Horizon PPO 100/80
Benefit Highlight

Horizon Blue Cross Blue Shield of New Jersey
Making Healthcare Work.

Office Visit Copayment	Deductible	Maximum Out of Pocket Network	Maximum Out of Pocket Non-Network
Option 1			
$10	**$250**	**$2,250**	**$2,250**
$10	**$500**	**$2,500**	**$2,500**
$10	**$1,000**	**$3,000**	**$3,000**
Option 2			
$20	**$500**	**$2,500**	**$2,500**
$20	**$1,000**	**$3,000**	**$3,000**

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	80% after deductible
	A primary care physician is a general or family practitioner, internist or pediatrician.	
Specialist Office Services	100% after copayment	80% 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 $25 copayment for initial visit only	80% after deductible
Allergy Testing and Treatment	100% after copayment	80% after deductible
Preventive Care	100% after copayment	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.	
Diagnostic Procedures		
Laboratory	100% when provided by a participating laboratory	80% after deductible
Outpatient X-ray/Radiology Services	100% when provided by a participating radiologist	80% 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. ***A hospital confinement rider can be purchased with this plan. If so, the hospital confinement will be waived** .	**With $10 office visit copayment** $100 hospital inpatient copayment per day $500 maximum per confinement $1,000 maximum per calendar year per person **With $20 office visit copayment** $250 hospital inpatient copayment per day $1,250 maximum per confinement $2,500 maximum per calendar year per person	80% after deductible
Pre-admission Testing	100%	80% after deductible
Inpatient Physician Services	100% after copayment	80% after deductible
Emergency Care		
Emergency Room Copayment waived if admitted within 24 hours	$50 copayment	80% after deductible and $50 copayment
Ambulance	100%	80% after deductible
Outpatient Care		
Outpatient Hospital Services	100%	80% after deductible
Outpatient/ASC Physician Services	100%	80% after deductible
Ambulatory SurgiCenter (ASC)	100%	80% after deductible
Mental Health Services		
Inpatient Biologically Based Mental Illness	100% after hospital inpatient copayment	80% after deductible
Outpatient Biologically Based Mental Illness	100% after copayment	80% after deductible
Inpatient Non-Biologically Based Mental Illness/Drug Abuse	100% after hospital inpatient copayment	75% 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	100% after copayment	75% 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	100% after inpatient copayment	80% after deductible
Outpatient department	100% after copayment	80% after deductible
Office setting	100% after copayment	80% after deductible
	Alcohol abuse is treated the same as any other illness.	

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Horizon
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Benefit	In-Network	Out-of-Network
Other Services		
Bariatric Surgery	100% Requires pre-approval	80% after deductible Requires pre-approval
Diabetic Education	100% after copayment	80% after deductible
Diabetic Supplies	100% Requires pre-approval	80% after deductible Requires pre-approval
Durable Medical Equipment	100% Requires pre-approval	80% after deductible Requires pre-approval
Orthotics & Prosthetics (per NJ mandate)	100% after copayment	80% after deductible
Home Health Care	100% Requires pre-approval	80% after deductible Requires pre-approval
Hospice Care	100% Requires pre-approval	80% after deductible Requires pre-approval
Infertility *Certain fertility services are excluded..*	100% Requires pre-approval	80% after deductible Requires pre-approval
Speech and Cognitive *30 visit limit combined per year*	100% after copayment	80% after deductible
Physical and Occupational *30 visit limit combined per year*	100% after copayment	80% after deductible
Skilled Nursing Facility/Extended Care Center	100% *120 days per calendar year* Must begin within 14 days of preceding hospital stay. Requires pre-approval.	80% after deductible *120 days per calendar year*
Therapeutic Manipulation *30 visit maximum per calendar year*	100% after copayment	80% after deductible
Vision Screening- *(Vision exams are not covered, only preventive care screenings for child dependent up to age 17 in your pediatricians office).*	100% after copayment	80% after deductible
Vision Hardware	Not covered	
Prescription Drugs *All MMRx charges accumulate to the maximum out of pocket *Other prescription options are available. Contact your broker or Horizon BCBSNJ representative for details.*	80% after deductible Prior authorization may be required	80% 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>**.	

* A Hospital Confinement Rider can be purchased with this plan. If so, the hospital confinement will be waived.

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 Warr

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Three Penn Plaza East, Newark, New Jersey 07105