

**CCESC Board of Education
Current Horizon HMO v. SEHBP Aetna HMO**

Yellow Shaded Boxes Reflect Reduction in Benefits (other than differences in copayments)

Green Shaded Boxes Reflect Enhancement in Benefits

	Current Horizon HMO (\$5 Copay for most services)		SEHBP AETNA HMO (\$10 Copay for most services)	
	In-Network	Out-of-Network	In-Network Only	Out-of-Network
Benefit Period	Calendar Year	No Coverage	Calendar Year	No Coverage
Provider Network	Horizon HMO	No Coverage	Aetna HMO	No Coverage
Service Area	Regional	No Coverage	Nationwide	No Coverage
Primary Care Physician	Yes	No Coverage	Yes	No Coverage
Specialist Referral Requirement	Yes	No Coverage	Yes	No Coverage
Coordination of Benefits	Yes	No Coverage	Yes	No Coverage
Office Copayments	100% after \$5 Copayment per visit for most services	No Coverage	100% after \$10 Copayment per visit for most services	No Coverage
Hospital Inpatient	100%; no copayment	No Coverage	100%; no copayment	No Coverage
Skilled Nursing Facility	100% up to 60 days per calendar year	No Coverage	100%; no copayment; for up to 120 days per calendar year	No Coverage
Physician (Surgery)	100%	No Coverage	100%; no copayment	No Coverage
Physician (Office Visits)	100% after \$5 copayment per visit	No Coverage	100% after \$10 copayment per visit	No Coverage
Allergy Testing	100% after \$5 copayment per visit	No Coverage	100% after \$10 copayment per visit	No Coverage
Chiropractic (Therapeutic Manipulations)	50% after \$5 copayment for first 6 visits; 25% after \$5 copayment for next 6 visits; Limited to 12 visits	No Coverage	100% after \$10 per visit copayment; limit of 20 visits per calendar year; PCP referral required	No Coverage
Hospital Emergency Room	100% after \$50 copayment (copayment waived if admitted)	No Coverage	100% after \$35 copayment; copayment waived if admitted	No Coverage
Durable Medical Equipment	80%	No Coverage	\$100 deductible; then 100% for rest of calendar year	No Coverage
Ambulance (For Emergency Transportation Only)	100%	No Coverage	100%; no copayment	No Coverage
Immunizations	100% after \$5 copayment per visit	No Coverage	100% after \$10 copayment per visit (except for travel and/or job related)	No Coverage
Maternity	\$5 copayment for first prenatal office visit then 100% covered	No Coverage	\$10 copayment for first prenatal office visit then 100% covered	No Coverage
Physical Exams	100% after \$5 copayment; 1 per year	No Coverage	100% after \$10 copayment per visit	No Coverage
Annual Routine OBGYN Exams	100% after \$5 copayment per visit; 1 routine exam per year no referral required	No Coverage	100% after \$10 copayment per visit	No Coverage
Annual Routine Mammogram	100%, covered per NJ state mandate	No Coverage	100%; no copayment	No Coverage
Prostate Screening	100%, covered per NJ state mandate	No Coverage	100% after \$10 copayment per visit	No Coverage
Well Baby	100% after \$5 copayment	No Coverage	100% after \$10 copayment per visit	No Coverage
Radiation/Chemo-therapy Outpatient	100% after \$5 copayment	No Coverage	100%; no copayment	No Coverage
Hospice Care	100% limited to \$100,000 lifetime maximum; Respite care limited to 7 days	No Coverage	100%; no copayment	No Coverage
Outpatient Therapy - Physical, Speech and Occupational Therapy	100% after \$5 copayment per visit; 25 visits per benefit period	No Coverage	100% after \$10 co-payment per visit; limit of 60 visits per condition per calendar year	No Coverage
X-Rays and Lab Tests (outpatient)	100% after \$5 copayment per visit (\$35 copayment if OPD is used)	No Coverage	100%; no copayment	No Coverage
Routine Vision Exam	100% after \$5 copayment; one exam per benefit period; no referral; hardware covered \$50 every 2 years	No Coverage	100% after \$10 copayment per visit; NO coverage for hardware	No Coverage
Alcohol Abuse (Inpatient)	100% limited to 30 days per year; 45 days per lifetime on all services except residential alcohol abuse services	No Coverage	Detox 100%; Rehab 100% up to 28 days per occurrence per calendar year	No Coverage
Drug Abuse (Inpatient)	100% limited to 30 days per year; 45 days per lifetime on all services except residential alcohol abuse services	No Coverage	Detox 100%; Rehab 100% up to 28 days per occurrence per calendar year	No Coverage
Alcohol Abuse (Outpatient)	100% after \$25 copayment limited to 20 visits per year	No Coverage	Detox 100%; Rehab 100% up to 60 visits per calendar year	No Coverage
Drug Abuse (Outpatient)	100% after \$25 copayment limited to 20 visits per year	No Coverage	Detox 100%; Rehab 100% up to 60 visits per calendar year	No Coverage

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	In-Network	Out-of-Network	In-Network Only	Out-of-Network
Mental Health (Inpatient)	100% limited to 30 days per year, 45 days per lifetime	No Coverage	100%; no copayment; up to 35 days per calendar year	No Coverage
Mental Health (Outpatient)	100% after \$25 copayment limited to 20 visits per year	No Coverage	100% after \$10 co-payment per visit; up to 30 visits per calendar year	No Coverage
Home Health Care	100% limited to 100 visits per benefit period	No Coverage	100%. Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered.	No Coverage
Private Duty Nursing (Must be Medically Necessary)	Maximum 60 8-hour shifts per benefit period per Member	No Coverage	100%; no copayment if deemed medically necessary	No Coverage
Infertility Services (Includes In-vitro Fertilization per NJ Mandate)	Covered per NJ State mandate - subject to \$5 copay	No Coverage	Diagnosis covered after \$10 copayment; treatment covered with limitations after \$10 copayment as per NJ State Mandate	No Coverage
Deductible (Individual)	None	No Coverage	None	No Coverage
Deductible (Family Maximum)	None	No Coverage	None	No Coverage
Maximum Out-of-Pocket (Individual)	\$400 per individual per year, Supplemental services only	No Coverage	No Maximum	No Coverage
Maximum Out-of-Pocket (Family)	Two individual family maximums per year, Supplemental services only	No Coverage	No Maximum	No Coverage
Maximum Plan covered Expenses Annual/Lifetime	\$100,000 per lifetime, Supplemental services only	No Coverage	Unlimited	No Coverage
Drug Copay Reimbursement	Not Applicable	No Coverage	Not Applicable	No Coverage
Office Copay Reimbursement	Not Applicable	No Coverage	Not Applicable	No Coverage
Out-of-Network UCR	Not Applicable	No Coverage	Not Applicable	No Coverage
Child Termination Age	23, end of calendar year	No Coverage	23, end of calendar year	No Coverage