Individual and Family Health Coverage
from Horizon Blue Cross Blue Shield of New Jersey

Plan Decision Guide

- Horizon Basic and Essential EPO and EPO Plus
- Horizon HMO
- Horizon Direct Access

Also Inside: Plan Premiums and Enrollment Form

Horizon Blue Cross Blue Shield of New Jersey

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Pre-existing Condition Limitation Only Applies to Individuals Age 19 and Older.

Pre-existing Conditions Limitation

Definition of a "pre-existing" condition:

A "pre-existing condition" is an illness or injury that manifests itself in the six months before the enrollment date and for which:

- a person sees a doctor, takes prescribed drugs or receives other medical care or treatment, or had medical treatment recommended by a doctor, or
- an ordinarily prudent or careful person would have sought medical advice, care or treatment.

A pregnancy that exists on the effective date of your coverage is also a pre-existing condition. However, complications of pregnancy, as defined in N.J.A.C. 11:1-4.3, are not considered pre-existing conditions and are not subject to the pre-existing condition limitation.

How does this limitation affect coverage?

If this limitation applies, no benefits will be paid for charges incurred for the covered person's pre-existing condition until 12 months after the enrollment date.

Exceptions to the limitation:

The pre-existing condition limitation does not apply to any individual under age 19 and to genetic information, in the absence of a diagnosis of the condition related to that information.

This limitation may not apply if you transfer from another health insurance plan and there has been no more than a 31-day lapse in coverage. The limitation also does not apply to Federally Defined Eligible Individuals who apply for coverage within 63 days of termination of prior coverage. Additional limitations and exclusions may apply.

Individual and Family Health Coverage

from the State's Leading Health Insurer: Horizon Blue Cross Blue Shield of New Jersey

Put our coverage advantages to work for you with a plan that meets your needs and fits your budget!

For over 75 years, we've been helping New Jersey residents with their health care coverage needs. Today, nearly 3.6 million members have come to us for reliable coverage and the security of the Blue Cross and Blue Shield name. Our strength, experience and dependable plans have helped make us the largest health insurer in New Jersey. Here are just a few advantages you'll find when you choose individual health coverage from Horizon Blue Cross Blue Shield of New Jersey.

A variety of plan choices for individuals and families

Horizon Blue Cross Blue Shield of New Jersey is pleased to offer a full range of health plan choices for individuals and families. Whether you are purchasing an individual health insurance plan for the first time, or simply looking to get more for your premium dollar, we're confident you'll find a plan that fits your exact needs and budget.

Access to broad provider network

With our plan choices, you have access to the large Horizon Managed Care Network. Our agreements with these participating doctors and specialists allow you to save on the premiums and the cost of covered services. Dozens of leading institutions recognize Horizon Blue Cross Blue Shield of New Jersey and accept our coverage with no paperwork required. It's likely that the doctors and hospitals you currently use participate in our network.

Available prescription drug coverage with selected plans

The high costs for outpatient prescription drugs are a concern for many New Jersey residents. That's why most of our plan options include coverage to help cover the costs of commonly prescribed medications.

Guaranteed renewability

Once coverage goes into effect, it is guaranteed renewable. This means that as long as your premiums are paid on time, your coverage will renew each year without proof of good health. Some limitations apply.

Coverage away from home

For all plans, medical emegencies are covered while traveling outside of the Horizon Managed Care Network at the in-network benefit level. Our HMO, EPO and EPO Plus plans do not cover non-emergency out-of-network services, unless otherwise authorized. The Individual Direct Access plans do cover eligible non-emergency medical services while outside of the Horizon Managed Care Network at the out-of-network level. To maximize eligible out-of-network benefits, Horizon Direct Access members have the option of using our BlueCard Traditional Network while traveling outside of the Horizon Managed Care Network. These BlueCard Traditional Providers will accept the negotiated rates and will not balance bill the member for the difference. To find a participating physcian, just call the toll-free number on the back of your ID card.

Choose the Plan that Works Best for You

At Horizon Blue Cross Blue Shield of New Jersey, we want to make it as easy as possible to choose the individual or family health care plan that works for you *and* meets your budget. Use the chart below to identify key features of each plan.

