



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work™

## Horizon Individual Health Benefit Plans: Monthly Rates

The below rates are effective from February 1, 2010 to April 30, 2010. Please call your broker or Horizon Blue Cross Blue Shield of New Jersey representative at 1-800-224-1234, Monday through Friday, from 8:30 a.m. to 5:00 p.m. Eastern Time (ET), to confirm your rate. The rate you receive on your effective date will be guaranteed for twelve months.

		Basic and Essential-Male (Territories A, B and D)*		Basic and Essential-Female (Territories A, B and D)*		Basic and Essential-Male (Territories C, E and F)*		Basic and Essential-Female (Territories C, E and F)*		Direct Access Plan C 100/70	Direct Access Plan A/50 70/50	Direct Access Plan C 80/70	HMO Coinsurance	HMO 50/70	HMO 30/50	HMO 30	HMO 15
		EPO	EPO Plus	EPO	EPO Plus	EPO	EPO Plus	EPO	EPO Plus								
<b>Single</b>	0-24	\$131.29	\$165.15	\$163.40	\$205.53	\$124.72	\$156.88	\$155.22	\$195.24	\$360.46	\$272.32	\$287.02	\$442.16	\$682.59	\$701.77	\$711.04	\$854.44
	25-29	\$131.29	\$165.15	\$192.83	\$242.55	\$124.72	\$156.88	\$183.19	\$230.42	\$403.56	\$304.89	\$321.36					
	30-34	\$153.04	\$192.50	\$229.17	\$288.27	\$145.38	\$182.86	\$217.71	\$273.84	\$476.88	\$360.25	\$379.71					
	35-39	\$183.26	\$230.51	\$234.38	\$294.82	\$174.09	\$218.97	\$222.66	\$280.08	\$512.36	\$387.07	\$407.99					
	40-44	\$192.83	\$242.55	\$237.84	\$299.16	\$183.19	\$230.42	\$225.94	\$284.19	\$526.25	\$397.56	\$419.04					
	45-49	\$225.66	\$283.84	\$229.17	\$288.27	\$214.37	\$269.65	\$217.71	\$273.84	\$543.82	\$410.84	\$433.04					
	50-54	\$263.03	\$330.84	\$254.76	\$320.45	\$249.87	\$314.30	\$242.01	\$304.41	\$615.78	\$465.21	\$490.32					
	55-59	\$332.90	\$418.73	\$271.18	\$341.10	\$316.24	\$397.77	\$257.63	\$324.06	\$704.25	\$532.03	\$560.78					
	60-64	\$410.10	\$515.84	\$310.42	\$390.46	\$389.60	\$490.06	\$294.88	\$370.91	\$832.95	\$629.26	\$663.25					
65+	\$436.52	\$549.08	\$317.98	\$399.97	\$414.72	\$521.65	\$302.08	\$379.97	\$969.48	\$732.39	\$771.95						
<b>Two Adults, Husband and Wife (or Domestic Partner/Civil Unions) rates will be based off of the older adult</b>	0-24	\$294.69	\$370.67	\$294.69	\$370.67	\$279.96	\$352.14	\$279.96	\$352.14	\$682.83	\$515.87	\$543.72	\$945.60	\$1,459.79	\$1,500.85	\$1,520.62	\$1,827.41
	25-29	\$324.13	\$407.69	\$324.13	\$407.69	\$307.91	\$387.31	\$307.91	\$387.31	\$751.04	\$567.39	\$598.04					
	30-34	\$382.21	\$480.76	\$382.21	\$480.76	\$363.10	\$456.71	\$363.10	\$456.71	\$885.63	\$669.06	\$705.19					
	35-39	\$417.64	\$525.31	\$417.64	\$525.31	\$396.76	\$499.06	\$396.76	\$499.06	\$967.72	\$731.07	\$770.56					
	40-44	\$430.66	\$541.69	\$430.66	\$541.69	\$409.13	\$514.62	\$409.13	\$514.62	\$997.90	\$753.87	\$794.60					
	45-49	\$454.82	\$572.09	\$454.82	\$572.09	\$432.07	\$543.47	\$432.07	\$543.47	\$1,053.89	\$796.17	\$839.17					
	50-54	\$517.78	\$651.28	\$517.78	\$651.28	\$491.89	\$618.71	\$491.89	\$618.71	\$1,199.78	\$906.38	\$955.34					
	55-59	\$604.07	\$759.83	\$604.07	\$759.83	\$573.86	\$721.82	\$573.86	\$721.82	\$1,399.75	\$1,057.44	\$1,114.58					
	60-64	\$720.52	\$906.30	\$720.52	\$906.30	\$684.49	\$860.98	\$684.49	\$860.98	\$1,669.58	\$1,261.29	\$1,329.43					
65+	\$754.53	\$949.07	\$754.53	\$949.07	\$716.80	\$901.62	\$716.80	\$901.62	\$2,036.58	\$1,538.55	\$1,621.64						

