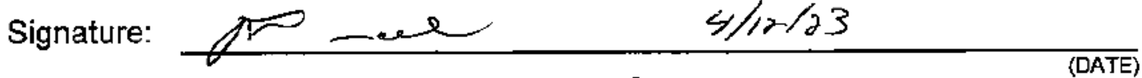
SIGNATURE PAGE
CC-17-2023

To the Monmouth County Board of County Commissioners:

THE UNDERSIGNED HEREBY DECLARES THAT I (WE) HAVE CAREFULLY EXAMINED THE SPECIFICATIONS. I (WE) HEREBY CERTIFY PRICES QUOTED ARE IN ACCORDANCE WITH YOUR REQUIREMENTS.

Company Name: MORSE CORRECTIONAL Healthcare
(PRINT)

Preparer's Name: Rick MORSE
(PRINT)

Signature:

4/12/23
(DATE)

Address: 16035 York Rd
SPARKS, MD 21152

Telephone No.: 443 797 7639

Fax No.: 615 271-5194

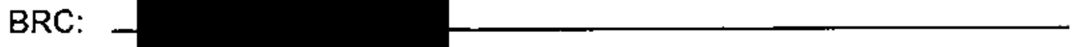
E-Mail Address: Rick@MORSECORRECTIONAL.COM

*****(This should be the email where Contracts would be sent)*****

Contact Person: Rick MORSE

FEIN:

(Federal Employee ID)

BRC:


(Revised 2/2017)

TAB I

Cost Proposal Sheets

Management Fee

Insurances

Start-up

Provider Network and Claims Management

Variances and Exceptions

ATTACHMENT 3
CC-17-2023
Cost Proposal Sheets

MANAGEMENT FEE FORM:

The monthly Management Fee proposed for the duration of the initial 30 month contract term shall be broken down into two separate amounts; one for the first 18-months and another for the subsequent 12-months. The Management Fee represents the Vendors gross profit, and all corporate overhead and support. Corporate overhead and support shall include, but not limited to all corporate and regional program support, services and personnel; as well as all Financial, IT, UM, and HR program support and services. Any and all legal defense and settlement costs and fees shall also be included within the Management Fee. Please note that Vendor's are proposing a monthly fee and not an annual fee below. 578,000 * 1.5

Monthly Management Fee (July 1, 2023 through December 31, 2024): $ 867,000

578,000
Monthly Management Fee (January 1, 2025 through December 31, 2025): $ 578,000

The Vendor shall detail or itemize below any and all corporate overhead and support that are NOT included within the Management Fee, and provide the estimated monthly cost that the Vendor proposes to charge as a Pass-Through Cost to the County.

	Monthly Cost
All Inclusive	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$

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INSURANCE FORM:

All insurance related costs below that the Vendor intends to charge as a pass-through cost to the County on an annual basis. The Vendor shall not include subcontractor costs, which are not allowed to be passed-through to the County. Please note that Vendor's will not be allowed to pass-through any costs greater than or more than five percent (5%) of the proposed costs for the duration of the 30-month contract.

Professional Liability Insurance

Malpractice Premium $ ______
Malpractice Claims $ ______
Tail coverage if separate $ ______
Errors and Omissions ______ $ ______
Other ______ $ ______
Other ______ $ ______
Total Annual Cost: $ 65,000

Commercial General Liability Insurance

Premium $ ______
Other ______ $ ______
Other ______ $ ______
Total Annual Cost: $ 6,800

Workers Compensation Insurance

Premium $ ______
Other ______ $ ______
Other ______ $ ______
Total Annual Cost: $ 87,000

Vehicle Insurance

Premium $ ______
Other ______ $ ______
Other ______ $ ______
Total Annual Cost: $ 0

Reinsurance / Stop Loss (\$125,000 deductible)

Premium $ ______
Other ______ $ ______
Other ______ $ ______
Total Annual Cost: $ 35,000

Guarantee (\$20,000) Wrote / Bank Check, will get surety upon Award. **Total Annual Cost:** $ 800

Agreement of Surety (\$1,600,000) **Total Annual Cost:** $ 16,000

START UP FORM:

Vendors are required to disclose all start-up costs, including staffing, travel, etc. to be passed-through to the County. All costs shall be provided and focused on MCCI start-up activity only. The Vendor shall only be reimbursed for those actual costs verified with the start-up and shall not exceed those costs in any given category below. Please note that costs may be incurred beginning on the date of contract award by the County and shall terminate on the 15th day post contract start date.