Horizon Basic and Essential EPO and EPO Plus plans

For exceptional affordability, essential coverage, no primary care physician requirement and no referrals

Plan features:

- Cost-saving features designed to keep premiums low
- Health care services through the Horizon Managed Care Network
- No Primary Care Physician required and no referrals needed
- $30 office visit copayment available with EPO Plus coverage

An ideal option for people on a limited budget – like recent college grads or the unemployed.

Horizon HMO plans

For comprehensive coverage, low out-of-pocket costs and an extensive network of physicians and hospitals, choose a Horizon HMO plan

Plan features:

- No cost sharing for preventive care
- A choice of copayment options starting as low as $15
- Low out-of-pocket costs with health care services received through a Primary Care Physician (PCP)
- Extensive HMO network of physicians and hospitals plus out-of-state medical emergency coverage

A combination of cost-saving features and comprehensive coverage makes this a popular choice for many New Jersey residents, especially those with families.

Horizon Direct Access plans

For comprehensive coverage, access to in- and out-of-network providers and no referrals

Plan features:

- Comprehensive coverage that includes preventive care
- Receive health care services through the Horizon Managed Care Network or go out-of-network
- Primary Care Physician (PCP) selection recommended for maximum benefit, but not required and no referral needed

A comprehensive health plan offering coverage for a wide range of services plus maximum freedom of choice.

Before Signing Up for a Plan, You Should Know…

Eligibility

Under New Jersey law, you may not be denied health insurance coverage because of a medical condition, age, sex, occupation or where you live in the state. However, you must be a New Jersey resident.

You or any dependents you wish to enroll must not be covered or eligible under:

- **Another individual health benefits plan**
- **A group health benefits plan that provides the same or similar coverage (as that phrase has been interpreted through regulation)**
- **Medicare**

Eligible dependents include your spouse, domestic partner or civil union partner, and your children (including those in your legal custody and guardianship) who are under age 26. Special rules apply to the continuation of coverage beyond age 26 for handicapped children.

How to apply

Simply complete the enclosed enrollment form. To save time in processing, be sure to answer all questions carefully and completely for yourself and all eligible dependents. Be sure to indicate your choice of plan and deductible or copayment, if applicable.

Payment options
You may pay your initial premium by credit card. Monthly premiums may be paid by automatic monthly bank draft or direct bill each month. **If paying by direct bill, please enclose a check or money order for your first month's premium.** If choosing automatic monthly bank draft, please attach a voided check to your enrollment form.

Changing plans?

If you have health insurance with us or another company, you need to know the following information when changing plans:

From group coverage…
If you are eligible for group coverage, you can only enroll in individual coverage that is not the same or similar to your group coverage during the November open enrollment for a January 1 effective date. Your group coverage termination must coincide with the effective date of your new policy with us.

From individual coverage…
If you already have coverage under an individual plan offered by Horizon Blue Cross Blue Shield of New Jersey or another carrier, restrictions may apply to changing coverage. Please call your agent, broker or a Horizon BCBSNJ Sales Representative at 1-888-425-5611 for more information.

Questions About Applying or Changing Plans? Need More Information?

Feel free to call your agent or broker – or call us toll-free at 1-888-425-5611, Monday through Friday, from 8:30 a.m. to 5:00 p.m. ET.
If you have a hearing impairment, call our telecommunication device at **1-800-852-7899.**

You can also visit us online at www.HorizonBlue.com

Horizon Basic and Essential EPO and EPO Plus

Benefits-at-a-Glance

The chart below is only for illustrative purposes. Once you are enrolled, a complete list of details and exclusions will be provided in your individual contract/policy.

