Horizon

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

DIRECT ACCESS PLAN 1

Benefit	In-Network	Out-of-Network
Benefit Period	Calendar year	
Deductible		
Individual	None	$100
Family	None	Two deductibles per family
	Deductible is Calendar year.	
Coinsurance	100%	80%
Maximum Out of Pocket		
Individual	$400	
Family	$800	
Split Maximum Out of Pocket is calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket. Balances from non-participating providers over our allowance are not eligible towards the Maximum Out of Pocket		
Benefit Period Maximum	Unlimited	Unlimited
Lifetime Maximum	Unlimited	Unlimited
Primary Care Physician Selection	Not Required	
Doctor's Office Visits		
Primary Care Office Visit	100% after $30 copay A primary care physician is a general or family practitioner, internist or pediatrician	80% after deductible
Specialist Office Visit	100% after $30 copay A referral is not required to visit a specialist.	80% after deductible
Maternity Visits	100% after $30 copay Copay applies to 1st visit only Dependent children are ineligible for Maternity/Obstetrical Benefits.	80% after deductible
Allergy Testing and Treatment	100%	80% after deductible
Preventive Care		
Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations	100%	80% (no deductible)
Well Child Exams	100%	80% (no deductible)
Well Child Immunizations and Lead Screening	100%	80% (no deductible)
Diagnostic Procedures		
Laboratory	100% in office or in a Preferred Lab 100% in Outpatient facility	80% after deductible
Outpatient X-ray/Radiology Services	100% in office 100% in Outpatient facility	80% after deductible
CT/CTA Scans, Pet Scans, MRIs/MRAs, Nuclear Medicine studies (including Nuclear Cardiology) require prior authorization. Advanced/Complex Radiology may pay at a different benefit level than listed above. The ordering physician should request the prior authorization by calling eviCore healthcare at **1-866-496-6200** and providing the necessary clinical information. Once the authorization number is received, the member may call eviCore healthcare at **1-866-969-1234** to schedule an appointment. *Note: Managed Care members can call **1-866-969-1234** to obtain a confirmation number for non-Advanced Imaging diagnostic procedures. Confirmation numbers*		
Hospital Care		
Inpatient Admission (including maternity)	100%	80% after deductible
Pre-admission Testing	100%	80% after deductible
Surgery in Hospital	100%	80% after deductible
Inpatient Physician Services	100%	80% after deductible
Outpatient Dept. Services	100%	80% after deductible
Emergency Care		
Emergency Room	100% after $100. facility payment Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.	
Ambulance	100%	80% after deductible

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

DIRECT ACCESS PLAN 1

Outpatient Surgery		
Hospital Outpatient Surgery	100%	80% after deductible
Surgery in an Ambulatory SurgiCenter	100%	80% after deductible
Services performed at a non-participating ambulatory surgery center are reimbursed at Horizon BCBSNJ's Payment Allowance and therefore may result in significant out of pocket costs.		
Mental Health Services		
Inpatient	100%	80% after deductible
Outpatient department	100%	80% after deductible
Office setting	100% after office copayment	80% after deductible
Substance Abuse Services		
Inpatient	100%	80% after deductible
Outpatient department	100%	80% after deductible
Office setting	100% after office copayment	80% after deductible
Alcohol Abuse Services		
Inpatient	100%	80% after deductible
Outpatient department	100%	80% after deductible
Office setting	100% after office copayment	80% after deductible
Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Horizon Behavioral Health at 1-800-626-2212.		
Other Services		
Acupuncture	100% after office copayment	80% after deductible
Bariatric Surgery	100%	80% after deductible
Diabetic Education	100% after office copayment	80% after deductible
Diabetic Supplies	100%	80% after deductible
Durable Medical Equipment	100%	80% after deductible
Orthotics and Prosthetics (Per NJ mandate)	100% after office copayment	80% after deductible
Home Health Care	100%	80% after deductible up to 100 visits
Hospice Care	100%	80% after deductible
Infertility (including in-vitro fertilization)	100% after office copayment Limited to 4 egg retrievals per lifetime	80% after deductible
Physical Rehabilitation Facility Inpatient Services	100% Limited to 60 days per benefit period	#REF!
Private Duty Nursing	100% Limited to 30 visits per benefit period (8-hour shifts)	80% after deductible
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after office copayment 30 visit maximum per therapy, per benefit period Note: If specialist copay is higher than PCP copay, the lower copay will apply to short-term therapies. Also, if PCP copay is $30, the STT copay will default to $20.	80% after deductible
Skilled Nursing Facility/Extended Care Center	100% Limited to 100 days per benefit period	80% after deductible Limited to 60 days per benefit period
Therapeutic Manipulation (Chiropractic Care)	100% after office copayment 25 visit maximum per benefit period	80% after deductible
Vision - Routine Eye Exam	100% after $30 copay	80% after deductible
Vision Hardware	Covered under freestanding program	
Telemedicine	100% after $15 copay	Not Covered
Prescription Drugs	Covered under freestanding program	

