

## Horizon Advantage Direct Access 100%/70% Benefit Highlight

Office Visit Copayment	Deductible Non-Network	Maximum Out of Pocket Network	Maximum Out of Pocket Non-Network
\$20/\$40	\$1,500	\$2,500	\$6,000
Two deductibles per family. Maximum Out of Pocket is calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket.			
Benefit	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 Services	100% after copayment	70% after deductible	
	A primary care physician is a general or family practitioner, internist or pediatrician.		
Specialist Office Services	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 \$25 copayment for initial visit only	70% after deductible	
Allergy Testing and Treatment	100% after copayment	70% after deductible	
<b>Preventive Care</b>	100%	100%	
<b>Diagnostic Procedures</b>			
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	
<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.	<b>\$250 hospital inpatient copayment per day</b> <b>\$1,250 maximum per confinement</b> <b>\$2,500 maximum per calendar year per person</b>	70% after deductible	
Pre-admission Testing	100% after copayment	70% after deductible	
Inpatient Physician Services	100% after copayment	70% after deductible	
<b>Emergency Care</b>			
Emergency Room Copayment waived if admitted within 24 hours	\$100 copayment		
Ambulance	Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.		
	100%	70% after deductible	
<b>Outpatient Care</b>			
Outpatient Hospital Services	100% after \$40 copayment	70% after deductible	
Outpatient Physician Services	100% after copayment	70% after deductible	
Ambulatory SurgiCenter (ASC)	100% after \$40 copayment	70% after deductible	
		Limited to a \$2,000 maximum per benefit period	
ASC Physician Services	100%	70% after deductible	
<b>Mental Health Services</b>			
Inpatient	100% after hospital inpatient copayment	70% after deductible	
Outpatient department	100% after copayment	70% after deductible	
Office setting	100% after hospital inpatient copayment	70% after deductible	
<b>Substance Abuse Services</b>			
Inpatient	100% after hospital inpatient copayment	70% after deductible	
Outpatient department	100% after \$40 copayment	70% after deductible	
Office setting	100% after copayment	70% after deductible	
<b>Alcohol Abuse Services</b>			
Inpatient	100% after hospital inpatient copayment	70% after deductible	
Outpatient department	100% after \$40 copayment	70% after deductible	
Office setting	100% after copayment	70% after deductible	
All Inpatient and Outpatient Mental Health/Substance Abuse/Alcohol Abuse Services must be coordinated through Magellan Behavioral Health at <b>1-800-626-2212</b> .			



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

## Horizon Advantage Direct Access 100%/70% Benefit Highlight *(continued)*

Benefit	Network	Out of Network
<b>Other Services</b>		
Bariatric Surgery Requires pre-approval	100% after copayment	70% after deductible
Diabetic Education	100% after copayment	70% after deductible
Diabetic Supplies	100%	70% after deductible
Durable Medical Equipment	50% Requires pre-approval	50% after deductible Requires pre-approval
Orthotics & Prosthetics (per NJ mandate)	100% after copayment	70% after deductible
Home Health Care (limit of 60 visits per year)	100%	70% after deductible
Hospice Care	Requires pre-approval 100%	Requires pre-approval 70% after deductible Requires pre-approval
Infertility <i>Certain fertility services are excluded.</i>	100% after copayment Requires pre-approval	70% after deductible Requires pre-approval
Speech & Cognitive <i>30 visit limit combined per year</i>	100% after \$20 copayment	70% after deductible
Physical & Occupational <i>30 visit limit combined per year</i>	100% after \$20 copayment	70% after deductible
Skilled Nursing Facility/Extended Care Center	100% after hospital inpatient copayment <i>120 days per calendar year</i> Must begin within 14 days of preceding hospital stay. Requires pre-approval.	70% after deductible <i>120 days per calendar year</i>
Therapeutic Manipulation <i>30 visit maximum per calendar year</i>	100% after \$20 copayment	70% 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%	100%
Vision Hardware	Not covered	
<b>Prescription Drugs</b> *All MMRX charges accumulate to the maximum out of pocket.	70% after deductible Prior authorization may be required	70% after deductible Prior authorization may be required
<b>Eligibility</b>	Dependent children, including full-time students are covered until their 26th birthday. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to the age of 26. Under certain conditions, coverage may be extended for qualified dependents up to age 31.	
<b>Pre-Existing Conditions</b>	This plan includes a 'pre-existing conditions' limitation. In general, a pre-existing condition is a medical condition diagnosed or treated during the six months prior to a covered person's enrollment date. It applies to groups of two to five eligible employees, and to late enrollees in groups of six or more. (A late enrollee is a person who failed to enroll within 30 days of becoming eligible.) If a pre-existing condition exists, no benefits will be paid for it for 180 days after the enrollment date. The 180 days may be reduced by the time the person was covered under certain other health care coverage (Creditable Coverage) that was continuously in force to a date not more than 90 days prior to the enrollment date. Some exceptions apply to this limitation, e.g., it does not apply to covered persons under age 19 or younger; pregnancy; a child's birth defect; genetic information, in the absence of a diagnosis of the condition related to that information; or an adopted child or a child placed for adoption."	
<b>Prior Authorization</b>	Some services/procedures require prior authorization. For a complete list, contact our customer service number at <b>1-800-355-BLUE (2583)</b> or refer to <a href="http://www.HorizonBlue.com">www.HorizonBlue.com</a> .	

\*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.
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
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,

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