Montgomery Township Board of Education
Horizon Medical Plan Designs - Plan Year 2018-2019

MONTHLY PREMIUM Effective 7/1/18-6/30/19:	Direct Access 10	Direct Access 15	Direct Access 1525	Direct Access 2030	Direct Access 2035	POS 10	POS 1525	POS 2030	POS 2035
Single	$ 837.80	$ 797.56	$ 774.08	$ 727.47	$ 625.63	$ 764.38	$ 705.84	$ 662.62	$ 570.80
Parent/Child(ren)	$ 1,558.31	$ 1,483.47	$ 1,439.78	$ 1,353.09	$ 1,163.67	$ 1,421.76	$ 1,312.85	$ 1,234.55	$ 1,061.70
2 Adult	$ 1,675.61	$ 1,595.13	$ 1,548.14	$ 1,454.95	$ 1,251.26	$ 1,528.76	$ 1,411.67	$ 1,327.47	$ 1,141.62
Family	$ 2,396.12	$ 2,281.04	$ 2,213.84	$ 2,080.56	$ 1,789.31	$ 2,186.09	$ 2,018.69	$ 1,901.46	$ 1,632.51
Composite Rate Difference vs. DA 15	**5%**		**-3%**	**-9%**	**-22%**	**-4%**	**-12%**	**-17%**	**-28%**
Network	**Inside NJ- Managed Care Network, including contiguous counties; Outside NJ-Blue Card Network**					**Inside NJ- Managed Care Network, including contiguous counties; No Coverage Outside NJ**			
Medical Cost Sharing									
Primary Care Copayment	$10	$15	$15	$20	$20	$10	$15	$20	$20
Specialist Care Copayment	$10	$15	$25	$30	$35	$10	$25	$30	$35
Emergency Room Copayment	$25	$50	$75	$100	$100	$35	$75	$100	$100
In-Network Deductible (Individual/Family)					$200/$400				$100/$250
In-Network Coinsurance	90% [1]	90% [1]	90% [1]	90% [1]	80%				80%
In-Network Coinsurance Maximum (Individual/Family)									
In-Network Out-of-Pocket Maximum (Individual/Family)	$400/$800	$400/$800	$400/$800	$800/$1,600	$2,500/$5,000	$3,000/$6,000 combined	$3,000/$6,000 combined	$3,000/$6,000 combined	$2,000/$4,000
Out-of-Network Deductible [2] (Individual/Family)	$100/$250	$100/$250	$100/$250	$200/$500	$800/$1,600	$500/$1,000	$500/$1,000	$500/$1,000	$500/$1,000
Out-of-Network Coinsurance [2]	80%	70%	70%	70%	60%	60%	60%	60%	60%
Out-of-Network Out-of-Pocket Maximum (Individual/Family)	$2,000/$5,000	$2,000/$5,000	$2,000/$5,000	$5,000/$12,500	$5,000/$10,000	$3,000/$6,000 combined	$3,000/$6,000 combined	$3,000/$6,000 combined	$4,000/$8,000
Out-of-Network Inpatient Hospital Deductible	80% after deductible	70% after deductible	70% after deductible; subject to $200 Copay	70% after deductible; subject to $500 Copay	60% after deductible; subject to $500 Copay	60% after deductible	60% after deductible	60% after deductible	60% after deductible

** Comparison for illustrative purposes only. Written plan document supersedes any errors on this illustration. Final benefits will be subject to "equal to or better than" letter as submitted by Horizon, and subject to State mandates.*

[1] On select services.

[2] After deductible. Reasonable and Customary fee schedule based at the 90th percentile of FAIR Health. You are responsible for any charges in excess of Reasonable and Customary allowances.

[3] Applies to services that do not require a copayment.

MAXOR PRESCRIPTION RATES	APSMT/ CWA and Sr. Admin Non-Rep (1000/2000)	All Other (3000)
Single	$ 277.05	$ 277.38
Parent/Child(ren	$ 385.58	$ 386.05
2Adult	$ 599.50	$ 600.22
Family	$ 599.50	$ 600.22

HORIZON DENTAL RATES	All
Single	$ 30.60
Parent/Child(ren	$ 74.97
2Adult	$ 74.97
Family	$ 139.00