Horizon

Prescription Drug Program
Plan I

The Prescription Drug Program covers FDA approved legend drugs. A prescription order from a physician is required for drugs to be eligible. Prescriptions may be refilled within one year of the original prescription date, when authorized by the physician and permitted by law. Any limitations that apply to an original prescription also apply to the refills.

The Horizon Prescription Formulary is a list of prescription medications developed by an independent Pharmacy and Therapeutics (P&T) Committee comprised of practicing physicians and pharmacists in New Jersey. The Horizon P&T Committee determines which drugs will be placed into preferred and non-preferred status within our open formulary. The priority consideration is clinical efficacy and safety, followed by other considerations such as second line therapies, and availability of commonly used and safe generics. At least two drugs from each therapeutic class are placed in the preferred status on the formulary. Once a quality review has determined that two or more drugs are equal to other therapeutic alternatives, the P&T Committee may place the most cost effective drug(s) into preferred status.

Type of Program	Preferred Generic Drugs	Preferred Brand Name Drugs	Non-Preferred Drugs
Three Tier Copayment Plan:			
Retail: Up to a 90 day supply (1 retail copay applies per 30-day supply)	$10	$20	$30
Mail Order: Up to 90 day supply (1 mail order copay applies for the 90-day supply)	$20	$40	$60
Front End Deductible: Amount excluding copayments/co-insurance, which must be incurred per member in a benefit period before benefits are paid.	Not Applicable		
Benefit Period Maximum	Unlimited		
Plan Includes:	Contraceptive drugs & devices obtained at a pharmacy Diabetic Supplies Erectile Dysfunction drugs - limit of 4 per month Fertility Drugs Self-Administered Contraceptives & Injectible Contraceptives Lifestyle Drugs Anti-Obesity Drugs		
Mandatory Generic:	Not Applicable		
Specialty Pharmacy Program: Certain specialty pharmaceuticals must be obtained from one of the contracted pharmacies. Specialty pharmaceuticals are typically used to treat conditions such as: Adenosine Deaminase Deficiency, Allergic Asthma, Alpha-1 Proteinase Inhibitor Deficiency, Anemia, Crohn's Disease, Cytomegalovirus, Fabry's Disease, Gaucher Disease, Hypercalcemia of Malignancy, Neutropenia, Prostate Cancer, Psoriasis, Pulmonary Hypertension, Respiratory Syncitial Virus, and Rheumatoid Arthritis.	• Personal attention from a pharmacist-led team that provides condition-specific education, administration instruction and expert advice to help manage therapy. • Claims assistance to help determine individual coverage and file the necessary paperwork. • Easy access to pharmacists and other health experts 24 hours a day, seven days a week. • Single, reliable source for specialty medication needs. • Easy ordering with a dedicated toll-free number. • Confidential and convenient delivery to the location of choice (i.e., home, physician's office.) • Helpful follow-up care calls to remind when it's time to refill a prescription, check on therapy progress and answer any questions. • NOTE: Specialty pharmacies are considered mail order pharmacies and are always subject to the retail copayment levels, even if the specialty pharmaceutical is obtained through the mail.		
Exclusions:	Immunization Agents and Allergy Serum Over The Counter Vitamins & Minerals Growth Hormones (unless prior authorized) Drugs for Cosmetic Purposes		

