



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work®

Horizon *My Way* HSA

Direct Access 100/80/60 (\$30/\$50)

Benefit Highlight

Office Visit Copayment	Deductible	Maximum Out of Pocket Network	Maximum Out of Pocket Out-of-Network
\$30/\$50	\$2,500	\$5,000	\$7,500
<p>Family deductible is two times the individual and is a true family aggregate. The true family aggregate requires the entire family deductible to be met before the covered family members are in benefits. The family Maximum Out of Pocket (MOOP) is two times the individual MOOP and is a true family aggregate. A family may meet the true family aggregate MOOP through one covered family member's expenses or a combination of family members' expenses. Once this balance is met, then all covered members in the family are in benefits.</p>			
Benefit	In-Network	Out-of-Network	
Benefit Period Maximum	Unlimited	Unlimited	
Lifetime Maximum	Unlimited	Unlimited	
Primary Care Physician Selection	Not Required		
Physician's Office Visits			
Physician Office Visit	Copayment after deductible	60% after deductible	
	A Primary Care Physician (PCP) is a general or family practitioner, internist or pediatrician.		
Specialist Office Visit	Copayment after deductible	60% after deductible	
	A referral is not required to visit a specialist.		
Maternity Visits (Total obstetrical care includes pre/post-natal visits and delivery.)	Specialist copayment for initial visit only after deductible	60% after deductible	
Allergy Testing and Treatment	Copayment after deductible	60% after deductible	
Preventive Care	100% after copayment	100%	
	\$750 maximum per covered dependent child through end of calendar year in which child turns age 1 year.		
	\$500 maximum per covered person per calendar year. Not subject to deductible or coinsurance.		
Diagnostic Procedures			
Laboratory	100% after deductible	60% after deductible	
Outpatient X-ray/Radiology Services	100% after deductible	60% after deductible	

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Benefit	In-Network	Out-of-Network	
Inpatient Care			
Inpatient Hospital Services (including maternity). Room and board is for a semi-private room or intensive care. All inpatient admissions require prior authorization from Horizon BCBSNJ.	80% after deductible	60% after deductible	
Pre-admission Testing	80% after deductible	60% after deductible	
Inpatient Physician Services	80% after deductible	60% after deductible	
Emergency Care			
Emergency Room	80% after deductible	60% after deductible	
Ambulance	80% after deductible	60% after deductible	
Outpatient Care			
Outpatient Hospital Services	80% after deductible	60% after deductible	
Outpatient/ASC Physician Services	80% after deductible	60% after deductible	
Ambulatory SurgiCenter (ASC)	80% after deductible	60% after deductible	
Mental Health Services			
Inpatient Biologically Based Mental Illness	80% after deductible	60% after deductible	
Outpatient Biologically Based Mental Illness	Office - copayment after deductible Outpatient facility - 80% after deductible	Office - 60% after deductible Outpatient facility - 60% after deductible	
Inpatient Non-Biologically Based Mental Illness/Drug Abuse	80% after deductible	60% after deductible	
	Limited to 30 inpatient days per calendar year combined. One inpatient day may be exchanged for two outpatient visits. Requires pre-approval		
Outpatient Non-Biologically Based Mental Illness/Drug Abuse	80% after deductible	60% after deductible	
	Limited to 20 outpatient days per calendar year combined. One inpatient day may be exchanged for two outpatient visits. Requires pre-approval		
	All Inpatient Non-Biologically Based Mental Health/Substance Abuse Services must be coordinated through Magellan Behavioral Health at 1-800-626-2212 .		
Alcohol Abuse Services			
Inpatient	80% after deductible	60% after deductible	

