

**Bridgewater-Raritan Board of Education**  
**Simplified Horizon BCBSNJ Medical & Prescription Plan Benefits Comparison with July 1, 2020 Rates**

	Horizon Direct 10		Horizon Direct 15		Horizon Direct 15/25		Horizon Direct 20/20		Horizon Direct 20/35	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Medical:</b>										
Referral Required	No		No		No		No		No	
Individual Deductible	None	\$100	None	\$100	None	\$100	None	\$200	\$200	\$800
Family Deductible	None	\$250	None	\$250	None	\$250	None	\$500	\$400	\$1,600
Coinsurance	10% (select serv)	20%	10% (select serv)	30%	10% (select serv)	30%	10% (select serv)	30%	20% after ded.	40%
Max. Coinsurance Single	\$400	\$2,000	\$400	\$2,000	\$400	\$2,000	\$800	\$5,000	\$2,000	\$5,000
Max. Coinsurance Family	\$800	\$5,000	\$800	\$5,000	\$800	\$5,000	\$1,600	\$12,500	\$4,000	\$12,500
Max. Out of Pocket Single	\$400	\$2,000	\$400	\$2,000	\$400	\$2,000	\$800	\$5,000	\$2,000	\$5,000
Max. Out of Pocket Family	\$800	\$5,000	\$800	\$5,000	\$800	\$5,000	\$1,600	\$12,500	\$4,000	\$12,500
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
PCP Office Copay	\$10	80% after ded.	\$15	70% after ded.	\$15	70% after ded.	\$20	70% after ded.	\$20	60% after ded.
Specialist Office Copay	\$10	80% after ded.	\$15	70% after ded.	\$25	70% after ded.	\$20	70% after ded.	\$35	60% after ded.
Inpatient Hospital Copay	100%	80% after ded.	100%	70% after ded.	100%	70% after ded. & \$200 copay	100%	70% after ded. & \$500 copay	80% after ded.	60% after ded. & \$500 copay
Emergency Room Copay	100% after \$25 copay		100% after \$50 copay		100% after \$75 copay		100% after \$100 copay		80% after \$100 copay	
<b>Medical Monthly Premium Rates:</b>										
Single		\$921.80		\$877.53		\$851.69		\$800.41		\$688.38
Parent/Child(ren)		\$1,613.17		\$1,535.70		\$1,490.45		\$1,400.72		\$1,204.66
2-Party		\$1,843.65		\$1,755.10		\$1,673.60		\$1,600.82		\$1,376.74
Family		\$2,534.98		\$2,413.25		\$2,301.23		\$2,201.13		\$1,893.03
<b>Prescription:</b>										
Retail Generic Copay		\$5		\$5		\$5		\$5		\$5
Retail Brand Copay		\$10		\$10		\$10		\$10		\$10
Mail Order Generic Copay		\$5		\$5		\$5		\$5		\$5
Mail Order Brand Copay		\$10		\$10		\$10		\$10		\$10
<b>Prescription Drug Monthly Premium Rates:</b>										
Single		\$207.75		\$207.75		\$207.75		\$207.75		\$207.75
Parent/Child(ren)		\$330.56		\$330.56		\$330.56		\$330.56		\$330.56
2-Party		\$411.43		\$411.43		\$411.43		\$411.43		\$411.43
Family		\$555.98		\$555.98		\$555.98		\$555.98		\$555.98
<b>Medical &amp; Rx Annual Premium</b>										
Single	Single	\$13,555	Single	\$13,023	Single	\$12,713	Single	\$12,098	Single	\$10,754
Parent/Child(ren)	P/C	\$23,325	P/C	\$22,395	P/C	\$21,852	P/C	\$20,775	P/C	\$18,423
2-Party	2A	\$27,061	2A	\$25,998	2A	\$25,020	2A	\$24,147	2A	\$21,458
Family	Family	\$37,092	Family	\$35,631	Family	\$34,287	Family	\$33,085	Family	\$29,388

**Bridgewater-Raritan Board of Education**  
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	POS 10		POS 15/25		POS 20/20		POS 20/35		OMNIA 10	
Medical:	In-Network		In-Network		In-Network		In-Network		Tier 1	Tier 2
Referral Required	YES		YES		YES		YES		No	
Individual Deductible	None		None		None		\$200		None	\$1,500
Family Deductible	None		None		None		\$400		None	\$3,000
Coinsurance	N/A		N/A		N/A		20%		N/A	N/A
Max. Coinsurance Single	N/A		N/A		N/A		\$2,000		\$400	\$2,000
Max. Coinsurance Family	N/A		N/A		N/A		\$4,000		\$800	\$4,000
Max. Out of Pocket Single	\$4,000		\$4,000		\$4,000		\$2,000		\$400	\$2,000
Max. Out of Pocket Family	\$8,000		\$8,000		\$8,000		\$4,000		\$800	\$4,000
Lifetime Benefit Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	Unlimited
PCP Office Copay	\$10		\$15		\$20		\$20		\$5	\$10
Specialist Office Copay	\$10		\$25		\$20		\$35		\$5	\$10
Inpatient Hospital Copay	100%		100%		100%		80%		100%	70% after ded.
Emergency Room Copay	100% after \$35 copay		100% after \$75 copay		100% after \$100		80% after \$100 copay		100% after \$25 copay	
<b>Medical Monthly Premium Rates:</b>										
Single	\$836.81		\$772.71		\$726.60		\$624.90		\$701.34	
Parent/Child(ren)	\$1,464.41		\$1,352.25		\$1,271.57		\$1,093.55		\$1,227.36	
2-Party	\$1,673.60		\$1,545.40		\$1,453.18		\$1,249.76		\$1,402.70	
Family	\$2,301.23		\$2,125.73		\$1,998.17		\$1,718.44		\$1,928.70	
<b>Prescription:</b>										
Retail Generic Copay	\$5		\$5		\$5		\$5		\$5	
Retail Brand Copay	\$10		\$10		\$10		\$10		\$10	
Mail Order Generic Copay	\$5		\$5		\$5		\$5		\$5	
Mail Order Brand Copay	\$10		\$10		\$10		\$10		\$10	
<b>Prescription Drug Monthly Premium Rates:</b>										
Single	\$207.75		\$207.75		\$207.75		\$207.75		\$207.75	
Parent/Child(ren)	\$330.56		\$330.56		\$330.56		\$330.56		\$330.56	
2-Party	\$411.43		\$411.43		\$411.43		\$411.43		\$411.43	
Family	\$555.98		\$555.98		\$555.98		\$555.98		\$555.98	
<b>Medical &amp; Rx Annual Premium</b>										
Single	Single	\$12,535	Single	\$11,766	Single	\$11,212	Single	\$9,992	Single	\$10,909
Parent/Child(ren)	P/C	\$21,540	P/C	\$20,194	P/C	\$19,226	P/C	\$17,089	P/C	\$18,695
2-Party	2A	\$25,020	2A	\$23,482	2A	\$22,375	2A	\$19,934	2A	\$21,770
Family	Family	\$34,287	Family	\$32,181	Family	\$30,650	Family	\$27,293	Family	\$29,816