DIRECT ACCESS PLAN 2
Wall Township

Benefit	In-Network	Out-of-Network
Benefit Period	Calendar year	
Deductible		
Individual	None	$500
Family	None	Two deductibles per family
	Deductible is Calendar year.	
Coinsurance	100%	80%
Maximum Out of Pocket		
Individual	$2,000	
Family	$4,000	
Split Maximum Out of Pocket is Calendar Year. The deductible, coinsurance, and copayments apply to the Maximum Out of Pocket. Balances from non-participating providers over our allowance are not eligible towards the Maximum Out of Pocket.		
Benefit Period Maximum	Unlimited	Unlimited
Lifetime Maximum	Unlimited	Unlimited
Primary Care Physician Selection	Not Required	
Doctor's Office Visits		
Primary Care Office Visit	100% after $30 copay A primary care physician is a general or family practitioner, internist or pediatrician	80% after deductible
Specialist Office Visit	100% after $30 copay A referral is not required to visit a specialist.	80% after deductible
Maternity Visits	100% after $30 copay Copay applies to 1st visit only Dependent children are eligible for Maternity/Obstetrical Benefits.	80% after deductible
Allergy Testing and Treatment	100%	80% after deductible
Preventive Care		
Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations	100%	80% (no deductible)
Well Child Exams	100%	80% (no deductible)
Well Child Immunizations and Lead Screening	100%	80% (no deductible)
Diagnostic Procedures		
Laboratory	100% in office or in a Preferred Lab 100% in Outpatient facility	80% after deductible
Outpatient X-ray/Radiology Services	100% in office 100% in Outpatient facility	80% after deductible
CT/CTA Scans, Pet Scans, MRIs/MRAs, Nuclear Medicine studies (including Nuclear Cardiology) require prior authorization. Advanced/Complex Radiology may pay at a different benefit level than listed above. The ordering physician should request the prior authorization by calling eviCore healthcare at **1-866-496-6200** and providing the necessary clinical information. Once the authorization number is received, the member may call eviCore healthcare at **1-866-969-1234** to schedule an appointment. *Note: Managed Care members can call **1-866-969-1234** to obtain a confirmation number for non-Advanced Imaging diagnostic procedures. Confirmation numbers from eviCore healthcare replace the need for a paper referral.*		
Hospital Care		
Inpatient Admission (including maternity)	100%	80% after deductible
Pre-admission Testing	100%	80% after deductible
Surgery in Hospital	100%	80% after deductible
Inpatient Physician Services	100%	80% after deductible
Outpatient Dept. Services	100%	80% after deductible
Emergency Care		
Emergency Room	100% after $100 facility copayment Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.	
Ambulance	100%	80% after deductible

DIRECT ACCESS PLAN 2
Wall Township

Outpatient Surgery		
Hospital Outpatient Surgery	100%	80% after deductible
Surgery in an Ambulatory SurgiCenter	100%	80% after deductible
Services performed at a non-participating ambulatory surgery center are reimbursed at Horizon BCBSNJ's Payment Allowance and therefore may result in significant out of pocket costs.		
Mental Health Services		
Inpatient	100%	80% after deductible
Outpatient department	100%	80% after deductible
Office setting	100% after office copayment	80% after deductible
Substance Abuse Services		
Inpatient	100%	80% after deductible
Outpatient department	100%	80% after deductible
Office setting	100% after office copayment	80% after deductible
Alcohol Abuse Services		
Inpatient	100%	80% after deductible
Outpatient department	100%	80% after deductible
Office setting	100% after office copayment	80% after deductible
Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Horizon Behavioral Health at 1-800-626-2212.		
Other Services		
Acupuncture	100% after office copayment	80% after deductible
Bariatric Surgery	100%	80% after deductible
Diabetic Education	100% after office copayment	80% after deductible
Diabetic Supplies	100%	80% after deductible
Durable Medical Equipment	100%	80% after deductible
Orthotics and Prosthetics (Per NJ mandate)	100% after office copayment	80% after deductible
Home Health Care	100%	80% after deductible up to 100 visits
Hospice Care	100%	80% after deductible
Infertility (including in-vitro fertilization)	100% after office copayment	80% after deductible Limited to 4 egg retrievals per lifetime
Physical Rehabilitation Facility Inpatient Services	100%	80% after deductible Limited to 60 days per benefit period
Private Duty Nursing	100%	80% after deductible Limited to 30 visits per benefit period (8-hour shifts)
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after office copayment	80% after deductible 30 visit maximum per therapy, per benefit period Note: If specialist copay is higher than PCP copay, the lower copay will apply to short-term therapies. Also, if PCP copay is $30, the STT copay will default to $20.
Skilled Nursing Facility/Extended Care Center	100% Limited to 100 days per benefit period	80% after deductible Limited to 60 days per benefit period
Therapeutic Manipulation (Chiropractic Care)	100% after office copayment	80% after deductible 25 visit maximum per benefit period
Vision - Routine Eye Exam	100% after $30 copay	80% after deductible
Vision Hardware	Covered under freestanding program	
Telemedicine	100% after $15 copay	Not Covered

Plan 2 Prescription Drug Program

Wall Township

The Prescription Drug Program covers FDA approved legend drugs. A prescription order from a physician is required for drugs to be eligible. Prescriptions may be refilled within one year of the original prescription date, when authorized by the physician and permitted by law. Any limitations that apply to an original prescription also apply to the refills.