STAFFING:

HR: Hiring, applications, interviewing, credentialing, etc.
Number of Hours: Rate: $ 0

HR: Orientation of new and existing staff
Number of Hours: Rate: $ 0

Regional Management: All activity, including orientation of new and existing staff, implementation of policy & procedures, etc.
Number of Hours: Rate: $ 0

Corp/Regional Medical Director: All activity, including orientation of providers, implementation of clinical protocols, policy & procedures, etc.
Number of Hours: Rate: $ 0

Corp/Regional Nursing Management: All activity, including orientation of new & existing staff, implementation of nursing policy & procedures, protocols, etc.
Number of Hours: Rate: $ 0

Other:
Number of Hours: Rate: $ 0

Other:
Number of Hours: Rate: $ 0

Other:
Number of Hours: Rate: $ 0

TRAVEL:

Airfare:	$ 4500
Mileage:	$ 2400
Parking:	$ 500
Rental Car:	$ 1500
Accommodations:	$ 8250
Meals:	$ 1800
Per Diem:	$
Other:	$
Other:	$

Travel Subtotal: $ 18,950

Team Building: Pizza, lunches, snacks, etc. (on-site) $ 500

Time Keeping System: + Implementation $ 5,741

Other Start-Up Costs: List

unknown	$ 1,000
	$
	$
	$
	$
	$
	$

Other Start-Up Subtotal: $ 7,241

Total Start-Up Costs: $ 26,191

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PROVIDER NETWORK AND CLAIMS MANAGEMENT (2023 rates):

What is the cost per Inmate per month to participate in a provider discount network (e.g. BC/BS, Optima, Anthem, Cigna, Amerihealth, etc.) and passed-through to the County? $ 0

If your company uses a third party administrator to process and pay each claim, then what is the cost per claim that will be passed-through to the County? $ 0

Is your company able to process and pay claims in-house? ✓ Yes ___ No

If yes, then what would be the cost per claim? $ Included in MGT Fee

Is your company able to process and pay claims electronically in-house? ✓ Yes ___ No

If yes, then what would be the cost per claim? $ Included in MGT Fee

ATTACHMENT 4
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VARIANCES AND EXCEPTIONS FORM:

The Vendor should indicate below any and all minor variances or exceptions to the specifications, terms and conditions of this RFP. The Vendor shall include for each variance or exception the financial impact, if any to the Management Fee or Pass-Through Cost, should the County accept. If the impact is unknown, then the Vendor should state "Unknown." By leaving this form blank, the Vendor is affirmatively stating that the proposal submitted in response to this RFP is "as specified", and the proposal will be evaluated based upon full compliance with the specifications, terms and conditions. Please see RFP Section II. E. for further guidance on variance and exceptions.

Pls See Attached Sheet

	RFP Section #	+/- Cost Impact

Attachment 4 CC-17-2023

Variances and Exceptions

All the Exceptions listed do not present as a complete rejection of the specification, but rather an explanation for a modification/variance, or statement of clarity. Each exception/variance also has a similar explanation in the proposal to create awareness as the proposal is read. There is no increase in cost for the County with any of these variances.

Insurances: The County has requested insurance pricing, but the RFP allows for no more than a 5% pass-through variance. The county hasn't provided sufficient information in all cases. For example, Reinsurance application requires financial information on recent cases. They can't quote a rate without it. Health Insurance. The County didn't provide info on participant ages and number of participants. Only the incumbent has this info. No agency can quote an exact price without this info. NJ Workers comp is likewise a quote which is underwritten for a jail. Compensation can be estimated but the year-end audit will determine the final rates. I've provided good quotes, but there are many variables plus or minus.	Sec Q, Insurance	$0.00
Non-Formulary approval: MCHC does not believe this is consistent with good practice of medicine as it delays care and is based upon money. In our proposal we provided a better process for managing pharmacy.	Sec V Pharmacy	$0.00
Invoicing: MCHC will submit three invoices and not two. One is mgt fee on the first. Second is a $200,000 advance on the first of the month. Third is the true invoice completed by the 15th business day of the month. The county can take up to 60 days to pay an invoice and MCHC would already be 45 days into the invoice and payroll periods at the time of close out. Two cost-plus contracts which pay 75% and 100% were provided. Further, a new requirement was found in the RFP requiring invoice payment within 14-days of receipt. This request is reasonable and an appropriate goodwill share.	Sec I Vendor Invoice and Payment	$0.00
Indemnification: MCHC agrees to indemnify the County, however two objections occur. One may never occur, but should MCHC get drug into litigation over a CFG claim and for which MCHC did not provide care to the inmate, we will pass through our charge for summary dismissal. The county can pursue CFG. Secondly, the third-party medical reviewer for the feds has been denying much reasonable and appropriate care at multiple jails. MCHC can't provide the care deemed necessary by our medical director which puts both the Jail and MCHC at risk. Should this occur, MCHC will meet with the county to determine our course of action as to sending and passing through the cost or asking the federal agency to remove the inmate. MCHC will document appropriately to protect both jail and company, however, should a litigation arise from denied care, MCHC will pass through the cost of summary dismissal as the county financially benefits from the federal contract.	Sec P Indemnification	$0.00
Electronic UM System: The MCHC process is more reliable in validating the financial liability of the inmates care and tying it into accounting and	Sec JJ (p99) Offsite Care and UM.	$0.00

payment. Further, our process provides more relationship building with the community providers to handle problems in a way the large vendors cannot. Further, CorEMR has functionality which should be utilized, not a stand alone system. As was explained in the proposal response, the authorization the jail requires can delay care (if urgent) and is based upon financial initiatives to save money.		