\*Territory A: Essex, Hudson, and Union

Territory B: Bergen and Passaic

Territory C: Monmouth, Morris, Sussex and Warren

Territory D: Hunterdon, Middlesex, Somerset

Territory E: Burlington, Camden and Mercer

Territory F: Atlantic, Cape May, Ocean, Salem, Cumberland and Gloucester

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## Horizon Individual Health Benefit Plans: Monthly Rates

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	Age	Basic and Essential-Male (Territories A, B and D)*		Basic and Essential-Female (Territories A, B and D)*		Basic and Essential-Male (Territories C, E and F)*		Basic and Essential-Female (Territories C, E and F)*		Direct Access Plan C 100/70	Direct Access Plan A/50 70/50	Direct Access Plan C 80/70	HMO Coinsurance	HMO 50/70	HMO 30/50	HMO 30	HMO 15
		EPO	EPO Plus	EPO	EPO Plus	EPO	EPO Plus	EPO	EPO Plus								
Family, Husband and Wife (or Domestic Partner/ Civil Unions) rates will be based off of the older adult	0-24	\$569.37	\$716.18	\$569.37	\$716.18	\$540.91	\$680.37	\$540.91	\$680.37	\$1,517.90	\$1,146.70	\$1,208.64	\$1,339.07	\$2,067.22	\$2,125.36	\$2,153.36	\$2,587.79
	25-29	\$598.81	\$753.20	\$598.81	\$753.20	\$568.87	\$715.55	\$568.87	\$715.55	\$1,596.34	\$1,205.97	\$1,271.11					
	30-34	\$656.90	\$826.27	\$656.90	\$826.27	\$624.04	\$784.93	\$624.04	\$784.93	\$1,751.21	\$1,322.98	\$1,394.43					
	35-39	\$692.33	\$870.84	\$692.33	\$870.84	\$657.72	\$827.31	\$657.72	\$827.31	\$1,845.69	\$1,394.33	\$1,469.65					
	40-44	\$705.35	\$887.22	\$705.35	\$887.22	\$670.09	\$842.87	\$670.09	\$842.87	\$1,880.40	\$1,420.56	\$1,497.30					
	45-49	\$729.49	\$917.59	\$729.49	\$917.59	\$693.04	\$871.73	\$693.04	\$871.73	\$1,944.77	\$1,469.19	\$1,548.56					
	50-54	\$792.47	\$996.80	\$792.47	\$996.80	\$752.85	\$946.95	\$752.85	\$946.95	\$2,112.64	\$1,596.01	\$1,682.21					
	55-59	\$878.76	\$1,105.34	\$878.76	\$1,105.34	\$834.83	\$1,050.08	\$834.83	\$1,050.08	\$2,546.76	\$1,923.97	\$2,027.90					
	60-64	\$995.21	\$1,251.81	\$995.21	\$1,251.81	\$945.44	\$1,189.20	\$945.44	\$1,189.20	\$3,061.23	\$2,312.63	\$2,437.54					
65+	\$1,029.22	\$1,294.59	\$1,029.22	\$1,294.59	\$977.75	\$1,229.86	\$977.75	\$1,229.86	\$3,560.04	\$2,689.47	\$2,834.73						
Adult/ Child(ren)	0-24	\$350.11	\$440.38	\$382.21	\$480.76	\$332.61	\$418.37	\$363.11	\$456.72	\$817.58	\$617.64	\$651.00	\$678.21	\$1,047.01	\$1,076.45	\$1,090.64	\$1,310.64
	25-29	\$350.11	\$440.38	\$411.66	\$517.80	\$332.61	\$418.37	\$391.07	\$491.90	\$857.35	\$647.69	\$682.68					
	30-34	\$371.85	\$467.74	\$447.98	\$563.49	\$353.26	\$444.34	\$425.58	\$535.30	\$925.13	\$698.90	\$736.64					
	35-39	\$402.08	\$505.75	\$453.20	\$570.05	\$381.98	\$480.47	\$430.54	\$541.55	\$958.19	\$723.87	\$762.97					
	40-44	\$411.66	\$517.80	\$456.65	\$574.38	\$391.07	\$491.90	\$433.82	\$545.67	\$971.08	\$733.60	\$773.24					
	45-49	\$444.48	\$559.08	\$447.98	\$563.49	\$422.25	\$531.12	\$425.58	\$535.30	\$987.62	\$746.09	\$786.40					
	50-54	\$481.85	\$606.08	\$473.59	\$595.69	\$457.76	\$575.79	\$449.89	\$565.90	\$1,054.34	\$796.52	\$839.54					
	55-59	\$551.71	\$693.96	\$490.01	\$616.36	\$524.13	\$659.27	\$465.50	\$585.52	\$1,136.66	\$858.71	\$905.08					
	60-64	\$628.92	\$791.08	\$529.23	\$665.68	\$597.48	\$751.54	\$502.76	\$632.40	\$1,256.09	\$948.93	\$1,000.17					
65+	\$655.37	\$824.35	\$536.80	\$675.21	\$622.60	\$783.13	\$509.96	\$641.45	\$1,599.12	\$1,208.08	\$1,273.33						

