Horizon MyWay HSA Plan Overview

Benefit Description	In-Network	Out-of-Network
Annual Deductible	$2,000 per individual, $4,000 per family	
Annual Out-of-Pocket Maximum *(includes prescription drugs)*	$6,900 per person, $13,800 per family	$10,000 per person, $20,000 per person
Coinsurance	You pay $0 after deductible	You pay 30% after deductible
Doctor Office Visits		
Routine Adult or Child Physical	$0 (no deductible)	30% coinsurance (no deductible)
Physician Office Visit *(Primary Care or Specialist)*	$0 after deductible	30% coinsurance after deductible
Diagnostic X-ray & Laboratory	$0 after deductible	30% coinsurance after deductible
Hospital Services		
Inpatient or Outpatient Services	$0 after deductible	30% coinsurance after deductible
Emergency Services		
Emergency Room	$0 after deductible	30% coinsurance after deductible
Ambulance *(ground & air transport)*	$0 after deductible	$0 after deductible
Therapy Services		
Short-Term Therapies: Physical, Speech, Occupational, & Cognitive Rehabilitation	$0 after deductible	30% coinsurance after deductible *40 visits for each therapy per calendar year in- and out-of-network combined; limit of 3 modalities per visit, out-of-network only*
Chiropractic Care	$0 after deductible	30% coinsurance after deductible *30 visits per calendar year in- and out-of-network combined*
Mental Health/Substance Abuse[1]		
Inpatient Services	$0 after deductible	30% coinsurance after deductible
Outpatient Services	$0 after deductible	30% coinsurance after deductible
Other Services		
Vision Care (Exam & Hardware)	$0 after deductible	30% coinsurance after deductible *$100 allowance provided every two years in- and out-of-network combined*
Skilled Nursing	$0 after deductible	30% coinsurance after deductible *120 days per calendar year, following a three or more day prior hospital stay*
Home Health Care	$0 after deductible	30% coinsurance after deductible *90 visits, direct admission*
Hospice Care[2]	$0 after deductible	30% coinsurance after deductible
Private Duty Nursing	$0 after deductible	30% coinsurance after deductible *30 visits per calendar year*
Durable Medical Equipment and Prosthetics	$0 after deductible	30% coinsurance after deductible
Infertility *(excludes in-vitro fertilization)*	$0 after deductible	30% coinsurance after deductible *$5,000 lifetime maximum in- and out-of-network combined*

[1] All Inpatient Facility Mental Health/ Substance Abuse Services must be coordinated through Horizon BCBSNJ (visit **www.horizonblue.com***).*

[2] Eligibility for this benefit requires a confirmed diagnosis of terminal illness with a life expectancy of six months or less.