

**2024**  
OVERVIEW

Small Group  
Insurance Coverage



[Why Horizon](#)

[BlueCard®](#)

[OMNIA<sup>SM</sup> Health Plans](#)

[Health Plan Benefits](#)

[Medical Plans](#)

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

[Horizon Level Select](#)

[Horizon MyWay®](#)

[Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

[Quick Resource Guide](#)

At Horizon<sup>®</sup>, we're guiding members to achieve their best health.

For more than 90 years, Horizon has helped New Jersey residents get the most out of their health care coverage. As a leader in providing access to quality, affordable health plans, we offer an extensive provider network to ensure you're cared for whenever, wherever. We keep things simple – every New Jersey hospital is in our network. Plus, we provide tools and support that make navigating health care easier.



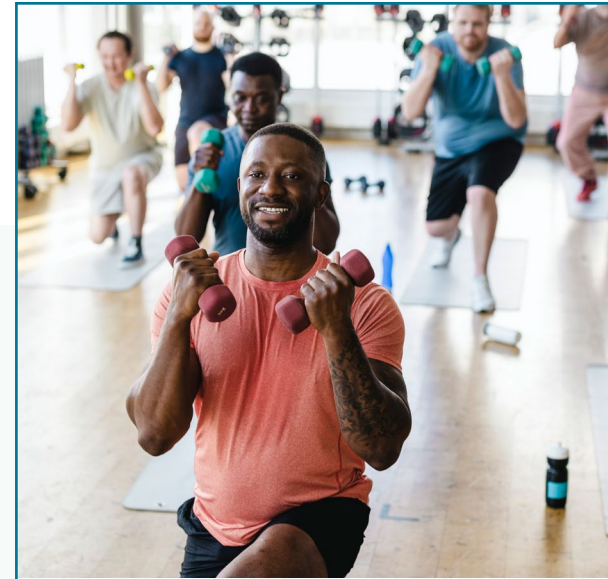
**Access to**  
more than  
67,000 local  
providers and  
95 hospitals<sup>[1]</sup>



**Affordable plans**  
with choices that  
meet your needs



**Innovative extras**  
like education  
resources and  
healthy living  
discounts



We have plans that keep your costs low.

Contact your Horizon Account Representative or Broker, or visit [HorizonBlue.com](https://HorizonBlue.com).

» **Why Horizon**

**BlueCard<sup>®</sup>**

**OMNIA<sup>SM</sup> Health Plans**

**Health Plan Benefits**

**Medical Plans**

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

**Horizon Level Select**

**Horizon MyWay<sup>®</sup>**

**Horizon EXPAND**

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

**Quick Resource Guide**

1. Physician data as of 6/30/2023

With BlueCard<sup>®</sup>, members can receive health care services nationwide and around the world.



When you choose a health plan with BlueCard, it includes medical care coverage beyond New Jersey. No matter where you are, you can take advantage of savings while getting the care you need.



BlueCard gives members the strongest network access while maximizing savings.

More than  
**1.8**  
**MILLION**  
providers<sup>[1]</sup>

**NATIONAL  
COVERAGE**  
spanning every  
U.S. zip code

**GLOBAL  
COVERAGE**  
in 190 countries  
and territories

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**Why Horizon**

» **BlueCard<sup>®</sup>**

**OMNIA<sup>SM</sup> Health Plans**

**Health Plan Benefits**

**Medical Plans**

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

**Horizon Level Select**

**Horizon MyWay<sup>®</sup>**

**Horizon EXPAND**

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

**Quick Resource Guide**

1. Provider Data Repository (PDR), March 2023. From national BlueCard PPO portion of the network reporting services (NRS) extract of PDR data. The data is limited to records in Plans' licensed service areas. Consists of providers, groups and facilities and the records are counted on a unique value to reduce potential double counting.

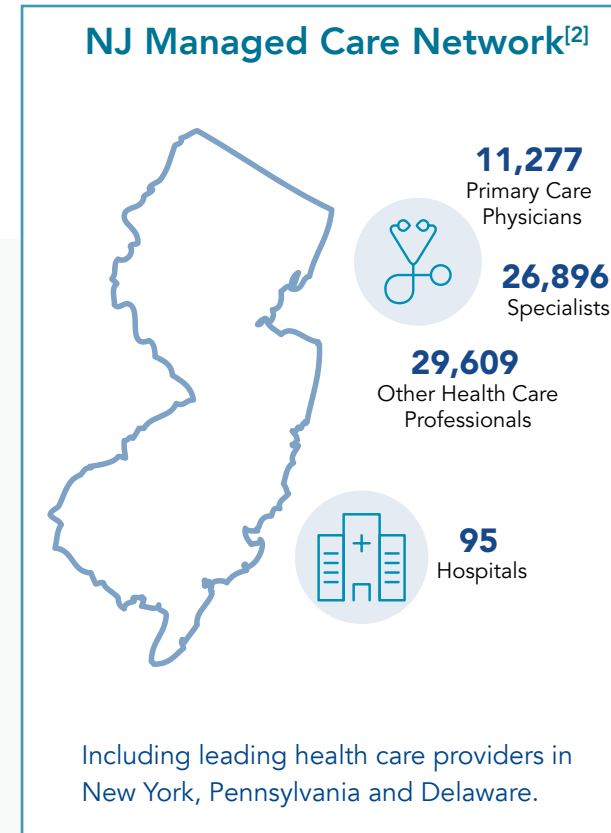
With OMNIA<sub>SM</sub>, members can receive health care services at an affordable price.

Our OMNIA Health Plans enable you to receive in-network medical care with leading doctors, hospitals and health care professionals. OMNIA offers even more cost savings when using Tier 1 physicians.

In fact, our OMNIA Silver Plans are some of the most affordably priced plans in New Jersey.

**Low copays and deductibles**  
with OMNIA Tier 1 doctors and hospitals<sup>[1]</sup>

**Enhance your employees' benefits**  
by choosing OMNIA with a Health Savings Account (HSA)



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**BlueCard®**

» **OMNIA<sub>SM</sub> Health Plans**

**Health Plan Benefits**

**Medical Plans**

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

**Horizon Level Select**

**Horizon MyWay®**

**Horizon EXPAND**

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

**Quick Resource Guide**

1. No referrals needed  
2. Physician data as of 6/30/2023

We're making good health care more convenient.



### Telemedicine

Telemedicine is a convenient way to bring U.S. board-certified, licensed doctors right to you for virtual care anytime, anywhere. You can connect with a doctor using the [Horizon Blue app](#),<sup>[1]</sup> video, chat or phone, 24 hours a day, seven days a week.



### 24/7 Nurse Line

When you have everyday health questions, or when you're faced with a more serious situation, you can call the 24/7 Nurse Line anytime to get doctor-approved information.



### Horizon Blue App

Locate in-network doctors, video chat with doctors, get quick claim status updates, and view and print member ID Cards all within the app.

1. There is no charge to download the Horizon Blue app, but rates from your wireless provider may apply.  
2. Some state and plan restrictions may apply.



More ways to get care virtually.



### Chronic Care Programs

These programs can help you take control of your health by providing support to manage the day-to-day challenges of living with chronic conditions such as asthma or diabetes.



### Virtual Health & Wellness Programs and Resources

These live webinars and recorded videos on a variety of wellness topics can help you ease stress and stay active.



## [Why Horizon](#)

## [BlueCard®](#)

## [OMNIA<sup>SM</sup> Health Plans](#)

## » [Health Plan Benefits](#)

### [Medical Plans](#)

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

### [Horizon Level Select](#)

### [Horizon MyWay®](#)

### [Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

## [Quick Resource Guide](#)

We can help your employees achieve their best health.



### Behavioral Health & Substance Use Disorder

Care for behavioral health conditions or alcohol/substance use disorder is offered through our extensive network of participating health care professionals who provide a full range of counseling services.



### Well Care and Preventative Care

Services such as an annual physical and gynecological exam, well-baby/child medical care and immunizations are covered when using an in-network doctor.



#### **Wellness Includes:**

- [My Health Manager](#) powered by WebMD® (Members may be eligible to earn a \$50 prepaid eCard)
- Healthy Living Discounts with [Blue365](#)®
- Online health education
- [PRECIOUS ADDITIONS](#)® program for parents-to-be



### Doctor & Hospital Finder

This tool makes it easy to find a health care provider or hospital that matches your needs. You can even create your own directory, view street maps and get door-to-door directions.



### Prescription Drug Coverage

Prescription drug coverage is an integrated part of our health plans, so you can get the medications you need.



### Amazon Pharmacy

Through Amazon Pharmacy, you can get a 90-day supply of your prescriptions delivered right to your door for just the cost of your mail order copay.



### Rx Savings Solutions

Sign up for Rx Savings Solutions to see if you can save money on your prescriptions. Rx Savings Solutions can even work directly with your prescriber/pharmacy to help you switch to a lower-cost medication.



### Away From Home Care

This program is available to members without BlueCard® coverage in Horizon Advantage EPO and OMNIA Health Plans. It gives eligible members access to participating doctors, facilities and other health care professionals throughout the country.