\*Territory A: Essex, Hudson, and Union  
 Territory B: Bergen and Passaic  
 Territory C: Monmouth, Morris, Sussex and Warren

Territory D: Hunterdon, Middlesex, Somerset  
 Territory E: Burlington, Camden and Mercer  
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Direct Access Plans are subject to finalization of supporting regulations.

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# INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:



Horizon Blue Cross Blue Shield of New Jersey

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## Horizon Basic and Essential EPO

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

DESCRIPTION OF SERVICE	Horizon Basic and Essential EPO	DESCRIPTION OF SERVICE	Horizon Basic and Essential EPO
<b>Physician/Specialist Services</b> 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.  Inpatient practitioner's fees connected with inpatient hospital confinement are covered under inpatient hospital services.	<b>Prescription Drugs</b> (Obtained while not confined in a hospital)	Not covered.
<b>Physical Therapy</b> Outpatient (30 visits per covered person per calendar year)	\$20 copayment per covered person per visit.	<b>Home Health Care</b>	Not covered.
<b>Maternity Services</b> Physician Services	Delivery charge covered; pre- and post-natal charges are covered when included in the delivery charge.	<b>Durable Medical Equipment</b>	Not covered.
<b>Inpatient Hospital Services</b> (90 days per covered person per calendar year)	\$500 copayment per covered person per period of confinement.	<b>Hospice Care</b>	Not covered.
<b>Outpatient Hospital Services</b> Outpatient Surgery and Ambulatory Surgery	\$250 copayment per covered person per surgery.	<b>Diabetes Benefits</b>	Not covered.
<b>Out-of-Hospital</b> Diagnostic Tests	\$500 maximum per covered person per calendar year.	<b>Birthing Center Confinement</b>	Birthing Center charges not covered.
<b>Emergency Room Services</b>	\$100 copayment per covered person per visit (waived if admitted).	<b>Rehabilitation Center Confinement</b>	Rehabilitation Center charges not covered.
<b>Alcohol and Substance Abuse</b> Inpatient (30 days per covered person per calendar year)	30% coinsurance after \$500 hospital confinement copayment.	<b>Casts, Braces, Trusses, Prosthetic Devices, Orthopedic Footwear and Crutches</b>	Not covered.
<b>Alcohol and Substance Abuse</b> Outpatient (30 visits per covered person per calendar year)	30% coinsurance.	<b>Chemotherapy, Infusion Therapy</b>	Not covered.
<b>Mental Illness (BBMI)</b> Inpatient (90 days per covered person per calendar year)	\$500 copayment per covered person per period of confinement.	<b>Transplants</b>	Not covered.
<b>Mental Illness (BBMI)</b> Outpatient	30% coinsurance.	<b>EXCLUSIONS*</b>	<b>Horizon Basic and Essential EPO</b>
		<b>Ambulance, Routine Foot Care, Skilled Nursing Facility Care, Therapeutic Manipulation (Chiropractic), Treatment of a Non-Biologically Based Mental Illness</b>	Not covered.

# INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:



Horizon Blue Cross Blue Shield of New Jersey

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## Horizon Basic and Essential EPO Plus

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

DESCRIPTION OF SERVICE	Horizon Basic and Essential EPO Plus	DESCRIPTION OF SERVICE	Horizon Basic and Essential EPO Plus
<b>Physician/Specialist Services</b> 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. A copayment will apply.  Inpatient practitioner's fees connected with inpatient hospital confinement are covered under inpatient hospital services.	<b>Prescription Drugs</b> (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.
<b>Physical Therapy</b> Outpatient (30 visits per covered person per calendar year)	\$20 copayment per covered person per visit.	<b>Home Health Care</b>	50% coinsurance up to \$2,500 maximum per covered person per calendar year.
<b>Maternity Services</b> Physician Services	\$30 copayment for initial visit; inpatient stay subject to inpatient hospital charges.	<b>Durable Medical Equipment</b>	50% coinsurance up to \$2,500 maximum per covered person, per calendar year.
<b>Inpatient Hospital Services</b> (90 days per covered person per calendar year)	\$500 copayment per covered person per period of confinement.	<b>Hospice Care</b>	50% coinsurance up to \$2,500 maximum per covered person, per calendar year.
<b>Outpatient Hospital Services</b> Outpatient Surgery and Ambulatory Surgery	\$250 copayment per covered person per surgery.	<b>Diabetes Benefits</b>	50% coinsurance up to \$2,500 maximum per covered person, per calendar year.
<b>Out-of-Hospital</b> Diagnostic Tests	\$500 maximum per covered person per calendar year.	<b>Birthing Center Confinement</b>	\$250 copayment per covered person per period of confinement.
<b>Emergency Room Services</b>	\$100 copayment per covered person per visit (waived if admitted).	<b>Rehabilitation Center Confinement</b>	\$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 calendar year.
<b>Alcohol and Substance Abuse</b> Inpatient (30 days per covered person per calendar year)	30% coinsurance after \$500 hospital confinement copayment.	<b>Casts, Braces, Trusses, Prosthetic Devices, Orthopedic Footwear and Crutches</b>	Casts, prosthetic devices and crutches are covered.
<b>Alcohol and Substance Abuse</b> Outpatient (30 visits per covered person per calendar year)	30% coinsurance.	<b>Chemotherapy, Infusion Therapy</b>	Covered.
<b>Mental Illness (BBMI)</b> Inpatient (90 days per covered person per calendar year)	\$500 copayment per covered person per period of confinement.	<b>Transplants</b>	Covered.
<b>Mental Illness (BBMI)</b> Outpatient	30% coinsurance.	<b>EXCLUSIONS*</b>	<b>Horizon Basic and Essential EPO Plus</b>
		<b>Ambulance, Routine Foot Care, Skilled Nursing Facility Care, Therapeutic Manipulation (Chiropractic), Treatment of a Non-Biologically Based Mental Illness</b>	Not covered.

# INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:



Horizon Blue Cross Blue Shield of New Jersey

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## Horizon Direct Access Plan C 100/70

