January 1, 2021 Benefits Plan Comparison

Edison Public Schools

Pre-Existing Conditions: Does not Apply with any plans due to the Affordable Care Act.

Horizon BCBSNJ	Horizon Direct Access (Design 8)		Horizon Direct Access EDU Plan Mandatory Benefit Plan for all New Employees hired as of 7/1/2020.	
Benefit Levels	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
*Network Deductible	None	$125 per person/$250 per family	None	$350 per person/$700 per family
Coinsurance	100%	80%	100%	70%
*Maximum Out-of-pocket	$400 individual/$800 family	$2,000 individual/ $5,000 per family	$500 per person/$1,000 per family	$2,000 per person/ $5,000 per family
Lifetime Maximums	Unlimited		Unlimited	
Primary Care Office Visits	100% after $10 copay (no referrals)	80% after deductible (no referrals)	100% after $10 copay	70% after deductible
Specialist Office Visits	100% after $15 copay (no referrals)	80% after deductible (no referrals)	100% after $15 copay	70% after deductible
Maternity Visits	100% after $15 copay (Copay applies to 1st visit only)	80% after deductible	100% after $15 copay (Copay applies to 1st visit only)	70% after deductible
Routine Physicals (GYN and Well Child Exams, PAP, Mammograms, Prostate Cancer Screenings, Immunizations & Lead Screenings)	100%	80% no deductible	100%	70% (no deductible)
X-ray and Lab	100% in Office, Labcorp or Outpatient Facility	80% after deductible	100%	70% after deductible
Emergency Room	100% after $50 facility copay (waived if admitted)		100% after $100 facility copay(waived if admitted)	
Ambulance	90%	80% after deductible	90%	70% after deductible
Hospital & Surgery: Inpatient	100%	80% after deductible	100%	70% after deductible
Hospital & Surgery: Outpatient	100%	80% after deductible	100%	70% after deductible
Mental Health, Susbstance Abuse & Alcohol Abuse: Inpatient/Outpatient Department	100%	80% after deductible	100% after $15 Copay	70% after deductible
Home Health Care	100%	80% after deductible	100%	70% after deductible
Hospice	100%	80% after deductible	100%	70% after deductible
*Skilled Nursing Facility/Extended Care	100% up to 120 days (combined for both in & out of Network)	80% after deductible up to 60 days	100% (Up to 120 days per benefit period)	70% after deductible (60 visits max)
Diabetic Supplies	100%	80% after deductible	100%	70% after deductible
Durable Medical Equipment	90%	80% after deductible	90%	70% after deductible
Diabetic Education	100% after $15 copay	80% after deductible	100% after $15 copay	70% after deductible
Acupuncture	100%	80% after deductible	100% after $15 Copay	70% after deductible maximum allowance per visit up to $60
Therapeutic Manipulations (Chiro)	100% after $15 office copay	80% after deductible	100% after $15 Copay	70% after deductible
Physical Therapy	100% after $10 copay	80% after deductible	100% after $15 Copay	70% after deductible maximum allowance per visit up to $52
Short Term Therapies: Occupational, Speech, and Respitory	100% after $10 copay	80% after deductible	100% after $15 Copay	70% after deductible
Routine Eye Exams	100% after $15 Copay	80% after deductible	100% after $15 Copayment (1 yr.)	Not Covered
Prescription Drug Coverage	ETEA Rx Plan: Retail: $5 generics /$15 Brand - Mail Order: $10 generics/$30 Brand Name for 90 day supply		Horizon Direct Access EDU Rx Plan: Retail: $5 - Generic/$10 - Brand Mail Order: $10 Generic/$20 Brand *Mandatory Programs Required Ex. Mandatory Generics, Step Therapy, etc.	Copay + amount above the Allowed Amount (Specialty drugs - not covered)
Prescription MOOP:	$3,550 Individual/$7,100 Family		$1,600 Individual/ $3,200 Family	Not Included in Out-of-Pocket Maximum

*Deductibles & Maximum Out of Pocket : Based on a calendar year

*Skilled Nursing Facility:(In-network days accumulate toward the OON benefit period max & vice versa - combined benefit max is 120 days)

*The NJEHP Prescription Program has many restrictions including: Step Therapy, Mandatory Generics Program, Performance Preferred Medication Program as well as Mandatory Mail-Order for Specialty Medication and a Restrictive Closed Formulary.

Benefit comparison is for illustrative purposes. It is not a contract and some limitations and exclusions may apply. Please refer to benefit summaries/booklets for detailed information.

