Association Member Trust℠
More Options. More Health.

MyWay HSA Horizon Direct Access 100% - Plan 620/630

BENEFIT DESCRIPTION

Benefit	Network	Non-Network
Deductible (Calendar year)	$1,700 single coverage/ $3,400 multiple coverage True Family Aggregate	No Benefit
Hospital Pre Certification and Utilization Review is required for all hospital admissions.		
Hospital		
Medical Emergency/Accidental Injury	100% after deductible and $150 Co-Pay	No Benefit for non-emergency diagnosis, true emergency diagnosis covered at the In-Network level
Facility Charges	100% after deductible, Subject to Pre-Approval and Per Admission Co-Pay	No Benefit
Professional Office Care	100% after deductible and up to $50 Co-Pay	No Benefit
Professional Care (Out-Patient)	100% after deductible	No Benefit
Skilled Nursing Facility	100% after deductible 100 Visits a year	No Benefit
Home Health Agency Care	100% after deductible	No Benefit
Hospice Care	100% after deductible	No Benefit
Physician Services		
Surgical Services	100% after deductible / Out-Patient 100% after deductible and $150 Co-Pay	No Benefit
In-Patient Services	100% after deductible	No Benefit
Primary Care Physician	100% after deductible and $25 Co-Pay	No Benefit
Specialist Services	100% after deductible and $50 Co-Pay	No Benefit
Preventive Care		
Immunizations, out-patient well baby care and periodic health exams	100% covered	No Benefit
Therapy Services		
Therapeutic Manipulation	100% after deductible and $25 Co-Pay 30 Visits a year	No Benefit
Respiratory	100% after deductible and $50 Co-Pay 30 Visits a year	No Benefit
Cognitive, Occupational, Physical, Speech	100% after deductible and $50 Co-Pay 60 Visits a year per Therapy	No Benefit
Chelation	100% after deductible and $50 Co-Pay	No Benefit
Chemotherapy, Dialysis, Infusion, Radiation Treatment	100% after deductible	No Benefit

Benefit	Network	Non-Network
Mental Health/Substance Abuse		
All Mental Health/Substance Abuse Care services must be coordinated through the Horizon BCBSNJ/Value Options. Mental Illness and Substance Abuse will be paid as any other medical condition pursuant to the NJ State mandate.		
In-Patient Services	100% after deductible, Subject to Pre-Approval and Per Admission Co-Pay	No Benefit
Out-Patient Services	100% after deductible	No Benefit
In-Patient Medical Visits	100% after deductible	No Benefit
Other services		
Anesthesia	100% after deductible	No Benefit
Ambulance (Air & Ground transportation only)	100% after deductible	No Benefit
Durable Medical Equipment	100% after deductible	No Benefit
Diagnostic X-Ray and Lab	100% after deductible	No Benefit
MRI / Cat Scan	100% after deductible and $150 Co-Pay	No Benefit
Infertility (Excludes In-Vitro Fertilization)	100% after deductible Subject to Pre-Approval	No Benefit
Private Duty Nursing	100% after deductible 30 Visits per year	No Benefit
Nutrition Counseling	100% after deductible and $50 Co-Pay 3 Visits per year	No Benefit
Vision Care	100% after deductible and $50 Co-Pay 1 Eye Examination and 1 Vision Survey per year	No Benefit
Vision Hardware Coverage	$50 allowance in a two-calendar year period	No Benefit
Prescription Drugs (Generic/Brand/Non-Preferred)	Subject to deductible and $15/$35/$50 copay for 30-day supply. Up to 90-day supplies are available through the mail order service subject to deductible and up to 3 times the applicable co-payment amount. Prior authorization may be required. Additional charges apply when using an out-of-network pharmacy.	
NETWORK	Horizon BCBSNJ's payment for eligible expenses when services are obtained from one of the providers in the Managed Care Network. Horizon BCBSNJ reimburses both Primary Care physicians and Specialist at the applicable allowance on a fee for service basis.	
NON-NETWORK EXPENSES	No Benefit	
PER-ADMISSION CO-PAY	$250 Co-Pay per day up to 5 days per admission 2 admission Co-Pay max per year	
COINSURANCE	In Network Eligible Expenses - 100%.	
MAXIMUM OUT OF POCKET (MOOP)	In-Network MOOP - $4,500 single / $9,000 multiple. 100% thereafter.	
For complete information & verification of all your benefits, refer to your benefits certificate. In the event a conflict exists between the information contained on this benefit description and the actual terms of the group contract, the terms of the contract will prevail. For further information on your contract, you may call customer service at (973) 379-1090.		
Plan 620/630	**BANKING/NON-BANKING HSA**	**Effective Date 01-01-2026**