

Horizon MyWay HSA

Direct Access 100/80/60 (\$30/\$50)

Benefit Highlight

Office Visit Copayment	Deductible	Maximum Out of Pocket	
		Network	Non-Network
\$30/\$50	\$2,500	\$5,000	\$7,500
<p>Family deductible is two times the individual and is a true family aggregate. The true family aggregate requires the entire family deductible to be met before the covered family members are in benefits. The family Maximum Out of Pocket (MOOP) is two times the individual MOOP and is a true family aggregate. A family may meet the true family aggregate MOOP through one covered family member expenses or a combination of family members' expenses. Once this balance is met, then all covered members in the family are in benefits.</p>			
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			
Physician Office Visit	Copayment after deductible	60% after deductible	
	A primary care physician is a general or family practitioner, internist or pediatrician.		
Specialist Office Visit	Copayment after deductible	60% after deductible	
	A referral is not required to visit a specialist.		
Maternity Visits (Total obstetrical care includes pre/post-natal visits and delivery)	Specialist copayment for initial visit only after deductible	60% after deductible	
Allergy Testing and Treatment	Copayment after deductible	60% after deductible	
Preventive Care	100%	100%	
Diagnostic Procedures			
Laboratory	100% after deductible	60% after deductible	
Outpatient X-ray/Radiology Services	100% after deductible	60% after deductible	
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	80% after deductible	60% after deductible	
Ambulance	80% after deductible	60% after deductible	
Outpatient Care			
Outpatient Hospital Services	80% after deductible	60% after deductible	
Outpatient/ASC Physician Services	80% after deductible	60% after deductible	
Ambulatory SurgiCenter (ASC)	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	Copayment after deductible	60% after deductible	
Substance Abuse Services			
Inpatient	80% after deductible	60% after deductible	
Outpatient department	80% after deductible	60% after deductible	
Office setting	Copayment after deductible	60% after deductible	
Alcohol Abuse Services			
Inpatient	80% after deductible	60% after deductible	
Outpatient department	80% after deductible	60% after deductible	
Office setting	Copayment after deductible	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 Requires pre-approval	60% after deductible Requires pre-approval	

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Benefit	In-Network	Out-of-Network
	Office- Copayment after deductible Other- 50% after deductible Requires pre-approval	Office- 60% after deductible Other- 50% after deductible Requires pre-approval
Durable Medical Equipment		
Orthotics & Prosthetics (per NJ mandate)	Copayment after deductible	60% after deductible
Home Health Care	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>	Office copayment after deductible Other- 80% after deductible 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- copayment after deductible Other- 80% after deductible	Office- 60% after deductible Other- 60% after deductible
Physical & Occupational <i>30 visit limit combined per year</i>	Office- copayment after deductible 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.	60% after deductible <i>120 days per calendar year</i> Requires pre-approval.
Therapeutic Manipulation <i>30 visit maximum per calendar year</i>	Office-copayment after deductible 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 <i>All CDHRx charges accumulate to the Maximum Out of Pocket.</i>	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:

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.