January 1, 2021 Benefits Plan Comparison

Edison Twp Public Schoos

Pre-Existing Conditions: Does not Apply with any plans due to the Affordable Care Act.

Horizon BCBSNJ	Advantage EPO Plan (In-Network Only)	Horizon Direct Access EDU Plan Mandatory Benefit Plan for all New Employees hired as of 7/1/2020.	
Benefit Levels	**In-Network Only (no referrals)**	**In-Network**	**Out-of-Network**
*Network Deductible	None	None	$350 per person/$700 per family
Coinsurance	100%	100%	70%
*Maximum Out-of-pocket	$2,500 individual/$5,0000 per family	$500 per person/$1,000 per family	$2,000 per person/ $5,000 per family
Lifetime Maximums	Unlimited	Unlimited	
Primary Care Office Visits	100% after $20 copay	100% after $10 copay	70% after deductible
Specialist Office Visits	100% after $40 copay	100% after $15 copay	70% after deductible
Maternity Visits	100% after $40 copay (Copay applies to 1st visit only)	100% after $15 copay (Copay applies to 1st visit only)	70% after deductible
Routine Physicals (GYN & Well Child Exams, PAP, Mammograms, Prostate Cancer Screenings, Immunizations & Lead Screenings)	100%	100%	70% (no deductible)
X-ray and Lab	100% in Office, Labcorp or Outpatient Facility	100%	70% after deductible
Emergency Room	100% after $100 facility copay	100% after $100 facility copay(waived if admitted)	
Ambulance	100%	90%	70% after deductible
Hospital & Surgery: Inpatient	100% after $250 copay per day (up to 5 days)	100%	70% after deductible
Hospital & Surgery: Outpatient	Hospital: 100% after $200 copay/Surgery in Ambulatory SurgiCenter: 100% after $100 copay	100%	70% after deductible
Mental Health, Susbstance Abuse & Alcohol Abuse: Inpatient/Outpatient Department	Inpatient: 100% after $250 copay per day (up to 5 days)/ Outpatient Dept: 100%	100% after $15 Copay	70% after deductible
Infertility Services (including in-vitro fertilization)	100% after office copay (100% in outpatient facility)	100% after $15 Copayment (Outpatient)	70% after deductible
Home Health Care	100%	100%	70% after deductible
Hospice	100%	100%	70% after deductible
*Skilled Nursing Facility/Extended Care	100% Limited to 100 days per benefit period	100% (Up to 120 days per benefit period)	70% after deductible (60 visits max)
Diabetic Supplies	100%	100%	70% after deductible
Diabetic Education	100% after office copayment	100% after office copayment	70% after deductible
Durable Medical Equipment	50%	90%	70% after deductible
Acupuncture	100% after $40 copay	100% after $15 Copay	70% after deductible maximum allowance pervisit up to $60
Therapeutic Manipulations (Chiro)	100% after $20 copay	100% after $15 Copay	70% after deductible
Limit	25 visits per benefit period	30 Visits per benefit period	
Physical Therapy	100% after $20 copay/30 visit max per therapy, per benefit period	100% after $15 Copay	70% after deductible maximum allowance per visit up to $52
Short Term Therapies: Occupational, Speech, Respitory	100% after $20 copay/30 visit max per therapy, per benefit period	100% after $15 Copay	70% after deductible
Routine Eye Exams	100% after $40 copay	100% after $15 Copayment (1 yr.)	Not Covered
Vision Hardware	$50 every two years	Not Covered	
Prescription Drug Coverage	Prescription Plan Corresponds to ETEA or Non-ETEA Rx Plan	Horizon Direct Access EDU Rx Plan: Retail: $5 - Generic/$10 - Brand Mail Order: $10 Generic/$20 Brand *Mandatory Programs Required Ex. Mandatory Generics, Step Therapy, etc.	Copay + amount above the Allowed Amount (Specialty drugs - not covered)
Prescription MOOP:		$1,600 Individual/ $3,200 Family	Not Included in Out-of-Pocket Maximum

*Deductibles & Maximum Out of Pocket : Based on a calendar year

*Skilled Nursing Facility:(In-network days accumulate toward the OON benefit period max & vice versa - combined benefit max is 120 days)

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January 1, 2021 Benefits Plan Comparison

Edison Twp Public Schools

Pre-Existing Conditions: Does not Apply with any plans due to the Affordable Care Act.