TAB J

Employee Health Insurance

Mid-Level Plan - Horizon

(rates need to be confirmed with ages and participants after award)

The Pass-through to the county includes

Insurance,

Prescription

Dental

Vision

Life

ADD

EASE

EMPLOYEE HEALTH INSURANCE FOR MIDLEVEL PRICED PLAN (2 OF 3):

The Vendor shall provide quotes or costs based upon their 2023 plan rates. This worksheet is for one (1) full time employee.

EMPLOYEE ONLY

What is the annual deductible, if any for the employee to meet? $ 2500

Does your company assist in meeting employee deductibles for this plan? ✓ Yes 2500 ____ No

Does your company assist in contributing to an employee FSA ____ Yes ✓ No

What is the employee's monthly premium? $ 125.00

What is the employee's bi-weekly premium deducted from paycheck? $ 62.50

What is the County's actual pass-through cost for this one insured employee? $ 662

Employee goes to a primary care doctor Tier 1/2nd+
What is the co-pay? $ 30+ can use 1/2 HRA Apply

Employee goes to a specialist
What is the co-pay? $ 65+ can use HRA

Employee goes to the Emergency Room
What is the co-pay? $ 100 After Deductible HRA can be used

Employee is hospitalized for two inpatient days. Medicare allowable cost is $4,500
What is the co-pay? 500/day $ 1000 AFTER Deductible Apply
What is the employee's out of pocket cost $ 1,000

Employee is authorized ten (10) Physical Therapy sessions 65/visit
What is the co-pay? $ 1/2 650 if HRA used Specialist Rate

Employee is authorized ten (10) Mental Health Counseling sessions 65/visit
What is the co-pay? Specialist Rate 65/visit $ 1/2 650 if HRA used Applied

MCHC Provides A Health Reimbursment Account (HRA) with 2500 value for Employee and 4,000 for Employee + Dep/Family.

EMPLOYEE + CHILD

Does this plan cover more than one child?	✓ Yes ___ No
What is the individual and/or annual deductible, if any for the employee to meet?	$ 5,000
Does your company assist in meeting employee deductibles for this plan?	✓ Yes 4,000 ___ No
Does your company assist in contributing to an employee FSA	___ Yes ✓ No
What is the employee's monthly premium?	$ 225
What is the employee's bi-weekly premium deducted from paycheck?	$ 112.50
What is the County's actual pass-through cost for this insured Employee + Child?	$ 1,495

Employee or child goes to a primary care doctor
What is the co-pay? $ 30 But can use 1/2 HRA $15

Employee or child goes to a specialist
What is the co-pay? $ 65 But can use 1/2 HRA $ 32.50

Employee or child goes to the Emergency Room
What is the co-pay? $ 100 After Deductible

Employee or child is hospitalized for two inpatient days. Medicare allowable cost is $4,500
500/day After Deductible
What is the co-pay? $ 1000
What is the employee's out of pocket cost $ 1000

Employee or child is authorized ten (10) Physical Therapy sessions
What is the co-pay? Specialist Rates ↑ $ 65 or use 1/2 HRA 32.50

Employee or child is authorized ten (10) Mental Health Counseling sessions
What is the co-pay? $ 65 or use 1/2 HRA 32.50

EMPLOYEE + FAMILY

What is the individual and/or annual family deductible if any, for the employee to meet? $ 5,000

Does your company assist in meeting employee deductibles for this plan? ✓ Yes 4000 ___ No

Does your company assist in contributing to an employee FSA ___ Yes ✓ No

What is the employee's monthly premium? $ 725

What is the employee's bi-weekly premium deducted from paycheck? $ 362.50

What is the County's actual pass-through cost for this insured employee + family? $ 1,585

Employee or family member goes to a primary care doctor

What is the co-pay? $ 30 but can use ½ HRA 15

Employee or family member goes to a specialist

What is the co-pay? $ 65 but can us ½ HRA 32.50

Employee or family member goes to the Emergency Room

What is the co-pay? $ 100 AFTER Deductible

Employee or family member is hospitalized for two inpatient days. Medicare allowable cost is $4,500

What is the co-pay? $ 1000 After Deductible

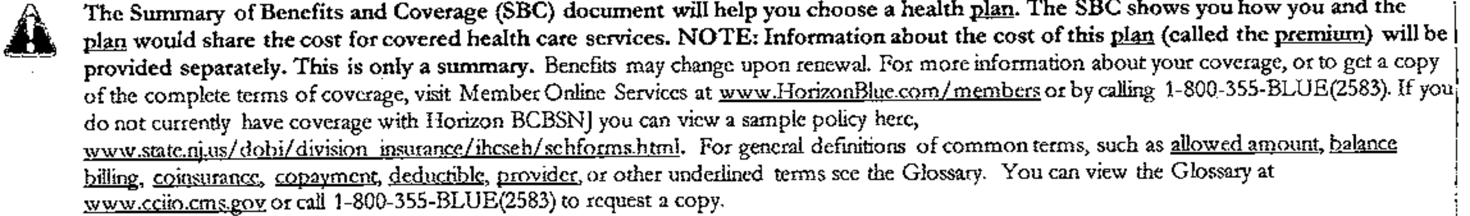
What is the employee's out of pocket cost $ 1000 " "

