Association Member Trust℠
More Options. More Health.

MyWay HSA Horizon Direct Access 80/60 - Plan 609/639

BENEFIT DESCRIPTION

Benefit	Network	Non-Network
Deductible (Calendar year)	$2,500 single coverage/ $5,000 multiple coverage	$7,500 single coverage/ $15,000 multiple coverage
	True Family Aggregate	
Hospital Pre Certification and Utilization Review is required for all hospital admissions.		
Hospital		
Medical Emergency/Accidental Injury	80% after deductible	80% after deductible Non-Network Non-Emergency 60% after Deductible
Facility Charges	80% after deductible	60% after deductible
	Subject to Pre-Approval	
Professional Office Care	100% after deductible	60% after deductible
Professional Care (Out-Patient)	80% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible 100 day a year	60% after deductible 60 day a year
Home Health Agency Care	80% after deductible	60% after deductible
Hospice Care	80% after deductible	60% after deductible
	30 days max	
Physician Services		
Surgical Services	80% after deductible	60% after deductible
In-Patient Services	80% after deductible	60% after deductible
Primary Care Physician	100% after deductible	60% after deductible
Specialist Services	100% after deductible	60% after deductible
Preventive Care		
Immunizations, out-patient well baby care and periodic health exams	100% covered	60% covered
Payment Limits per Calendar Year		
Therapeutic Manipulation	80% after deductible	60% after deductible
	Combined Network/Non-Network: 30 Visits a year	
Respiratory	100% after deductible / Out-Patient 80% after deductible	60% after deductible
	Combined Network/Non-Network: 30 Visits a year	
Cognative, Occupational, Physical, Speech	100% after deductible / Out-Patient 80% after deductible	60% after deductible
	Combined Network/Non-Network: 60 Visits a year for each therapy	
Chelation, Chemotherapy, Dialysis, Infusion, Radiation Treatment	100% after deductible / Out-Patient 80% after deductible	60% after deductible

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	80% after deductible	60% after deductible
	Subject to Pre-Approval	
Out-Patient Services	80% after deductible	60% after deductible
In-Patient Medical Visits	80% after deductible	60% after deductible
Other services		
Anesthesia	80% after deductible	60% after deductible
Ambulance (Air & Ground transportation only)	80% after deductible	60% after deductible
Durable medical equipment	80% after deductible	60% after deductible
Diagnostic X-Ray and Lab	80% after deductible	60% after deductible
Infertility (Excludes In-Vitro Fertilization)	80% after deductible	60% after deductible
	Subject to Pre-Approval	
Private Duty Nursing	80% after deductible	60% after deductible
	Combined Network/Non-Network: 30 Visits a year	
Nutrition Counseling	80% after deductible	60% after deductible
	30 Visits per year	
Vision Care	100% after deductible	60% after deductible
	1 Eye Examination and 1 Vision Survey per year	
Vision Hardware Coverage	$50 allowance in a two-calendar year period	
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	Horizon BCBSNJ's payment for eligible services that are not obtained from one of the providers in the Managed Care Network. The member may see any physician if he/she is willing to pay a greater share of the costs. Horizon BCBSNJ reimburses participating providers at the applicable allowance. Non-network providers are reimbursed up to our applicable allowance and may balance bill to charges. The member is responsible for complying with all utilization review and cost containment.	
COINSURANCE	In Network Eligible Expenses - 80% / Out of Network Eligible Expenses - 60% coinsurance for Eligible Expenses.	
MAXIMUM OUT OF POCKET (MOOP)	In-Network MOOP - $4,500 single / $9,000 multiple. 100% thereafter. Out of Network MOOP - $7,500 single / $15,000 multiple.	
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 609/639	**BANKING/NON-BANKING HSA**	**Effective Date 11-01-2025**