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

DESCRIPTION OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
<b>Primary Care Physician Copayment</b>	\$30 copayment per visit to selected PCP.	Subject to out-of-network deductible and 30% coinsurance.
<b>Specialist Copayment</b>	\$50 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.
<b>Annual Deductible</b>	N/A	\$7,500 Individual / \$15,000 Family (Aggregate).
<b>Coinsurance</b>	Applies to Prescription Drugs only. Plan pays 50%/You pay 50%.	Plan pays 70%/ You pay 30% (50% for Prescription Drugs).
<b>Maximum Out-of-Pocket</b> (Does not include prescription drugs)	\$5,000 Individual / \$10,000 Family.	\$22,500 Individual / \$45,000 Family.
<b>Lifetime Benefit Maximum</b>	Unlimited	
<b>Inpatient Hospital</b> (Subject to preapproval) (including biologically based mental illness)	\$300 copayment per day for a maximum of 5 days per admission; \$3,000 maximum per calendar year.	Subject to out-of-network deductible and 30% coinsurance.
<b>Ambulatory Surgical Center Facility Charges</b>	\$30 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.
<b>Hospital Outpatient Surgery Facility Charges</b>	\$60 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.
<b>Emergency Room Copayment</b>	\$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.
<b>Alcoholism</b> (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.
<b>Non-Biologically Based Mental Illness and Substance Abuse</b> • 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.
<b>Blood/Blood Products/Processing</b>	Plan pays 100%.	Subject to out-of-network deductible and 30% coinsurance.
<b>Diagnostic X-ray/Lab</b>	Plan pays 100% when provided by a network lab.	Subject to out-of-network deductible and 30% coinsurance.
<b>Durable Medical Equipment</b> (Subject to preapproval)	Plan pays 100%.	Subject to out-of-network deductible and 30% coinsurance.
<b>Home Health Care and Hospice Care</b> (Subject to preapproval)	Unlimited days.	Subject to out-of-network deductible and 30% coinsurance.
<b>Maternity</b>	\$25 copayment for the initial office visit only; Subject to inpatient hospital copayment.	Subject to out-of-network deductible and 30% coinsurance.
<b>Prescription Drugs</b> (does not count toward maximum out-of-pocket)	50% coinsurance.	Not subject to deductible Covered at 50% coinsurance.
<b>Preventive Care</b>	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.
<b>Rehabilitation Centers</b> (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.
<b>Speech, Physical, Occupational and Cognitive Rehabilitation Therapies</b> Limited to 30 visits per calendar year per therapy	\$30 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.
<b>Therapeutic Manipulations</b> 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.

# INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:

## Horizon Direct Access Plan C 80/70

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

DESCRIPTION OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
<b>Primary Care Physician Copayment</b>	\$30 copayment per visit to selected PCP.	Subject to out-of-network deductible and 30% coinsurance.
<b>Specialist Copayment</b>	\$50 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.
<b>Annual Deductible</b>	\$2,500 Individual / \$5,000 Family (Aggregate).	\$5,000 Individual / \$10,000 Family (Aggregate).
<b>Coinsurance</b>	Plan pays 80%/You pay 20%. (50% for Prescription Drugs).	Plan pays 70%/You pay 30%.
<b>Maximum Out-of-Pocket</b> (Does not include prescription drugs)	\$5,000 Individual / \$10,000 Family.	\$10,000 Individual / \$20,000 Family.
<b>Lifetime Benefit Maximum</b>	Unlimited	
<b>Inpatient Hospital</b> (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.
<b>Ambulatory Surgical Center Facility Charges</b>	Subject to in-network deductible and 20% coinsurance.	Subject to out-of-network deductible and 30% coinsurance.
<b>Hospital Outpatient Surgery Facility Charges</b>	Subject to in-network deductible and 20% coinsurance.	Subject to out-of-network deductible and 30% coinsurance.
<b>Emergency Room Copayment</b>	\$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.
<b>Alcoholism</b> (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.
<b>Non-Biologically Based Mental Illness and Substance Abuse</b> • 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.
<b>Blood/Blood Products/Processing</b>	Subject to in-network deductible and 20% coinsurance.	Subject to out-of-network deductible and 30% coinsurance.
<b>Diagnostic X-ray/Lab</b>	Plan pays 100% of allowance when provided by a network lab.	Subject to out-of-network deductible and 30% coinsurance.
<b>Durable Medical Equipment</b> (Subject to preapproval)	Subject to in-network deductible and 20% coinsurance.	Subject to out-of-network deductible and 30% coinsurance.
<b>Home Health Care and Hospice Care</b> (Subject to preapproval)	Subject to in-network deductible and 20% coinsurance.	Subject to out-of-network deductible and 30% coinsurance.
<b>Maternity</b>	\$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.
<b>Prescription Drugs</b> (does not count toward maximum out-of-pocket)	Not subject to deductible. Covered at 50% coinsurance.	
<b>Preventive Care</b>	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.	
<b>Rehabilitation Centers</b> (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.
<b>Speech, Physical, Occupational and Cognitive Rehabilitation Therapies</b> Limited to 30 visits per calendar year per therapy	\$30 copayment per visit.	Subject to out-of-network deductible and 30% coinsurance.
<b>Therapeutic Manipulations</b> 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.

# INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:



Horizon Blue Cross Blue Shield of New Jersey

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## Horizon Direct Access Plan A/50 70/50

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

DESCRIPTION OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
<b>Primary Care Physician Copayment</b>	\$30 copayment per visit to selected PCP.	Subject to out-of-network deductible and 50% coinsurance.
<b>Specialist Copayment</b>	\$50 copayment per visit.	Subject to out-of-network deductible and 50% coinsurance.
<b>Annual Deductible</b>	\$2,500 Individual / \$5,000 Family (Aggregate).	\$7,500 Individual / \$15,000 Family (Aggregate).
<b>Coinsurance</b>	Plan pays 70%/You pay 30%. (50% for Prescription Drugs).	Plan pays 50%/You pay 50%.
<b>Maximum Out-of-Pocket</b> (Does not include prescription drugs)	\$5,000 Individual / \$10,000 Family.	\$15,000 Individual / \$30,000 Family.
<b>Lifetime Benefit Maximum</b>	Unlimited	
<b>Inpatient Hospital</b> (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.
<b>Ambulatory Surgical Center Facility Charges</b>	Subject to in-network deductible and 30% coinsurance.	Subject to out-of-network deductible and 50% coinsurance.
<b>Hospital Outpatient Surgery Facility Charges</b>	Subject to in-network deductible and 30% coinsurance.	Subject to out-of-network deductible and 50% coinsurance.
<b>Emergency Room Copayment</b>	\$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.
<b>Alcoholism</b> (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.
<b>Non-Biologically Based Mental Illness and Substance Abuse</b> • 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.
<b>Blood/Blood Products/Processing</b>	Subject to in-network deductible and 30% coinsurance.	Subject to out-of-network deductible and 50% coinsurance.
<b>Diagnostic X-ray/Lab</b>	Plan pays 100% of allowance when provided by a network lab.	Subject to out-of-network deductible and 50% coinsurance.
<b>Durable Medical Equipment</b> (Subject to preapproval)	Subject to in-network deductible and 30% coinsurance.	Subject to out-of-network deductible and 50% coinsurance.
<b>Home Health Care and Hospice Care</b> (Subject to preapproval)	Subject to in-network deductible and 30% coinsurance.	Subject to out-of-network deductible and 50% coinsurance.
<b>Maternity</b>	\$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.
<b>Prescription Drugs</b> (does not count toward maximum out-of-pocket)	Not subject to deductible. Covered at 50% coinsurance.	
<b>Preventive Care</b>	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.	
<b>Rehabilitation Centers</b> (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.
<b>Speech, Physical, Occupational and Cognitive Rehabilitation Therapies</b> Limited to 30 visits per calendar year per therapy	\$30 copayment per visit.	Subject to out-of-network deductible and 50% coinsurance.
<b>Therapeutic Manipulations</b> 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.

# INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:



Horizon Blue Cross Blue Shield of New Jersey

*Making Healthcare Work<sup>®</sup>*

## Horizon HMO \$15

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

DESCRIPTION OF SERVICE	HORIZON HMO \$15
Primary Care Physician Copayment	\$15 per visit.
Specialist Copayment	\$15 per visit.
Annual Deductible	N/A
Coinsurance	50% for prescription drugs.
Maximum Out-of-Pocket	N/A
Lifetime Benefit Maximum	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.
Ambulatory Surgical Center Facility Charges	\$15 per visit.
Hospital Outpatient Surgery Facility Charges	\$15 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%.
Diagnostic X-ray/Lab	\$15 copayment per visit.
Durable Medical Equipment (Subject to preapproval)	Plan pays 100%.
Home Health Care and Hospice Care (Subject to preapproval)	Unlimited days.
Maternity	\$25 copayment for the initial visit; \$0 copayment thereafter.
Prescription Drugs	50% coinsurance.
Preventive Care	\$15 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.
Therapeutic Manipulations	\$15 copayment per visit. Limited to 30 visits per calendar year and 2 modalities per visit.

# INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:



Horizon Blue Cross Blue Shield of New Jersey

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## Horizon HMO \$30

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

DESCRIPTION OF SERVICE	HORIZON HMO \$30
Primary Care Physician Copayment	\$30 per visit.
Specialist Copayment	\$30 per visit.
Annual Deductible	N/A
Coinsurance	50% for prescription drugs.
Maximum Out-of-Pocket	N/A
Lifetime Benefit Maximum	Unlimited
Inpatient Hospital (including biologically based mental illness and alcoholism) (subject to preapproval)	\$300 copayment per day for a maximum of 5 days per admission; \$3,000 maximum per calendar year.
Ambulatory Surgical Center Facility Charges	\$30 per visit.
Hospital Outpatient Surgery Facility Charges	\$30 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%.
Diagnostic X-ray/Lab	\$30 copayment per visit.
Durable Medical Equipment (Subject to preapproval)	Plan pays 100%.
Home Health Care and Hospice Care (Subject to preapproval)	Unlimited days.
Maternity	\$25 copayment for the initial visit; \$0 copayment thereafter.
Prescription Drugs	50% coinsurance.
Preventive Care	\$30 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	\$30 copayment per visit.
Therapeutic Manipulations	\$30 copayment per visit. Limited to 30 visits per calendar year and 2 modalities per visit.

# INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:



Horizon Blue Cross Blue Shield of New Jersey

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## Horizon HMO \$30/\$50

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

DESCRIPTION OF SERVICE	HORIZON HMO \$30/\$50
Primary Care Physician Copayment	\$30 per visit.
Specialist Copayment	\$50 per visit.
Annual Deductible	N/A
Coinsurance	50% for prescription drugs.
Maximum Out-of-Pocket	N/A
Lifetime Benefit Maximum	Unlimited
Inpatient Hospital (including biologically based mental illness and alcoholism) (subject to preapproval)	\$300 copayment per day for a maximum of 5 days per admission; \$3,000 maximum per calendar year.
Ambulatory Surgical Center Facility Charges	\$30 per visit.
Hospital Outpatient Surgery Facility Charges	\$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%.
Diagnostic X-ray/Lab	\$30 copayment per visit.
Durable Medical Equipment (Subject to preapproval)	Plan pays 100%.
Home Health Care and Hospice Care (Subject to preapproval)	Unlimited days.
Maternity	\$25 copayment for the initial visit; \$0 copayment thereafter.
Prescription Drugs	50% coinsurance.
Preventive Care	\$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	\$30 copayment per visit.
Therapeutic Manipulations	\$30 or \$50 copayment per visit. Limited to 30 visits per calendar year and 2 modalities per visit.

# INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:



Horizon Blue Cross Blue Shield of New Jersey

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## Horizon HMO \$50/\$70

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

DESCRIPTION OF SERVICE	HORIZON HMO \$50/\$70
Primary Care Physician Copayment	\$50 per visit.
Specialist Copayment	\$70 per visit.
Annual Deductible	N/A
Coinsurance	50% for prescription drugs.
Maximum Out-of-Pocket	N/A
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.
Ambulatory Surgical Center Facility Charges	\$50 per visit.
Hospital Outpatient Surgery Facility Charges	\$100 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%.
Diagnostic X-ray/Lab	\$50 copayment per visit.
Durable Medical Equipment (Subject to preapproval)	Plan pays 100%.
Home Health Care and Hospice Care (Subject to preapproval)	Unlimited days.
Maternity	\$25 copayment for the initial visit; \$0 copayment thereafter.
Prescription Drugs	50% coinsurance.
Preventive Care	\$50 or \$70 copayment per visit.
Rehabilitation Centers (Subject to preapproval)	Subject to inpatient hospital copayment above. Waived if immediately preceded by a hospital inpatient stay.
Speech, Physical (subject to preapproval), Occupational and Cognitive Rehabilitation Therapies	\$50 copayment per visit.
Therapeutic Manipulations	\$50 or \$70 copayment per visit. Limited to 30 visits per calendar year and 2 modalities per visit.

# INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:



Horizon Blue Cross Blue Shield of New Jersey

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## Horizon HMO Coinsurance

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

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 (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 (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)	Subject to deductible and coinsurance
Non-Biologically Based Mental Illness and Substance Abuse	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/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	Office visit 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.

## IMPORTANT INFORMATION

Horizon Individual Direct Access Members have the option of using our BlueCard Network while traveling outside of the Managed Care Network. These services will be paid at the out-of-network level. BlueCard Providers will accept the negotiated rates and will not be able to balance bill the member for the difference.



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