Employee or family member is authorized ten (10) Physical Therapy sessions

What is the co-pay? SPECIALIST RATES $ 650 can us ½ HRA/325

Employee or family member is authorized ten (10) Mental Health Counseling sessions

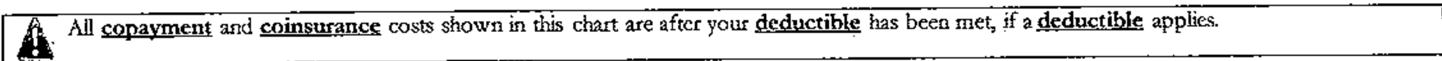
What is the co-pay? $ 650 But can use ½ HRA 325.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. Benefits may change upon renewal. For more information about your coverage, or to get a copy of the complete terms of coverage, visit Member Online Services at www.HorizonBlue.com/members or by calling 1-800-355-BLUE(2583). If you do not currently have coverage with Horizon BCBSNJ you can view a sample policy here, www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-355-BLUE(2583) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,800.00**/Individual or **$3,600.00**/Family for OMNIA Tier 1 providers. **$2,500.00**/Individual or **$5,000.00**/Family for Tier 2 providers. OMNIA Tier 1 accumulates to Tier 2.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. For Non-Generic prescription drugs **$250.00**/Individual or **$500.00**/Family for Tier 1 Pharmacies. All Tiers apply to Tier 1. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For Health/Pharmacy OMNIA Tier 1 providers **$9,100.00** Individual/**$18,200.00** Family and for Tier 2 providers **$9,100.00** Individual/**$18,200.00** Family. Aggregate family. OMNIA Tier 1 accumulates to Tier 2.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.HorizonBlue.com or call 1-800-355-BLUE (2583) for a list of network providers.	You pay the least if you use a provider in OMNIA Tier 1. You pay more if you use a provider in Tier 2. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network

		provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.


All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier1 Provider(You will pay the least)	Tier2 Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30.00 Copayment per visit. $15.00 Copayment per visit for Telemedicine services. Deductible does not apply.	50% Coinsurance per visit. 50% Coinsurance per visit for Telemedicine services.	Not Covered.	Horizon CareOnline telemedicine services is an additional telemedicine feature provided through Horizon BCBSNJ's telemedicine vendor.
	Specialist visit	$65.00 Copayment per visit. $15.00 Copayment per visit for Telemedicine services. Deductible does not apply.	50% Coinsurance per visit. 50% Coinsurance per visit for Telemedicine services.	Not Covered.	
	Preventive care/ screening/ immunization	No Charge. Deductible does not apply.	No Charge. Deductible does not apply.	Not Covered.	One per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge for Home, Office, Independent Laboratory. Deductible does not apply. $100.00 Copayment for Outpatient Hospital.	No Charge for Home, Office, Independent Laboratory. Deductible does not apply. 50% Coinsurance for Outpatient Hospital.	Not Covered.	Molecular and genomic testing are subject to pre-service and post-service medical necessity review.
	Imaging (CT/PET scans, MRIs)	$100.00 Copayment for Outpatient Facility.	50% Coinsurance for Outpatient Facility.	Not Covered.	Requires pre-approval.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier1 Provider(You will pay the least)	Tier2 Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Prime Therapeutics LLC (Prime) Service Center www.MyPrime.com or 1-800-370-5088. View the formulary at www.myprime.com/content/dam/prime/memberportal/WebDocs/2023/Formularies/HIM/2023_NJ_3T_HealthInsuranceMarketplace.pdf	Generic drugs	$25.00 Copayment/ Retail. $50.00 Copayment Mail order. Deductible does not apply.	$25.00 Copayment/ Retail. $50.00 Copayment Mail order. Deductible does not apply.	$25.00 Copayment/ Retail. $50.00 Copayment Mail order. Deductible does not apply.	Prior authorization may be required. Covers up to a 30 day supply per copayment, up to a 90 day supply applying separate copayments (retail) and a 90 day supply (mail order). Additional charges apply when using an out-of-network pharmacy.
	Preferred brand drugs	50% Coinsurance Retail/Mail order.	50% Coinsurance Retail/Mail order.	50% Coinsurance Retail/Mail order.	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order). Deductible for all Tiers apply to Tier 1 Deductible. Additional charges apply when using an out-of-network pharmacy.
	Non-preferred brand drugs	50% Coinsurance Retail/Mail order.	50% Coinsurance Retail/Mail order.	50% Coinsurance Retail/Mail order.	
	Specialty drugs	50% Coinsurance Retail.	50% Coinsurance Retail.	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250.00 Copayment for Ambulatory Surgical Center, Outpatient Hospital.	50% Coinsurance for Ambulatory Surgical Center, Outpatient Hospital.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review.
	Physician/surgeon fees	Deductible applies for Ambulatory Surgical Center, Outpatient Hospital.	50% Coinsurance for Ambulatory Surgical Center, Outpatient Hospital.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review. Deductible applies for OMNIA Tier 1 anesthesia. 50% Coinsurance for Tier 2 anesthesia.
If you need immediate medical attention	Emergency room care	$100.00 Copayment for Outpatient Hospital.	$100.00 Copayment for Outpatient Hospital.	$100.00 Copayment for Outpatient Hospital.	Copayment waived if admitted within 24 hours. Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries. Accumulates to OMNIA Tier 1 deductible.

