

## Horizon PPO 90/80/60 Benefit Highlight

	Office Visit Copayment	Deductible	Maximum Out of Pocket Network	Maximum Out of Pocket Non-Network
<b>Horizon PPO 90/80/60 Plan B</b>	\$0	\$250	\$2,250	\$3,375
	\$0	\$500	\$2,500	\$3,750
	\$0	\$1,000	\$3,000	\$4,500
	\$0	\$2,500	\$4,500	\$6,750
Two deductibles per family. Maximum Out of Pocket is calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket. Prescription copayments do not apply towards the Maximum Out of Pocket.				
Benefit	Network	Out of Network		
<b>Benefit Period Maximum</b>	Unlimited	Unlimited		
<b>Lifetime Maximum</b>	Unlimited	Unlimited		
<b>Primary Care Physician Selection</b>	Not Required			
<b>Doctor's Office Visits</b>				
Physician Office Visits	90%	60% after deductible		
	A primary care physician is a general or family practitioner, internist or pediatrician.			
Specialist Office Services	90%	60% after deductible		
	A referral is not required to visit a specialist.			
Maternity Visits (Total obstetrical care includes pre/post-natal visits and delivery)	80% after deductible	60% after deductible		
Allergy Testing and Treatment	90%	60% after deductible		
<b>Preventive Care</b>				
	100%	100%		
	\$ 750 maximum per covered dependent child through end of calendar year in which child turns one. \$500 maximum per covered person per calendar year. Not subject to deductible or coinsurance.			
<b>Diagnostic Procedures</b>				
Laboratory	Office- 90% Other- 80% after deductible	Office- 60% after deductible Other- 60% after deductible		
Outpatient X-ray/Radiology Services	Office- 90% Other- 80% after deductible	Office- 60% after deductible Other- 60% after deductible		
<b>Inpatient Care</b>				
Inpatient Hospital Services (including maternity) Room & 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 \$200 copayment per day \$1,000 maximum per confinement \$2,000 maximum per calendar year per person		
Pre-admission Testing	80% after deductible	60% after deductible		
Inpatient Physician Services	80% after deductible	60% after deductible		
<b>Emergency Care</b>				
Emergency Room Copayment waived if admitted within 24 hours	80% after deductible and \$50 copayment	60% after deductible and \$50 copayment		
Ambulance	80% after deductible	60% after deductible		
<b>Outpatient Care</b>				
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		
<b>Mental Health Services</b>				
Inpatient Biologically Based Mental Illness	80% after deductible	60% after deductible \$200 copayment per day \$1,000 maximum per confinement \$2,000 maximum per calendar year per person		
Outpatient Biologically Based Mental Illness	Office- 90% Other- 80% after deductible	Office- 60% after deductible Other- 60% after deductible		
Inpatient Non-Biologically Based Mental Illness/Drug Abuse	80% after deductible	60% after deductible \$200 copayment per day \$1,000 maximum per confinement \$2,000 maximum per calendar year per person		
	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.			
<b>Alcohol Abuse Services</b>				
Inpatient	80% after deductible	60% after deductible		
Outpatient department	80% after deductible	60% after deductible		
Office setting	90%	60% after deductible		
	Alcohol abuse is treated the same as any other illness.			



## Horizon PPO 90/80/60 Benefit Highlight *(continued)*

Benefit	Network	Out of Network
<b>Other Services</b>		
Bariatric Surgery <i>Requires pre-approval.</i>	80% after deductible	60% after deductible
Diabetic Education	80% after deductible	60% after deductible
Diabetic Supplies	80% after deductible <i>Requires pre-approval</i>	60% after deductible <i>Requires pre-approval</i>
Durable Medical Equipment	Office- 90% Other- 80% after deductible <i>Requires pre-approval</i>	Office- 60% after deductible Other- 60% after deductible <i>Requires pre-approval</i>
Orthotics & Prosthetics (per NJ mandate)	90%	60% after deductible
Home Health Care	80% after deductible <i>Requires pre-approval</i>	60% after deductible <i>Requires pre-approval</i>
Hospice Care	80% after deductible <i>Requires pre-approval</i>	60% after deductible <i>Requires pre-approval</i>
Infertility <i>Certain fertility services are excluded.</i>	Office -90% Other- 80% after deductible <i>Requires pre-approval</i>	Office- 60% after deductible Other- 60% after deductible <i>Requires pre-approval</i>
Speech and Cognitive <i>30 visit limit combined per year</i>	Office- 90% no deductible applies Other-80% after deductible	Office- 60% after deductible Other- 60% after deductible
Physical and Occupational <i>30 visit limit combined per year</i>	Office- 90% no deductible applies Other- 80% after deductible	Office- 60% after deductible Other- 60% after deductible
Skilled Nursing Facility/Extended Care Center	80% after deductible <i>120 days per calendar year</i> <i>Must begin within 14 days of preceding hospital stay.</i>	60% after deductible <i>120 days per calendar year</i> <i>Requires pre-approval.</i>
Therapeutic Manipulation <i>30 visit maximum per calendar year</i>	Office- 90% no deductible applies Other- 80% after deductible	Office- 60% after deductible Other- 60% after deductible
Vision Screening- <i>(Vision exams are not covered, only preventive care screenings for child dependent up to age 17 in your pediatricians office).</i>	100%	60% after deductible
Vision Hardware	Not covered	
<b>Prescription Drugs</b> <i>*All MMRx charges accumulate to the maximum out of pocket</i> <i>Other prescription options are available.</i> <i>Contact your broker or Horizon BCBSNJ representative for details.</i>	60% after deductible Prior authorization may be required	60% after deductible Prior authorization may be required
<b>Eligibility</b>	Coverage for dependents include unmarried children under the age of 19. Full-time students who are enrolled at an Accredited School, are covered until the day in which he or she turns 23 years of age.	
<b>Pre-Existing Conditions</b>	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.	
<b>Prior Authorization</b>	Some services/procedures require prior authorization. For a complete list, contact our customer service number at <b>1-800-355-BLUE (2583)</b> or refer to <a href="http://www.HorizonBlue.com">www.HorizonBlue.com</a> .	

You can save money when you choose to receive care from providers that participate in the Horizon BCBSNJ networks. When you use participating hospitals or other medical facilities or doctors, 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 for this amount directly to the non-participating hospital, ambulatory surgery center or provider. By using our Horizon-BCBSNJ network providers, 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:**

- 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.
- We require the employer to contribute a minimum of 10 percent to the cost of the group health benefits plan.
- 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.
- 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.
- 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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Three Penn Plaza East, Newark, New Jersey 07105