INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work®

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
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. 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.
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
Prescription Drugs (Obtained while not confined in a hospital)	Not covered.
Home Health Care	Not covered.
Durable Medical Equipment	Not covered.
Hospice Care	Not covered.
Diabetes Benefits	Not covered.
Birthing Center Confinement	Birthing Center charges not covered.
Rehabilitation Center Confinement	Rehabilitation Center charges not covered.
Casts, Braces, Trusses, Prosthetic Devices, Orthopedic Footwear and Crutches	Not covered.
Chemotherapy, Infusion Therapy	Not covered.
Transplants	Not covered.
EXCLUSIONS*	**Horizon Basic and Essential EPO**
Ambulance, Routine Foot Care, Skilled Nursing Facility Care, Therapeutic Manipulation (Chiropractic), Treatment of a Non-Biologically Based Mental Illness	Not covered.

INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work®

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
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. 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	$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 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.

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work®

INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:

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
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; $3,000 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 • 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.
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 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.

INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work®

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
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 • 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.
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 Blue Cross Blue Shield of New Jersey

Making Healthcare Work®

INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:

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
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 • 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.
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.

INDIVIDUAL AND FAMILY HEALTH PLAN OVERVIEW:

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work®

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

Making Healthcare Work®

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

Making Healthcare Work®

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

Making Healthcare Work®

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

Making Healthcare Work®

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.