	NJ DIRECT 10 - 50	NJ DIRECT 15 - 150	HORIZON HMO -11
IN-NETWORK (IN):			
Service Area Available	Nationwide	Nationwide	NJ and contiguous counties
Specialist Referral	No referral required	No referral required	Referral required
Deductible			
Individual	$0	$0	See DME
Family	$0	$0	See DME
Coinsurance	10%	10%	0%
Coinsurance Out-of-Pocket Maximum			
Individual	$400	$400	Not applicable
Family	$1,000	$1,000	Not applicable
Total Out-of-Pocket Maximum (Copay+Deductible+Coinsurance)			
Individual	$400	$6,960	$6,960
Family	$1,000	$13,920	$13,920
HEALTH CARE SERVICES:			
Primary Care Office Visit	$10	$15	$10
Annual Routine Physical (In-Network Only)	$0	$0	$0
Direct Primary Care (DPC) Doctors Office	$0	$0	Not available
Horizon CareOnline (Telemedicine)	Cost share may apply	Cost share may apply	Cost share may apply
Specialist Office Visit	$10	$15	$10
Annual Routine Vision (In-Network Only)	$10	$15	$10
Chiropractic	$10	$15	$10
Physical/Occupational/Speech Therapy	$10	$15	$10
DIAGNOSTIC LABORATORY9/RADIOLOGY/ADVANCED IMAGING:			
Outpatient Laboratory/Radiology/Advanced Imaging	$0	$0	$0
Freestanding Laboratory/Radiology/Advanced Imaging	$0	$0	$0
EMERGENCY/URGENT MEDICAL SERVICES:			
Urgent Care Center	$10	$15	$10
Emergency Room	$75	$100	$85
Ambulance	10%	10%	$0
OTHER SERVICES:			
Inpatient Facility	$0	$0	$0
Outpatient Facility	$0	$0	$0
Outpatient Behavioral Health	$10	$15	$10
Durable Medical Equipment (DME)	10%	10%	$100 deductible, then covered in full
OUT-OF-NETWORK (OON):			
Deductible - Individual	$100	$100	No out-of-network benefits
Deductible - Family	$250	$250	No out-of-network benefits
Coinsurance after Deductible	20%	30%	No out-of-network benefits
Out-of-Pocket Coinsurance Maximum - Individual	$2,000	$2,000	No out-of-network benefits
Out-of-Pocket Coinsurance Maximum - Family	$5,000	$5,000	No out-of-network benefits
Inpatient Hospital Deductible	$200/stay	$200/stay	No out-of-network benefits