



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.®

# Horizon Advantage Direct Access

## 100%/90%/70%

### Benefit Highlight (effective 12/1/09)

Office Visit Copayment	Deductible		Maximum Out of Pocket	
	Network	Out-of-Network	Network	Out-of-Network
\$30/\$50	\$1,000	\$2,500	\$2,500	\$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
<b>Benefit Period Maximum</b>	Unlimited	Unlimited
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Primary Care Physician Selection</b>	Not Required	

#### Doctor's Office Visits

Primary Care Office Visit	100% after copayment	70% after deductible
	A Primary Care Physician (PCP) is a general or family practitioner, internist or pediatrician.	
Specialist Office Visit	100% after copayment	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 copayment \$25 copayment per pregnancy for initial visit only	70% after deductible
Allergy Testing and Treatment	100% after copayment	70% 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	70% after deductible
Outpatient X-ray/Radiology Services	100% when provided by a participating radiologist	70% 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.

*Note: Managed Care members can call **1-866-969-1234** to obtain a confirmation number for non-Advanced Imaging diagnostic procedures. Confirmation numbers from CCN replace the need for a paper referral.*

Office Visit Copayment	Deductible		Maximum Out of Pocket	
	Network	Out-of-Network	Network	Out-of-Network
\$30/\$50	\$1,000	\$2,500	\$2,500	\$7,500
<p><b>Family Deductible and Maximum out of Pocket are two times the individual amount.</b></p> <p><b>Maximum Out of Pocket is calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket.</b></p>				
Benefit	In-Network		Out-of-Network	
<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.	90% after deductible		70% after deductible	
Pre-admission testing	90% after deductible		70% after deductible	
Inpatient Physician Services	90% after deductible		70% after deductible	
<b>Emergency Care</b>				
Emergency Room Copayment waived if admitted within 24 hours	\$100 copayment then 90% coinsurance. No deductible applies to the Emergency Room facility charges.		\$100 copayment then deductible and 70% coinsurance apply.	
Ambulance	90% after deductible Pre-approval required on non-emergency transportation.		70% after deductible	
<b>Outpatient Care</b>				
Outpatient Hospital Services	90% after deductible		70% after deductible	
Outpatient Physician Services	90% after deductible		70% after deductible	
Ambulatory SurgiCenter (ASC)/	90% after deductible		70% after deductible Limited to a \$2,000 maximum per person per calendar year.	
ASC Physician Services	90% after deductible		70% after deductible	
<b>Mental Health Services</b>				
Inpatient Biologically Based Mental Illness	90% after deductible		70% after deductible	
Outpatient Biologically Based Mental Illness	Office - 100% after copayment Outpatient facility - 90% after deductible		Office - 70% after deductible Other - 70% after deductible	
Inpatient Non-Biologically Based Mental Illness/Drug Abuse	90% after deductible Limited to 30 inpatient days per calendar year combined. One inpatient day may be exchanged for two outpatient visits. (Requires pre-approval)		70% after deductible	
Outpatient Non-Biologically Based Mental Illness/Drug Abuse	90% 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> .		70% after deductible	

Office Visit Copayment	Deductible		Maximum Out of Pocket	
	Network	Out-of-Network	Network	Out-of-Network
\$30/\$50	\$1,000	\$2,500	\$2,500	\$7,500
<b>Family Deductible and Maximum out of Pocket are two times the individual amount.</b> <b>Maximum Out of Pocket is calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket.</b>				
Benefit	In-Network		Out-of-Network	
<b>Alcohol Abuse Services</b>				
Inpatient	90% after deductible		70% after deductible	
Outpatient department	90% after deductible		70% after deductible	
Office setting	100% after copayment		70% after deductible	
	Alcohol abuse is treated the same as any other illness.			
<b>Other Services</b>				
Bariatric Surgery (Requires Pre-approval)	90% after deductible		70% after deductible	
Diabetic Education	90% after deductible		70% after deductible	
Diabetic Supplies	90% after deductible		70% 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		70% after deductible	
Home Health Care - limited to 60 visit maximum per person per calendar year.	90% after deductible Requires pre-approval		70% after deductible Requires pre-approval	
Hospice Care	90% after deductible Requires pre-approval		70% after deductible Requires pre-approval	
Infertility <i>Certain fertility services are excluded.</i>	100% after copayment in office 90% after deductible for all other requires pre-approval		Office - 70% after deductible Other - 70% Deductible Requires pre-approval	
Speech & Cognitive 30 visit limit combined per year	Office - 100% after \$30 copayment Other - 90% after deductible		Office - 70% after deductible Other - 70% after deductible	
Physical, Occupational 30 visit limit combined per year	Office - 100% after \$30 copayment Other- 90% after deductible		Office - 70% after deductible Other - 70% after deductible	
Skilled Nursing Facility/ Extended Care Center	90% 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	Office - 100% after \$30 copayment Other - 90% after deductible		Office - 70% after deductible Other - 70% 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		70% after deductible	

Office Visit Copayment	Deductible		Maximum Out of Pocket	
	Network	Out-of-Network	Network	Out-of-Network
\$30/\$50	\$1,000	\$2,500	\$2,500	\$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
<b>Other Services (cont'd.)</b>		
Vision Hardware	Not covered	Not covered
Prescription Drugs * All MMRx charges accumulate to the out-of-network maximum out-of-pocket.	70% after out-of-network deductible. Prior authorization may be required. Advantage formulary applies.	
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 <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 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:**

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.

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

27157 (W0310)