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 75 years, we've been helping New Jersey residents with their health care coverage needs. Today, nearly 3.2 million members have come to rely on us for reliable coverage and the security of the Blue Cross and Blue Shield name. Our strength, experience and solid 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.

Comprehensive affordable plans 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 networks

With most of our plan choices, you have access to the large Horizon Managed Care Network. Our agreements with these contracting 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 the doctors and hospitals you currently use participate in our networks.

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. See the enclosed "Benefits At-a-Glance" summaries for details.

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

As a member of Horizon Blue Cross Blue Shield of New Jersey you are covered when you travel. With our HMO, EPO and EPO Plus plans, out-of-network coverage is provided in cases of medical emergencies only. With our other plan options, you will have access to the BlueCard® network. This is a nationwide network of doctors and hospitals that allows you to receive benefits and covered services when you travel. To find a participating physician while you're away, just call the toll-free number on the back of your ID card. It's that easy.

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 checklist below to identify key features of each plan. Then review the specific benefit features presented on the Benefits At-a-Glance tables that appear in this booklet.

Horizon Basic and Essential EPO and EPO Plus plans

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

Plan features:

- Priced with 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 young families.

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:

- Comprehensive coverage that includes 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 coverage with the BlueCard® network

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

Also Available…

Horizon Basic and Traditional Plans

Plan features:

- Comprehensive benefit for traditional health care services, including hospital, surgical and major medical care
- Unlike managed care options, you are free to use any physician or hospital for your care
- Several coverage levels available to meet your expected health care needs and your budget
- A variety of ways to manage costs through your deductibles, coinsurance and out-of-pocket maximums

If traditional coverage features and freedom of choice are important to you, consider choosing a Basic or Traditional Plan

Horizon High Deductible Plans C and D

Plan features:

- Traditional fee-for service plans offering a high level of flexibility
- High level of coverage for medically necessary care (70% with Plan C, 80% with Plan D)
- Higher deductible amounts help keep premiums affordable
- Extensive physician network and access to benefits when you travel

If you want comprehensive coverage and flexible plan features that can lower your costs, consider one of these plan options.

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 or civil union partner, and your children (including those in your legal custody and guardianship) who are under age 19. Full-time students are eligible up to age 23. Special rules apply to handicapped children.

How to apply

Simply complete the enclosed application. 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 can pay your premiums by credit card, 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 bank draft, please attach a voided check to your application.

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 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 or broker or a Horizon BCBSNJ Sales Representative at 1-800-224-1234 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, Monday through Friday, from 8:30 a.m. to 5:00 p.m., at 1-800-224-1234. 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 for illustrative purposes only. See individual contract/policy for details and exclusions.

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 after $50 deductible and 20% coinsurance.	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 calendar year.	
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 Services	$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 copayment.	
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% 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; maxmium 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.	

** 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 for illustrative purposes only. See individual contract/policy for details and exclusions.

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	$30	$30
Specialist Copayment	$15	$30	$50
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 (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	$30	$30
Hospital Outpatient Facility Charges	$15	$30	$60
Emergency Room Copayment	$100 (Credited toward inpatient admission if admitted within 24 hours).		
Biologically Based Mental Illness and Alcoholism (Inpatient is subject to preapproval)	Inpatient: $150 copayment per day for a maximum of 5 days per admission; $1,500 maximum per calendar year.	Inpatient: $300 copayment per day for a maximum of 5 days per admission; $3,000 maximum per calendar year.	
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/Lab	$15 office visit copayment per visit.	$30 office visit copayment per visit.	
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	Office visit copayment per visit.	Office visit copayment per visit.	Office visit 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 office visit copayment per visit.	$30 office visit copayment per visit.	
Therapeutic Manipulations	Office visit 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	$40
Specialist Copayment	$70	Subject to deductible and coinsurance.
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 (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	Subject to deductible and coinsurance.
Hospital Outpatient Facility Charges	$100	Subject to deductible and coinsurance.
Emergency Room Copayment	$100 (Credited toward inpatient admission if admitted within 24 hours).	$100 (Credited toward inpatient admission if admitted within 24 hours). Emergency room copayment is payable in addition to applicable copayment, deductible and coinsurance.
Biologically Based Mental Illness and Alcoholism (Inpatient is subject to preapproval)	Inpatient: $500 copayment per day for a maximum of 5 days per admission; $5,000 maximum per calendar year.	Subject to 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.	Maximum of 3 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/Lab	$50 office visit copayment per visit.	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	Office visit 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**	$50 office visit copayment per visit.	Subject to deductible and coinsurance. Limited to 30 visits per calendar year.
Therapeutic Manipulations	Office visit 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 Basic and Traditional Plans

