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 HMO Coinsurance

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 HMO COINSURANCE
Primary Care Physician Copayment	$40 per visit.
Specialist Copayment	Subject to deductible and coinsurance
Annual Deductible	$2,500 Individual/$5,000 Family Deductible (Aggregate).
Coinsurance	50% coinsurance.
Maximum Out-of-Pocket	$5,000 Individual/$10,000 Family.
Lifetime Benefit Maximum	Unlimited
Inpatient Hospital (including biologically based mental illness and alcoholism) (Subject to preapproval)	Subject to deductible and coinsurance.
Ambulatory Surgical Center Facility Charges	Subject to deductible and coinsurance.
Hospital Outpatient Surgery Facility Charges	Subject to deductible and coinsurance.
Emergency Room Copayment	$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	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	Subject to deductible and coinsurance.
Diagnostic X-ray	Subject to deductible and coinsurance.
Lab	Subject to deductible and coinsurance.
Durable Medical Equipment (Subject to preapproval)	Subject to deductible and coinsurance.
Home Health Care and Hospice Care (Subject to preapproval)	Unlimited days; subject to deductible and coinsurance.
Maternity	$25 copayment for the initial visit; $0 copayment thereafter.
Prescription Drugs	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.
Rehabilitation Centers (Subject to preapproval)	Subject to deductible and coinsurance.
Speech, Physical (subject to preapproval), Occupational and Cognitive Rehabilitation Therapies	Subject to deductible and coinsurance. Limited to 30 visits per calendar year.
Therapeutic Manipulations	Subject to deductible and coinsurance. Limited to 30 visits per calendar year and 2 modalities per visit.