Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

Horizon HSA Compatible Direct Access 100/80/60 ($30/$50)

Benefit Highlight

Office Visit Copayment	Deductible	Maximum Out of Pocket In-Network	Maximum Out of Pocket Out-of-Network
$30/$50	$2,500	$5,000	$7,500

**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's expenses or a combination of family members' expenses. Once this balance is met, then all covered members in the family are in benefits.**

Benefit	In-Network	Out-of-Network
Benefit Period Maximum	Unlimited.	Unlimited.
Lifetime Maximum	Unlimited.	Unlimited.
Primary Care Physician Selection	Not required.	
Physician's Office Visits		
Physician Office Visit	Copayment after deductible.	60% after deductible.
	A Primary Care Physician (PCP) 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/postnatal 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%.	$750 maximum per covered dependent child through end of calendar year in which child turns 1. $500 maximum per covered person per calendar year. Not subject to coinsurance.
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 and 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.

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Inpatient Care (cont'd.)		
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.
Ambulatory Surgery Center (ASC)	80% after deductible.	60% after deductible.
Outpatient/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	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/Alcoholism Services must be coordinated through Magellan Behavioral Health at **1-800-626-2212**.		
Other Services		
Bariatric Surgery	80% after deductible. (Requires pre-approval.)	60% after deductible. (Requires pre-approval.)
Diabetic Education	80% after deductible.	60% after deductible.

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Other Services (cont'd.)		
Diabetic Supplies	80% after deductible. (Requires pre-approval.)	60% after deductible. (Requires pre-approval.)
Durable Medical Equipment (DME)	Office copayment after deductible. Other – 50% after deductible. (Requires pre-approval.)	Office – 60% after deductible. Other – 50% after deductible. (Requires pre-approval.)
Orthotics and Prosthetics (*per New Jersey 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 *Certain fertility services are excluded*	Office – copayment after deductible. Other – 80% after deductible. (Requires pre-approval.)	Office – 60% after deductible. Other – 60% after deductible. (Requires pre-approval.)
Speech and Cognitive Therapy (30 visit limit combined per year)	Office – copayment after deductible. Other – 80% after deductible.	Office – 60% after deductible. Other – 60% after deductible.
Physical and Occupational Therapy (30 visit limit combined per year)	Office – copayment after deductible. Other – 80% after deductible.	Office – 60% after deductible. Other – 60% after deductible.
Skilled Nursing Facility/ Extended Care Center 120 days per calendar year	80% after deductible.	60% after deductible.
	Must begin within 14 days of preceding hospital stay. (Requires pre-approval.)	
Therapeutic Manipulation (30 visit maximum per calendar year)	Office - copayment after deductible. Other - 80% after deductible.	Office – 60% after deductible. Other – 60% after deductible.
Vision Screening (Vision exams are not covered, only preventive care screenings for dependents up to age 17 years in his/her pediatricians office.)	100% after copayment	$750 maximum per covered dependent child through end of calendar year in which child turns 1. $500 maximum per covered person per calendar year. Not subject to coinsurance.
Vision Hardware	Not covered.	Not covered.
Prescription Drugs All CDHRx charges accumulates to the Maximum Out of Pocket.	60% after deductible. Pre-approval may be required.	60% after deductible. Pre-approval may be required.

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Other Services (cont'd.)	
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 age 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, call Member Services at **1-800-355-BLUE (2583)** or visit <**www.HorizonBlue.com**>.

Members can save money when they choose to receive care from health care professionals who participate in the Horizon BCBSNJ networks. When members use participating hospitals or other medical facilities or physicians, they generally only pay their copayment and any applicable in-network coinsurance or deductible. If members have services performed at an out-of-network facility or by an out-of-network provider, their out-of-network benefits will apply. This means that members will be responsible for amounts exceeding Horizon BCBSNJ's allowable reimbursement for that particular service, which may result in significant out-of-pocket costs. Members will be responsible for paying this amount directly to the nonparticipating hospital, ambulatory surgery center or provider. By using our Horizon BCBSNJ network of health care professionals, members keep their health care costs down.

This summary highlights the major features of the 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. Members should refer to their 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.

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