## Why Horizon

### BlueCard®

### OMNIA<sub>SM</sub> Health Plans

## » Health Plan Benefits

### Medical Plans

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

### Horizon Level Select

### Horizon MyWay®

### Horizon EXPAND

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

## Quick Resource Guide

2024 BENEFITS	OMNIA Platinum		OMNIA Platinum Value		OMNIA Gold Blue Card*		OMNIA Gold HSA BlueCard*			
	Tier 1	Tier 2	Tier 1	Tier 2	Tier 1	Tier 2	Tier 1	Tier 2		
<b>GENERAL PROVISIONS</b>	Out-of-State Coverage	n/a	n/a	n/a	n/a	n/a	at Tier 2	Yes	at Tier 2	Yes
	Individual Deductible	\$0	\$1,500	\$50	\$1,500	\$1,250	\$2,000	\$2,350	\$2,500	
	Family Deductible	\$0	\$3,000	\$100	\$3,000	\$2,500	\$4,000	\$4,700	\$5,000	
	Individual Drug Deductible	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
	Family Drug Deductible	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
	Individual Maximum Out-of-Pocket	\$3,000	\$4,500	\$3,250	\$4,750	\$7,250	\$8,500	\$7,500	\$7,500	
	Family Maximum Out-of-Pocket	\$6,000	\$9,000	\$6,500	\$9,500	\$14,500	\$17,000	\$15,000	\$15,000	
<b>HEALTH CARE SERVICES</b>	PCP Office Visits & Consultations	\$10 copay	\$15 copay	\$10 copay	\$15 copay	\$20 copay	\$30 copay	Deductible	Ded then 20% coin	
	Specialist Visits & Consultations	\$15 copay	\$35 copay	\$20 copay	\$35 copay	\$40 copay	\$50 copay	Deductible	Ded then 20% coin	
<b>DIAGNOSTIC TESTING AND IMAGING</b>	Lab/Radiology Freestanding	No charge	No charge	No charge	No charge	No charge	No charge	Deductible	Deductible	
	Lab Office Visit	No charge	No charge	No charge	No charge	No charge	No charge	Deductible	Deductible	
	Radiology Office Visit	No charge	No charge	No charge	No charge	No charge	No charge	Deductible	Deductible	
	Lab/Radiology Outpatient	No charge	Ded then 30% coin	\$25 copay	Ded then 40% coin	Ded then 25% coin	Ded then 40% coin	Deductible	Ded then 20% coin	
	Complex Imaging Outpatient**	\$15 copay	Ded then 30% coin	Ded then \$15 copay	Ded then 40% coin	Ded then 25% coin	Ded then 40% coin	Deductible	Ded then 20% coin	
	Complex Imaging Freestanding**	\$15 copay	n/a	\$15 copay	n/a	Ded then 25% coin	Ded then 40% coin	Deductible	Ded then 20% coin	
<b>PHARMACY SERVICES</b>	Generic Drugs	\$5 copay (retail) \$10 copay (mail order)	\$5 copay (retail) \$10 copay (mail order)	\$10 copay (retail) \$20 copay (mail order)	\$10 copay (retail) \$20 copay (mail order)	\$10 copay (retail) \$20 copay (mail order)	\$10 copay (retail) \$20 copay (mail order)	Ded then \$10 copay (retail) Ded then \$20 copay (mail order)	Ded then \$10 copay (retail) Ded then \$20 copay (mail order)	
	Preferred Brand Drugs	\$15 copay (retail) \$30 copay (mail order)	\$15 copay (retail) \$30 copay (mail order)	\$25 copay (retail) \$50 copay (mail order)	\$25 copay (retail) \$50 copay (mail order)	\$40 copay (retail) \$80 copay (mail order)	\$40 copay (retail) \$80 copay (mail order)	Ded then \$40 copay (retail) Ded then \$80 copay (mail order)	Ded then \$40 copay (retail) Ded then \$80 copay (mail order)	
	Non-Preferred Brand Drugs & Specialty Drugs	\$30 copay (retail) \$60 copay (mail order)	\$30 copay (retail) \$60 copay (mail order)	\$50 copay (retail) \$100 copay (mail order)	\$50 copay (retail) \$100 copay (mail order)	\$75 copay (retail) \$150 copay (mail order)	\$75 copay (retail) \$150 copay (mail order)	Ded then \$75 copay (retail) Ded then \$150 copay (mail order)	Ded then \$75 copay (retail) Ded then \$150 copay (mail order)	
<b>EMERGENCY/ URGENT MEDICAL SERVICES</b>	ER Hospital	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay & ded then 25% coin	\$100 copay & ded then 25% coin	Ded then 20% coin	Ded then 20% coin	
	ER Professional	No charge	No charge	No charge	No charge	Ded then 25% coin	Ded then 25% coin	Ded then 20% coin	Ded then 20% coin	
	Medical Transportation	No charge	No charge	Ded then no charge	Ded then no charge	Ded then no charge	Ded then 40% coin	Deductible	Ded then 20% coin	
	Urgent Care Center	\$30 copay	\$70 copay	\$40 copay	\$70 copay	\$75 copay	\$75 copay	Deductible	Ded then 20% coin	
<b>HOSPITAL SERVICES</b>	Outpatient Hospital & Physician	\$15 copay	Ded then 30% coin	Ded then \$15 copay	Ded then 40% coin	Ded then 25% coin	Ded then 40% coin	Deductible	Ded then 20% coin	
	Inpatient Hospital	\$300 per day copay	Ded then 30% coin	Ded then \$450 per day copay	Ded then 40% coin	Ded then 25% coin	Ded then 40% coin	Deductible	Ded then 20% coin	
	Physician/Surgeon	No charge	Ded then 30% coin	Ded then no charge	Ded then 40% coin	Ded then 25% coin	Ded then 40% coin	Deductible	Ded then 20% coin	
<b>OCCUPATIONAL/ PHYSICAL THERAPY</b>	Office	\$10 copay	\$15 copay	\$10 copay	\$15 copay	\$20 copay	\$30 copay	Deductible	Ded then 20% coin	
	Outpatient	\$15 copay	Ded then 30% coin	Ded then \$15 copay	Ded then 40% coin	Ded then 25% coin	Ded then 40% coin	Deductible	Ded then 20% coin	
<b>MATERNITY SERVICES</b>	Delivery & All Inpatient Services	\$300 per day copay	Ded then 30% coin	Ded then \$450 per day copay	Ded then 40% coin	Ded then 25% coin	Ded then 40% coin	Deductible	Ded then 20% coin	
<b>OTHER SERVICES</b>	In-Home Health Care	\$5 copay	\$5 copay	\$5 copay	\$5 copay	\$10 copay	\$15 copay	Deductible	Ded then 20% coin	
	Rehabilitation, Hospice & Skilled Nursing Care*** – Inpatient	\$300 per day copay	Ded then 30% coin	Ded then \$450 per day copay	Ded then 40% coin	Ded then 25% coin	Ded then 40% coin	Deductible	Ded then 20% coin	
	Durable Medical Equipment	50% coin	n/a	50% coin	n/a	50% coin	50% coin	Ded then 50% coin	Ded then 50% coin	
	Chiropractic Care – 30 Visits Per Year Maximum	\$10 copay	\$15 copay	\$10 copay	\$15 copay	\$20 copay	\$30 copay	Deductible	Ded then 20% coin	
	Virtual PCP/Specialist Visits	\$5 copay	\$5 copay	\$5 copay	\$5 copay	\$10 copay	\$15 copay	Deductible	Ded then 20% coin	

Abbreviations: "ded" refers to deductible, "coin" refers to coinsurance, "copay" refers to copayment.  
 \*Away From Home Care Program not available for HSA eligible or BlueCard plans. Out-of-state benefits available through BlueCard.  
 \*\*Complex Imaging includes CT/PET scans, MRIs.  
 \*\*\* For 2024, all Hospice & Skilled Nursing providers are Tier 1 except BlueCard providers. All BlueCard providers are Tier 2.

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**Health Plan Benefits**

**Medical Plans**

» [OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

**Horizon Level Select**

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**Horizon EXPAND**

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

**Quick Resource Guide**

2024 BENEFITS	OMNIA Gold		OMNIA Silver BlueCard*		OMNIA Silver		
	Tier 1	Tier 2	Tier 1	Tier 2	Tier 1	Tier 2	
<b>GENERAL PROVISIONS</b>	Out-of-State Coverage	n/a	n/a	at Tier 2	Yes	n/a	n/a
	Individual Deductible	\$1,150	\$2,500	\$2,450	\$2,500	\$1,500	\$2,500
	Family Deductible	\$2,300	\$5,000	\$4,900	\$5,000	\$3,000	\$5,000
	Individual Drug Deductible	\$250	\$250	\$250	\$250	\$250	\$250
	Family Drug Deductible	\$500	\$500	\$500	\$500	\$500	\$500
	Individual Maximum Out-of-Pocket	\$8,000	\$9,000	\$9,450	\$9,450	\$9,450	\$9,450
	Family Maximum Out-of-Pocket	\$16,000	\$18,000	\$18,900	\$18,900	\$18,900	\$18,900
<b>HEALTH CARE SERVICES</b>	PCP Office Visits & Consultations	\$10 copay	Ded then \$30 copay	\$30 copay	\$40 copay	\$25 copay	Ded then 50% coin
	Specialist Visits & Consultations	\$25 copay	Ded then \$50 copay	\$50 copay	\$60 copay	\$50 copay	Ded then 50% coin
<b>DIAGNOSTIC TESTING AND IMAGING</b>	Lab/Radiology Freestanding	No charge	No charge	No charge	No charge	No charge	No charge
	Lab Office Visit	No charge	No charge	No charge	No charge	No charge	No charge
	Radiology Office Visit	No charge	No charge	No charge	No charge	No charge	No charge
	Lab/Radiology Outpatient	Ded then \$30 copay	Ded then 30% coin	Ded then 40% coin	Ded then 50% coin	Ded then \$100 copay	Ded then 50% coin
	Complex Imaging Outpatient**	Ded then \$30 copay	Ded then 30% coin	Ded then 40% coin	Ded then 50% coin	Ded then \$100 copay	Ded then 50% coin
	Complex Imaging Freestanding**	\$30 copay	n/a	Ded then 40% coin	Ded then 50% coin	\$100 copay	n/a
<b>PHARMACY SERVICES</b>	Generic Drugs	Ded then \$10 copay (retail) Ded then \$20 copay (mail order)	Ded then \$10 copay (retail) Ded then \$20 copay (mail order)	Ded then \$25 copay (retail) Ded then \$50 copay (mail order)	Ded then \$25 copay (retail) Ded then \$50 copay (mail order)	\$25 copay (retail) \$50 copay (mail order)	\$25 copay (retail) \$50 copay (mail order)
	Preferred Brand Drugs	Ded then \$40 copay (retail) Ded then \$80 copay (mail order)	Ded then \$40 copay (retail) Ded then \$80 copay (mail order)	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin
	Non-Preferred Brand Drugs & Specialty Drugs	Ded then \$75 copay (retail) Ded then \$150 copay (mail order)	Ded then \$75 copay (retail) Ded then \$150 copay (mail order)	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin
<b>EMERGENCY/ URGENT MEDICAL SERVICES</b>	ER Hospital	\$100 copay & ded	\$100 copay & ded	\$100 copay & ded then 40% coin	\$100 copay & ded then 40% coin	\$100 copay & ded	\$100 copay & ded
	ER Professional	Deductible	Deductible	Ded then 40% coin	Ded then 40% coin	Deductible	Deductible
	Medical Transportation	Ded then no charge	Ded then no charge	Ded then no charge	Ded then 50% coin	Ded then no charge	Ded then no charge
	Urgent Care Center	\$50 copay	Ded then \$75 copay	\$75 copay	\$75 copay	\$75 copay	Ded then 50% coin
<b>HOSPITAL SERVICES</b>	Outpatient Hospital & Physician	Ded then \$20 copay	Ded then 30% coin	Ded then 40% coin	Ded then 50% coin	Ded then \$50 copay	Ded then 50% coin
	Inpatient Hospital	Ded then \$500 per day copay	Ded then 30% coin	Ded then 40% coin	Ded then 50% coin	Ded then \$500 per day copay	Ded then 50% coin
	Physician/Surgeon	Deductible	Ded then 30% coin	Ded then 40% coin	Ded then 50% coin	Deductible	Ded then 50% coin
<b>OCCUPATIONAL/ PHYSICAL THERAPY</b>	Office	\$10 copay	Ded then \$30 copay	\$30 copay	\$30 copay	\$25 copay	Ded then 50% coin
	Outpatient	Ded then \$20 copay	Ded then 30% coin	Ded then 40% coin	Ded then 50% coin	Ded then \$50 copay	Ded then 50% coin
<b>MATERNITY SERVICES</b>	Delivery & All Inpatient Services	Ded then \$500 per day copay	Ded then 30% coin	Ded then 40% coin	Ded then 50% coin	Ded then \$500 per day copay	Ded then 50% coin
<b>OTHER SERVICES</b>	In-Home Health Care	\$5 copay	Ded then \$15 copay	\$15 copay	\$20 copay	\$10 copay	Ded then 50% coin
	Rehabilitation, Hospice & Skilled Nursing Care*** – Inpatient	Ded then \$500 per day copay	Ded then 30% coin	Ded then 40% coin	Ded then 50% coin	Ded then \$500 per day copay	Ded then 50% coin
	Durable Medical Equipment	Ded then 50% coin	n/a	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	n/a
	Chiropractic Care – 30 Visits Per Year Maximum	\$10 copay	Ded then \$30 copay	\$30 copay	\$30 copay	\$25 copay	Ded then 50% coin
	Virtual PCP/Specialist Visit	\$5 copay	Ded then \$15 copay	\$15 copay	\$15 copay	\$10 copay	Ded then 50% coin

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[Why Horizon](#)

[BlueCard®](#)

[OMNIA<sup>SM</sup> Health Plans](#)

[Health Plan Benefits](#)

[Medical Plans](#)

» [OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

[Horizon Level Select](#)

[Horizon MyWay®](#)

[Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

[Quick Resource Guide](#)