* For more information about limitations and exceptions, see the plan or policy document at www.HorizonBlue.com/members.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier1 Provider(You will pay the least)	Tier2 Network Provider	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	Deductible applies.	Deductible applies.	Deductible applies.	Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Urgent care	$75.00 Copayment per visit. Deductible does not apply.	50% Coinsurance.	50% Coinsurance.	No coverage for non-urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500.00 Copayment per day for Inpatient Hospital.	50% Coinsurance for Inpatient Hospital.	Not Covered.	Requires pre-approval. OMNIA Tier 1 in-network separation period is limited to 90 days in-network. $2,500.00 OMNIA Tier 1 copayment maximum per admission.
	Physician/surgeon fees	Deductible applies for Inpatient Hospital.	50% Coinsurance for Inpatient Hospital.	Not Covered.	Deductible applies for OMNIA Tier 1 anesthesia. 50% Coinsurance for Tier 2 anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30.00 Copayment for Outpatient Hospital.	50% Coinsurance for Outpatient Hospital.	Not Covered.	_______none_______
	Inpatient services	$500.00 Copayment per day for Inpatient Hospital.	50% Coinsurance for Inpatient Hospital.	Not Covered.	Requires pre-approval. OMNIA Tier 1 In-network separation period is limited to 90 days in-network. $2,500.00 OMNIA Tier 1 copayment maximum per admission.
If you are pregnant	Office visits	$30.00 Copayment per visit for Office. $65.00 Copayment per visit for Specialist. Deductible does not apply.	50% Coinsurance for Office.	Not Covered.	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound.)
	Childbirth/delivery professional services	Deductible applies for Inpatient Hospital.	50% Coinsurance for Inpatient Hospital.	Not Covered.	_______none_______
	Childbirth/delivery facility services	$500.00 Copayment per day for Inpatient Hospital.	50% Coinsurance for Inpatient Hospital.	Not Covered.	OMNIA Tier 1 in-network separation period is limited to 90 days in-network. $2,500.00 OMNIA Tier 1 copayment maximum per admission.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier1 Provider(You will pay the least)	Tier2 Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$15.00 Copayment per visit for Outpatient Facility. Deductible does not apply.	50% Coinsurance for Outpatient Facility.	Not Covered.	Requires pre-approval. Private-duty nursing is only covered under the Home health care benefit when required by a Home health care plan. Coverage is limited to 60 visits per calendar year.
	Rehabilitation services	$500.00 Copayment per day for Inpatient Hospital.	50% Coinsurance for Inpatient Hospital.	Not Covered.	Requires pre-approval. OMNIA Tier 1 in-network separation period is limited to 90 days in-network. $2,500.00 OMNIA Tier 1 copayment maximum per admission.
	Habilitation services	$500.00 Copayment per day for Inpatient Hospital.	50% Coinsurance for Inpatient Hospital.	Not Covered.	
	Skilled nursing care	$500.00 Copayment per day for Inpatient Facility.	50% Coinsurance for Inpatient Facility.	Not Covered.	
	Durable medical equipment	50% Coinsurance.	50% Coinsurance.	Not Covered.	Requires pre-approval.
	Hospice services	$500.00 Copayment per day for Inpatient Facility.	50% Coinsurance for Inpatient Facility.	Not Covered.	Requires pre-approval. OMNIA Tier 1 In-network separation period is limited to 90 days in-network. $2,500.00 OMNIA Tier 1 copayment maximum per admission.
If your child needs dental or eye care	Children's eye exam	No Charge. Deductible does not apply.	No Charge. Deductible does not apply.	Not Covered.	This benefit is administered by Davis Vision. In-network routine vision exam child visit limit is 1 visit in-network.
	Children's glasses	Amounts greater than $150.00 for non-collection frames. Deductible does not apply.	Amounts greater than $150.00 for non-collection frames. Deductible does not apply.	Not Covered.	This benefit is administered by Davis Vision. Lenses and Hardware are covered once every 12 months. Limit includes 1 pair of frames from the select Davis Vision collection or $150.00 allowance for non-collection frames.
	Children's dental check-up	Not Covered.	Not Covered.	Not Covered.	none

