

Horizon HMO Access Coinsurance Plus 100/50 Plus Benefit Highlights (effective 4/1/10)

Selected PCP Copayment	Other Physician Copayment	Deductible	Maximum Out of Pocket
\$30	\$50	\$2,500	\$5,000
Two deductibles per family Maximum Out of Pocket is calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket. Prescription copayments do not apply towards the Maximum Out of Pocket.			
Benefit		Network	
Benefit Period Maximum		Unlimited	
Lifetime Maximum		Unlimited	
Primary Care Physician Selection		Not required, however, the lower copayment for PCP services is only available for a pre-selected PCP.	
Doctor's Office Visits			
Primary Care Office Visit		100% after PCP office visit copayment	
Specialist Office Visit		100% after Specialist office visit copayment	
Maternity Visits (Total obstetrical care includes pre/post-natal visits and delivery)		A referral is not needed to see a specialist, although, certain services still require pre-approval. 100% after \$25 copayment for initial visit only	
Allergy Testing and Treatment		100% after office visit copayment	
Preventive Care		100%	
Diagnostic Procedures			
Laboratory		100% when provided by a participating laboratory	
Outpatient X-ray/Radiology Services		Office-100%; Outpatient hospital setting-\$100% after office visit copayment; Inpatient hospital setting- 50% after deductible (Requires pre-approval)	
<small>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.</small>			
<small>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.</small>			
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.		50% after deductible	
Pre-admission Testing		50% after deductible	
Inpatient Physician Services		50% after deductible	
Emergency Care			
Emergency Room		50% (no deductible applies)	
Ambulance		100% (Requires pre approval)	
Outpatient Care			
Outpatient Hospital Services		50% after deductible	
Outpatient/ASC Physician Services		50% after deductible	
Ambulatory SurgiCenter (ASC)		100% after \$50 copayment	
Mental Health Services			
Inpatient		50% after deductible (Requires pre approval)	
Outpatient department		50% after deductible (Requires pre approval)	
Office setting		100% after office copayment	
Substance Abuse Services			
Inpatient		50% after deductible (Requires pre approval)	
Outpatient department		50% after deductible (Requires pre approval)	
Office setting		100% after office copayment	
Alcohol Abuse Services			
Inpatient		50% after deductible (Requires pre approval)	
Outpatient department		50% after deductible (Requires pre approval)	
Office setting		100% after office copayment	
<small>All Inpatient and Outpatient Mental Health/Substance Abuse/Alcohol Abuse Services must be coordinated through Magellan Behavioral Health at 1-800-626-2212.</small>			
Other Services			
Bariatric Surgery (Requires pre-approval)		50% after deductible	
Diabetic Education		100% after office visit copayment	
Diabetic Supplies		100% (Requires pre-approval)	
Durable Medical Equipment		50% (Requires pre-approval)	
Orthotics & Prosthetics (per NJ mandate)		100% after office visit copayment	
Home Health Care		50% after deductible (Requires pre approval)	
Hospice Care		50% after deductible (Requires pre approval)	



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Benefit	Network
Infertility <i>(Certain infertility services are excluded)</i>	100% after office visit copayment (Requires pre-approval)
Speech & Cognitive 30 visit limit combined per year	100% after office visit copayment
Physical & Occupational 30 visit limit combined per year	100% after office visit copayment
Skilled Nursing Facility/Extended Care Center	50% after deductible (Requires pre approval)
Therapeutic Manipulation 30 visit maximum per calendar year	100% after office visit copayment
Vision Exam <i>(Routine physical examinations, including eye examinations.)</i>	100%
Vision Hardware	Not covered
Prescription Drugs <i>Other prescription options are available. Contact your broker or Horizon BCBSNJ representative for details.</i>	50% after full payment at the pharmacy (No 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 .

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 market place, 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.

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