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

DESCRIPTION OF SERVICE	Horizon Basic and Essential EPO	Horizon Basic and Essential EPO Plus
Physician/Specialist Services Consultation, medical and surgical services, assistant surgeon, anesthesia and maternity care	Outpatient/Out-of-hospital/Illness and injury office visits covered to $700 per covered person per calendar year. Wellness visits covered to $600 per covered person per calendar year.	Outpatient/Out-of-hospital/Office visits — $30 copayment per covered person per visit. Wellness visits covered to $600 per covered person per calendar year.
	Inpatient practitioner's fees connected with inpatient hospital confinement are covered under inpatient hospital services.	
Physical Therapy Outpatient *(30 visits per covered person per calendar year)*	$20 copayment per covered person per visit.	
Maternity Services Physician Services	Delivery charge covered; pre- and post-natal charges are covered when included in the delivery charge.	$30 copayment for initial visit; inpatient stay subject to inpatient hospital charges.
Inpatient Hospital Services *(90 days per covered person per calendar year)*	$500 copayment per covered person per period of confinement.	
Outpatient Hospital Services Outpatient Surgery and Ambulatory Surgery	$250 copayment per covered person per surgery.	
Out-of-Hospital Diagnostic Tests	$500 **maximum** per covered person per calendar year.**	
Emergency Room Copayment	$100 copayment per covered person per visit (waived if admitted).	
Alcohol and Substance Abuse Inpatient *(30 days per covered person per calendar year)*	30% coinsurance after $500 hospital confinement deductible.	
Alcohol and Substance Abuse Outpatient *(30 visits per covered person per calendar year)*	30% coinsurance.	
Mental Illness (BBMI) Inpatient *(90 days per covered person per calendar year)*	$500 copayment per covered person per period of confinement.	
Mental Illness (BBMI) Outpatient *(30 visits per covered person per calendar year)*	30% coinsurance.	

DESCRIPTION OF SERVICE	Horizon Basic and Essential EPO	Horizon Basic and Essential EPO Plus
Prescription Drugs (Obtained while not confined in a hospital)	Not covered.	$15 copayment for generic drugs with one copayment per 30-day supply for retail and mail order; 50% coinsurance for brand name drugs up to $500 maximum per covered person per calendar year.
Home Health Care	Not covered.	50% coinsurance up to $2,500 maximum per covered person per calendar year.
Durable Medical Equipment	Not covered.	50% coinsurance up to $2,500 maximum per covered person per calendar year.
Hospice Care	Not covered.	50% coinsurance up to $2,500 maximum per covered person per calendar year.
Diabetes Benefits	Not covered.	50% coinsurance up to $2,500 maximum per covered person per calendar year.
Birthing Center Confinement	Birthing Center charges not covered.	$250 copayment per covered person per period of confinement.
Rehabilitation Center Confinement	Rehabilitation Center charges not covered.	$500 copayment per covered person per period of confinement; the copayment does not apply if admission is preceded by a hospital confinement; maximum 90 days per calender year.
Casts, Braces, Trusses, Prosthetic Devices, Orthopedic Footwear and Crutches	Not covered.	Casts, prosthetic devices and crutches are covered.
Chemotherapy, Infusion Therapy	Not covered.	Covered.
Transplants	Not covered.	Covered.
EXCLUSIONS*	Horizon Basic and Essential EPO	Horizon Basic and Essential EPO Plus
Ambulance, Routine Foot Care, Skilled Nursing Facility Care, Therapeutic Manipulation (Chiropractic), Treatment of a Non-Biologically Based Mental Illness	Not covered.	

**For diagnostic services rendered in the office, freestanding or an outpatient facility.

*This is only a summary of benefits; a complete list of exclusions will be provided in your Evidence of Coverage.

Horizon HMO

Benefits-at-a-Glance

The chart below is only for illustrative purposes. Once you are enrolled, a complete list of details and exclusions will be provided in your individual contract/policy.