Benefits At-a-Glance

The chart below is for illustrative purposes only. See individual contract/policy for details and exclusions.

Horizon
Horizon Blue Cross Blue Shield of New Jersey
Making Healthcare Work.

DESCRIPTION OF SERVICE	HORIZON BASIC PLAN A/50	HORIZON TRADITIONAL PLAN B
Annual Deductible	$1,000 Individual/$2,000 Family (Aggregate). $2,500 Individual/$5,000 Family (Aggregate). $5,000 Individual/$10,000 Family (Aggregate). $10,000 Individual/$20,000 Family (Aggregate).	1,000 Individual/$2,000 Family (Aggregate). $2,500 Individual/$5,000 Family (Aggregate).
Coinsurance	Plan pays 50%/You pay 50%.	Plan pays 60%/You pay 40%.
Maximum Out of Pocket (Does not include prescription drug coverage)	$6,000 Individual/$12,000 Family. $7,500 Individual/$15,000 Family. $10,000 Individual/$20,000 Family. $15,000 Individual/$30,000 Family.	$4,000 Individual/$8,000 Family. $5,500 Individual/$11,000 Family.
Lifetime Benefit Maximum	Unlimited	
Office Visits	Subject to annual deductible and coinsurance.	
Inpatient Hospital: Semi-Private Inpatient Services and Supplies (Subject to preapproval)	365 days a year. Subject to annual deductible and coinsurance.	365 days a year, separate $200 copayment per individual per day up to $1,000 per admission, $2,000 per year maximum. Subject to annual deductible and coinsurance.
Extended Care or Rehabilitation Services (Subject to preapproval)	Subject to annual deductible and coinsurance. Limited to 120 days combined per year.	Subject to annual deductible, any other copayments and coinsurance. Limited to 120 days combined per year.
Emergency Room	$100 copayment (waived if admitted within 24 hours). Subject to annual deductible and coinsurance.	$100 copayment (waived if admitted within 24 hours). Subject to annual deductible and other copayments and coinsurance.
Home Health Care (Subject to preapproval)	Subject to annual deductible and coinsurance.	
Hospice Care (Subject to preapproval)	Subject to annual deductible and coinsurance.	
Biologically Based Mental Illness	Inpatient and Outpatient: Subject to annual deductible and 50%/50% coinsurance.	Inpatient: Subject to hospital copayment, annual deductible and coinsurance. Outpatient: Subject to annual deductible and coinsurance.
Non-Biologically Based Mental Illness and Substance Abuse	Inpatient and Outpatient: Subject to annual deductible and coinsurance. Inpatient confinement: 30 days per calendar year. Outpatient: 20 visits per calendar year. One inpatient day may be exchanged for two outpatient visits.	Inpatient: Subject to hospital copayment, annual deductible and coinsurance. Outpatient: Subject to annual deductible and coinsurance. Inpatient confinement: 30 days per calendar year. One inpatient day may be exchanged for two outpatient visits.
Alcoholism (Subject to preapproval)	Inpatient and Outpatient: Subject to annual deductible and coinsurance.	Inpatient: Subject to hospital copayment, annual deductible and coinsurance. Outpatient: Subject to annual deductible and coinsurance.
Practitioner's Charge	Subject to annual deductible and coinsurance.	
Preventive Care	$500 per individual (except newborns) per year. Newborns: $750 per year maximum benefit up to age 1. Not subject to annual deductible and coinsurance.	
Maternity	Subject to annual deductible and coinsurance.	
Therapy Services	Subject to annual deductible and coinsurance. Cognitive rehabilitation therapy, occupational therapy, physical therapy and speech therapy limited to 30 visits per calendar year. Radiation therapy, chemotherapy, chelation therapy, dialysis treatment and respiration therapy covered as any other illness. Infusion therapy subject to preapproval.	
Therapeutic Manipulations	Subject to annual deductible and coinsurance. Limited to 30 visits per calendar year.	
Prescription Drugs	Subject to annual deductible and coinsurance.	
Durable Medical Equipment (Subject to preapproval)	Subject to annual deductible and coinsurance.	
Blood/Blood Products/ Processing	Subject to annual deductible and coinsurance.	