* For more information about limitations and exceptions, see the plan or policy document at www.HorizonBlue.com/members.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery • Dental care (Adult) • Long-term care	• Most coverage provided outside the United States. • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult, Optometrist/ Ophthalmologist office. For verification of coverage on routine vision services, please see your policy or plan document) • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture when used as a substitute for other forms of anesthesia • Bariatric surgery	• Chiropractic care • Hearing aids	• Infertility treatment (limited to artificial insemination; requires pre-approval)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.getcovered.nj.gov or call 1-833-677-1010.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact 1-800-355-BLUE (2583) or visit www.Horizonblue.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the NJ Department of Banking and Insurance Consumer Protection Services at 1-888-393-1062 ext 50998.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

———————To see examples of how this plan might cover costs for a sample medical situation, see the next section.———————

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,800.00**
- **Specialist *Copayment*** **$65.00**
- **Hospital (facility) *Copayment*** **$500.00**
- **Other *Coinsurance*** **50%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700.00

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,800.00
Copayments	$600.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$2,460.00**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,800.00**
- **Specialist *Copayment*** **$65.00**
- **Hospital (facility) *Copayment*** **$500.00**
- **Other *Coinsurance*** **50%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600.00

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250.00
Copayments	$900.00
Coinsurance	$1,600.00
What isn't covered	
Limits or exclusions	$20.00
The total Joe would pay is	**$2,770.00**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,800.00**
- **Specialist *Copayment*** **$65.00**
- **Hospital (facility) *Copayment*** **$500.00**
- **Other *Coinsurance*** **50%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800.00

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,800.00
Copayments	$400.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$2,200.00**

This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

TAB K

Employee Health Insurance

Premium Plan – Aetna

(rates need to be confirmed with Consensus of participants after award. This information was not provided by County.)

The Pass-through to the county includes

Insurance,

Prescription

Dental

Vision

Life

ADD

EASE

EMPLOYEE HEALTH INSURANCE FOR PREMIUM PRICED PLAN (3 OF 3):

The Vendor shall provide quotes or costs based upon their 2023 plan rates. This worksheet is for one (1) full time employee.

EMPLOYEE ONLY

What is the annual deductible, if any for the employee to meet? $ 2500

Does your company assist in meeting employee deductibles for this plan? ✓ Yes 2500 ___ No

Does your company assist in contributing to an employee FSA ___ Yes ✓ No

What is the employee's monthly premium? $ 195

What is the employee's bi-weekly premium deducted from paycheck? $ 97.50

What is the County's actual pass-through cost for this one insured employee? $ ~~1,568~~ 1433 ✓

Employee goes to a primary care doctor

What is the co-pay? $ 25 can use ½ HRA 12.50

Employee goes to a specialist

What is the co-pay? $ 75 can use ½ HRA 37.5

Employee goes to the Emergency Room can use HRA

What is the co-pay? $ ~~500~~ 500 ~~After~~ Deductible Does not apply

Employee is hospitalized for two inpatient days. Medicare allowable cost is $4,500

What is the co-pay? $ 0 After Deductible can use HRA

What is the employee's out of pocket cost $ 0

Employee is authorized ten (10) Physical Therapy sessions

What is the co-pay? $ 75/ea or ½ HRA 37.50

750 or 375.

↑ Specialist Rates ↓

Employee is authorized ten (10) Mental Health Counseling sessions

What is the co-pay? $ 75/ea or ½ HRA 37.50

750 or 375

MCHC Provides A HRA with $2500 value for Employee and $4,000 for Employee Plus dep/family.

Premier

EMPLOYEE + CHILD

Does this plan cover more than one child? ✓ Yes ____ No

What is the individual and/or annual deductible, if any for the employee to meet? $ 5,000 (4000)

Does your company assist in meeting employee deductibles for this plan? ✓ Yes ____ No

Does your company assist in contributing to an employee FSA ____ Yes ✓ No

What is the employee's monthly premium? $ 350

What is the employee's bi-weekly premium deducted from paycheck? $ 175

What is the County's actual pass-through cost for this insured Employee + Child? $ 1433

Employee or child goes to a primary care doctor

What is the co-pay? $ 25 OR USE 1/2 HRA 12.50 APPLY

Employee or child goes to a specialist

What is the co-pay? $ 75 OR APPLY USE 1/2 HRA 37.50

Employee or child goes to the Emergency Room

What is the co-pay? $ 500 Deductible Does NOT APPLY

Employee or child is hospitalized for two inpatient days. Medicare allowable cost is $4,500

After Deductible

What is the co-pay? $ 0

What is the employee's out of pocket cost $ 0

Employee or child is authorized ten (10) Physical Therapy sessions

What is the co-pay? Specialist Rate $ 750 OR Apply 1/2 HRA = 375.

