The information within this summary of the coverage, terms, conditions, and exclusions is subject to change upon approval and adoption of the underlying policy or contract forms by the New Jersey State Individual Health Coverage Program Board. In the event of a conflict between the information within this summary and the actual terms of the adopted policy or contract, the terms of the policy or contract will prevail.

IHCBEN (W0910)

INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work®

Horizon Basic and Essential EPO Plus

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	Horizon Basic and Essential EPO Plus
Physician/Specialist Services Consultation, medical and surgical services, assistant surgeon, anesthesia and maternity care	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	$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 Plus
Prescription Drugs (Obtained while not confined in a hospital)	$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	50% coinsurance up to $2,500 maximum per covered person per calendar year.
Durable Medical Equipment	50% coinsurance up to $2,500 maximum per covered person, per calendar year.
Hospice Care	50% coinsurance up to $2,500 maximum per covered person, per calendar year.
Diabetes Benefits	50% coinsurance up to $2,500 maximum per covered person, per calendar year.
Birthing Center Confinement	$250 copayment per covered person per period of confinement.
Rehabilitation Center Confinement	$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	Casts, prosthetic devices and crutches are covered.
Chemotherapy, Infusion Therapy	Covered.
Transplants	Covered.
EXCLUSIONS*	**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.

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