Drug Abuse (Outpatient)	Covered at 50% up to 20 visits per benefit period in eligible expenses, subject to deductible, combined in and out of network and combined with Mental Health	Covered at 50% up to 20 visits per benefit period in eligible expenses, subject to deductible, combined in and out of network and combined with Mental Health	100%, no visit limit	80% after deductible	100%; no copayment; no visit limit	70% after deductible
Mental Health (Inpatient)	100% - 30 days maximum per benefit period, combined in and out of network and combined with Mental Health	100% - 30 days maximum per benefit period, combined in and out of network and combined with Mental Health	100%; no copayment; up to 25 days per calendar year; balance at 90% up to annual and/or lifetime maximums	50 days per calendar year at 50% after deductible up to annual lifetime maximum	100%; no copayment; up to 25 days per calendar year; balance at 90% up to annual and/or lifetime maximums	50 days per calendar year at 50% after deductible up to annual lifetime maximum
Mental Health (Outpatient)	Covered at 50% up to 20 visits per benefit period in eligible expenses, subject to deductible, combined in and out of network and combined with Mental Health	Covered at 50% up to 20 visits per benefit period in eligible expenses, subject to deductible, combined in and out of network and combined with Mental Health	90% up to annual and/or lifetime maximums	80% after deductible up to annual and/or lifetime maximums	90% up to annual and/or lifetime maximums	70% after deductible up to annual and/or lifetime maximums
Home Health Care	100% - 90 visits, up to $4,500 per benefit period, direct admission	80% after deductible - 90 visits, up to $4,500 per benefit period, direct admission	100%. Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered.	80% after deductible. Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered.	100%. Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered.	70% after deductible. Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered.
Private Duty Nursing (Must be Medically Necessary)	80% after deductible - 240 hours per benefit period subject to medical necessity; services of an RN or LPN are eligible out-of-hospital only	80% after deductible - 240 hours per benefit period subject to medical necessity; services of an RN or LPN are eligible out-of-hospital only	90%. Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities.	80% after deductible. Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities.	100%. Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities.	70% after deductible. Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities.
Infertility Services (Must be pre-authorized)	100% after $20 copayment - 4 egg retrievals per lifetime	80% after deductible - 4 egg retrievals per lifetime	Diagnosis covered after $10 copayment; treatment covered with limitations after $10 copayment as per NJ State Mandate	Diagnosis covered at 80% after deductible; treatment covered with limitations at 80% after deductible as per NJ State Mandate	Diagnosis covered after $15 copayment; treatment covered with limitations after $15 copayment	Diagnosis covered at 70% after deductible; treatment covered with limitations at 70% after deductible
Deductible (Individual)	$200 per calendar year, Supplemental services only	$200 per calendar year	None	$100 per calendar year	None	$100 per calendar year
Deductible (Family Maximum)	Two individual per calendar year, Supplemental services only	Two individual per calendar year	None	$250 per family, per calendar year	None	$250 per family, per calendar year
Maximum Out-of-Pocket (Individual)	$1,000 per calendar year, Supplemental services only, combined in and out of network (coinsurance only)	$1,000 per calendar year, combined in and out of network (coinsurance only)	$400 per calendar year (includes in-network copayments and coinsurance)	$2,000 per calendar year (both in-network and out-of-network copays and coinsurance accrue toward satisfaction of out-of- network out-of-pocket maximum).	$400 per calendar year (coinsurance only)	$2,000 per calendar year (coinsurance only)
Maximum Out-of-Pocket (Family)	Two individual per calendar year , Supplemental services only, combined in and out of network (coinsurance only)	Two individual per calendar year, combined in and out of network (coinsurance only)	$1,000 per calendar year (includes in-network copayments and coinsurance)	$5,000 per calendar year (Both in-network and out-of-network copays and coinsurance accrue toward satisfaction of out-of-network out-of-pocket maximum).	$1,000 per calendar year (coinsurance only)	$5,000 per calendar year (coinsurance only)
Maximum Plan covered Expenses Annual/Lifetime	Unlimited	Unlimited	Unlimited, $15,000 annual mental health; $50,000 lifetime mental health; up to $2,000 restoration feature each year up to $50,000.	$1,000,000 lifetime; $15,000 annual mental health; $50,000 lifetime mental health; up to $2,000 restoration feature each year up to $50,000.	Unlimited, $15,000 annual mental health; $50,000 lifetime mental health; up to $2,000 restoration feature each year up to $50,000.	$1,000,000 lifetime; $15,000 annual mental health; $50,000 lifetime mental health; up to $2,000 restoration feature each year up to $50,000.
Drug Copay Reimbursement	Not Applicable	Not Applicable	No Coverage	No Coverage	No Coverage	No Coverage
Office Copay Reimbursement	Not Applicable	Not Applicable	No Coverage	No Coverage	No Coverage	No Coverage
Out-of-Network UCR	Not Applicable	80th HIAA	Not Applicable	90th HIAA	Not Applicable	90th HIAA
Child Termination Age	23, end of calendar year		23, end of calendar year		23, end of calendar year	