DESCRIPTION OF SERVICE	HORIZON TRADITIONAL PLAN C	HORIZON TRADITIONAL PLAN D
Annual Deductible	$1,000 Individual/$2,000 Family (Aggregate). $2,500 Individual/$5,000 Family (Aggregate).	$1,000 Individual/$2,000 Family (Aggregate). $2,500 Individual/$5,000 Family (Aggregate).
Coinsurance	Plan pays 70%/You pay 30%.	Plan pays 80%/You pay 20%.
Maximum Out of Pocket (Does not include prescription drug coverage)	$3,500 Individual/$7,000 Family. $5,000 Individual/$10,000 Family.	$3,000 Individual/$6,000 Family. $4,500 Individual/$9,000 Family.
Lifetime Benefit Maximum	Unlimited	
Office Visits	Subject to annual deductible and coinsurance.	
Inpatient Hospital: Semi-Private Inpatient Services and Supplies (Subject to preapproval)	365 days a year. Subject to annual deductible and coinsurance.	
Extended Care or Rehabilitation Services (Subject to preapproval)	Subject to annual deductible and coinsurance. Limited to 120 days combined per year.	
Emergency Room	$100 copayment (waived if admitted within 24 hours). Subject to annual deductible and coinsurance.	
Home Health Care (Subject to preapproval)	Subject to annual deductible and coinsurance.	
Hospice Care (Subject to preapproval)	Subject to annual deductible and coinsurance.	
Biologically Based Mental Illness	Inpatient and Outpatient: Subject to annual deductible and 70%/30% coinsurance.	Inpatient and Outpatient: Subject to annual deductible and 80%/20% coinsurance.
Non-Biologically Based Mental Illness and Substance Abuse	Inpatient and Outpatient: Subject to annual deductible and coinsurance. Inpatient confinement: 30 days per calendar year. Outpatient: 20 visits per calendar year. One inpatient day may be exchanged for two outpatient visits.	
Alcoholism (Subject to preapproval)	Inpatient and Outpatient: Subject to annual deductible and coinsurance.	
Practitioner's Charge	Subject to annual deductible and coinsurance.	
Preventive Care	$500 per individual (except newborns) per year. Newborns: $750 per year maximum benefit up to age 1. Not subject to annual deductible and coinsurance.	
Maternity	Subject to annual deductible and coinsurance.	
Therapy Services	Subject to annual deductible and coinsurance. Cognitive rehabilitation therapy, occupational therapy, physical therapy and speech therapy limited to 30 visits per calendar year. Radiation therapy, chemotherapy, chelation therapy, dialysis treatment and respiration therapy covered as any other illness. Infusion therapy subject to preapproval.	
Therapeutic Manipulations	Subject to annual deductible and coinsurance. Limited to 30 visits per calendar year.	
Prescription Drugs	Subject to annual deductible and coinsurance.	
Durable Medical Equipment (Subject to preapproval)	Subject to annual deductible and coinsurance.	
Blood/Blood Products/ Processing	Subject to annual deductible and coinsurance.	

Horizon High Deductible Plans C and D

Benefits At-a-Glance

The chart below is for illustrative purposes only. See individual contract/policy for details and exclusions.