2024 BENEFITS	OMNIA Silver HSA*		OMNIA Silver Value		OMNIA Bronze		
	Tier 1	Tier 2	Tier 1	Tier 2	Tier 1	Tier 2	
GENERAL PROVISIONS	Out-of-State Coverage	n/a	n/a	n/a	n/a	n/a	
	Individual Deductible	\$2,250	\$2,500	\$2,500	\$2,500	\$3,000	\$3,000
	Family Deductible	\$4,500	\$5,000	\$5,000	\$5,000	\$6,000	\$6,000
	Individual Drug Deductible	n/a	n/a	n/a	n/a	n/a	n/a
	Family Drug Deductible	n/a	n/a	n/a	n/a	n/a	n/a
	Individual Maximum Out-of-Pocket	\$7,500	\$7,500	\$9,450	\$9,450	\$9,450	\$9,450
	Family Maximum Out-of-Pocket	\$15,000	\$15,000	\$18,900	\$18,900	\$18,900	\$18,900
HEALTH CARE SERVICES	PCP Office Visits & Consultations	Ded then \$10 copay	Ded then \$25 copay	\$35 copay	Ded then 50% coin	Ded then \$50 copay	Ded then 50% coin
	Specialist Visits & Consultations	Ded then \$20 copay	Ded then \$50 copay	\$75 copay	Ded then 50% coin	Ded then \$75 copay	Ded then 50% coin
DIAGNOSTIC TESTING AND IMAGING	Lab/Radiology Freestanding	Deductible	Deductible	No charge	No charge	No charge	No charge
	Lab Office Visit	Deductible	Deductible	No charge	No charge	No charge	No charge
	Radiology Office Visit	Deductible	Deductible	No charge	No charge	No charge	No charge
	Lab/Radiology Outpatient	Ded then \$75 copay	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin
	Complex Imaging Outpatient**	Ded then 30% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin
	Complex Imaging Freestanding**	Ded then 30% coin	n/a	Ded then 50% coin	n/a	Ded then 50% coin	n/a
PHARMACY SERVICES	Generic Drugs	Ded then 50% coin	Ded then 50% coin	Ded then \$10 copay (retail) Ded then \$20 copay (mail order)	Ded then \$10 copay (retail) Ded then \$20 copay (mail order)	\$25 copay (retail) \$50 copay (mail order)	\$25 copay (retail) \$50 copay (mail order)
	Preferred Brand Drugs	Ded then 50% coin	Ded then 50% coin	Ded then 10% coin	Ded then 10% coin	Ded then 50% coin	Ded then 50% coin
	Non-Preferred Brand Drugs & Specialty Drugs	Ded then 50% coin	Ded then 50% coin	Ded then 10% coin	Ded then 10% coin	Ded then 50% coin	Ded then 50% coin
EMERGENCY/ URGENT MEDICAL SERVICES	ER Hospital	Ded then \$100 copay & 30% coin	Ded then \$100 copay & 30% coin	\$100 copay & ded then 50% coin	\$100 copay & ded then 50% coin	\$100 copay & ded then 50% coin	\$100 copay & ded then 50% coin
	ER Professional	Ded then 30% coin	Ded then 30% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin
	Medical Transportation	Ded then 30% coin	Ded then 30% coin	Ded then no charge	Ded then no charge	Ded then no charge	Ded then no charge
	Urgent Care Center	Ded then \$40 copay	Ded then \$75 copay	Ded then \$75 copay	Ded then 50% coin	Ded then \$75 copay	Ded then 50% coin
HOSPITAL SERVICES	Outpatient Hospital & Physician	Ded then 30% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin
	Inpatient Hospital	Ded then 30% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin
	Physician/Surgeon	Ded then 30% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin
OCCUPATIONAL/ PHYSICAL THERAPY	Office	Ded then \$10 copay	Ded then \$25 copay	\$35 copay	Ded then 50% coin	Ded then \$40 copay	Ded then 50% coin
	Outpatient	Ded then 30% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin
MATERNITY SERVICES	Delivery & All Inpatient Services	Ded then 30% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin
OTHER SERVICES	In-Home Health Care	Ded then \$5 copay	Ded then \$10 copay	\$15 copay	Ded then 50% coin	Ded then \$25 copay	Ded then 50% coin
	Rehabilitation, Hospice & Skilled Nursing Care*** – Inpatient	Ded then 30% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin
	Durable Medical Equipment	Ded then 50% coin	n/a	Ded then 50% coin	n/a	Ded then 50% coin	n/a
	Chiropractic Care – 30 Visits Per Year Maximum	Ded then \$10 copay	Ded then \$25 copay	\$30 copay	Ded then 50% coin	Ded then \$30 copay	Ded then 50% coin
	Virtual PCP/Specialist Visit	Ded then \$5 copay	Ded then \$10 copay	\$15 copay	Ded then 50% coin	Ded then \$15 copay	Ded then 50% coin

Abbreviations: "ded" refers to deductible, "coin" refers to coinsurance, "copay" refers to copayment.

\*Away From Home Care Program not available for HSA eligible or BlueCard plans. Out-of-state benefits available through BlueCard.

\*\*Complex Imaging includes CT/PET scans, MRIs.

\*\*\* For 2024, all Hospice & Skilled Nursing providers are Tier 1 except BlueCard providers. All BlueCard providers are Tier 2

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[Why Horizon](#)

[BlueCard®](#)

[OMNIA<sup>SM</sup> Health Plans](#)

[Health Plan Benefits](#)

[Medical Plans](#)

» [OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

[Horizon Level Select](#)

[Horizon MyWay®](#)

[Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

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# 2024 Small Group | Advantage EPO Health Plans

2024 BENEFITS		Gold 100 \$25/\$45	Gold 100 \$40/\$60	Gold 100/80	Silver 100/60	Silver 100/50	Bronze 50
<b>GENERAL PROVISIONS</b>	Out-of-State Coverage	Optional*	Optional*	Optional*	Optional*	Optional*	Optional*
	Individual Deductible	\$0	\$0	\$1,500	\$2,450	\$2,500	\$3,000
	Family Deductible	\$0	\$0	\$3,000	\$4,900	\$5,000	\$6,000
	Individual Drug Deductible	n/a	n/a	n/a	n/a	n/a	n/a
	Family Drug Deductible	n/a	n/a	n/a	n/a	n/a	n/a
	Individual Maximum Out-of-Pocket	\$7,000	\$7,750	\$7,500	\$9,450	\$9,450	\$9,450
	Family Maximum Out-of-Pocket	\$14,000	\$15,500	\$15,000	\$18,900	\$18,900	\$18,900
<b>HEALTH CARE SERVICES</b>	PCP Office Visits & Consultations	\$25 copay	\$40 copay	\$20 copay	\$45 copay	\$30 copay	Ded then 50% coin
	Specialist Visits & Consultations	\$45 copay	\$60 copay	\$40 copay	\$70 copay	\$65 copay	Ded then 50% coin
<b>DIAGNOSTIC TESTING AND IMAGING</b>	Lab/Radiology Freestanding	No charge	No charge	No charge	No charge	No charge	No charge
	Lab Office Visit	No charge	No charge	No charge	No charge	No charge	No charge
	Radiology Office Visit	No charge	No charge	No charge	No charge	No charge	No charge
	Lab/Radiology Outpatient	\$100 copay	\$100 copay	\$75 copay	Ded then \$100 copay	Ded then \$100 copay	Ded then \$100 copay
	Complex Imaging Outpatient**	\$100 copay	\$100 copay	\$75 copay	Ded then \$100 copay	Ded then 50% coin	Ded then 50% coin
	Complex Imaging Freestanding**	No charge	\$100 copay	No charge	No charge	No charge	Ded then 50% coin
<b>PHARMACY SERVICES</b>	Generic Drugs	\$25 copay (retail) \$50 copay (mail order)	\$20 copay (retail) \$40 copay (mail order)	\$10 copay (retail) \$20 copay (mail order)	\$25 copay (retail) \$50 copay (mail order)	\$20 copay (retail) \$40 copay (mail order)	\$25 copay (retail) \$50 copay (mail order)
	Preferred Brand Drugs	\$50 copay (retail) \$100 copay (mail order)	50% coin	\$25 copay (retail) \$50 copay (mail order)	\$50 copay (retail) \$100 copay (mail order)	\$50 copay (retail) \$100 copay (mail order)	Ded then 50% coin***
	Non-Preferred Brand Drugs & Specialty Drugs	\$75 copay (retail) \$150 copay (mail order)	50% coin	\$50 copay (retail) \$100 copay (mail order)	\$75 copay (retail) \$150 copay (mail order)	\$75 copay (retail) \$150 copay (mail order)	Ded then 50% coin***
<b>EMERGENCY/ URGENT MEDICAL SERVICES</b>	ER Hospital	\$100 copay	\$100 copay	\$100 copay & ded then 20% coin	\$100 copay & ded then 40% coin	\$100 copay & ded then 50% coin	\$100 copay & ded then 50% coin
	ER Professional	No charge	No charge	Ded then 20% coin	Ded then 40% coin	Ded then 50% coin	Ded then 50% coin
	Medical Transportation	No charge	No charge	Ded then 20% coin	Ded then 40% coin	Ded then 50% coin	Ded then no charge
	Urgent Care Center	\$75 copay	\$75 copay	\$75 copay	\$75 copay	\$75 copay	Ded then 50% coin
<b>HOSPITAL SERVICES</b>	Outpatient Hospital & Physician	\$45 copay	\$50 copay	Ded then 20% coin	Ded then 40% coin	Ded then 50% coin	Ded then 50% coin
	Inpatient Hospital	\$500 per day copay	\$500 per day copay	Ded then 20% coin	Ded then 40% coin	Ded then 50% coin	Ded then \$100 per day copay
	Physician/Surgeon	No charge	No charge	Ded then 20% coin	Ded then 40% coin	Ded then 50% coin	Ded then no charge
<b>OCCUPATIONAL/ PHYSICAL THERAPY</b>	Office	\$25 copay	\$40 copay	\$20 copay	\$40 copay	\$30 copay	Ded then 50% coin
	Outpatient	\$45 copay	\$50 copay	Ded then 20% coin	Ded then 40% coin	Ded then 50% coin	Ded then 50% coin
<b>MATERNITY SERVICES</b>	Delivery & All Inpatient Services	\$500 per day copay	\$500 per day copay	Ded then 20% coin	Ded then 40% coin	Ded then 50% coin	Ded then \$100 per day copay
<b>OTHER SERVICES</b>	In-Home Health Care	\$10 copay	\$20 copay	\$10 copay	\$20 copay	\$15 copay	Ded then 50% coin
	Rehabilitation, Hospice & Skilled Nursing Care – Inpatient	\$500 per day copay	\$500 per day copay	Ded then 20% coin	Ded then 40% coin	Ded then 50% coin	Ded then \$100 per day copay
	Durable Medical Equipment	50% coin	50% coin	50% coin	50% coin	50% coin	Ded then 50% coin
	Chiropractic Care – 30 Visits Per Year Maximum	\$25 copay	\$30 copay	\$20 copay	\$30 copay	\$30 copay	Ded then 50% coin
	Virtual PCP/Specialist Visit	\$10 copay	\$15 copay	\$10 copay	\$15 copay	\$15 copay	Ded then 50% coin

Abbreviations: "ded" refers to deductible, "coin" refers to coinsurance, "copay" refers to copayment.

\*Away From Home Care Program not available for HSA eligible or BlueCard plans. Out-of-state benefits available through BlueCard.

\*\*Complex Imaging includes CT/PET scans, MRIs.

\*\*\*Advantage EPO Bronze Preferred and Non-Preferred Brand drugs subject to a \$250 maximum per script.

