

Horizon PPO 100/80/60 Plus Benefit Highlight



	Office Visit Copayment	Deductible	Maximum Out of Pocket Network	Maximum Out of Pocket Non-Network
Option 1	\$10, \$20, or \$30	\$1,000	\$3,000	\$4,500
Option 2	\$10, \$20, or \$30	\$1,500	\$3,500	\$5,250
Option 3	\$10, \$20, or \$30	\$2,500	\$4,500	\$6,750
Family deductible and Maximum Out of Pocket are two times the individual amount. 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	In-Network		Out-of-Network	
Benefit Period Maximum	Unlimited		Unlimited	
Lifetime Maximum	Unlimited		Unlimited	
Primary Care Physician Selection	Not Required			
Doctor's Office Visits				
Physician office Visits	100% after copayment		60% after deductible	
	A primary care physician is a general or family practitioner, internist or pediatrician			
Specialist Office Services	100% after copayment		60% after deductible	
	A referral is not required to visit a specialist.			
Maternity Visits (Total obstetrical care includes pre/post-natal visits and delivery)	100% after copayment for initial visit only		60% after deductible \$200 copayment per day \$1,000 maximum per stay \$2,000 maximum per calendar year per person	
Allergy Testing and Treatment	100% after copayment		60% after deductible	
Preventive Care	100% after copayment \$ 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.		100%	
Diagnostic Procedures				
Laboratory	100% after copayment when provided by a participating laboratory		60% after deductible	
Outpatient X-ray/Radiology Services	100% after copayment when provided by a participating radiologist		60% after deductible	
Inpatient Care				
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 stay \$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	
Emergency Care				
Emergency Room Copayment waived if admitted within 24 hours	\$50 copayment and 80% coinsurance No deductible applies		60% after deductible and \$50 copayment	
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 \$200 copayment per day \$1,000 maximum per stay \$2,000 maximum per calendar year per person	
Outpatient Biologically Based Mental Illness	Office- 100% after copayment 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 stay \$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 .			
Alcohol Abuse Services				
Inpatient	80% after deductible		60% after deductible	
Outpatient department	80% after deductible		60% after deductible	
Office setting	100% after copayment		60% after deductible	
	Alcohol abuse is treated the same as any other illness.			

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Benefit	In-Network	Out-of-Network
Other Services		
Bariatric Surgery	80% after deductible Requires pre-approval	60% after deductible Requires pre-approval
Diabetic Education	80% after deductible	60% after deductible
Diabetic Supplies	80% after deductible Requires pre-approval	60% after deductible Requires pre-approval
Durable Medical Equipment	Office-100% after copayment Other- 80% after deductible Requires pre-approval	Office- 60% after deductible Other- 60% after deductible Requires pre-approval
Orthotics & Prosthetics (per NJ mandate)	100% after copayment	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 <i>Certain fertility services are excluded.</i>	Office- 100% after copayment Other- 80% after deductible Requires pre-approval	Office- 60% after deductible Other- 60% after deductible Requires pre-approval
Speech and Cognitive <i>30 visit limit combined per year</i>	Office- 100% after copayment Other- 80% after deductible	Office- 60% after deductible Other- 60% after deductible
Physical and Occupational <i>30 visit limit combined per year</i>	Office- 100% after copayment 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> Must begin within 14 days of preceding hospital stay.	60% after deductible <i>120 days per calendar year</i> Requires pre-approval
Therapeutic Manipulation <i>30 visit maximum per calendar year</i>	Office-100% after copayment 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% after copayment	60% after deductible
Vision Hardware	Not covered	
Prescription Drugs *All MMRx charges accumulate to the maximum out of pocket <i>Other prescription options are available. 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
Eligibility	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.	
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 service number at 1-800-355-BLUE (2583) or refer to www.HorizonBlue.com .	

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:

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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