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

DESCRIPTION OF SERVICE	HORIZON HMO $15	HORIZON HMO $30	HORIZON HMO $30/$50
Primary Care Physician Copayment	$15 per visit.	$30 per visit.	$30 per visit.
Specialist Copayment	$15 per visit.	$30 per visit.	$50 per visit.
Annual Deductible	N/A	N/A	N/A
Coinsurance	50% for prescription drugs.	50% for prescription drugs.	50% for prescription drugs.
Maximum Out-of-Pocket	N/A	N/A	N/A
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited
Inpatient Hospital (including biologically based mental illness and alcoholism) (subject to preapproval)	$150 copayment per day for a maximum of 5 days per admission; $1,500 maximum per calendar year.	$300 copayment per day for a maximum of 5 days per admission; $3,000 maximum per calendar year.	
Ambulatory Surgical Center Facility Charges	$15 per visit.	$30 per visit.	$30 per visit.
Hospital Outpatient Surgery Facility Charges	$15 per visit.	$30 per visit.	$60 per visit.
Emergency Room Copayment	$100 copayment (waived if admitted within 24 hours).		
Non-Biologically Based Mental Illness and Substance Abuse	**Inpatient** (subject to preapproval): 100% after the hospital copayment for a maximum of 30 days per year (1 inpatient day may be exchanged for 2 outpatient visits). **Outpatient:** 100% after the office visit copayment for a maximum 20 visits per calendar year.		
Blood/Blood Products/Processing	Plan pays 100%.	Plan pays 100%.	Plan pays 100%.
Diagnostic X-ray	$15 copayment per visit.	$30 copayment per visit.	
Lab	Plan pays 100% when provided by a network lab.		
Durable Medical Equipment (Subject to preapproval)	Plan pays 100%.	Plan pays 100%.	Plan pays 100%.
Home Health Care and Hospice Care (Subject to preapproval)	Unlimited days.	Unlimited days.	Unlimited days.
Maternity	$25 copayment for the initial visit; $0 copayment thereafter.		
Prescription Drugs	50% coinsurance.	50% coinsurance.	50% coinsurance.
Preventive Care	$0 copayment per visit.	$0 copayment per visit.	$0 copayment per visit.
Rehabilitation Centers (Subject to preapproval)	Subject to inpatient hospital copayment above. Waived if immediately preceded by an inpatient stay.		
Speech, Physical (subject to preapproval), **Occupational and Cognitive Rehabilitation Therapies**	$15 copayment per visit.	$30 copayment per visit.	
Therapeutic Manipulations	$15 copayment per visit. Limited to 30 visits per calendar year and 2 modalities per visit.	$30 copayment per visit. Limited to 30 visits per calendar year and 2 modalities per visit.	$30 or $50 copayment per visit. Limited to 30 visits per calendar year and 2 modalities per visit.

DESCRIPTION OF SERVICE	HORIZON HMO $50/$70	HORIZON HMO COINSURANCE
Primary Care Physician Copayment	$50 per visit.	$40 per visit.
Specialist Copayment	$70 per visit.	Subject to deductible and coinsurance.
Annual Deductible	N/A	$2,500 Individual/$5,000 Family Deductible (Aggregate).
Coinsurance	50% for prescription drugs.	50% coinsurance.
Maximum Out-of-Pocket	N/A	$5,000 Individual/$10,000 Family.
Lifetime Benefit Maximum	Unlimited	
Inpatient Hospital (including biologically based mental illness and alcoholism)(subject to preapproval)	$500 copayment per day for a maximum of 5 days per admission; $5,000 maximum per calendar year.	Subject to deductible and coinsurance.
Ambulatory Surgical Center Facility Charges	$50 per visit.	Subject to deductible and coinsurance.
Hospital Outpatient Surgery Facility Charges	$100 per visit.	Subject to deductible and coinsurance.
Emergency Room Copayment	$100 copayment (waived if admitted within 24 hours).	$100 copayment (waived if admitted within 24 hours). Emergency room copayment is payable in addition to applicable deductible and coinsurance.
Non-Biologically Based Mental Illness and Substance Abuse	**Inpatient** (subject to preapproval): 100% after the hospital copayment for a maximum of 30 days per year (1 inpatient day may be exchanged for 2 outpatient visits). **Outpatient:** 100% after the office visit copayment for a maximum 20 visits per calendar year.	Subject to deductible and coinsurance/Maximum of 30 days inpatient care per calendar year. One inpatient day may be exchanged for 2 outpatient visits; maximum 20 visits per calendar year.
Blood/Blood Products/Processing	Plan pays 100%.	Subject to deductible and coinsurance.
Diagnostic X-ray	$50 copayment per visit.	Subject to deductible and coinsurance.
Lab	Plan pays 100% when provided by a network lab.	Subject to deductible and coinsurance.
Durable Medical Equipment (Subject to preapproval)	Plan pays 100%.	Subject to deductible and coinsurance.
Home Health Care and Hospice Care (Subject to preapproval)	Unlimited days.	Unlimited days; subject to deductible and coinsurance.
Maternity	$25 copayment for the initial visit; $0 copayment thereafter.	
Prescription Drugs	50% coinsurance.	Subject to deductible and coinsurance. Coinsurance paid for covered prescription drugs does not count toward the maximum out-of-pocket.
Preventive Care	$0 copayment per visit.	$0 copayment per visit.
Rehabilitation Centers (Subject to preapproval)	Subject to inpatient hospital copayment above. Waived if immediately preceded by a hospital inpatient stay.	Subject to deductible and coinsurance.
Speech, Physical (subject to preapproval), **Occupational and Cognitive Rehabilitation Therapies**	$30 copayment per visit.	Subject to deductible and coinsurance. Limited to 30 visits per calendar year.
Therapeutic Manipulations	$30 copayment per visit. Limited to 30 visits per calendar year and 2 modalities per visit.	Subject to deductible and coinsurance. Limited to 30 visits per calendar year and 2 modalities per visit.