Horizon BCBSNJ	OMNIA Plan (Tier 1 & 2) (In-Network Only)		Horizon Direct Access EDU Plan Mandatory Benefit Plan for all New Employees hired as of 7/1/2020.	
Benefit Levels	**Tier 1 Benefit Level**	**Tier 2 Benefit Level**	**In-Network**	**Out-of-Network**
*Network Deductible	$0	$1,500/$3,000	None	$350 per person/$700 per family
Coinsurance	100%	80%	100%	70%
*Maximum Out-of-pocket	$2,500 individual/$5,000 family	$4,500 individual/ $9,000 per family	$500 per person/$1,000 per family	$2,000 per person/ $5,000 per family
Lifetime Maximums	Unlimited		Unlimited	
Primary Care Office Visits	$5 copay	$20 copay	100% after $10 copay	70% after deductible
Specialist Office Visits	$15 copay	$30 copay	100% after $15 copay	70% after deductible
Maternity Visits	100% after $15 copay (Copay applies to 1st visit only)	100% after $30 copay (Copay applies to 1st visit only)	100% after $15 copay (Copay applies to 1st visit only)	70% after deductible
Routine Physicals (GYN & Well Child Exams, PAP, Mammograms, Prostate Cancer Screenings, Immunizations & Lead Screenings)	100%		100%	70% (no deductible)
X-ray and Lab	100% in Office or Labcorp/ 100% Outpatient	100% in Office or Labcorp/80% after deductible in Outpatient Facility	100%	70% after deductible
Emergency Room	100% after $100 facility copay		100% after $100 facility copay(waived if admitted)	
Ambulance	100%		90%	70% after deductible
Hospital & Surgery: Inpatient	$250 copayment per day up to 5 day maximum	80% after deductible	100%	70% after deductible
Hospital & Surgery: Outpatient	$150 copay	80% after deductible	100%	70% after deductible
Mental Health, Susbstance Abuse & Alcohol Abuse: Inpatient/Outpatient Department	$250 per day up to 5 day maximum	80% after deductible	100% after $15 Copay	70% after deductible
Infertility Services (including in-vitro fertilization)	100% after $15 copay	100% after $30 copay (80% after deductible for outpatient)	100% after $15 Copayment (Outpatient)	70% after deductible
Home Health Care	100% after $5 copay	100% after $20 copay	100%	70% after deductible
Hospice	$250 per day up to 5 day maximum	80% after deductible	100%	70% after deductible
*Skilled Nursing Facility/Extended Care	$250 per day up to 5 day maximum	80% after deductible	100% (Up to 120 days per benefit period)	70% after deductible (60 visits max)
Diabetic Supplies	100%	80% after deductible	100%	70% after deductible
Durable Medical Equipment	100%	80% after deductible	90%	70% after deductible
Diabetic Education	100% after office visit copay	100% after office visit copay	100% after $15 copay	70% after deductible
Acupuncture	100% after office copayment	100% after office copayment	100% after $15 Copay	70% after deductible maximum allowance pervisit up to $60
Therapeutic Manipulations (Chiro)	100% after $15 copay	100% after $30 copay	100% after $15 Copay	70% after deductble
Limit	25 Visits per benefit period		30 Visits per benefit period	
Physical Therapy	100% after $5 copay/30 visit max per therapy, per benefit period	100% after $20 copay/30 visit max per therapy, per benefit period	100% after $15 copay	70% after deductible maximum allowance per visit up to $52
Short Term Therapies: Occupational, Speech, Respitory	100% after $5 copay/30 visit max per therapy, per benefit period	100% after $20 copay/30 visit max per therapy, per benefit period	100% after $15 Copay	70% after deductible -
Routine Eye Exams	100% after $15 copay	100% after $30 copay	100% after $15 Copayment (1 yr.)	Not Covered
Vision Hardware	Not Covered		Not Covered	
Prescription Drug Coverage	Prescription Plan Corresponds to ETEA or Non-ETEA Rx Plan		Horizon Direct Access EDU Rx Plan: Retail: $5 Generic/$10 Brand Mail Order: $10 Generic/$20 Brand *Mandatory Programs Required Ex. Mandatory Generics, Step Therapy, etc.	Copay + amount above the Allowed Amount (Specialty drugs - not covered)
Prescription MOOP:			$1,600 Individual/ $3,200 Family	Not Included in Out-of-Pocket Maximum

*Deductibles & Maximum Out of Pocket : Based on a calendar year

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