



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.®

Horizon Advantage PPO

100%/80%/60%

Benefit Highlight (effective 12/1/09)

Office Visit Copayment	Deductible		Maximum Out of Pocket	
	Network	Out-of-Network	Network	Out-of-Network
\$30/\$50	\$1,500	\$3,000	\$3,000	\$7,500

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.

Benefit	In-Network	Out-of-Network
Benefit Period Maximum	Unlimited	Unlimited
Lifetime Maximum	Unlimited	Unlimited
General Practitioner Selection	Not Required	

Doctor's Office Visits

Primary Care Office Visit	100% after copayment	60% after deductible
	A general practitioner is a general or family practitioner, internist or pediatrician.	
Specialist Office Visit	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 \$25 copayment per pregnancy for initial visit only	60% after deductible
Allergy Testing and Treatment	100% after copayment	60% 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	60% after deductible
Outpatient X-ray/Radiology Services	100% when provided by a participating radiologist	60% after deductible

CT/CTA Scans, Pet Scans, MRIs/MRAs, Nuclear Medicine studies (including Nuclear Cardiology) require prior authorization. The ordering physician should request the prior authorization by calling CareCore National, LLC (CCN) at **1-866-496-6200** and providing the necessary clinical information. Once the authorization number is received, the member may call CCN at **1-866-969-1234** to schedule an appointment.

Office Visit Copayment	Deductible		Maximum Out of Pocket	
	Network	Out-of-Network	Network	Out-of-Network
\$30/\$50	\$1,500	\$3,000	\$3,000	\$7,500

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.

Benefit	In-Network	Out-of-Network
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
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.	\$100 copayment then 80% coinsurance No deductible applies to the Emergency Room facility charges	\$100 copayment then deductible and 60% coinsurance
Ambulance	80% after deductible Pre-approval required on non-emergency transportation.	60% after deductible
Outpatient Care		
Outpatient Hospital Services	80% after deductible	60% after deductible
Outpatient Physician Services	80% after deductible	60% after deductible
Ambulatory SurgiCenter (ASC)/	80% after deductible	60% after deductible Limited to a \$2,000 maximum per person per calendar year.
ASC Physician Services	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 - 100% after copayment Outpatient facility- 80% after deductible	Office- 60% after deductible Other- 60% after deductible
Inpatient Non-Biologically Based Mental Illness/Drug Abuse	80% after deductible Limited to 30 inpatient days per calendar year combined. One inpatient day may be exchanged for two outpatient visits. (Requires pre-approval)	60% after deductible
Outpatient Non-Biologically Based Mental Illness/Drug Abuse	80% 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 .	60% after deductible

Office Visit Copayment	Deductible		Maximum Out of Pocket	
	Network	Out-of-Network	Network	Out-of-Network
\$30/\$50	\$1,500	\$3,000	\$3,000	\$7,500
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.				
Benefit	In-Network		Out-of-Network	
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.			
Other Services				
Bariatric Surgery (Requires Pre-approval)	80% after deductible		60% after deductible	
Diabetic Education	80% after deductible		60% after deductible	
Diabetic Supplies	80% after deductible		60% after deductible	
Durable Medical Equipment	50% coinsurance		50% after deductible	
	Combined limit of \$2,500 per person per calendar year.			
Orthotics & Prosthetics (per NJ mandate)	100% after copayment		60% after deductible	
Home Health Care - Limited to 60 visit maximum per person per calendar year.	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>	100% after copayment in office 80% after deductible for all other Requires pre-approval		Office- 60% after deductible Other- 60% after deductible Requires pre-approval	
Speech & Cognitive 30 visit limit combined per year	Office - 100% after \$30 copayment Other - 80% after deductible		Office - 60% after deductible Other - 60% after deductible	
Physical, Occupational 30 visit limit combined per year	Office - 100% after \$30 copayment Other - 80% after deductible		Office - 60% after deductible Other - 60% after deductible	
Skilled Nursing Facility/ Extended Care Center	80% after deductible 120 days per calendar year		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 benefit period	Office - 100% after \$30 copayment Other - 80% after deductible		Office - 60% after deductible Other - 60% after deductible	
Vision Screening- (Vision exams are not covered, only preventive care screenings for child dependent up to age 17 in your pediatrician's office).	100% after copayment		60% after deductible	
Vision Hardware	Not covered			

Office Visit Copayment	Deductible		Maximum Out of Pocket	
	Network	Out-of-Network	Network	Out-of-Network
\$30/\$50	\$1,500	\$3,000	\$3,000	\$7,500

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.

Benefit	In-Network	Out-of-Network
Prescription Drugs * All MMRx charges accumulate to the maximum out-of-pocket.	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 member services 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 that 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 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:

- 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.

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.

© 2009 Horizon Blue Cross Blue Shield of New Jersey,

Three Penn Plaza East, Newark, New Jersey 07105

27156 (W1109)