Horizon Direct Access

Benefits-at-a-Glance

The chart below is only for illustrative purposes. Once you are enrolled, a complete list of details and exclusions will be provided in your individual contract/policy.

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

	INDIVIDUAL DIRECT ACCESS PLAN C 100/70	
DESCRIPTION OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
Primary Care Physician Copayment*	$30 copayment per visit to selected PCP. $50 copayment per visit if no PCP is selected.	Subject to out-of-network deductible and 30% coinsurance.
Specialist Copayment	$50 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.
Annual Deductible	N/A	$7,500 Individual / $15,000 Family (Aggregate).
Coinsurance	Applies to Prescription Drugs only. Plan pays 50%/You pay 50%.	Plan pays 70%/ You pay 30% (50% for Prescription Drugs).
Maximum Out-of-Pocket (Does not include prescription drugs)	$5,000 Individual / $10,000 Family.	$22,500 Individual / $45,000 Family.
Lifetime Benefit Maximum	Unlimited	
Inpatient Hospital (Subject to preapproval) (including biologically based mental illness)	$300 copayment per day for a maximum of 5 days per admission; $5,000 maximum per calendar year.	Subject to out-of-network deductible and 30% coinsurance.
Ambulatory Surgical Center Facility Charges	$30 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.
Hospital Outpatient Surgery Facility Charges	$60 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.
Emergency Room Copayment	$100 copayment per visit (waived if admitted within 24 hours).	$100 copayment (waived if admitted within 24 hours) is in addition to out-of-network deductible and 30% coinsurance.
Alcoholism (Subject to preapproval)	Inpatient: $300 copayment per day for maximum of 5 days per admission; $3,000 maximum per calendar year.	Subject to out-of-network deductible and 30% coinsurance.
Non-Biologically Based Mental Illness and Substance Abuse • Inpatient confinement: subject to preapproval, limited to 30 days per calendar year (1 inpatient day may be exchanged for 2 outpatient visits) • Outpatient: 20 visits per calendar year	**Inpatient:** 100% after the inpatient hospital copayment. **Outpatient:** 100% after the office visit copayment.	Subject to out-of-network deductible and 30% coinsurance.
Blood/Blood Products/Processing	Plan pays 100%.	Subject to out-of-network deductible and 30% coinsurance.
Diagnostic X-ray	Determined by place of service.	Subject to out-of-network deductible and 30% coinsurance.
Lab	Plan pays 100% when provided by a network lab.	Subject to out-of-network deductible and 30% coinsurance.
Durable Medical Equipment (Subject to preapproval)	Plan pays 100%.	Subject to out-of-network deductible and 30% coinsurance.
Home Health Care and Hospice Care (Subject to preapproval)	Unlimited days.	Subject to out-of-network deductible and 30% coinsurance.
Maternity	$25 copayment for the initial office visit only; Subject to inpatient hospital copayment.	Subject to out-of-network deductible and 30% coinsurance.
Prescription Drugs (does not count toward maximum out-of-pocket)	50% coinsurance.	Not subject to deductible. Covered at 50% coinsurance.
Preventive Care	$0 copayment per visit.	Not subject to deductible and coinsurance. Maximum of $500 per individual (except newborns) per calendar year. Newborns: Maximum of $750 per calendar year up to age 1.
Rehabilitation Centers (Subject to preapproval)	Subject to inpatient hospital copayment. Waived if immediately preceded by an inpatient hospital stay.	Subject to out-of-network deductible and 30% coinsurance.
Speech, Physical, Occupational and Cognitive Rehabilitation Therapies Limited to 30 visits per calendar year per therapy	$30 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.
Therapeutic Manipulations Limited to 30 visits per calendar year and 2 modalities per visit	$30 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.

