Fair Lawn Board of Education
SEHBP/Horizon Blue Cross Blue Shield of NJ Side by Side Plan Comparison
Effective 7/1/2025

Gallagher

Benefits	Horizon Direct Access 10	Horizon Direct Access 15	Horizon NJ Educators Health Plan (NJEHP)	Horizon Garden State Health Plan (GSHP)
	In-Network	In-Network	In-Network	In-Network
Deductible	$0/$0	$0/$0	$0/$0	$0/$0
Coinsurance	100% *90% on select services**	100% *90% on select services**	100% *90% on select services**	100% *90% on select services**
Coinsurance Maximum Out of Pocket	Not Applicable	$400/$1,000	Not Applicable	Not Applicable
Maximum Out of Pocket	$400/$1,000	$7,360/$14,720	$500/$1,000	$500/$1,000
Primary Care Physician	$10	$15	$10	$10
Specialist	$10	$15	$15	$15
Maternity Visits	100%	$15	$10 / $15 specialist	$10 / $15 specialist
Allergy Test & Treatment	100%	100%	100%	100%
Preventive Care	100%	100%	100%	100%
Diagnostic Procedures *(Laboratory, Outpatient X-Ray/Radiology Services)*	100% in Office, Preferred Lab or Outpatient Facility	100% in Office, Preferred Lab or Outpatient Facility	100% in Office, Preferred Lab or Outpatient Facility	100% in Office, Preferred Lab or Outpatient Facility
Hospital Inpatient	100%	100%	100%	100%
Emergency Room	$25 Copay	$50 Copay	$125 Copay	$125 Copay
Ambulance	90%	90%	90%	90%
Outpatient Surgery	100%	100%	100%	100%
Mental Health/Substance Abuse/Alcohol Abuse Services	100% Inpatient/Outpatient $10 Copay Office setting	100% Inpatient/Outpatient $15 Copay Office setting	100% Inpatient/Outpatient $15 Copay Office setting	100% Inpatient/Outpatient $15 Copay Office setting
Acupuncture	100% after $10 Copay	100% after Office Copay	$15	$15
Bariatric Surgery	100%	100%	100%	100%
Diabetic Education	100% after Office Copay	100% after Office Copay	100% after Office Copay	100% after Office Copay
Diabetic Supplies	90%	90%	90%	90%
Durable Medical Equipment	90%	90%	90%	90%
Home Health Care	100%	100%	100%	100%
Hospice Care	100%	100%	100%	100%
Infertility Treatment *(including in-vitro fertilization)*	100% after Office Copay *Limited to 4 egg retrievals per lifetime*	100% after Office Copay *Limited to 4 egg retrievals per lifetime*	100% after Office Copay *Limited to 4 egg retrievals per lifetime*	100% after Office Copay *Limited to 4 egg retrievals per lifetime*
Nutritional Counseling	$10 *Limited to 3 visits per benefit period*	$15 *Limited to 3 visits per benefit period*	$15 *Limited to 3 visits per benefit period*	$15 *Limited to 3 visits per benefit period*
Orthotics & Prosthetics	$10	$15	$15	$15
Physical Rehabilitation Inpatient Services	100%	100%	100%	100%
Private Duty Nursing	90% *Unlimited*	90% *Unlimited*	90% *Unlimited*	90% *Unlimited*
Short Term Therapies *(Physical, Occupational, Speech, Respiratory)*	$10	$15	$15	$15
Skilled Nursing Facility/Extended Care	100% *Up to 120 Days* *Overall Max 120 days Combined In & OON*	100% *Up to 120 Days* *Overall Max 120 days Combined In & OON*	100% *Up to 120 Days* *Overall Max 120 days Combined In & OON*	100% *Up to 120 Days* *Overall Max 120 days Combined In & OON*
Therapeutic Manipulation (Chiropractic Care)	100% after Office Copay *30 Visit MAX Combined In & OON*	100% after Office Copay *30 Visit MAX Combined In & OON*	100% after Office Copay *30 Visit MAX Combined In & OON*	100% after Office Copay *30 Visit MAX Combined In & OON*
Vision Routine Eye Exam	$10	$15	$15	$15
Vision Hardware	Not Covered	$15	Not Covered	Not Covered
Telemedicine	$10	Not Covered	Not Covered	Not Covered