DESCRIPTION OF SERVICE	HORIZON HIGH DEDUCTIBLE PLAN C	HORIZON HIGH DEDUCTIBLE PLAN D
Annual Deductible	OPTION 1: $1,500 Single policy. $3,000 Family unit policy.* OPTION 2: $2,250 Single policy. $4,500 Family unit policy.*	OPTION 1: $1,500 Single policy. $3,000 Family unit policy.* OPTION 2: $2,250 Single policy. $4,500 Family unit policy.*
Coinsurance	Plan pays 70%/ You pay 30%.	Plan pays 80%/ You pay 20%.
Maximum Out of Pocket (Includes prescription drug coverage)	$3,000 Single policy. $5,500 Family unit policy.	
Lifetime Benefit Maximum	Unlimited	
Office Visits	Subject to annual deductible and coinsurance.	
Inpatient Hospital: Semi-Private Inpatient Services and Supplies (Subject to preapproval)	365 days a year. Subject to annual deductible and coinsurance.	
Extended Care or Rehabilitation Services (Subject to preapproval)	Subject to annual deductible and coinsurance. Limited to 120 day combined per year.	
Emergency Room	Subject to annual deductible and coinsurance.	
Home Health Care (Subject to preapproval)	Subject to annual deductible and coinsurance.	
Hospice Care (Subject to preapproval)	Subject to annual deductible and coinsurance.	
Biologically Based Mental Illness	Inpatient and Outpatient: Subject to annual deductible and coinsurance.	
Non-Biologically Based Mental Illness and Substance Abuse	Inpatient and Outpatient: Subject to annual deductible and coinsurance. Inpatient confinement: 30 days per calendar year. Outpatient: 20 visits per calendar year. One inpatient day may be exchanged for two outpatient visits.	
Alcoholism (Subject to preapproval)	Inpatient and Outpatient: Subject to annual deductible and coinsurance.	
Practitioner's Charge	Subject to annual deductible and coinsurance.	
Preventive Care	$500 per individual (except newborns) per year. Newborns: $750 per year maximum benefit up to age 1. Not subject to annual deductible and coinsurance.	
Maternity	Subject to annual deductible and coinsurance.	
Therapy Services	Subject to annual deductible and coinsurance. Cognitive rehabilitation therapy, occupational therapy, physical therapy and speech therapy limited to 30 visits per calendar year. Radiation therapy, chemotherapy, chelation therapy, dialysis treatment and respiration therapy coverage as any other illness. Infusion therapy subject to preapproval.	
Therapeutic Manipulations	Subject to deductible and coinsurance. Limited to 30 visits per calendar year.	
Prescription Drugs	Subject to annual deductible and coinsurance. Coinsurance paid for prescription drugs counts toward the Maximum Out of Pocket.	
Durable Medical Equipment (Subject to preapproval)	Subject to annual deductible and coinsurance.	
Blood/Blood Products/ Processing	Subject to annual deductible and coinsurance.	

* No amounts are payable until one person or any combination of persons in the family has satisfied the total Family Deductible. Family unit coverage includes (1) family, (2) husband and wife and (3) adult and child coverage.

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 Cole Vision, you can save on eyeglasses, accessories and examinations through the SmartEyes discount program. Participating locations include optical departments in Sears, JCPenney, Target, 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 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 of up to 25% of the usual charge for 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. There's even a one-week free trial.

MedicAlert®˝˝

MedicAlert protects and saves lives by providing instant access to identification and critical medical information to first responders in emergency situations. You can receive a 30% savings on the regular initial membership fee. You can also receive up to a 25% discount on all MedicAlert bracelets and pendants.

SafeTech Bicycle Helmets

Save up to 50% off bicycle and in-line skating helmets for the whole family.

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 of $10 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.

What's Not Covered by Our Plans

Pre-existing Condition Limitation

For the first 12 months following the effective date of your coverage, Horizon Blue Cross Blue Shield of New Jersey will not pay for:

- Conditions for which medical advice, diagnosis, care or treatment was recommended or received during the six months before enrollment.
- Conditions for which during the last six months there were symptoms that would cause a prudent person to seek medical advice, care or treatment.
- Pregnancy existing on the effective date of your policy. 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.

Pre-existing condition limitation does not apply to a newborn child, an adopted child or a child placed in the household for adoption if the child is enrolled and required premium payments are made within 31 days of birth, adoption or placement for adoption.

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 apply.