Employee or child is authorized ten (10) Mental Health Counseling sessions

What is the co-pay? $ 750 OR Apply 1/2 HRA = 375

Premium

EMPLOYEE + FAMILY

What is the individual and/or annual family deductible if any, for the employee to meet?	$ 5,000 / 4,000
Does your company assist in meeting employee deductibles for this plan?	✓ Yes ___ No
Does your company assist in contributing to an employee FSA	___ Yes ✓ No
What is the employee's monthly premium?	$ 868
What is the employee's bi-weekly premium deducted from paycheck?	$ 434
What is the County's actual pass-through cost for this insured employee + family?	$ 1568

Employee or family member goes to a primary care doctor
What is the co-pay? $ 25 may apply 1/2 HRA 12.50

Employee or family member goes to a specialist
What is the co-pay? $ 75 may apply 1/2 HRA 37.50

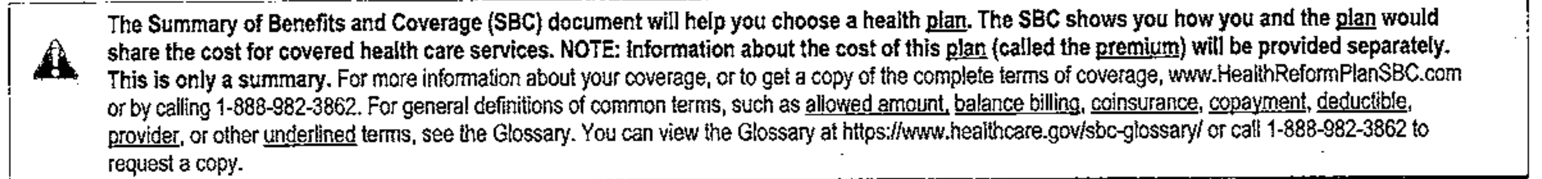
Employee or family member goes to the Emergency Room
What is the co-pay? $ 500 deductible does not apply. can use HRA

Employee or family member is hospitalized for two inpatient days. Medicare allowable cost is $4,500
What is the co-pay? $ 0 after deductible is met
What is the employee's out of pocket cost $ 0 can apply HRA

Employee or family member is authorized ten (10) Physical Therapy sessions
What is the co-pay? Specialist Rate $ 750 or apply 1/2 HRA = 325

Employee or family member is authorized ten (10) Mental Health Counseling sessions
What is the co-pay? $ 750 or apply 1/2 HRA = 325

Coverage for: Employee + Family | Plan Type: POS


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $2,500 / Family $5,000. Out-of-Network: Individual $5,000 / Family $15,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain office visits, preventive care, emergency care, urgent care and prescription drugs in-network.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $5,500 / Family $11,000. Out-of-Network: Individual $15,000 / Family $45,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See http://www.aetna.com/docfind or call 1-888-982-3862 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit, deductible does not apply	50% coinsurance	No charge for in-network virtual primary care telemedicine provider visits for certain services.
	Specialist visit	$75 copay/visit, deductible does not apply	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrolaetna	Preferred generic drugs	Tier 1A: $3 copay/ prescription (retail), $6 copay/ prescription (mail order); Tier 1: $10 copay/ prescription (retail), $20 copay/ prescription (mail order), deductible does not apply	50% coinsurance (retail), deductible does not apply	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to out-of-pocket limit. No charge for preferred generic FDA-approved women's contraceptives in-network. No coverage for mail order prescriptions out-of-network. Maintenance drugs- after two retail fills, you are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.
	Preferred brand drugs	$45 copay/ prescription (retail), $90 copay/ prescription (mail order), deductible does not apply	50% coinsurance (retail), deductible does not apply	
	Non-preferred generic/brand drugs	$75 copay/ prescription (retail), $150 copay/ prescription (mail order), deductible does not apply	50% coinsurance (retail), deductible does not apply	
	Specialty drugs	Preferred: 20% coinsurance up to a $250 maximum/ prescription for up to a 30 day supply; Non-preferred: 40% coinsurance up to a $500	Not covered	First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		maximum/ prescription for up to a 30 day supply, deductible does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$500 copay/visit, deductible does not apply	$500 copay/visit, deductible does not apply	Copay waived if admitted. Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	$75 copay/visit, deductible does not apply	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: No charge; All other outpatient services: 0% coinsurance	Office visits and all other outpatient services: 50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	Coverage is limited to 60 visits per year. Out-of-network precertification required or $400 penalty applies per occurrence.
	Rehabilitation services	$75 copay/visit	50% coinsurance	Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
	Habilitation services	0% coinsurance	50% coinsurance	None
	Skilled nursing care	0% coinsurance	50% coinsurance	Coverage is limited to 60 days per year. Out-of-network precertification required or $400 penalty applies per occurrence.
	Durable medical equipment	50% coinsurance	50% coinsurance	Coverage is limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
r child needs dental : care	Children's eye exam	No charge	50% coinsurance	Coverage is limited to 1 exam every 12 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - Coverage is limited to 10 visits per year for in-network only.
- Chiropractic care - Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
- Routine eye care (Adult) - Coverage is limited to 1 exam every 12 months.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
[illegible]ialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,570**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,300
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-982-3862.