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	In-Network	In-Network	In-Network	In-Network
Benefits	Out-of-Network	Out-of-Network	Out-of-Network	Out-of-Network
Deductible	$100/$250	$100/$250	$350/$700	$350/$700
Coinsurance	80%	70%	70%	70%
Coinsurance Maximum Out of Pocket	Not Applicable	$2,000/$5,000	Not Applicable	Not Applicable
Maximum Out of Pocket	$2,000/$5,000	$2,000/$5,000	$2,000/$5,000	$2,000/$5,000
Primary Care Physician	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Specialist	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Maternity Visits	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Allergy Test & Treatment	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Preventive Care	Not covered	Not Covered	Not Covered	Not Covered
Diagnostic Procedures *(Laboratory, Outpatient X-Ray/Radiology Services)*	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Hospital Inpatient	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Emergency Room	$25 Copay	$50 Copay	$125 Copay	$125 Copay
Ambulance	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Outpatient Surgery	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Mental Health/Substance Abuse/Alcohol Abuse Services	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Acupuncture	80% after deductible	70% after deductible	70% after deductible **Max Allowance up to $60 per visit*	70% after deductible **Max Allowance up to $60 per visit*
Bariatric Surgery	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Diabetic Education	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Diabetic Supplies	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Durable Medical Equipment	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Home Health Care	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Hospice Care	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Infertility Treatment *(including in-vitro fertilization)*	80% after deductible **Limited to 4 egg retrievals per lifetime*	70% after deductible **Limited to 4 egg retrievals per lifetime*	70% after deductible **Limited to 4 egg retrievals per lifetime*	70% after deductible **Limited to 4 egg retrievals per lifetime*
Nutritional Counseling	80% after deductible **Limited to 3 visits per benefit period*	70% after deductible **Limited to 3 visits per benefit period*	70% after deductible **Limited to 3 visits per benefit period*	70% after deductible **Limited to 3 visits per benefit period*
Orthotics & Prosthetics	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Physical Rehabilitation Inpatient Services	80% after deductible	70% after deductible	70% after deductible	70% after deductible
Private Duty Nursing	80% after deductible **Unlimited*	70% after deductible **Unlimited*	70% after deductible **Unlimited*	70% after deductible **Unlimited*
Short Term Therapies *(Physical, Occupational, Speech, Respiratory)*	80% after deductible	70% after deductible	Physical Therapy: 70% after deductible **Max Allowance up to $52 per visit* OT/Speech/Resp: 70% after deductible	Physical Therapy: 70% after deductible **Max Allowance up to $52 per visit* OT/Speech/Resp: 70% after deductible
Skilled Nursing Facility/Extended Care	80% after deductible **Up to 60 Days *Overall Max 120 days Combined In & OON*	70% after deductible **Up to 60 Days *Overall Max 120 days Combined In & OON*	70% after deductible **Up to 60 Days *Overall Max 120 days Combined In & OON*	70% after deductible **Up to 60 Days *Overall Max 120 days Combined In & OON*
Therapeutic Manipulation (Chiropractic Care)	80% after deductible **30 Visit MAX Combined In & OON*	70% after deductible **30 Visit MAX Combined In & OON*	70% after deductible **Max Allowance up to $32 per visit *30 Visit MAX Combined In & OON*	70% after deductible **Max Allowance up to $32 per visit *30 Visit MAX Combined In & OON*
Vision Routine Eye Exam	Not Covered	Not Covered	Not Covered	Not Covered
Vision Hardware	Not Covered	Not Covered	Not Covered	Not Covered
Telemedicine	Not Covered	Not Covered	Not Covered	Not Covered

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Benefits	Horizon Direct Access 10	Horizon Direct Access 15	Horizon NJ Educators Health Plan (NJEHP)	Horizon Garden State Health Plan (GSHP)
	In-Network	In-Network	In-Network	In-Network
Prescription Benefits				
Formulary	Open	Open	Closed: Mandatory Generic	Closed: Mandatory Generic
Maximum Out of Pocket	$1,840/$3,680	$1,840/$3,680	$1,600/$3,200	$1,600/$3,200
Generic (Retail/Mail Order)	$3/$5	$3/$5	$5/$10	$5/$10
Preferred Brand (Retail/Mail Order)	$10/$15	$10/$15	$10/$20	$10/$20
Non-Preferrred Brand (Retail/Mail Order)	$10/$15	$10/$15	Member Pays the Difference between Generic and Brand plus Brand Copayment*	Member Pays the Difference between Generic and Brand plus Brand Copayment*