*Primary Care Physician (PCP) selection recommended for maximum benefits, but not required and no referral needed.

	INDIVIDUAL DIRECT ACCESS PLAN C 80/70	
DESCRIPTION OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
Primary Care Physician Copayment*	$30 copayment per visit to selected PCP. $50 copayment per visit if no PCP is selected.	Subject to out-of-network deductible and 30% coinsurance.
Specialist Copayment	$50 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.
Annual Deductible	$2,500 Individual / $5,000 Family (Aggregate).	$5,000 Individual / $10,000 Family (Aggregate).
Coinsurance	Plan pays 80%/You pay 20%. (50% for Prescription Drugs).	Plan pays 70%/You pay 30%.
Maximum Out-of-Pocket (Does not include prescription drugs)	$5,000 Individual / $10,000 Family.	$10,000 Individual / $20,000 Family.
Lifetime Benefit Maximum	Unlimited	
Inpatient Hospital (Subject to preapproval) (including biologically based mental illness)	Subject to in-network deductible and 20% coinsurance.	Subject to out-of-network deductible and 30% coinsurance.
Ambulatory Surgical Center Facility Charges	Subject to in-network deductible and 20% coinsurance.	Subject to out-of-network deductible and 30% coinsurance.
Hospital Outpatient Surgery Facility Charges	Subject to in-network deductible and 20% coinsurance.	Subject to out-of-network deductible and 30% coinsurance.
Emergency Room Copayment	$100 copayment (waived if admitted within 24 hours) is in addition to in-network deductible and 20% coinsurance.	$100 copayment (waived if admitted within 24 hours) is in addition to out-of-network deductible and 30% coinsurance.
Alcoholism (Subject to preapproval)	Inpatient and outpatient: Subject to in-network deductible and 20% coinsurance.	Inpatient and outpatient: Subject to out-of-network deductible and 30% coinsurance.
Non-Biologically Based Mental Illness and Substance Abuse • Inpatient confinement: subject to preapproval, limited to 30 days per calendar year (1 inpatient day may be exchanged for 2 outpatient visits) • Outpatient: 20 visits per calendar year	Subject to in-network deductible and 20% coinsurance.	Subject to out-of-network deductible and 30% coinsurance.
Blood/Blood Products/Processing	Subject to in-network deductible and 20% coinsurance.	Subject to out-of-network deductible and 30% coinsurance.
Diagnostic X-ray	Determined by place of service.	Subject to out-of-network deductible and 30% coinsurance.
Lab	Plan pays 100% when provided by a network lab.	Subject to out-of-network deductible and 30% coinsurance.
Durable Medical Equipment (Subject to preapproval)	Subject to in-network deductible and 20% coinsurance.	Subject to out-of-network deductible and 30% coinsurance.
Home Health Care and Hospice Care (Subject to preapproval)	Subject to in-network deductible and 20% coinsurance.	Subject to out-of-network deductible and 30% coinsurance.
Maternity	$25 copayment for initial office visit only; All other services subject to in-network deductible and 20% coinsurance.	Subject to out-of-network deductible and 30% coinsurance.
Prescription Drugs (does not count toward maximum out-of-pocket)	Not subject to deductible. Covered at 50% coinsurance.	
Preventive Care	Not subject to deductible, copayment and coinsurance.	Not subject to deductible and coinsurance. Maximum of $500 per individual (except newborns) per calendar year. Newborns: Maximum of $750 per calendar year up to age 1.
Rehabilitation Centers (Subject to preapproval)	Subject to in-network deductible and 20% coinsurance. Limited to 120 days combined.	Subject to out-of-network deductible and 30% coinsurance.
Speech, Physical, Occupational and Cognitive Rehabilitation Therapies Limited to 30 visits per calendar year per therapy	$50 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.
Therapeutic Manipulations Limited to 30 visits per calendar year and 2 modalities per visit	$50 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.

