Horizon Basic and Traditional Plans

If freedom and flexibility are important to you, consider these four plan options, which provide:

- Traditional major medical coverage.
- Cost-cutting deductible options.
- Freedom to use any physician and hospital.
- Lower out-of-pocket costs when you receive in-network care and services.
- And much more!

Is traditional coverage right for you?

For thousands of New Jersey residents who buy their own health insurance, traditional coverage – the kind they grew up with – is still the best option. If that sounds like you, you'll be happy to know that Horizon Blue Cross Blue Shield of New Jersey offers four great comprehensive plans!

Unlike managed care options, you're free to choose any physician and hospital for your care. With Horizon Basic Plan A and Horizon Traditional Plans B, C and D, you select from various coverage levels designed to accommodate your expected health care needs and your budget. Of course, all four plans include coverage for traditional health care services for hospital, medical-surgical and major medical benefits.

What you need to know ...

Each of the four plans offers a variety of ways to manage costs and coverage through deductibles, coinsurance and out-of-pocket maximums.

As you may already know, your deductible is the amount you pay before your plan begins reimbursing you for covered services. If you choose a $1,000 deductible, you're responsible for that amount each year – before your plan begins to reimburse you for services.*

Coinsurance is the percentage of eligible expenses you pay after your deductible has been met. For example, if your health plan reimburses you for 80 percent of covered services, your coinsurance amount is 20 percent.

The maximum out of pocket is the absolute limit you will be expected to pay in any year, after which your insurance pays 100 percent (except for prescription drugs).

* All payments are based on our plan allowance.

The chart on the next page is for illustrative purposes only. See individual contract/policy for details and exclusions.

What is not covered by these plans?

Pre-existing condition limitation. For the 12 months following the enrollment date of your health insurance plan, Horizon Blue Cross Blue Shield of New Jersey does not cover you for health care services received 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 are symptoms which would cause a prudent person to seek medical advice, care or treatment.
- Pregnancy existing on the enrollment date of your policy. However, complications of the pregnancy defined by NJAC 11:1-4.3 are not considered pre-existing conditions and are not subject to the pre-existing condition limitation. The limitation also does not apply to a newborn child, an adopted child or child placed in the home for adoption if the child is enrolled and required payments are made within 31 days after the birth, adoption or placement for adoption.

This limitation may not apply if you transfer from other health insurance plans and there has been no more than a 31-day lapse in coverage. The limitation also does not apply to Federally Defined Eligible Individuals if the individual applies for coverage within 63 days of termination of prior coverage. Additional limitations and exclusions apply.

Making Healthcare Work.

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This is not a contract/policy. This brochure is a summary of the standardized plans approved by New Jersey's Individual Health Program Board and offered by Horizon Blue Cross Blue Shield of New Jersey. For complete information and verification of all your benefits, refer to your contract/policy. In the event of a conflict between the information and the actual terms of a policy or contract, the terms of the policy or contract will prevail.

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Four great plans ... At-A-Glance!

Description of Service	Horizon Basic Plan A/50	Horizon Traditional Plan B
Annual Deductible	$1,000 Individual/$2,000 Family (Aggregate). $2,500 Individual/$5,000 Family (Aggregate). $5,000 Individual/$10,000 Family (Aggregate). $10,000 Individual/$20,000 Family (Aggregate).	$1,000 Individual/$2,000 Family (Aggregate). $2,500 Individual/$5,000 Family (Aggregate).
Coinsurance	Plan pays 50%/You pay 50%.	Plan pays 60%/You pay 40%.
Maximum Out of Pocket *(Does not include prescription drug coverage)*	$6,000 Individual/$12,000 Family. $7,500 Individual/$15,000 Family. $10,000 Individual/$20,000 Family. $15,000 Individual/$30,000 Family.	$4,000 Individual/$8,000 Family. $5,500 Individual/$11,000 Family.
Lifetime Benefit Maximum	Unlimited	Unlimited
Office Visits	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Inpatient Hospital: Semi-Private Inpatient Services and Supplies *(Subject to preapproval)*	365 days a year. Subject to annual deductible and coinsurance.	365 days a year, separate $200 copayment per individual per day up to $1,000 per admission, $2,000 per year maximum. Subject to annual deductible and coinsurance.
Extended Care or Rehabilitation Services *(Subject to preapproval)*	Subject to annual deductible and coinsurance. Limited to 120 days combined per year.	Subject to annual deductible, any other copayments and coinsurance. Limited to 120 days combined per year.
Emergency Room	$100 copayment (waived if admitted within 24 hours). Subject to annual deductible and coinsurance.	$100 copayment (waived if admitted within 24 hours). Subject to annual deductible and other copayments and coinsurance.
Home Health Care *(Subject to preapproval)*	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Hospice Care *(Subject to preapproval)*	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Biologically Based Mental Illness	Inpatient and Outpatient: Subject to annual deductible and 50%/50% coinsurance.	Inpatient: Subject to hospital copayment, annual deductible and coinsurance. Outpatient: Subject to annual deductible and coinsurance.
Non-Biologically Based Mental Illness and Substance Abuse	Inpatient and Outpatient: Subject to annual deductible and coinsurance. Inpatient confinement: 30 days per calendar year. Outpatient: 20 visits per calendar year. One inpatient day may be exchanged for two outpatient visits.	Inpatient: Subject to hospital copayment, annual deductible and coinsurance. Outpatient: Subject to annual deductible and coinsurance. Inpatient confinement: 30 days per calendar year. Outpatient: 20 visits per calendar year. One inpatient day may be exchanged for two outpatient visits.
Alcoholism *(Subject to preapproval)*	Inpatient and Outpatient: Subject to annual deductible and coinsurance.	Inpatient: Subject to hospital copayment, annual deductible and coinsurance. Outpatient: Subject to annual deductible and coinsurance.
Practitioner's Charge	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Preventive Care	$500 per individual (except newborns) per year. Newborns: $750 per year maximum benefit up to age 1. Not subject to annual deductible and coinsurance.	$500 per individual (except newborns) per year. Newborns: $750 per year maximum benefit up to age 1. Not subject to annual deductible and coinsurance.
Maternity	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Therapy Services	Subject to annual deductible and coinsurance. Cognitive rehabilitation therapy, occupational therapy, physical therapy and speech therapy limited to 30 visits per calendar year. Radiation therapy, chemotherapy, chelation therapy, dialysis treatment and respiration therapy covered as any other illness. Infusion therapy subject to preapproval.	Subject to annual deductible and coinsurance. Cognitive rehabilitation therapy, occupational therapy, physical therapy and speech therapy limited to 30 visits per calendar year. Radiation therapy, chemotherapy, chelation therapy, dialysis treatment and respiration therapy covered as any other illness. Infusion therapy subject to preapproval.
Therapeutic Manipulations	Subject to annual deductible and coinsurance. Limited to 30 visits per calendar year.	Subject to annual deductible and coinsurance. Limited to 30 visits per calendar year.
Prescription Drugs	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Durable Medical Equipment *(Subject to preapproval)*	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Blood/Blood Products/Processing	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.