The plan would be responsible for the other costs of these EXAMPLE covered services.

TAB L

Employee Dental, Vision, Life, ADD

The Pass-through to the county includes the above included in pricing.

Included in Employee Health

EMPLOYEE DENTAL INSURANCE PLANS (2023 rates):

Preventative $0.00 Every 6-Month

LOWEST PRICED PLAN

Employee Only

Basic = fillings, Root canals, Extractions 80/20

Major = Crowns, Bridges, Dentures = 50/50

Employee Monthly Cost	$ 0
Employee Deductible	$ 50 Basic 150 Major
Employee Plan Maximum	$ 1500
What is the County's actual pass-through cost for this one insured employee?	$ included in Health INS

Employee + Family // //

Basic 80/20
Major 50/50

Employee Monthly Cost	$ 0
Employee Deductible	$ 50 basic 150-Major
Employee Plan Maximum	$ 1500 Each Dep
What is the County's actual pass-through cost for this one insured employee + family?	$ included in Health INS

SAME for All Plans

MID-LEVEL PRICED PLAN

Employee Only

Employee Monthly Cost	$
Employee Deductible	$
Employee Plan Maximum	$
What is the County's actual pass-through cost for this one insured employee?	$

Employee + Family

Employee Monthly Cost	$
Employee Deductible	$
Employee Plan Maximum	$
What is the County's actual pass-through cost for this one insured employee + family?	$

EMPLOYEE EYE INSURANCE PLANS (2023 rates):

All Plans are the Same Mid + Premium

LOWEST PRICED PLAN

Employee Only

Employee Monthly Cost	$ 0
Annual Eye Exam Co-pay	$ 0
Glasses Deductible or limit (Deduct is on Frames only)	$ 0 up To 150. 20% After
What is the County's actual pass-through cost for this one insured employee?	$ 0 Included in Ins Pricing

Lenses, Progressive Scratch, Poly, Reflect etc are All Included with no Limit

Employee + Family

Employee Monthly Cost	$
Annual Eye Exam Co-pay	$
Glasses Deductible or limit	$
What is Monmouth County's actual pass through cost for this one insured employee + family?	$

MID-LEVEL PRICED PLAN

Employee Only

Annual Eye Exam Co-pay	$
Glasses Deductible or limit	$
Employee Plan Maximum	$
What is the County's actual pass-through cost for this one insured employee?	$

Employee + Family

Employee Monthly Cost	$
Annual Eye Exam Co-pay	$
Glasses Deductible or limit	$
What is the County's actual pass-through cost for this one insured employee + family?	$

Effective Date: 6/1/2023

BENEFITS SUMMARY	Horizon DOP $50/$1500 100/80/50 NO WAIT NATGRID+ D2646
Contribution Type	Contributory
Provider Search	View
Deductible (Individual / Family)	$50/$150
Deductible Waived For Class I	Class I: Waived
Annual Maximum	$1,500
Office Visit Copay	$0
Class I - Diagnostic & Preventive (IN / OON)	100% / 100%
Class II - Basic (IN / OON)	80% / 80%
Class III - Major (IN / OON)	50% / 50%
Orthodontics (IN / OON)	Not Covered
Orthodontics Lifetime Maximum	N/A
Prior Ortho Requirement	N/A
Out of Network Reimbursement	MAC
Waiting Period	None
APPROXIMATE RATES	
Employee	$35.03
Employee & Spouse	$63.61
Employee & Child	$71.55
Employee & Children	$71.55
Employee & Family	$97.08

RATES were already calculated into the Total Health Insurance Plans

Effective Date: 10/1/2022

VISION COVERAGE OPTIONS BENEFITS SUMMARY	Horizon BCBS of NJ Horizon Expanse V
Network	Davis Vision View Network
Exam Frequency	12 Months
Lens Frequency	12 Months
Frames Frequency	12 Months
Elective Contact Lenses Frequency	12 Months
Necessary Contact Lenses Frequency	12 Months
Exam (INN / OON)	$0 / Reimbursement up to $40
Single Lenses (INN / OON)	$10 / Reimbursement up to $40
Bifocal (INN / OON)	$10 / Reimbursement up to $60
Trifocal (INN / OON)	$10 / Reimbursement up to $80
Progressive (INN / OON)	See Plan Document / Reimbursement up to $60
Frames (INN / OON)	Up to $150 or $200 plus a 20% discount on any overage / Reimbursement up to $50
Elective Contact Lenses (INN / OON)	Up to $150 plus 15% discount on any overage / Reimbursement up to $105
Glasses Covered if Contacts Elected	FALSE
APPROXIMATE RATES	
Employee	$7.87
Employee & Spouse	$15.74
Employee & Child	$16.53
Employee & Children	$16.53
Employee & Family	$23.06

RATES were Already calculated into the Total Health insurance Pass - Through