The Horizon Prescription Formulary is a list of prescription medications developed by an independent Pharmacy and Therapeutics (P&T) Committee comprised of practicing physicians and pharmacists in New Jersey. The Horizon P&T Committee determines which drugs will be placed into preferred and non-preferred status within our open formulary. The priority consideration is clinical efficacy and safety, followed by other considerations such as second line therapies, and availability of commonly used and safe generics. At least two drugs from each therapeutic class are placed in the preferred status on the formulary. Once a quality review has determined that two or more drugs are equal to other therapeutic alternatives, the P&T Committee may place the most cost effective drug(s) into preferred status.

Type of Program	Preferred Generic Drugs	Preferred Brand Name Drugs	Non-Preferred Drugs
Three Tier Copayment Plan:			
Retail: Up to a 90 day supply (1 retail copay applies per 30-day supply)	$10	$25	$50
Mail Order: Up to 90 day supply (1 mail order copay applies for the 90-day supply)	$20	$50	$100
Front End Deductible: Amount excluding copayments/co-insurance, which must be incurred per member in a benefit period before benefits are paid.	Not Applicable		
Benefit Period Maximum	Unlimited		
Plan includes:	Contraceptive drugs & devices obtained at a pharmacy Diabetic Supplies Erectile Dysfunction drugs - limit of 4 per month Fertility Drugs Self-Administered Contraceptives & Injectible Contraceptives Lifestyle Drugs Anti-Obesity Drugs		
Mandatory Generic:	Not Applicable		
Specialty Pharmacy Program: Certain specialty pharmaceuticals must be obtained from one of the contracted pharmacies. Specialty pharmaceuticals are typically used to treat conditions such as: Adenosine Deaminase Deficiency, Allergic Asthma, Alpha-1 Proteinase Inhibitor Deficiency, Anemia, Crohn's Disease, Cytomegalovirus, Fabry's Disease, Gaucher Disease, Hypercalcemia of Malignancy, Neutropenia, Prostate Cancer, Psoriasis, Pulmonary Hypertension, Respiratory Synctial Virus, and Rheumatoid Arthritis.	• Personal attention from a pharmacist-led team that provides condition-specific education, administration instruction and expert advice to help manage therapy. • Claims assistance to help determine individual coverage and file the necessary paperwork. • Easy access to pharmacists and other health experts 24 hours a day, seven days a week. • Single, reliable source for specialty medication needs. • Easy ordering with a dedicated toll-free number. • Confidential and convenient delivery to the location of choice (i.e., home, physician's office.) • Helpful follow-up care calls to remind when it's time to refill a prescription, check on therapy progress and answer any questions. • NOTE: Specialty pharmacies are considered Mail Order pharmacies and are always subject to the retail copayment levels, even if the specialty pharmaceutical is obtained through the mail.		
Exclusions:	Over The Counter Vitamins & Minerals Growth Hormones (unless prior authorized) Drugs for Cosmetic Purposes Immunization Agents and Allergy Serum		

Wall Township
Group # 03585
Delta Dental PPO Plus Premier™

Preventive & Diagnostic	80%
* Exams, Cleanings & Bitewing X-rays (each twice per calendar year)	
* Fluoride Treatment (once per calendar year, children to age 19)	
Remaining Basic	80%
* Fillings, Extractions	
* Endodontics (root canal)	
* Periodontics, Oral Surgery	
* Sealants	
* Repair of Dentures	
Crowns & Prosthodontics	50%
* Crowns, Gold Restorations (over natural teeth)	
* Bridgework	
* Full & Partial Dentures	
Calendar Year Maximum (per patient)	$1,400
Calendar Year Deductible (waived on Preventive & Diagnostic)	
* Per Person	$25
* Family Aggregate Deductible	$75
Orthodontic Benefits, full comprehensive treatment (Adult & Child)	50%
* Lifetime Maximum (per patient)	$1,000

