



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work<sup>®</sup>

# Horizon My Way HSA Direct Access 100/70 Benefit Highlight

	Office Visit Copayment	Deductible	Maximum Out of Pocket Network	Maximum Out of Pocket Out-of-Network
Option 1	Not Applicable	\$1,500	\$4,500	\$4,500
Option 2	Not Applicable	\$2,500	\$5,000	\$5,500

**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 family aggregate. There are two ways a family may meet the family aggregate: 1) Every covered person's contribution goes toward the MOOP before all covered persons are in benefits; 2) One covered person may meet the individual MOOP and be in benefits, while the other covered family members contributions meet the balance of the family MOOP. Once this balance is met, then all covered members in the family are in benefits.

Benefit	In-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>		
Primary Care Office Visit	100% after deductible	70% after deductible
	A Primary Care Physician (PCP) is a general or family practitioner, internist or pediatrician.	
Specialist Office Visit	100% after deductible	70% 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 deductible	70% after deductible
Allergy Testing and Treatment	100% after deductible	70% after deductible
Preventive Care	100%	100%
	\$750 maximum per covered dependent child through end of calendar year in which child turns age one year.	
	\$500 maximum per covered person per calendar year. Not subject to deductible or coinsurance.	
<b>Diagnostic Procedures</b>		
Laboratory	100% after deductible when provided by a participating laboratory	70% after deductible
Outpatient X-ray/Radiology Services	100% after deductible when provided by a participating radiologist	70% after deductible

Office Visit Copayment		Deductible	Maximum Out of Pocket Network	Out-of-Network
Option 1	Not Applicable	\$1,500	\$4,500	\$4,500
Option 2	Not Applicable	\$2,500	\$5,000	\$5,500
<p align="center"><b>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 family aggregate. There are two ways a family may meet the family aggregate: 1) Every covered person's contribution goes toward the MOOP before all covered persons are in benefits; 2) One covered person may meet the individual MOOP and be in benefits, while the other covered family members contributions meet the balance of the family MOOP. Once this balance is met, then all covered members in the family are in benefits.</b></p>				
Benefit	In-Network	Out-of-Network		
<b>Inpatient Care</b>				
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.	100% after deductible	70% after deductible		
Pre-admission Testing	100% after deductible	70% after deductible		
Inpatient Physician Services	100% after deductible	70% after deductible		
<b>Emergency Care</b>				
Emergency Room	100% after deductible	70% after deductible		
Ambulance	100% after deductible	70% after deductible		
<b>Outpatient Care</b>				
Outpatient Hospital Services	100% after deductible	70% after deductible		
Outpatient/ASC Physician Services	100% after deductible	70% after deductible		
Ambulatory SurgiCenter (ASC)	100% after deductible	70% after deductible		
<b>Mental Health Services</b>				
Inpatient Biologically Based Mental Illness	100% after deductible	70% after deductible		
Outpatient Biologically Based Mental Illness	100% after deductible	70% after deductible		
Inpatient Non-Biologically Based Mental Illness/Drug Abuse	100% after deductible	70% 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 deductible	70% 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 <b>1-800-626-2212</b> .			
<b>Alcohol Abuse Services</b>				
Inpatient	100% after deductible	70% after deductible		
Outpatient Department	100% after deductible	70% after deductible		

Office Visit Copayment		Deductible	Maximum Network	Out of Pocket Out-of-Network
Option 1	Not Applicable	\$1,500	\$4,500	\$4,500
Option 2	Not Applicable	\$2,500	\$5,000	\$5,500

**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 family aggregate. There are two ways a family may meet the family aggregate: 1) Every covered person's contribution goes toward the MOOP before all covered persons are in benefits; 2) One covered person may meet the individual MOOP and be in benefits, while the other covered family members contributions meet the balance of the family MOOP. Once this balance is met, then all covered members in the family are in benefits.**

Benefit	In-Network	Out-of-Network
<b>Alcohol Abuse Services (cont'd)</b>		
Office Setting	100% after deductible	70% after deductible
	Alcohol abuse is treated the same as any other illness.	
<b>Other Services</b>		
Bariatric Surgery Requires pre-approval	100% after deductible	70% after deductible
Diabetic Education	100% after deductible	70% after deductible
Diabetics Supplies	100% after deductible Requires pre-approval	70% after deductible Requires pre-approval
Durable Medical Equipment	100% after deductible Requires pre-approval	70% after deductible Requires pre-approval
Orthotics and Prosthetics (per New Jersey mandate)	100% after copayment	70% after deductible
Home Health Care	100% after deductible Requires pre-approval	70% after deductible Requires pre-approval
Hospice Care	100% after deductible Requires pre-approval	70% after deductible Requires pre-approval
Infertility Certain fertility services are excluded	100% after deductible Requires pre-approval	70% after deductible Requires pre-approval
Speech and Cognitive 30-visit limit combined per year	100% after deductible	70% after deductible
Physical, Occupational 30-visit limit combined per year	100% after deductible	70% after deductible
Skilled Nursing Facility/Extended Care Center	100% after deductible 120 days per calendar year	70% 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	100% after deductible	70% after deductible

	Office Visit Copayment	Deductible	Maximum Out of Pocket Network	Maximum Out of Pocket Out-of-Network
Option 1	Not Applicable	\$1,500	\$4,500	\$4,500
Option 2	Not Applicable	\$2,500	\$5,000	\$5,500

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 family aggregate. There are two ways a family may meet the family aggregate: 1) Every covered person's contribution goes toward the MOOP before all covered persons are in benefits; 2) One covered person may meet the individual MOOP and be in benefits, while the other covered family members contributions meet the balance of the family MOOP. Once this balance is met, then all covered members in the family are in benefits.

Benefit	In-Network	Out-of-Network
<b>Other Services (cont'd.)</b>		
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%	70% after deductible
Vision Hardware	Not covered	Not covered
Prescription Drugs * All CDHRx charges accumulate to the Maximum Out of Pocket.	70% after deductible Pre-approval may be required. Advantage formulary applies.	70% after deductible Pre-approval 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 <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 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.

**Additional Information** *(cont'd)*:

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.

Services and products provided by Horizon Blue Cross Blue Shield of New Jersey, an independent licensee of the Blue Cross and Blue Shield Association.

® Registered marks of the Blue Cross and Blue Shield Association.

® and SM Registered and service marks of Horizon Blue Cross Blue Shield of New Jersey.

© 2010 Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza East, Newark, New Jersey 07105

7751 (W0110)