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[OMNIA<sub>SM</sub> Health Plans](#)

[Health Plan Benefits](#)

[Medical Plans](#)

[OMNIA Health Plans](#)

» [Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

[Horizon Level Select](#)

[Horizon MyWay®](#)

[Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

[Quick Resource Guide](#)



# 2024 Small Group | Advantage Direct Access Health Plans

2024 BENEFITS	Platinum 100/70*		Gold 100/80/60*		Silver HSA 100/70/60*		
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	
<b>GENERAL PROVISIONS</b>	Out-of-State Coverage		Yes*		Yes*		
	Individual Deductible	\$0	\$1,500	\$2,000	\$4,000	\$2,300	\$3,000
	Family Deductible	\$0	\$3,000	\$4,000	\$8,000	\$4,600	\$6,000
	Individual Drug Deductible	n/a	n/a	n/a	n/a	n/a	n/a
	Family Drug Deductible	n/a	n/a	n/a	n/a	n/a	n/a
	Individual Maximum Out-of-Pocket	\$4,500	\$6,500	\$6,500	\$8,000	\$7,500	\$8,000
	Family Maximum Out-of-Pocket	\$9,000	\$13,000	\$13,000	\$16,000	\$15,000	\$16,000
<b>HEALTH CARE SERVICES</b>	PCP Office Visits & Consultations	\$20 copay	Ded then 30% coin	\$30 copay	Ded then 40% coin	Ded then \$30 copay	Ded then 40% coin
	Specialist Visits & Consultations	\$40 copay	Ded then 30% coin	\$50 copay	Ded then 40% coin	Ded then \$50 copay	Ded then 40% coin
<b>DIAGNOSTIC TESTING AND IMAGING</b>	Lab/Radiology Freestanding	No charge	Ded then 30% coin	No charge	Ded then 40% coin	Deductible	Ded then 40% coin
	Lab Office Visit	No charge	Ded then 30% coin	No charge	Ded then 40% coin	Deductible	Ded then 40% coin
	Radiology Office Visit	No charge	Ded then 30% coin	No charge	Ded then 40% coin	Deductible	Ded then 40% coin
	Lab/Radiology Outpatient	No charge	Ded then 30% coin	Ded then 20% coin	Ded then 40% coin	Ded then 30% coin	Ded then 40% coin
	Complex Imaging Outpatient**	No charge	Ded then 30% coin	Ded then 20% coin	Ded then 40% coin	Ded then 30% coin	Ded then 40% coin
	Complex Imaging Freestanding**	No charge	Ded then 30% coin	No charge	Ded then 40% coin	Deductible	Ded then 40% coin
<b>PHARMACY SERVICES</b>	Generic Drugs		\$10 copay (retail) \$20 copay (mail order)		\$15 copay (retail) \$30 copay (mail order)		Ded then 40% coin
	Preferred Brand Drugs		\$25 copay (retail) \$50 copay (mail order)		\$40 copay (retail) \$80 copay (mail order)		Ded then 40% coin
	Non-Preferred Brand Drugs & Specialty Drugs		\$50 copay (retail) \$100 copay (mail order)		\$75 copay (retail) \$150 copay (mail order)		Ded then 40% coin
<b>EMERGENCY/ URGENT MEDICAL SERVICES</b>	ER Hospital	\$100 copay	\$100 copay	\$100 copay & ded then 20% coin	\$100 copay & ded then 20% coin	Ded then \$100 copay & 30% coin	Ded then \$100 copay & 30% coin
	ER Professional	No charge	No charge	Ded then 20% coin	Ded then 20% coin	Ded then 30% coin	Ded then 30% coin
	Medical Transportation	No charge	Ded then 30% coin	Ded then 20% coin	Ded then 40% coin	Ded then 30% coin	Ded then 40% coin
	Urgent Care Center	\$75 copay	Ded then 30% coin	\$75 copay	Ded then 40% coin	Ded then \$75 copay	Ded then 40% coin
<b>HOSPITAL SERVICES</b>	Outpatient Hospital & Physician	\$40 copay	Ded then 30% coin	Ded then 20% coin	Ded then 40% coin	Ded then 30% coin	Ded then 40% coin
	Inpatient Hospital	\$250 per day copay	Ded then 30% coin	Ded then 20% coin	Ded then 40% coin	Ded then 30% coin	Ded then 40% coin
	Physician/Surgeon	No charge	Ded then 30% coin	Ded then 20% coin	Ded then 40% coin	Ded then 30% coin	Ded then 40% coin
<b>OCCUPATIONAL/ PHYSICAL THERAPY</b>	Office	\$20 copay	Ded then 30% coin	\$30 copay	Ded then 40% coin	Ded then \$30 copay	Ded then 40% coin
	Outpatient	\$40 copay	Ded then 30% coin	Ded then 20% coin	Ded then 40% coin	Ded then 30% coin	Ded then 40% coin
<b>MATERNITY SERVICES</b>	Delivery & All Inpatient Services	\$250 per day copay	Ded then 30% coin	Ded then 20% coin	Ded then 40% coin	Ded then 30% coin	Ded then 40% coin
<b>OTHER SERVICES</b>	In-Home Health Care	\$10 copay	Ded then 30% coin	\$15 copay	Ded then 40% coin	Ded then \$15 copay	Ded then 40% coin
	Rehabilitation, Hospice & Skilled Nursing Care – Inpatient	\$250 per day copay	Ded then 30% coin	Ded then 20% coin	Ded then 40% coin	Ded then 30% coin	Ded then 40% coin
	Durable Medical Equipment	50% coin	Ded then 50% coin	50% coin	Ded then 50% coin	Ded then 50% coin	Ded then 50% coin
	Chiropractic Care – 30 Visits Per Year Maximum	\$20 copay	Ded then 30% coin	\$30 copay	Ded then 40% coin	Ded then \$30 copay	Ded then 40% coin
	Virtual PCP/Specialist	\$10 copay	Ded then 30% coin	\$15 copay	Ded then 40% coin	Ded then \$15 copay	Ded then 40% coin

Abbreviations: "ded" refers to deductible, "coin" refers to coinsurance, "copay" refers to copayment.

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[Health Plan Benefits](#)

[Medical Plans](#)

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

» [Advantage Direct Access Health Plans](#)

[Horizon Level Select](#)

[Horizon MyWay®](#)

[Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

[Quick Resource Guide](#)



# Horizon Level Select

Horizon Level Select plans are level-funded health plan solutions that combine the cost savings and flexibility of a self-funded plan with the stability and protection of a traditional fully insured plan.

Horizon Level Select provides:

- The choice of standard Horizon health care plans
- Built-in protection to minimize financial risk
- Cost-savings opportunities
- Simplified billing with a fixed monthly payment
- BlueCard® options for out-of-state employee coverage
- Health Savings Account (HSA) plan available for extra savings

What's the difference between fully insured and level-funded plans?	
Horizon Fully Insured Plans	Horizon Level Select
<ul style="list-style-type: none"> <li>• A set monthly cost</li> <li>• Protection from unexpected claim costs</li> <li>• Access to the right care for your needs</li> </ul>	<ul style="list-style-type: none"> <li>• A set monthly cost</li> <li>• Protection from unexpected claim costs with stop loss coverage</li> <li>• Access to the right care for your needs</li> </ul> <p style="text-align: center;"><b>+ Potential Savings</b></p> <ul style="list-style-type: none"> <li>• Reduced mandates, fees and taxes</li> <li>• 50% reimbursement of the surplus if claims are lower than expected – so a healthier employee population means potential cost savings*</li> </ul>

\*Reimbursement is in the form of a hard copy check once renewal is completed.



**Horizon offers:**

- Administrative fee credits
- Monthly reporting
- Illustrative quoting available
- Surplus paid directly to the employer upon renewal

**Eligibility requirements:**

- Minimum of 10 eligible/5 enrolled

Contact your Horizon Account Representative or Broker, or visit [HorizonBlue.com](https://HorizonBlue.com).

**Why Horizon**

**BlueCard®**

**OMNIA<sub>SM</sub> Health Plans**

**Health Plan Benefits**

**Medical Plans**

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

**» Horizon Level Select**

**Horizon MyWay®**

**Horizon EXPAND**

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

**Quick Resource Guide**

# Horizon *MyWay*<sup>®\*</sup>

These coverage options enable your employees to lower their health care costs.

## Health Savings Accounts (HSAs)

An HSA is a savings account your employees can use to save and pay for qualified medical expenses.

- All contributions roll over, are pre-tax and are portable.
- HSA funds earn interest as they grow.
- Funds can also be invested to help reach long-term retirement goals.
- Certain eligibility requirements apply.

## Flexible Spending Accounts (FSAs)

An FSA is a savings account your employees can use to save and pay for qualified medical expenses and dependent care.

- Funds are not portable.
- Funds roll over only at the employer's discretion.
- There are no eligibility requirements, unless the FSA is for dependent care.

\*Horizon *MyWay* is not available on OMNIA products.



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**Horizon Blue app** – Manage your account from the palm of your hand.

**Expert assistance** – Enjoy access to a dedicated team of experts every step of the way.

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### BlueCard<sup>®</sup>

### OMNIA<sup>SM</sup> Health Plans

### Health Plan Benefits

### Medical Plans

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

### Horizon Level Select

### » Horizon *MyWay*<sup>®</sup>

### Horizon EXPAND

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

### Quick Resource Guide



# Horizon MyWay®

Choose how you'd like to support your employees – while reducing your company's health expenditures at the same time.

Quick Comparison	HSA	FSA
<b>Employee Account Features</b>		
Employees can use the money to pay their deductibles or copays.	✓	✓
Employees can use the money in the account as they save.	✓	✓
Employees own the account.	✓	
Employers own the account.		✓
Contributions are made pre-tax.	✓	✓
Employees can invest funds toward retirement.	✓	
A debit card may be available at the employer's discretion.	✓	✓
<b>Maximum Contributions</b>		
Individual	<b>\$4,150</b>	<b>\$3,050</b>
Family	<b>\$8,300</b>	
FSA Dependent Care		<b>\$5,000</b>

Source: [IRS.gov](https://www.irs.gov)



## [Why Horizon](#)

## [BlueCard®](#)

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## [Health Plan Benefits](#)

## [Medical Plans](#)

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

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[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

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[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

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Accessing account funds is easier than ever. Eligible members can pay medical bills using a Horizon MyWay Visa® Debit Card, which will pull directly from the tax-advantaged funds they've saved up.

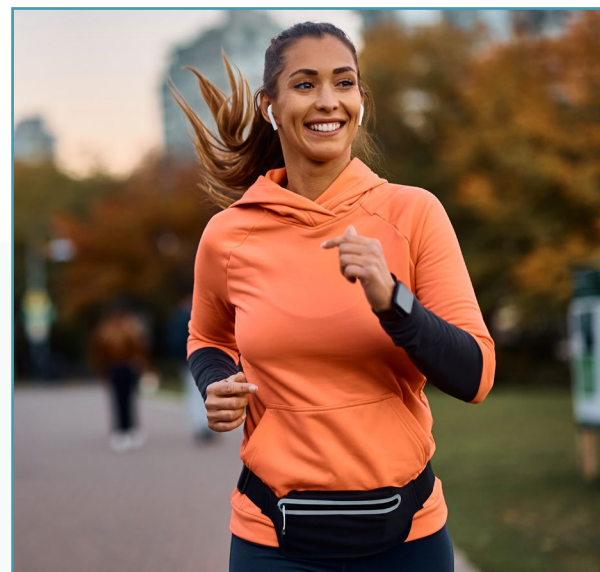


Learn more by visiting [HorizonBlue.com/myway](https://HorizonBlue.com/myway)

Horizon EXPAND goes beyond health insurance with a full suite of additional benefits, while allowing you to simplify administrative expenses.

**You can purchase these Horizon products together or separately:**

- Dental
- Voluntary Dental
- Vision
- Health Plus Plan
- Life & Disability
- International Medical Coverage
- Pet Insurance



Get one-stop shopping with enhanced support.

Contact your Horizon Account Representative or Broker, or visit [HorizonBlue.com](https://www.HorizonBlue.com).

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[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

**Quick Resource Guide**

## Horizon Dental

Combining dental with medical coverage makes great sense. By integrating dental and medical records, you give health care providers better insight to treat your employees. And it's less expensive and easier to administer your benefits program.

### Horizon Young Grins

A pediatric essential plan that emphasizes prevention and early intervention through routine oral screenings and evaluations. *Affordable Care Act (ACA) Compliant*

### Horizon Family Grins & Horizon Family Grins Plus

Offers the same quality pediatric coverage as Horizon Young Grins, along with dental coverage for parents or guardians. Horizon Family Grins Plus adds out-of-network coverage for members over age 19. *Affordable Care Act (ACA) Compliant*

### Horizon Dental Option Plan (DOP)

Provides access to the largest Horizon dental network and includes both in- and out-of-network benefits.

### Horizon Dental PPO Plan

Includes both in- and out-of-network benefits; lowest fees available through our Horizon Dental PPO network.

### Horizon Healthy Smiles & Horizon Healthy Smiles Plus

Comprehensive in-network-only coverage. Horizon Healthy Smiles Plus includes greater access to the Horizon dental network.

### Horizon Dental PPO Access Plan & Horizon Dental Companion Plan

Lowest fees available when choosing a dentist through our Horizon Dental PPO Network; plans cover preventive and diagnostic at 100%; all other services are at a discount.