Over 301,000 participating dental offices nationwide participate with the national Delta Dental system, although you may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Delta Dental to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Delta Dental will make payment directly to the subscriber. **Maximum benefit may be derived by utilizing the services of a participating dentist.**

Where the eligible patient is treated by a Delta Dental PPO dentist, the fee for the covered service(s) will not exceed the Delta Dental PPO maximum allowable charge(s). Where the eligible patient is treated by a Delta Dental Premier® dentist who does not participate in Delta Dental PPO or by a *Participating Specialist*, the dentist has agreed not to charge eligible patients more than the dentist's filed fee or Delta Dental's established maximum plan allowance, and Delta Dental will pay such dentists based on the least of the actual fee, the filed fee, or Delta Dental's established maximum plan allowance for the procedure(s). Claims for services provided by dentists who are neither Delta Dental Premier, Delta Dental PPO dentists, or *Participating Specialists* are paid based on the lesser of the dentist's actual charge or the prevailing fee.

Visit your own dentist. If you do not have a dentist, there is a directory available with your plan administrator listing participating dentists. You may call **1-800-DELTA-OK** and a list of participating dentists located in your area will be mailed directly to your home, or you may access our Website at www.deltadentalnj.com.

During your FIRST appointment, tell your dentist that you are covered under this program. Give him/her your Group's name, its Delta Dental Group Number and your Member ID number.

If you have any questions regarding your benefits, you may contact our Customer Service Department Monday through Thursday, 8:00 a.m. to 6:30 p.m. EST and Friday, 8:00 a.m. to 5:00 p.m. EST, at 1-800-452-9310.

January 2021

Horizon Focus I (Horizon/Davis Vision View Network)

	Horizon Focus I
	Once every:
Eye Examinations	Ineligible under vision plan; eye exams may be eligible under the group health plan
Spectacle lenses	12 months
Frame	24 months
Contact lens evaluation, fitting and follow-up care	12 months
Contact lenses (in lieu of eyeglasses)	12 months
	Copayments
Spectacle lenses	$25
Contact lens evaluation, fitting and follow-up care	$0
Eyeglass Benefit — Frame	**Member charges**
Non-collection frame allowance (retail)	Up to $100 or $150[1] plus a 20% discount on any overage[2]
Davis Vision Frame Collection[3] (in lieu of allowance): Fashion level / Designer level / Premier level	Included / $15 / $40
Eyeglass Benefit — Spectacle Lenses	
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	Included
Oversize lenses	Included
Tinting of plastic lenses	Included
Scratch-resistant coating	$15
Premium scratch-resistant coating	$30
Polycarbonate lenses[4]	$0 or $35
Ultraviolet coating	$15
Anti-reflective (AR) coating (standard / premium / ultra / ultimate)	$40 / $55 / $69 / $85
Progressive lenses (standard / premium / ultra / ultimate)	$65 / $105 / $140 / $175
High-index lenses: 1.67 / 1.74	$60 / $120
Trivex lenses	$50
Polarized lenses	$75
Plastic photochromic lenses	$70
Digital single vision lenses	$30
Scratch Protection Plan: Single vision / Multifocal lenses	$20 / $40
Blue Light Filtering	$15
Contact Lens Benefit (in lieu of eyeglasses)	
Contact lenses: Materials allowance	Up to $100 plus a 15% discount[2] on any overage
Evaluation, fitting and follow-up care — standard and specialty lens types	15% discount[2]

Out-of-Network Reimbursement Schedule - Up to:			
Single-Vision Lenses: $40	Bifocal: $60	Progressive Lenses: $60 (in lieu of bifocal reimbursement)	Trifocal: $80
Lenticular: $100	Frame: $50	Elective Contacts: $105	Visually Required Contacts: $225

1 Members receive an additional $50 allowance at Visionworks retail locations.
2 Additional discounts not applicable at Walmart, Sam's Club or Costco locations.
3 Davis Vision Collection is available at most participating independent provider offices. Frame collection is subject to change.
4 Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

Horizon®

HorizonBlue.com/vision

Horizon Focus III (Horizon/Davis Vision View Network)

