## 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℠

Horizon Blue Cross Blue Shield of New Jersey

*Making Healthcare Work®*

# Table of contents

# 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.



# 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.

### 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 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 Direct Access plans, coverage is provided for services received both in and out of the network. With our HMO, EPO and EPO Plus plans, out-of-network coverage is provided in cases of medical emergencies only. When you travel, all Direct Access members 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 are away from home. 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:

- 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:

- 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 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, no primary care physician requirement 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
- No Primary Care Physician (PCP) selection required and no referrals

***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 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 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 can pay your initial premium by credit card. Monthly premiums can 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 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 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.<br>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.<br>Wellness visits covered to $600 per covered person per calendar year. A copayment will apply. |
| | 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 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; 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. | |

* 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

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| 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 biological 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 (Credited toward inpatient admission 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/Lab** | $15 copayment per visit. | $30 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** | $15 copayment per visit. | $30 copayment per visit. | $30 or $50 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 (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. |
| **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 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/Lab** | $50 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** | $50 or $70 copayment per visit. | 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 copayment per visit. | Subject to deductible and coinsurance. Limited to 30 visits per calendar year. |
| **Therapeutic Manipulations** | $50 or $70 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 for illustrative purposes only. See individual contract/policy for details and exclusions.

Horizon Blue Cross Blue Shield of New Jersey

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| DESCRIPTION OF SERVICE | INDIVIDUAL DIRECT ACCESS PLAN C 100/70 IN-NETWORK | INDIVIDUAL DIRECT ACCESS PLAN C 100/70 OUT-OF-NETWORK |
|---|---|---|
| **Primary Care Physician Copayment** | $30 copayment per visit to selected PCP. | 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**<br>• Inpatient confinement: subject to preapproval, limited to 30 days per calendar year (1 inpatient day may be exchanged for 2 outpatient visits)<br>• Outpatient: 20 visits per calendar year | Inpatient: 100% after the inpatient hospital copayment.<br>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/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<br>Covered at 50% coinsurance. |
| **Preventive Care** | Office visit 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. |

| DESCRIPTION OF SERVICE | INDIVIDUAL DIRECT ACCESS PLAN C 80/70 IN-NETWORK | INDIVIDUAL DIRECT ACCESS PLAN C 80/70 OUT-OF-NETWORK |
|---|---|---|
| **Primary Care Physician Copayment** | $30 copayment per visit to selected PCP. | 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**<br>• Inpatient confinement: subject to preapproval, limited to 30 days per calendar year (1 inpatient day may be exchanged for 2 outpatient visits)<br>• 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/Lab** | Plan pays 100% of allowance 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 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 | $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. |

# Horizon Direct Access (cont.)

## Benefits-at-a-Glance

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

| | INDIVIDUAL DIRECT ACCESS PLAN A/50 70/50 | |
|---|---|---|
| **DESCRIPTION OF SERVICE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Primary Care Physician Copayment** | $30 copayment per visit to selected PCP. | 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**<br>• Inpatient confinement: subject to preapproval, limited to 30 days per calendar year (1 inpatient day may be exchanged for 2 outpatient visits)<br>• 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/Lab** | Plan pays 100% of allowance 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 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. |



# 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 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 off 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.

### 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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