Description of Service	Horizon Traditional Plan C	Horizon Traditional Plan D
Annual Deductible	$1,000 Individual/$2,000 Family (Aggregate). $2,500 Individual/$5,000 Family (Aggregate).	$1,000 Individual/$2,000 Family (Aggregate). $2,500 Individual/$5,000 Family (Aggregate).
Coinsurance	Plan pays 70%/You pay 30%.	Plan pays 80%/You pay 20%.
Maximum Out of Pocket *(Does not include prescription drug coverage)*	$3,500 Individual/$7,000 Family. $5,000 Individual/$10,000 Family.	$3,000 Individual/$6,000 Family. $4,500 Individual/$9,000 Family.
Lifetime Benefit Maximum	Unlimited	Unlimited
Office Visits	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Inpatient Hospital: Semi-Private Inpatient Services and Supplies *(Subject to preapproval)*	365 days a year. Subject to annual deductible and coinsurance.	365 days a year. Subject to annual deductible and coinsurance.
Extended Care or Rehabilitation Services *(Subject to preapproval)*	Subject to annual deductible and coinsurance. Limited to 120 days combined per year.	Subject to annual deductible and coinsurance. Limited to 120 days combined per year.
Emergency Room	$100 copayment (waived if admitted within 24 hours). Subject to annual deductible and coinsurance.	$100 copayment (waived if admitted within 24 hours). Subject to annual deductible and coinsurance.
Home Health Care *(Subject to preapproval)*	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Hospice Care *(Subject to preapproval)*	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Biologically Based Mental Illness	Inpatient and Outpatient: Subject to annual deductible and 70%/30% coinsurance.	Inpatient and Outpatient: Subject to annual deductible and 80%/20% coinsurance.
Non-Biologically Based Mental Illness and Substance Abuse	Inpatient and Outpatient: Subject to annual deductible and coinsurance. Inpatient confinement: 30 days per calendar year. Outpatient: 20 visits per calendar year. One inpatient day may be exchanged for two outpatient visits.	Inpatient and Outpatient: Subject to annual deductible and coinsurance. Inpatient confinement: 30 days per calendar year. Outpatient: 20 visits per calendar year. One inpatient day may be exchanged for two outpatient visits.
Alcoholism *(Subject to preapproval)*	Inpatient and Outpatient: Subject to annual deductible and coinsurance.	Inpatient and Outpatient: Subject to annual deductible and coinsurance.
Practitioner's Charge	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Preventive Care	$500 per individual (except newborns) per year. Newborns: $750 per year maximum benefit up to age 1. Not subject to annual deductible and coinsurance.	$500 per individual (except newborns) per year. Newborns: $750 per year maximum benefit up to age 1. Not subject to annual deductible and coinsurance.
Maternity	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Therapy Services	Subject to annual deductible and coinsurance. Cognitive rehabilitation therapy, occupational therapy, physical therapy and speech therapy limited to 30 visits per calendar year. Radiation therapy, chemotherapy, chelation therapy, dialysis treatment and respiration therapy covered as any other illness. Infusion therapy subject to preapproval.	Subject to annual deductible and coinsurance. Cognitive rehabilitation therapy, occupational therapy, physical therapy and speech therapy limited to 30 visits per calendar year. Radiation therapy, chemotherapy, chelation therapy, dialysis treatment and respiration therapy covered as any other illness. Infusion therapy subject to preapproval.
Therapeutic Manipulations	Subject to annual deductible and coinsurance. Limited to 30 visits per calendar year.	Subject to annual deductible and coinsurance. Limited to 30 visits per calendar year.
Prescription Drugs	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Durable Medical Equipment *(Subject to preapproval)*	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.
Blood/Blood Products/Processing	Subject to annual deductible and coinsurance.	Subject to annual deductible and coinsurance.