	Horizon Focus III
	Once every:
Eye Examinations	Ineligible under vision plan; eye exams may be eligible under the group health plan.
Spectacle lenses	12 months
Frame	12 months
Contact lens evaluation, fitting and follow-up care	12 months
Contact lenses (in lieu of eyeglasses)	12 months
	Copayments
Spectacle lenses	$10
Contact lens evaluation, fitting and follow-up care	$0
Eyeglass Benefit — Frame	**Member charges**
Non-collection frame allowance (retail)	Up to $180 or $230[1] plus a 20% discount on any overage[2]
Davis Vision Frame Collection[3] (in lieu of allowance): Fashion level / Designer level / Premier level	Included
Eyeglass Benefit — Spectacle Lenses	
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	Included
Oversize lenses	Included
Tinting of plastic lenses	Included
Scratch-resistant coating	Included
Premium scratch-resistant coating	$30
Polycarbonate lenses[4]	$0 or $30
Ultraviolet coating	$12
Anti-reflective (AR) coating (standard / premium / ultra / ultimate)	$35 / $48 / $60 / $85
Progressive lenses (standard / premium / ultra / ultimate)	$50 / $90 / $140 / $175
High-index lenses: 1.67 / 1.74	$55 / $120
Trivex lenses	$50
Polarized lenses	$75
Plastic photochromic lenses	$65
Digital single vision lenses	$30
Scratch Protection Plan: Single vision / Multifocal lenses	$20 / $40
Blue Light Filtering	$15
Contact Lens Benefit (in lieu of eyeglasses)	
Contact lenses: Materials allowance	Up to $180 plus a 15% discount[2] on any overage
Evaluation, fitting and follow-up care — standard and specialty lens types	15% discount[2]

1 Members receive an additional $50 allowance at Visionworks retail locations.
2 Additional discounts not applicable at Walmart, Sam's Club or Costco locations.
3 Davis Vision Collection is available at most participating independent provider offices. Frame collection is subject to change.
4 Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

Horizon®

HorizonBlue.com/vision

Horizon Focus III (Horizon/Davis Vision View Network)

Out-of-Network Reimbursement Schedule - Up to:			
Single-Vision Lenses: $40	Bifocal: $60	Progressive Lenses: $60 (in lieu of bifocal reimbursement)	Trifocal: $80
Lenticular: $100	Frame: $50	Elective Contacts: $105	Visually Required Contacts: $225

Horizon®

HorizonBlue.com/vision

2024 HEALTH INSURANCE

Direct Access Plan 1

Contract Type	Medical & Vision	Prescription	Dental	Monthly	Annual Cost
Single	$914.48	$242.47	$32.91	$1,189.86	$14,278.32
EE & Children	$1,572.20	$412.41	$69.85	$2,054.46	$24,653.52
2 Adults	$1,829.86	$485.19	$65.82	$2,380.87	$28,570.44
Family	$2,482.11	$654.99	$98.72	$3,235.82	$38,829.84

Direct Access Plan 2

Contract Type	Medical & Vision	Prescription	Dental	Monthly	Annual Cost
Single	$857.41	$208.73	$32.91	$1,099.05	$13,188.60
EE & Children	$1,475.11	$346.35	$69.85	$1,891.31	$22,695.72
2 Adults	$1,725.86	$407.46	$65.82	$2,199.14	$26,389.68
Family	$2,327.93	$550.07	$98.72	$2,976.72	$35,720.64

2023 HEALTH INSURANCE

Direct Access Plan 1

Contract Type	Medical & Vision	Prescription	Dental	Monthly	Annual Cost
Single	$762.89	$210.84	$32.31	$1,006.04	$12,072.47
EE & Children	$1,298.63	$358.62	$68.50	$1,725.75	$20,709.01
2 Adults	$1,526.56	$421.90	$64.62	$2,013.08	$24,157.00
Family	$2,061.43	$569.56	$96.93	$2,727.92	$32,735.05

Direct Access Plan 2

Contract Type	Medical & Vision	Prescription	Dental	Monthly	Annual Cost
Single	$713.26	$181.50	$32.31	$927.07	$11,124.84
EE & Children	$1,214.20	$308.70	$68.50	$1,591.40	$19,096.82
2 Adults	$1,427.27	$363.17	$64.62	$1,855.06	$22,260.69
Family	$1,927.36	$490.28	$96.93	$2,514.57	$30,174.86

Contract Type	Monthly Focus 3 Vision Buy Up Cost	Annual Cost
Single	$1.59	$19.08
EE/Children	$3.35	$40.20
2 Adults	$3.19	$38.28
Family	$4.66	$55.92