*Primary Care Physician (PCP) selection recommended for maximum benefits, but not required and no referral needed.

Horizon Direct Access (cont.)

Benefits-at-a-Glance

The chart below is only for illustrative purposes. Once you are enrolled, a complete list of details and exclusions will be provided in your individual contract/policy.

DESCRIPTION OF SERVICE	INDIVIDUAL DIRECT ACCESS PLAN A/50 70/50 IN-NETWORK	OUT-OF-NETWORK
Primary Care Physician Copayment*	$30 copayment per visit to selected PCP. $50 copayment per visit if no PCP is selected.	Subject to out-of-network deductible and 50% coinsurance.
Specialist Copayment	$50 copayment per visit.	Subject to out-of-network deductible and 50% coinsurance.
Annual Deductible	$2,500 Individual / $5,000 Family (Aggregate).	$7,500 Individual / $15,000 Family (Aggregate).
Coinsurance	Plan pays 70%/You pay 30%. (50% for Prescription Drugs).	Plan pays 50%/You pay 50%.
Maximum Out-of-Pocket (Does not include prescription drugs)	$5,000 Individual / $10,000 Family.	$15,000 Individual / $30,000 Family.
Lifetime Benefit Maximum	Unlimited	
Inpatient Hospital (Subject to preapproval) (including biologically based mental illness)	Subject to in-network deductible and 30% coinsurance.	Subject to out-of-network deductible and 50% coinsurance.
Ambulatory Surgical Center Facility Charges	Subject to in-network deductible and 30% coinsurance.	Subject to out-of-network deductible and 50% coinsurance.
Hospital Outpatient Surgery Facility Charges	Subject to in-network deductible and 30% coinsurance.	Subject to out-of-network deductible and 50% coinsurance.
Emergency Room Copayment	$100 copayment (waived if admitted within 24 hours) is in addition to in-network deductible and 30% coinsurance.	$100 copayment (waived if admitted within 24 hours) is in addition to out-of-network deductible and 50% coinsurance.
Alcoholism (Subject to preapproval)	Inpatient and outpatient: Subject to in-network deductible and 30% coinsurance.	Inpatient and outpatient: Subject to annual out-of-network deductible and 50% coinsurance.
Non-Biologically Based Mental Illness and Substance Abuse • Inpatient confinement: subject to preapproval, limited to 30 days per calendar year (1 inpatient day may be exchanged for 2 outpatient visits) • Outpatient: 20 visits per calendar year	Subject to in-network deductible and 30% coinsurance.	Subject to out-of-network deductible and 50% coinsurance.
Blood/Blood Products/Processing	Subject to in-network deductible and 30% coinsurance.	Subject to out-of-network deductible and 50% coinsurance.
Diagnostic X-ray	Determined by place of service.	Subject to out-of-network deductible and 50% coinsurance.
Lab	Plan pays 100% when provided by a network lab.	Subject to out-of-network deductible and 50% coinsurance.
Durable Medical Equipment (Subject to preapproval)	Subject to in-network deductible and 30% coinsurance.	Subject to out-of-network deductible and 50% coinsurance.
Home Health Care and Hospice Care (Subject to preapproval)	Subject to in-network deductible and 30% coinsurance.	Subject to out-of-network deductible and 50% coinsurance.
Maternity	$25 copayment for initial office visit only; All other services subject to in-network deductible and 30% coinsurance.	Subject to out-of-network deductible and 50% coinsurance.
Prescription Drugs (does not count toward maximum out-of-pocket)	Not subject to deductible. Covered at 50% coinsurance.	
Preventive Care	Not subject to deductible, copayment and coinsurance.	Not subject to deductible and coinsurance. Maximum of $500 per individual (except newborns) per calendar year. Newborns: Maximum of $750 per calendar year up to age 1.
Rehabilitation Centers (Subject to preapproval)	Subject to in-network deductible and 30% coinsurance. Limited to 120 days combined.	Subject to out-of-network deductible and 50% coinsurance.
Speech, Physical, Occupational and Cognitive Rehabilitation Therapies Limited to 30 visits per calendar year per therapy	$30 copayment per visit.	Subject to out-of-network deductible and 50% coinsurance.
Therapeutic Manipulations Limited to 30 visits per calendar year and 2 modalities per visit	$30 copayment per visit.	Subject to out-of-network deductible and 50% coinsurance.