We offer affordable, comprehensive dental options designed to complement your overall health benefits strategy.

For more information, visit [HorizonBlue.com/dental](https://HorizonBlue.com/dental).

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### [OMNIA<sup>SM</sup> Health Plans](#)

### [Health Plan Benefits](#)

### [Medical Plans](#)

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

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### [Horizon MyWay®](#)

### [Horizon EXPAND](#)

» [Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

### [Quick Resource Guide](#)



# 2024 Dental Plan Small Group Guide



Horizon Young Grins	
Coverage Type	Pediatric In-Network (under 19)
Preventive (cleanings, oral exams, bitewing X-rays)	100% after deductible
Basic (fillings, extractions)	80% after deductible
Major (bridges, dentures, crowns)	50% after deductible
Cosmetic Orthodontia (under 19 only)	n/a
Preventive Deductible per individual	\$25
Basic & Major Deductible Per Individual/Family	\$100/\$200
Annual Maximum	n/a
Out-of-Pocket Maximum	\$400 individual \$800 family
Dependent Eligibility	End of month they turn age 19

Horizon Family Grins		
Coverage Type	Pediatric In-Network (under 19)	Adult In-Network (19 and over)
Preventive (cleanings, oral exams, bitewing X-rays)	100% after deductible	100%
Basic (fillings, extractions)	80% after deductible	Discount (eligible services only)
Major (bridges, dentures, crowns)	50% after deductible	Discount (eligible services only)
Cosmetic Orthodontia (under 19 only)	50% \$1000 lifetime maximum	n/a
Preventive Deductible per individual	\$25	\$0
Basic & Major Deductible Per Individual/Family	\$100/\$200	n/a
Annual Maximum	n/a	n/a
Out-of-Pocket Maximum	\$400 individual \$800 family	n/a
Dependent Eligibility	End of month they turn age 26	

Horizon Family Grins Plus			
Coverage Type	Pediatric In-Network (under 19)	Adult In-Network (19 and over)	Adult Out-of-Network <sup>(1)</sup> (19 and over)
Preventive (cleanings, oral exams, bitewing X-rays)	100% after deductible	100%	100%
Basic (fillings, extractions)	80% after deductible	80% after deductible	80% after deductible
Major (bridges, dentures, crowns)	50% after deductible	50% after deductible	50% after deductible
Cosmetic Orthodontia (under 19 only)	50% \$1000 lifetime maximum	n/a	n/a
Preventive Deductible per individual	\$25	\$0	\$0
Basic & Major Deductible Per Individual/Family	\$100/\$200	\$50/\$150	\$50/\$150 combined with in network
Annual Maximum	n/a	\$1500	\$1500 combined with in network
Out-of-Pocket Maximum	\$400 individual \$800 family	n/a	n/a
Dependent Eligibility	End of month they turn age 26		

1. Payment is based upon the Horizon allowance and the provider may bill the member up to charges. This document is for informational purposes only and does not constitute a binding agreement. Please note that rates are subject to change. Contact Horizon for the most current rates. The information provided by this document is not intended to replace or modify the terms, conditions, limitations and exclusions contained within health, dental or vision benefit plans issued or administered by Horizon. In the event of a conflict between the information contained in this document and your plan documents, your plan documents shall control.

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### Medical Plans

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# 2024 Dental Plan Small Group Guide



Plan Type	Horizon Dental Option Plan (DOP)	Horizon Dental PPO	Horizon Healthy Smiles Plans
Network	12,000 in NJ/376,000 nationwide	9,000 in NJ/329,000 nationwide	Healthy Smiles: 9,000 in NJ/329,000 nationwide Healthy Smiles Plus: 12,000 in NJ/376,000 nationwide
Underwriting Guidelines			
Participation: 2-9 Eligible Employees	100% <sup>[1]</sup>	100% <sup>[1]</sup>	100% <sup>[1]</sup>
Participation: 10-50 Eligible Employees	75% <sup>[1]</sup>	75% <sup>[1]</sup>	75% <sup>[1]</sup>
Minimum Employer Contribution	The single rate or 50% of total premium	The single rate or 50% of total premium	The single rate or 50% of total premium
New Business Effective Dates	1st and 15th of the month	1st and 15th of the month	1st and 15th of the month
Group Size Requirement	2 eligible/2 enrolled <sup>[2]</sup>	2 eligible/2 enrolled <sup>[2]</sup>	2 eligible/2 enrolled <sup>[2]</sup>
Annual Deductible	\$50/\$150	\$50/\$150	\$50/\$150
Annual Maximum Options	\$1,000 or \$1,500	\$1,000 or \$1,500	\$1,000
Coinsurance Options Available: Preventive/Diagnostic/Basic/Major	100%/80%/50%, 100%/100%/50%	100%/80%/50%	100%/80%/50%
Dependent Eligibility	Dependent to age 19 and full-time students to 23	Dependent to age 19 and full-time students to 23	Dependent to age 26
Orthodontics			
Cosmetic Orthodontia for Under 19 Only (50% coinsurance)	No ortho, or \$750 or \$1000 lifetime maximum	No ortho or \$750 lifetime maximum	No ortho or \$1000 lifetime maximum
Orthodontia Eligibility	Group size of 5 or more	Group size of 5 or more	Group size of 2 or more

1. Includes spousal waivers.

2. Will write down to one (1) when medical has one (1) enrolled. Participation requirement must still be met.

Number of participating office locations is approximate and may vary across plans.  
Call Member Services at **1-800-4DENTAL (433-6825)** to verify dentists' continued participation.

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# 2024 Dental Plan Small Group Guide



Plan Type	Horizon Dental PPO Access	Horizon Dental Companion
Network	Over 10,000 participating dental offices within NJ, NY, DE and PA	Over 10,000 participating dental offices within NJ, NY, DE and PA
Underwriting Guidelines		
Participation: 2-9 Employees	100% <sup>[1]</sup>	Must match medical
Participation: 10-50 Employees	75% <sup>[1]</sup>	Must match medical
Benefit Waiting Periods	n/a	n/a
Minimum Employer Contribution	The single rate or 50% of total premium	Must match medical
New Business Effective Dates	1st and 15th of the month	1st and 15th of the month
Group Size Requirement	2 eligible/2 enrolled <sup>[2]</sup>	Must match medical
Annual Deductible Options	None	None
Annual Maximum Options	No maximum	No maximum
Eligible Preventive Services (exams, X-rays, cleanings and sealants)	100%	100%
Eligible Basic Service Options (root canals, periodontal and extractions)	Silver fillings and space maintainers 100%; discounted fee for all other eligible basic services (in-network benefit only)	Silver fillings and space maintainers 100%; discounted fee for all other eligible basic services (in-network benefit only)
Eligible Major Service Options (crowns, bridges and dentures)	Discounted fee (in-network benefit only)	Discounted fee (in-network benefit only)
Dependent Eligibility	Dependent to age 19 and full-time student(s) to 23	End of month they turn 26
Orthodontia Eligibility and Benefits	Group(s) with 2+ employees	Group(s) with 2+ employees

1. Includes spousal waivers.  
 2. Will write down to one (1) when medical has one (1) enrolled. Participation requirement must still be met.

Number of participating office locations is approximate and may vary across plans.  
 Call Member Services at **1-800-4DENTAL (433-6825)** to verify dentists' continued participation.

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[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

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# 2024 Dental Plan Small Group Rates

PREMIUMS ARE BASED ON THE AGE OF MEMBERS AND TERRITORY



Horizon Young Grins						
2024 Child Rate						
Age	Territory A	Territory B	Territory C	Territory D	Territory E	Territory F
0-14	\$21.24	\$23.17	\$24.02	\$23.35	\$23.24	\$27.87
15	\$23.97	\$26.15	\$27.11	\$26.35	\$26.23	\$31.46
16	\$23.08	\$25.17	\$26.09	\$25.36	\$25.25	\$30.28
17	\$22.36	\$24.40	\$25.29	\$24.58	\$24.47	\$29.34
18	\$20.11	\$21.93	\$22.73	\$22.10	\$22.00	\$26.38

Horizon Family Grins						
2024 Child Rate						
Age	Territory A	Territory B	Territory C	Territory D	Territory E	Territory F
0-14	\$21.96	\$23.95	\$24.83	\$24.13	\$24.02	\$28.81
15	\$24.78	\$27.03	\$28.02	\$27.24	\$27.11	\$32.51
16	\$23.85	\$26.02	\$26.97	\$26.21	\$26.10	\$31.29
17	\$23.12	\$25.22	\$26.14	\$25.41	\$25.29	\$30.33
18	\$20.78	\$22.67	\$23.50	\$22.84	\$22.74	\$27.27

Horizon Family Grins Plus						
2024 Child Rate						
Age	Territory A	Territory B	Territory C	Territory D	Territory E	Territory F
0-14	\$21.96	\$23.95	\$24.83	\$24.13	\$24.02	\$28.81
15	\$24.78	\$27.03	\$28.02	\$27.24	\$27.11	\$32.51
16	\$23.85	\$26.02	\$26.97	\$26.21	\$26.10	\$31.29
17	\$23.12	\$25.22	\$26.14	\$25.41	\$25.29	\$30.33
18	\$20.78	\$22.67	\$23.50	\$22.84	\$22.74	\$27.27

2024 Adult Rate						
Age	Territory A	Territory B	Territory C	Territory D	Territory E	Territory F
19-22	\$13.33	\$14.09	\$14.24	\$13.95	\$13.31	\$14.32
23-24	\$13.02	\$13.76	\$13.91	\$13.62	\$13.00	\$13.98
25-29	\$13.48	\$14.24	\$14.39	\$14.10	\$13.46	\$14.47
30-34	\$13.70	\$14.48	\$14.64	\$14.34	\$13.69	\$14.72
35-39	\$13.84	\$14.63	\$14.79	\$14.48	\$13.82	\$14.87
40-44	\$13.89	\$14.68	\$14.84	\$14.54	\$13.87	\$14.92
45-49	\$13.98	\$14.77	\$14.93	\$14.62	\$13.96	\$15.01
50-54	\$14.14	\$14.95	\$15.11	\$14.80	\$14.12	\$15.19
55-59	\$14.34	\$15.16	\$15.32	\$15.00	\$14.32	\$15.40
60-63	\$14.59	\$15.42	\$15.59	\$15.27	\$14.57	\$15.67
64+	\$14.63	\$15.47	\$15.63	\$15.31	\$14.61	\$15.72

2024 Adult Rate						
Age	Territory A	Territory B	Territory C	Territory D	Territory E	Territory F
19-22	\$27.53	\$29.10	\$29.41	\$28.80	\$27.49	\$29.57
23-24	\$23.89	\$25.25	\$25.52	\$24.99	\$23.85	\$25.66
25-29	\$29.40	\$31.07	\$31.40	\$30.75	\$29.36	\$31.57
30-34	\$31.23	\$33.00	\$33.36	\$32.67	\$31.18	\$33.54
35-39	\$32.86	\$34.72	\$35.10	\$34.37	\$32.81	\$35.29
40-44	\$33.97	\$35.91	\$36.29	\$35.54	\$33.93	\$36.49
45-49	\$35.84	\$37.88	\$38.28	\$37.49	\$35.79	\$38.49
50-54	\$38.96	\$41.17	\$41.62	\$40.76	\$38.90	\$41.84
55-59	\$43.64	\$46.12	\$46.61	\$45.65	\$43.58	\$46.87
60-63	\$48.22	\$50.96	\$51.50	\$50.44	\$48.15	\$51.79
64+	\$52.49	\$55.47	\$56.07	\$54.91	\$52.41	\$56.37

### Territory Legend

Area	Counties
Territory A	Essex, Hudson, Union
Territory B	Bergen, Passaic
Territory C	Monmouth, Morris, Sussex, Warren
Territory D	Hunterdon, Middlesex, Somerset
Territory E	Burlington, Camden, Mercer
Territory F	Atlantic, Cape May, Ocean, Salem, Cumberland, Gloucester

Contact your Broker or Horizon Account Representative for specific rates for Horizon Dental Option Plan (DOP), Horizon Dental PPO, Horizon Healthy Smiles Plans, Horizon Dental Companion and Horizon Dental PPO Access.

