LINDEN BOARD OF EDUCATION — COMPARISON OF HEALTH INSURANCE PLANS					
	Horizon Direct Access 15	**Horizon Direct Access 10**	**Horizon EPO[1]**	**Omnia Plan**	**Horizon HDHP Direct Access 1500***
Medical Cost Sharing					High Deductible Health Plan –
Primary Care Copayment	$15	$10	$10	$5 Tier one doctor $20 Tier two doctor	20% after deductible
Specialist Care Copayment	$15	$10	$10	$15 Tier one doctor $30 Tier two doctor	20% after deductible
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%, no deductible
Chiropractic Care	$15 copay up to 30 visits	$10 copay up to 30 visits	$10 copay up to 25 visits	$15 Tier one doctor $30 Tier two doctor Up to 25 visits	20% after deductible, up to 30 visits
Vision - Routine Eye Exam	$15 copay	$10 copay	$10 copay	$15 Tier one doctor $30 Tier two doctor	20% after deductible
Vision Hardware	Not Covered	Not Covered	$50 reimbursement every 24 months	Adult – Not Covered Pediatric – up to $125	Not Covered
Acupuncture	$15 copay	$10 copay	$10 copay		20% after deductible
Diabetic Supplies	90%	90%	100%	100%	20% after deductible
Durable Medical Equipment (DME)	90%	90%	50%	100%	20% after deductible
Emergency Room Copayment	$50	$25	$100	$100	20% after deductible
In-Network Deductible	N/A	N/A	N/A		$1,500 / $3,000 aggregate
In-Network Coinsurance	0% / 10%[2]	0% / 10%[2]	0% / 50%[2]	0% / 20% after deductible	20% after deductible
In-Network Out-of-Pocket Maximum (Individual/Family)	$400/$800	$400/$800	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000
Out-of-Network Deductible (Individual/Family) [3]	$100/$250	$100/$250	No out of network covered	No out of network covered	See In-Network Deductible
Out-of-Network Coinsurance [3]	30%	20%	No out of network covered	No out of network covered	40%
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	$2,000/$5,000	$2,000/$5,000	n/a	n/a	$3,500/$7,000
Out-of-Network Inpatient Hospital Deductible	Out of network deductible applies	Out of network deductible applies	n/a	n/a	In-network deductible applies
Health Savings Account Fund[4]	n/a	n/a	n/a	n/a	Available
Prescription Drug Copayments					
Retail: Generic/Brand Copayments	$5.00 / $10.00	$5.00 / $10.00	$5.00 / $10.00	$20.00 / $40.00	Subject to deductible and 20% coinsurance
Mail: Generic/Brand Copayments	$0.00	$0.00	$0.00	2x retail (90 day supply)	

The Horizon HDHP plan meets ACA minimum essential requirements.	Differences are highlighted in YELLOW. ***This is a summary and not intended to provide total information or a guarantee of coverage.***