



Horizon Advantage PPO 100%/80%/60% Benefit Highlight

Office Visit Copayment	Deductible		Maximum Out of Pocket	
	Network	Non-Network	Network	Non-Network
\$30/\$50	\$1,500	\$3,000	\$3,000	\$7,500
Two deductibles per family. 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		
Primary Care Physician Selection	Not Required			
Doctor's Office Visits				
Primary Care Office Visit	100% after copayment	60% after deductible		
	A primary care physician 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 \$25 copayment for initial visit only	60% after deductible		
Allergy Testing and Treatment	100% after copayment	60% after deductible		
Preventive Care	100%	100%		
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.				
<i>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.</i>				
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	80% coinsurance No deductible applies to the emergency room facility charges Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.			
Ambulance	100%	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		
ASC Physician Services	80% after deductible	60% after deductible		
Mental Health Services				
Inpatient	80% after deductible	60% after deductible		
Outpatient department	80% after deductible	60% after deductible		
Office setting	100% after copayment	60% after deductible		
Substance 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		

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Benefit Highlight (continued)

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
	All Inpatient and Outpatient Mental Health/Substance Abuse/Alcohol Abuse Services must be coordinated through Magellan Behavioral Health at 1-800-626-2212 .	
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
Orthotics & Prosthetics (per NJ mandate)	100% after copayment	60% after deductible
Home Health Care (limit of 60 visits per 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 <i>30 visit limit combined per year</i>	Office- 100% after \$30 copayment Other- 80% after deductible	Office- 60% after deductible Other- 60% after deductible
Physical & Occupational <i>30 visit limit combined per year</i>	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 <i>120 days per calendar year</i> Must begin within 14 days of preceding hospital stay. Requires pre-approval.	60% after deductible <i>120 days per calendar year</i>
Therapeutic Manipulation <i>30 visit maximum per benefit period</i>	Office- 100% after \$30 copayment Other- 80% after deductible	Office- 60% after deductible Other- 60% 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	
Prescription Drugs *All MMRX charges accumulate to the maximum out of pocket.	60% after deductible Prior authorization may be required	60% after deductible Prior authorization may be required
Eligibility	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.	
Pre-Existing Conditions	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."	
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 .	

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:

- 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.