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## Voluntary Dental

Extend your dental offerings with no employer contribution required. Voluntary Dental gives your employees low-cost, self-paid access to Horizon providers.

### Voluntary Dental features include:

- A 100% employee-paid benefit through payroll deduction
- Easy administration
- Simple underwriting rules
- No minimum participation
- Six plan options

### Underwriting and Product Information

- Voluntary dental plans are offered to groups with 2-50 employees. Employers may choose to offer either voluntary plans or employer-funded plans but may not offer both at the same time. **\*Exception:** Young Grins may be offered alongside the Voluntary PPO or DOP plans.
- There are no benefit waiting periods on the DOP or PPO plans.
- Only groups with 5+ eligible employees can offer the DOP or PPO plans with orthodontia.
- Employers may offer up to two plans: Family Grins or Family Grins Plus and one DOP or PPO plan.
- Dental Option Plan and Dental PPO are offered for dependent children to age 19 and full-time students to age 23.
- Family Grins and Family Grins Plus are offered for dependent children to age 26.
- Dental Option Plan and Dental PPO out-of-network allowance is set at Maximum Allowable Charge (MAC).



### Voluntary Dental Plans:

Horizon Family Grins

Horizon Family Grins Plus

Horizon Dental PPO

No ortho, \$50 ded, \$1,500 annual max, 100/80/50

Horizon Dental PPO (with Ortho)

\$750 ortho, \$50 ded, \$1,500 annual max, 100/80/50

Horizon Dental Option

No ortho, \$50 ded, \$1,500 annual max, 100/80/50

Horizon Dental Option (with Ortho)

\$750 ortho, \$50 ded, \$1,500 annual max, 100/80/50

For additional details, please contact your Horizon EXPAND Account Manager.

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[Medical Plans](#)

[OMNIA Health Plans](#)

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[Horizon Level Select](#)

[Horizon MyWay®](#)

[Horizon EXPAND](#)

[Dental Plans](#)

» [Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

[Quick Resource Guide](#)

# 2024 Voluntary Dental Plans



Horizon Family Grins Voluntary						
Age	Territory A	Territory B	Territory C	Territory D	Territory E	Territory F
0-14	\$20.22	\$22.05	\$22.86	\$22.22	\$22.11	\$26.51
15-18	\$20.61	\$22.48	\$23.30	\$22.65	\$22.55	\$27.05
19+	\$13.12	\$13.87	\$14.02	\$13.74	\$13.11	\$14.10

Horizon Family Grins Plus Voluntary						
Age	Territory A	Territory B	Territory C	Territory D	Territory E	Territory F
0-14	\$20.22	\$22.05	\$22.86	\$22.22	\$22.11	\$26.51
15-18	\$20.61	\$22.48	\$23.30	\$22.65	\$22.55	\$27.05
19+	\$32.59	\$34.44	\$34.81	\$34.11	\$32.55	\$35.01

For Family Grins and Family Grins Plus, employer premiums are based on the member's age and the employer's county.

## Dental Rate Example

Voluntary Dental Option and Dental PPO rates are based on group size and industry group. The rate example below is for an employer in Industry Group C.

Voluntary Dental Product								
Number of eligible employees	Group Size 2-9				Group Size 10-50			
	SING	H&W	Family	P&C	SING	H&W	Family	P&C
Dental PPO, no ortho, \$50 ded, \$1,500 annual max, 100/80/50	\$35.29	\$64.09	\$97.81	\$72.11	\$32.08	\$58.26	\$88.91	\$65.54
Dental PPO, \$750 ortho, \$50 ded, \$1,500 annual max, 100/80/50	\$35.29	\$64.09	\$103.67	\$76.43	\$32.08	\$58.26	\$94.24	\$69.47
Dental Option Plan, no ortho, \$50 ded, \$1,500 annual max, 100/80/50	\$48.86	\$88.71	\$135.39	\$99.79	\$44.41	\$80.64	\$123.07	\$90.71
Dental Option Plan, \$750 ortho, \$50 ded, \$1,500 annual max, 100/80/50	\$48.86	\$88.71	\$143.51	\$105.78	\$44.41	\$80.64	\$130.45	\$96.16

Industry Group*	Description	Factor
A	Agricultural Products	0.95
A	Auto Repair/Garages	0.95
A	Logging/Sawmills	0.95
A	Quarries/Gravel Pits/Mining	0.95
A	Sanitary Services/Waste Removal/Junkyards	0.95
A	Trucking	0.95
B	Accounting/Engineering/Research/Consulting Services	1.15
B	Advertising	1.15
B	Auto Dealerships	1.15
B	Embassies/Consulates	1.15
B	Law Offices/Legal Services	1.15
B	Professional Athletic Teams/Promoters	1.15
B	Teachers/Schools/School Districts	1.15
D	Dentistry Offices & Sports Teams	1.5
C	Other	1

\*Certain SIC codes may fall into different industry groups.

## Territory Legend

Area	Counties
Territory A	Essex, Hudson, Union
Territory B	Bergen, Passaic
Territory C	Monmouth, Morris, Sussex, Warren
Territory D	Hunterdon, Middlesex, Somerset
Territory E	Burlington, Camden, Mercer
Territory F	Atlantic, Cape May, Ocean, Salem, Cumberland, Gloucester

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## Health Plan Benefits

## Medical Plans

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

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## Horizon MyWay®

## Horizon EXPAND

[Dental Plans](#)

» [Voluntary Dental](#)

[Vision](#)

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[Life & Disability](#)

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## Horizon Vision

Vision care is a worthy investment. Our plans are in place to help detect issues early and provide frame and lens options at affordable prices.

### All Horizon Vision plans offer:

- An annual eye exam, including dilation
- Coverage for eyeglasses and contact lenses
- A higher frame allowance when purchased through Visionworks

#### Vision View Network

- Horizon Vista II
- Horizon Panorama IVA
- Horizon Panorama IVB
- Horizon Expanse V

**More than 111,000 points of access:** Independent eye care professionals, Visionworks, Glasses.com, 1 800 Contacts®, and Befitting as well as additional participating retail providers.<sup>[1]</sup>

#### Vision Select Network

- Horizon Vista III
- Horizon Vista IV
- Horizon Expanse VIIA
- Horizon Expanse VIIB
- Horizon Expanse VIII

**More than 66,000 points of access:** Independent eye care professionals, Visionworks, Glasses.com, 1 800 Contacts®, Befitting, Sam's Club, Walmart and Costco.<sup>[1]</sup>



**Employer Paid (Funded):** An employer must contribute 75% or more to be considered funded.

**Employee Paid (Voluntary):** When an employer contributes less than 75%, the plan is considered voluntary.

For more information, visit [HorizonBlue.com/vision](https://HorizonBlue.com/vision).

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[Advantage Direct Access Health Plans](#)

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### [Horizon MyWay®](#)

### [Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

» [Vision](#)

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1. Horizon Vision plans access Davis Vision's nationwide networks. Network counts are based on data as of 8/2023 and are subject to change.

# Horizon/Davis Vision View Network



Plan	Horizon Vista II	Horizon Panorama IVA	Horizon Panorama IVB	Horizon Expanse V
Frequency – Once Every				
Eye examination including dilation (when professionally indicated)	12 months	12 months	12 months	12 months
Spectacle lenses	12 months	12 months	12 months	12 months
Frame	24 months	12 months	24 months	12 months
Contact lens evaluation, fitting and follow-up care	12 months	12 months	12 months	12 months
Contact lenses (in lieu of eyeglasses)	12 months	12 months	12 months	12 months
Copayments				
Eye examination	\$10	\$10	\$10	\$0
Spectacle lenses	\$25	\$25	\$25	\$10
Contact lens evaluation, fitting and follow-up care	-	\$0 <sup>(1)</sup>	\$0 <sup>(1)</sup>	\$0 <sup>(1)</sup>
Member Charges				
<b>Eyeglass Benefit – Frame</b>				
Non-collection frame allowance (retail) plus a 20% discount <sup>(2)</sup> on any overage	Up to \$100 or \$150 <sup>(2)</sup>	Up to \$130 or \$180 <sup>(2)</sup>	Up to \$130 or \$180 <sup>(2)</sup>	Up to \$150 or up to \$200 <sup>(2)</sup>
Davis Vision Frame Collection <sup>(3)</sup> (in lieu of allowance): Fashion level / Designer level / Premier level	Included / \$15 / \$40	Included / Included / \$25	Included / Included / \$25	Included
Member Charges				
<b>Eyeglass Benefit – Spectacle Lenses</b>				
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any Rx)	Included	Included	Included	Included
Oversize lenses	Included	Included	Included	Included
Tinting of plastic lenses	\$15	Included	Included	Included
Scratch-resistant coating	Included	Included	Included	Included
Polycarbonate lenses <sup>(4)</sup>	\$0 or \$35	\$0 or \$30	\$0 or \$30	Included
Ultraviolet coating	\$15	\$12	\$12	Included
Anti-reflective (AR) coating (standard / premium / ultra / ultimate)	\$40 / \$45 / \$60 / \$85	\$35 / \$48 / \$60 / \$85	\$35 / \$48 / \$60 / \$85	\$35 / \$48 / \$60 / \$85
Progressive lenses (standard / premium / ultra / ultimate)	\$65 / \$105 / \$140 / \$175	\$50 / \$90 / \$140 / \$175	\$50 / \$90 / \$140 / \$175	Included / \$40 / \$90 / \$125
Intermediate-vision lenses	\$30	\$30	\$30	Included
High-index lenses	\$60	\$55	\$55	\$55
Polarized lenses	\$75	\$75	\$75	\$75
Plastic photosensitive lenses	\$70	\$65	\$65	\$65
Scratch Protection Plan: Single vision / Multifocal lenses	\$20 / \$40	\$20 / \$40	\$20 / \$40	\$20 / \$40
Blue Light Filtering	\$15	\$15	\$15	\$15
Contact Lens Benefit (in lieu of eyeglasses)				
Contact lenses: Materials allowance plus a 15% discount <sup>(5)</sup> on any overage	Up to \$100	Up to \$130	Up to \$130	Up to \$150
Evaluation, fitting and follow-up care – standard and specialty lens types	15% discount <sup>(5)</sup>	15% discount <sup>(5)</sup>	15% discount <sup>(5)</sup>	15% discount <sup>(5)</sup>
Collection Contact Lenses <sup>(3)</sup> (in lieu of allowance)				
– Disposable	-	4 boxes/multipacks	4 boxes/multipacks	8 boxes/multipacks
– Planned replacement	-	2 boxes/multipacks	2 boxes/multipacks	4 boxes/multipacks
– Evaluation, fitting and follow-up care	-	Included	Included	Included
Medically required contact lenses (with prior approval) Materials, evaluation, fitting and follow-up care	Included	Included	Included	Included

1. \$0 copay only applies when member purchases from the collection of contact lenses.

2. Enhanced \$50 frame allowance is available at all Visionworks locations nationwide.

3. Davis Vision Collection is available at most participating independent provider offices. Collection is subject to change.

This document is for informational purposes only and does not constitute a binding agreement. Please note that rates are subject to change. Contact Horizon for the most current rates.

4. Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

5. Discount not applicable at Walmart, Sam's Club or Costco.

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## Quick Resource Guide





# Horizon/Davis Vision Select Network



Plan	Horizon Vista III	Horizon Vista IV	Horizon ExpansE VIIA	Horizon ExpansE VIIB	Horizon ExpansE VIII
Frequency – Once Every					
Eye examination including dilation (when professionally indicated)	12 months	12 months	12 months	12 months	12 months
Spectacle lenses	12 months	12 months	12 months	12 months	12 months
Frame	12 months	24 months	12 months	24 months	24 months
Contact lens evaluation, fitting and follow-up care	12 months	12 months	12 months	12 months	12 months
Contact lenses (in lieu of eyeglasses)	12 months	12 months	12 months	12 months	12 months
Copayments					
Eye examination	\$0	\$10	\$0	\$10	\$10
Spectacle lenses	\$10	\$25	\$10	\$25	\$25
Contact lens evaluation, fitting and follow-up care	n/a	n/a	\$0 <sup>(1)</sup>	\$0 <sup>(1)</sup>	\$0 <sup>(1)</sup>
Member Charges					
<b>Eyeglass Benefit – Frame</b>					
Non-collection frame allowance (retail) plus a 20% discount <sup>(2)</sup> on any overage	Up to \$100 or \$150 <sup>(2)</sup>	Up to \$100 or \$150 <sup>(2)</sup>	Up to \$150 or \$200 <sup>(2)</sup>	Up to \$150 or \$200 <sup>(2)</sup>	Up to \$150 or \$200 <sup>(2)</sup>
Davis Vision Frame Collection <sup>(3)</sup> (in lieu of allowance): Fashion level / Designer level / Premier level	Included / \$15 / \$40	Included / \$15 / \$40	Included	Included	Included
Member Charges					
<b>Eyeglass Benefit – Spectacle Lenses</b>					
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any Rx)		Included	Included	Included	Included
Oversize lenses		Included	Included	Included	Included
Tinting of plastic lenses		\$15	Included	Included	Included
Scratch-resistant coating		Included	Included	Included	Included
Polycarbonate lenses (children <sup>(4)</sup> / adults)		\$0 / \$35	Included	Included	Included
Ultraviolet coating		\$15	Included	Included	Included
Anti-reflective (AR) coating (standard / premium / ultra / ultimate)		\$40 / \$55 / \$69 / \$85	\$35 / \$48 / \$60 / \$85	\$35 / \$48 / \$60 / \$85	\$0 / \$0 / \$0 / \$85
Progressive lenses (standard / premium / ultra / ultimate)		\$65 / \$105 / \$140 / \$175	Included / \$40 / \$90 / \$125	Included / \$40 / \$90 / \$125	\$0 / \$0 / \$0 / \$175
Intermediate-vision lenses		\$30	Included	Included	Included
High-index lenses		\$60	\$55	\$55	Included
Polarized lenses		\$75	\$75	\$75	Included
Plastic photosensitive lenses		\$70	\$65	\$65	Included
Scratch Protection Plan: Single vision / Multifocal lenses		\$20 / \$40	\$20 / \$40	\$20 / \$40	\$20 / \$40
Blue Light Filtering		\$15	\$15	\$15	\$15
<b>Contact Lens Benefit (in lieu of eyeglasses)</b>					
Non-collection contact lenses: Materials allowance	Up to \$100 plus a 15% discount <sup>(5)</sup> on any overage		Up to \$150 plus a 15% discount <sup>(5)</sup> on any overage		
Evaluation, fitting and follow-up care – standard and specialty lens types	15% discount		15% discount		
<b>Collection Contact Lenses<sup>(3)</sup> (in lieu of allowance)</b>					
– Disposable		n/a	Up to 8 boxes/multipacks		
– Planned Replacement		n/a	Up to 4 boxes/multipacks		
– Evaluation, fitting and follow-up care		n/a	Included		
Medically required contact lenses (with prior approval) Materials, evaluation, fitting and follow-up care		Included	Included		

1. \$0 copay only applies when member purchases from the collection of contact lenses.

2. Enhanced \$50 frame allowance is available at all Visionworks locations nationwide.

3. Davis Vision Collection is available at most participating independent provider offices. Collection is subject to change.

This document is for informational purposes only and does not constitute a binding agreement. Please note that rates are subject to change. Contact Horizon for the most current rates.

4. Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

5. Discount not applicable at Walmart, Sam's Club or Costco.



## [Why Horizon](#)

## [BlueCard®](#)

## [OMNIA<sup>SM</sup> Health Plans](#)

## [Health Plan Benefits](#)

## [Medical Plans](#)

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

## [Horizon Level Select](#)

## [Horizon MyWay®](#)

## [Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

» [Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

## [Quick Resource Guide](#)

# Horizon Vision

## Out-of-Network Reimbursement Schedule

Your employees will always save the most when they use in-network vision professionals. If they use a vision professional from outside the network, they will need to pay in full at the time of service and submit a claim for reimbursement. Horizon Vision offers the following reimbursement schedule for all plans.

Service	Reimbursement up to:
Eye examination	\$40
Single-vision lenses	\$40
Frame	\$50
Bifocal/progressive lenses	\$60
Trifocal lenses	\$80
Lenticular lenses	\$100
Elective contact lenses	\$105 (\$80 for Vista plans)
Medically required contact lenses	\$225



### LASIK Discounts

Horizon Vision members enjoy lower prices on LASIK procedures than those offered by other carriers, along with flexible financing options – up to 12 months interest free. Horizon Vision members can save 40 to 50 percent off the national average for traditional LASIK at one of the more than 1,000 locations across our nationwide network of laser vision correction providers.<sup>[1]</sup>

1. Laser vision correction services are administered by QualSight, LLC. Terms and conditions are subject to change. This document is for informational purposes only and does not constitute a binding agreement. Please note that rates are subject to change. Contact Horizon for the most current rates.

[Why Horizon](#)

[BlueCard®](#)

[OMNIA<sup>SM</sup> Health Plans](#)

[Health Plan Benefits](#)

[Medical Plans](#)

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

[Horizon Level Select](#)

[Horizon MyWay®](#)

[Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

» [Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

[Quick Resource Guide](#)

# Horizon/Davis Vision View Network



Horizon Vista II	
Premium Rates (Voluntary)	
Employee Only	\$5.26
Employee + Spouse	\$10.54
Employee + Child(ren)	\$11.06
Employee + Family	\$15.43
Premium Rates (Funded)	
Employee Only	\$3.62
Employee + Spouse	\$7.24
Employee + Child(ren)	\$7.60
Employee + Family	\$10.61

Horizon Panorama IVA	
Premium Rates (Voluntary)	
Employee Only	\$7.57
Employee + Spouse	\$15.15
Employee + Child(ren)	\$15.91
Employee + Family	\$22.19
Premium Rates (Funded)	
Employee Only	\$4.45
Employee + Spouse	\$8.90
Employee + Child(ren)	\$9.35
Employee + Family	\$13.04

Horizon Expanse V	
Premium Rates (Voluntary)	
Employee Only	\$11.18
Employee + Spouse	\$22.36
Employee + Child(ren)	\$23.48
Employee + Family	\$32.77
Premium Rates (Funded)	
Employee Only	\$7.87
Employee + Spouse	\$15.74
Employee + Child(ren)	\$16.53
Employee + Family	\$23.06

Horizon Panorama IVB	
Premium Rates (Voluntary)	
Employee Only	\$6.21
Employee + Spouse	\$12.44
Employee + Child(ren)	\$13.05
Employee + Family	\$18.21
Premium Rates (Funded)	
Employee Only	\$4.28
Employee + Spouse	\$8.56
Employee + Child(ren)	\$8.99
Employee + Family	\$12.54

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## Why Horizon

### BlueCard®

### OMNIA<sup>SM</sup> Health Plans

### Health Plan Benefits

### Medical Plans

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

### Horizon Level Select

### Horizon MyWay®

### Horizon EXPAND

[Dental Plans](#)

[Voluntary Dental](#)

» [Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

### Quick Resource Guide

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# Horizon/Davis Vision Select Network



Horizon Vista III	
Premium Rates (Voluntary)	
Employee Only	\$6.39
Employee + Spouse	\$12.79
Employee + Child(ren)	\$13.43
Employee + Family	\$18.73
Premium Rates (Funded)	
Employee Only	\$4.71
Employee + Spouse	\$9.42
Employee + Child(ren)	\$9.89
Employee + Family	\$13.80

Horizon Expense VIIA	
Premium Rates (Voluntary)	
Employee Only	\$9.38
Employee + Spouse	\$18.76
Employee + Child(ren)	\$19.69
Employee + Family	\$27.48
Premium Rates (Funded)	
Employee Only	\$6.54
Employee + Spouse	\$13.08
Employee + Child(ren)	\$13.73
Employee + Family	\$19.16

Horizon Expense VIII	
Premium Rates (Voluntary)	
Employee Only	\$9.89
Employee + Spouse	\$19.79
Employee + Child(ren)	\$20.78
Employee + Family	\$28.98
Premium Rates (Funded)	
Employee Only	\$6.88
Employee + Spouse	\$13.76
Employee + Child(ren)	\$14.45
Employee + Family	\$20.16

Horizon Vista IV	
Premium Rates (Voluntary)	
Employee Only	\$4.55
Employee + Spouse	\$9.10
Employee + Child(ren)	\$9.55
Employee + Family	\$13.33
Premium Rates (Funded)	
Employee Only	\$3.18
Employee + Spouse	\$6.36
Employee + Child(ren)	\$6.68
Employee + Family	\$9.32

Horizon Expense VIIB	
Premium Rates (Voluntary)	
Employee Only	\$7.12
Employee + Spouse	\$14.23
Employee + Child(ren)	\$14.93
Employee + Family	\$20.84
Premium Rates (Funded)	
Employee Only	\$4.96
Employee + Spouse	\$9.92
Employee + Child(ren)	\$10.42
Employee + Family	\$14.53

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## Why Horizon

### BlueCard®

### OMNIA<sup>SM</sup> Health Plans

### Health Plan Benefits

### Medical Plans

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

### Horizon Level Select

### Horizon MyWay®

### Horizon EXPAND

[Dental Plans](#)

[Voluntary Dental](#)

» [Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

### Quick Resource Guide

This document is for informational purposes only and does not constitute a binding agreement. Please note that rates are subject to change. Contact Horizon for the most current rates.



## Health Plus Plan

Consolidating benefits and simplifying processes is one step away with this benefit plan. It's a comprehensive package with competitive rates.



### Dental

We offer one of the largest dental networks in New Jersey.

- Access to some of the deepest discounts in the state
- Little to no out-of-pocket expenses for preventive services



### Vision

The View network has more than 100,000 points of access which include independent eye care professionals, Visionworks, 1 800 Contacts®, Glasses.com and Befitting as well as additional participating retail providers.

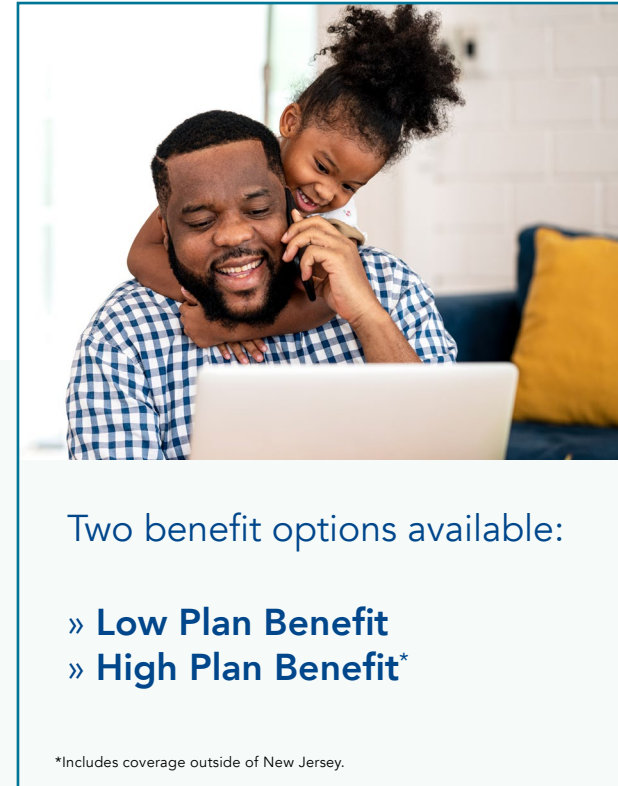
- Low-cost annual eye exam, including dilation
- Coverage for eyeglasses and contact lenses



### Life/AD&D

USABLE Life's Small Group Plans for Life and Accidental Death & Dismemberment provide a quality benefits package while maintaining your bottom line.

*Health Plus Plans are not Affordable Care Act (ACA) certified*



Two benefit options available:

- » **Low Plan Benefit**
- » **High Plan Benefit\***

\*Includes coverage outside of New Jersey.