*Primary Care Physician (PCP) selection recommended for maximum benefits, but not required and no referral needed.

Enjoy Added Savings

on Products and Services Made Available by Horizon

Horizon Blue Cross Blue Shield of New Jersey works hard to keep you healthy with important savings on products and services beyond your health care coverage. With our Horizon Wellness Discounts,† you can save money when you present your plan ID card at the select businesses described below or mention that you are a Horizon BCBSNJ member when calling them.

SmartEyes℠´

Thanks to our partnership with EyeMed, you can save on eyeglasses, accessories and examinations through the SmartEyes discount program. Participating locations include optical departments in LensCrafters, Sears Optical, JCPenney Optical, Target Optical, and Pearle Vision, as well as many independent optometrist and ophthalmologist offices.

Complete Advantage®´´

With this program through Davis Vision, you can enjoy discounts on eyeglasses, laser vision correction services, accessories and examinations.

TruVision — Traditional LASIK and Custom LASIK

Save on LASIK vision services, including a pre-operative exam, surgery, and post-operative care through TruVision, a national organization that offers board certified eligible ophthalmologists. You can also save through TruVision's Mail Order Contact Lens Program.

HearRx, a HearUSA Company

HearRx, a HearUSA Company, provides diagnostic audiology services and hearing aid dispensing nationwide. With locations throughout the U.S., it's easy to visit any center for a test and counseling. You will receive a 10% discount on any hearing aid purchased — even those on sale.

Healthyroads

Healthyroads allows you to save on a variety of health-related products, including vitamins, dietary supplements, homeopathic remedies, smoking cessation, weight management and stress reduction programs, plus much more.

Horizon Alternative Therapies

Receive discounts on services including acupuncture, massage therapy, chiropractic, nutrition counseling and vitamins.

New York Sports Clubs

Through our exclusive arrangement with New York Sports Clubs, you can take steps to stay healthy by getting the exercise you need and you can save money. You'll pay a discounted initiation fee of only $49, and the lowest corporate monthly dues available.

MedicAlert®´´´

MedicAlert protects and saves lives by providing instant access to identification and critical medical information to first responders in emergency situations. You will receive a free Basic Stainless Steel Bracelet or pendant with free shipping when you enroll.

Weight Watchers®´´´´

Weight Watchers has helped millions of people around the world lose weight. Receive discounts on three Weight Watchers programs, free registration at traditional meetings (in participating areas) and savings on Weight Watchers Online and an at-home kit.

†Please note: Discount programs are not insured. They are "value-added" features and may be terminated or changed without notice. Horizon BCBSNJ assumes no responsibility for any circumstances arising out of the use, misuse, interpretation or application of any information, products or services provided by or made available by the companies specified herein offering information, products, or services to you through Horizon Wellness Discounts. Horizon Wellness Discounts are made available for your convenience and do not constitute or imply endorsement of the companies, their information, products or services by Horizon BCBSNJ.

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