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Alcohol Abuse Services (cont'd)			
Outpatient Department	80% after deductible	60% after deductible	
Office Setting	Copayment after deductible	60% after deductible	
	Alcohol abuse is treated the same as any other illness.		
Other Services			
Bariatric Surgery Requires pre-approval	80% after deductible	60% after deductible	
Diabetic Education	80% after deductible	60% after deductible	
Diabetics Supplies	80% after deductible Requires pre-approval	60% after deductible Requires pre-approval	
Durable Medical Equipment	Office - copayment after deductible Other - 50% after deductible Requires pre-approval	Office - 60% after deductible Other - 50% after deductible Requires pre-approval	
	\$2,500 maximum per calendar year		
Orthotics and Prosthetics (per New Jersey mandate)	Copayment after deductible	60% after deductible	
Home Health Care	80% after deductible Requires pre-approval	60% after deductible Requires pre-approval	
Hospice Care	80% after deductible Requires pre-approval	60% after deductible Requires pre-approval	
Infertility Certain fertility services are excluded	Office - copayment after deductible Other - 80% after deductible Requires pre-approval	Office - 60% after deductible Other - 60% after deductible Requires pre-approval	
Speech and Cognitive 30-visit limit combined per year	Office - copayment after deductible Other - 80% after deductible	Office - 60% after deductible Other - 60% after deductible	
Physical, Occupational 30-visit limit combined per year	Office - copayment after deductible Other - 80% after deductible	60% after deductible Other - 60% after deductible	
Skilled Nursing Facility/Extended Care Center	80% after deductible 120 days per calendar year	Office - 60% after deductible 120 days per calendar year	
	Must begin within 14 days of preceding hospital stay. Requires pre-approval		
Therapeutic Manipulation 30-visit maximum per calendar year	Office - copayment after deductible Other - 80% after deductible	Office - 60% after deductible Other - 60% after deductible	

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Other Services (cont'd.)		
Vision Screening (Vision exams are not covered, only preventive care screenings for dependents up to age 17 years in his/her pediatrician's office.)	100% after copayment	60% after deductible
Vision Hardware	Not covered	Not covered
Prescription Drugs * All CDHRx charges accumulate to the MOOP.	60% after deductible Prior authorization may be required Advantage Formulary applies.	60% after deductible Prior authorization may be required Advantage Formulary applies.
Eligibility	Coverage for dependents include unmarried children under age 19 years. Full-time students who are enrolled at an accredited school are covered until the day in which he or she turns age 23 years.	
Pre-Existing Conditions	A pre-existing condition is a medical condition diagnosed or treated in the six months prior to the effective date of coverage. This applies to groups of two to five eligible employees and to late enrollees in groups of six or more (those not enrolling within 30 days of being eligible). Prior coverage may be credited toward satisfying the pre-existing condition limitation if that coverage did not lapse more than 90 days prior to the effective date.	
Prior Authorization	Some services/procedures require prior authorization. For a complete list, contact our customer services department at 1-800-355-BLUE (2583) or refer to www.HorizonBlue.com .	

You can save money when you choose to receive care from health care professionals who participate in the Horizon BCBSNJ networks. When you use participating hospitals or other medical facilities or physicians, you generally only pay your copayment and any applicable in-network coinsurance or deductible. If you have services performed at an out-of-network facility or by an out-of-network provider, your out-of-network benefits will apply. This means that you will be responsible for amounts exceeding Horizon BCBSNJ's allowable reimbursement for that particular service and this may result in significant out-of-pocket costs. You will be responsible to pay this amount directly to the nonparticipating hospital, ambulatory surgery center or provider. By using our Horizon BCBSNJ network of health care professionals, you keep your health care costs down.

This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract. Please refer to your benefit booklet for more information.

Additional Information:

1. We will continue to renew coverage at the option of the plan sponsor except for the following reasons: nonpayment of premiums, fraud, violation of contribution or participation rules, withdrawal of this plan from the marketplace or the lack of any enrollee who lives or works in the service area.
2. We require the employer to contribute a minimum of 10 percent to the cost of the group health benefits plan.

3. We require 75 percent of your eligible employees (those working 25 hours or more) to participate in a group plan you offer. Those covered by a spouse's group plan will count toward the 75 percent. All affiliated, subsidiary, commonly owned companies count as one company.
4. A pre-existing condition is a medical condition diagnosed or treated in the six months prior to the effective date of coverage. This applies to groups of two to five eligible employees and to late enrollees in groups of six or more (those not enrolling within 30 days of being eligible). Prior coverage may be credited toward satisfying the pre-existing condition limitation if that coverage did not lapse more than 90 days prior to the effective date.
5. Our service area spans all 21 counties of New Jersey: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union and Warren.

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