Contact your Horizon Account Representative or Broker, or visit [HorizonBlue.com](https://HorizonBlue.com).

[Why Horizon](#)

[BlueCard®](#)

[OMNIA<sup>SM</sup> Health Plans](#)

[Health Plan Benefits](#)

[Medical Plans](#)

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

[Horizon Level Select](#)

[Horizon MyWay®](#)

[Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

» [Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

[Quick Resource Guide](#)

# Health Plus Plan Benefits – Low Option



Horizon Dental Benefits

Benefit	Low Option	
	Under 19 in network	Age 19 in network
Plan	<b>Horizon Family Grins</b>	
Coinsurance	100/80/50%	100%/Discount/Discount
Annual Maximum	None	None
MOOP	\$400/\$800	None
Benefit		
Deductible Preventive/Diagnostic	\$25 preventive	None
Deductible Basic/Major	\$100/\$200 Class II & III	None
Preventive & Diagnostic	100%; deductible applies	100%
Minor Restorative	80%; deductible applies	100%
Endodontics/Periodontics/Oral Surgery	80%; deductible applies	Discount
Major Care	50%; deductible applies	Discount
Orthodontia (Medically Necessary)	50%; MOOP applies	n/a
Orthodontia (Cosmetic)	50%	n/a
Cosmetic Orthodontia Lifetime Maximum	\$1,000	n/a
Benefit Waiting Periods	None	None

If you require coverage outside of New Jersey, you must select the High Option.

Horizon Vision Benefits

Benefit	Low Option
Plan	<b>Vista II</b>
Eye Exam (Every Year)	\$10 copay
Spectacle Lens (Every Year)	\$25 copay
Eyeglass Frame (Every Other Year)	\$100 allowance or \$150 at Visionworks
Contact Lens in Lieu of Eyeglasses (Every Year)	\$100 allowance

USABLE Life Insurance

Benefit	Small Group Plan
Work Requirement	Active full-time employees working 25 hours or more per week
Employee Life and AD&D Benefit	\$25,000
Dependent Life Benefits	
Eligible Spouse	\$5,000*
Eligible Child(ren) to age 26	\$2,000*

\*\$100 from 14 days to 6 months.  
Benefits for employees reduce to 65% at age 65 and reduce to 50% of the pre-age 65 amount at age 70. All amounts of coverage are issued on a guaranteed basis.

## Plan Rates – Low Option\*

Enrolled Group Size	Single	Two Adults	Parent & Child	Family
2-4	\$22.74	\$38.23	\$57.98	\$80.65
5-9	\$20.69	\$32.33	\$45.31	\$65.15
10-24	\$19.07	\$29.36	\$40.43	\$57.62
25-50	\$17.95	27.31	\$32.81	\$45.82

\*The life rate is \$8.50 per employee per month, which is included in the rates above for the high option. Rates are guaranteed for two years from the initial effective date of the policy. Please note that the initial bill, as well as all future billing and administration for the Life/AD&D portion of this plan, will be administered directly by USABLE Life.

This document is for informational purposes only and does not constitute a binding agreement. Please note that rates are subject to change. Contact Horizon for the most current rates.

Contact your Horizon Account Representative or Broker, or visit [HorizonBlue.com](https://HorizonBlue.com).

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### BlueCard®

### OMNIA<sup>SM</sup> Health Plans

### Health Plan Benefits

### Medical Plans

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

### Horizon Level Select

### Horizon MyWay®

### Horizon EXPAND

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

» [Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

### Quick Resource Guide



# Health Plus Plan Benefits – High Option



Horizon Dental Benefits

Benefit	High Option	
	Under 19 in network	Age 19 in & out of network
Plan	Horizon Family Grins Plus	
Coinsurance	100/80/50%	100/80/50%
Annual Maximum	None	\$1,500
MOOP	\$400/\$800	None
Benefit		
Deductible Preventive/Diagnostic	\$25 preventive	\$0
Deductible Basic/Major	\$100/\$200 Class II & III	\$50/\$150
Preventive & Diagnostic	100%; deductible applies	100%
Minor Restorative	80%; deductible applies	80%; deductible applies
Endodontics/Periodontics/Oral Surgery	80%; deductible applies	80%; deductible applies
Major Care	50%; deductible applies	50%; deductible applies
Orthodontia (Medically Necessary)	50%; MOOP applies	n/a
Orthodontia (Cosmetic)	50%	n/a
Cosmetic Orthodontia Lifetime Maximum	\$1,000	n/a
Benefit Waiting Periods	None	None

If you require coverage outside of New Jersey, you must select the High Option.

Horizon Vision Benefits

Benefit	High Option
Plan	Panorama IVB
Eye Exam (Every Year)	\$10 copay
Spectacle Lens (Every Year)	\$25 copay
Eyeglass Frame (Every Other Year)	\$130 allowance or \$180 at Visionworks
Contact Lens in Lieu of Eyeglasses (Every Year)	\$130 allowance

USABLE Life Insurance

Benefit	Small Group Plan
Work Requirement	Active full-time employees working 25 hours or more per week
Employee Life and AD&D Benefit	\$25,000
Dependent Life Benefits	
Eligible Spouse	\$5,000*
Eligible Child(ren) to age 26	\$2,000*

\*\$100 from 14 days to 6 months.  
Benefits for employees reduce to 65% at age 65 and reduce to 50% of the pre-age 65 amount at age 70. All amounts of coverage are issued on a guaranteed basis.

## Plan Rates – High Option\*

Enrolled Group Size	Single	Two Adults	Parent & Child	Family
2-4	\$43.92	\$80.56	\$85.56	\$130.16
5-9	\$39.41	\$66.61	\$66.67	\$106.80
10-24	\$35.88	\$60.17	\$59.41	\$95.04
25-50	\$33.65	\$56.10	\$48.94	\$79.05

\*The life rate is \$8.50 per employee per month, which is included in the rates above for the high option. Rates are guaranteed for two years from the initial effective date of the policy. Please note that the initial bill, as well as all future billing and administration for the Life/AD&D portion of this plan, will be administered directly by USABLE Life.

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## Why Horizon

[BlueCard®](#)

[OMNIA<sub>SM</sub> Health Plans](#)

[Health Plan Benefits](#)

[Medical Plans](#)

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

[Horizon Level Select](#)

[Horizon MyWay®](#)

[Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

» [Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

[Quick Resource Guide](#)



## Additional Coverage

Expand your coverage and consolidate expenses with these additional options.



### Life & Disability

USABLE Life's Small Group Plans for Life and Accidental Death & Dismemberment offer employers with 2 to 50 employees the ability to provide a quality benefits package while maintaining your bottom line.

For more information, contact your Horizon Account Manager.



### International Medical Coverage

With international medical coverage, Horizon can give you peace of mind about getting care if you need it while outside the United States. Through our collaboration with GeoBlue®, a leader and innovator in international health coverage, you have access to doctors and hospitals around the world with plans designed for a single trip, frequent traveling or long term/Expat.

Learn more at [GeoBlueTravelInsurance.com/horizontravel](https://www.geoblue.com/horizontravel).



### Pet Insurance\*

Horizon members have access to discounted pet insurance plans from ASPCA, an advocate for animal welfare and a leader in the pet insurance industry. Members receive a 10% discount on coverage so they can give their pets the best care possible without worrying about overwhelming medical bills.

Learn more at [ASPCAPetInsurance.com/horizonbcsnj](https://www.aspcapetinsurance.com/horizonbcsnj).

\*Pet Insurance is not a Horizon product. Horizon members enjoy a discount. Pre-existing conditions are not covered. Coverage for prescription food does not include prevention or general health maintenance (including weight loss). Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms and conditions visit [aspcapetinsurance.com/terms](https://www.aspcapetinsurance.com/terms). Customers enrolled on product Levels 1-4 should visit the Member Center for their policy benefits. Products, rates and discounts may vary and are subject to change.

[Why Horizon](#)

[BlueCard®](#)

[OMNIA<sub>SM</sub> Health Plans](#)

[Health Plan Benefits](#)

[Medical Plans](#)

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

[Horizon Level Select](#)

[Horizon MyWay®](#)

[Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

» [Life & Disability](#)

» [International Medical](#)

» [Pet Insurance](#)

[Quick Resource Guide](#)



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Behavioral Health Care: [HorizonBlue.com/behavioralhealth](https://horizonblue.com/behavioralhealth) or call **1-800-626-2212**, 24/7

Doctor & Hospital Finder: [HorizonBlue.com/doctorfinder](https://horizonblue.com/doctorfinder)

Blue National Doctor & Hospital Finder: [provider.bcbs.com](https://provider.bcbs.com) or call BlueCard Access at **1-800-810-BLUE (2583)**



## Pharmacy:

Pharmacy: [myprime.com](https://myprime.com) or call **1-877-627-6337 (TTY 711)** Monday through Friday, from 8 a.m. to 8 p.m. Eastern Time

Rx Savings Solutions: [HorizonBlue.com/rxss](https://horizonblue.com/rxss)

Amazon Pharmacy home delivery of 90-day supplies of prescriptions: [Amazon.com/horizonblue](https://amazon.com/horizonblue)



## Health & Wellness:

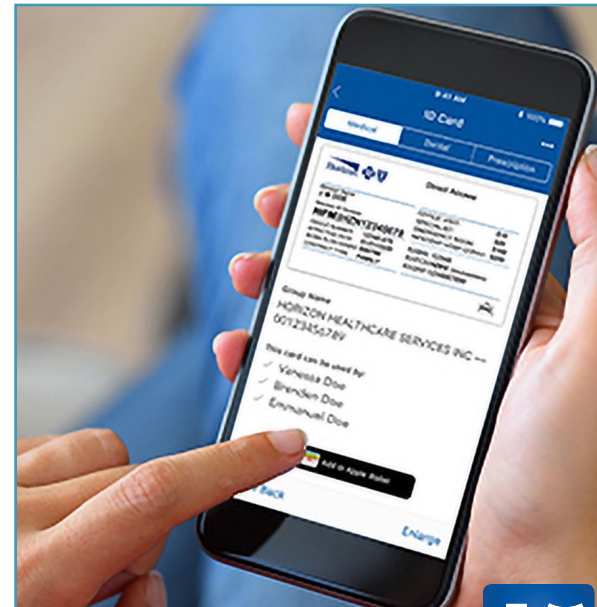
Blue365<sup>®</sup> Healthy Living Discounts: [Blue365deals.com/horizonbcbs](https://blue365deals.com/horizonbcbs)

Chronic Care Programs: [HorizonBlue.com/chronic-care](https://horizonblue.com/chronic-care)

My Health Manager powered by WebMD<sup>®</sup>: [HorizonBlue.com/mhm](https://horizonblue.com/mhm)

PRECIOUS ADDITIONS<sup>®</sup> for parents-to-be: [HorizonBlue.com/preciousadditions](https://horizonblue.com/preciousadditions)

**24/7 Nurse Line:** call **1-888-624-3096**.



Text **GetApp** to **422-272** to download the Horizon Blue app.\*



\*There is no charge to download the Horizon Blue app, but rates from your wireless provider may apply.

[Why Horizon](#)

[BlueCard<sup>®</sup>](#)

[OMNIA<sup>SM</sup> Health Plans](#)

[Health Plan Benefits](#)

[Medical Plans](#)

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

[Horizon Level Select](#)

[Horizon MyWay<sup>®</sup>](#)

[Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

» [Quick Resource Guide](#)

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## [Why Horizon](#)

## [BlueCard®](#)

## [OMNIA<sup>SM</sup> Health Plans](#)

## [Health Plan Benefits](#)

## [Medical Plans](#)

[OMNIA Health Plans](#)

[Advantage EPO Health Plans](#)

[Advantage Direct Access Health Plans](#)

## [Horizon Level Select](#)

## [Horizon MyWay®](#)

## [Horizon EXPAND](#)

[Dental Plans](#)

[Voluntary Dental](#)

[Vision](#)

[Health Plus Plan](#)

[Life & Disability](#)

[International Medical](#)

[Pet Insurance](#)

## [Quick Resource Guide](#)