Horizon℠

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work®

Horizon HMO Access HSA Compatible

Plan Design Benefit Highlight

Selected Primary Care Physician (PCP) Copayment		Other Physician Copayment	Maximum Out of Pocket (MOOP)	Deductible
$30		$50	$5,000	$2,500
Hospital Outpatient Copayment-Laboratory and Radiology	**Hospital Outpatient Copayment Surgery**	**Hospital Outpatient Copayment other than Laboratory and Radiology**	**Hospital Inpatient Copayment**	**Surgery Center Copayment**
$50 $100 for CAT, MRI, MRA, MRS, PET, Nuclear Testing	$250	$50	$500	$250

Family deductible is two times the Individual deductible 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 is two times the Individual Maximum Out of Pocket and is a true family aggregate. A family may meet the true family aggregate Maximum Out of Pocket through one covered family member's expense 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
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.
Physician's Office Visits	
Primary Care Office Visit	100% after deductible and PCP copayment.
Specialist Office Visit	100% after deductible and other physician copayment. A referral is not needed to see a specialist, although, certain services still require pre-approval.
Maternity Visits (Total obstetrical care includes pre/postnatal visits and delivery.)	100% after deductible and $25 copayment for initial visit only.
Allergy Testing and Treatment	100% after deductible and physician copayment.
Preventive Care	100%.
Diagnostic Procedures	
Laboratory	**Office** - 100% after deductible and physician copayment; **Facility Outpatient** - 100% after deductible and $50 copayment. (Requires pre-approval.)
Outpatient X-ray/Radiology Services (Non-Complex) Outpatient X-ray/Radiology Services (Complex)	100% after deductible and $50 copayment. 100% after deductible and $100 copayment.
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. **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.	
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.	100% after deductible and $500 hospital inpatient copayment per day, $2,500 maximum per admission. Unlimited days.
Pre-admission Testing	100% after deductible.
Inpatient Physician Services	100% after deductible.

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Benefit	In-network
Emergency Room copayment waived if admitted within 24 hours	100% after deductible and $100 copayment.
Ambulance	100% after deductible. (Requires pre-approval.)
Outpatient Hospital Services	100% after deductible and $50 copayment.
Ambulatory Surgery Center (ASC)	100% after deductible and $250 copayment.
Outpatient/ASC Physician Services	100% after deductible.
Inpatient	100% after deductible and $500 hospital inpatient copayment per day, $2,500 maximum per admission. Unlimited days.
Outpatient department	100% after deductible and $50 copayment.
Office Setting	100% after deductible and physician copayment.
Inpatient	100% after deductible and $500 hospital inpatient copayment per day, $2,500 maximum per admission. Unlimited days.
Outpatient department	100% after deductible and $50 copayment.
Office Setting	100% after deductible and physician copayment.
Inpatient	100% after deductible and $500 hospital inpatient copayment per day, $2,500 maximum per admission. Unlimited days.
Outpatient department	100% after deductible and $50 copayment.
Office Setting	100% after deductible and physician copayment.
All Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Magellan Behavioral Health at **1-800-626-2212**.	
Bariatric Surgery	100% after deductible and copayment. (Requires pre-approval.)
Diabetic Education	100% after deductible and physician copayment.
Diabetic Supplies	100% after deductible. (Requires pre-approval.)
Durable Medical Equipment (DME)	50% after deductible. (Requires pre-approval.)
Orthotics and Prosthetics (per New Jersey mandate)	100% after deductible and PCP copayment.
Home Health Care	100% after deductible and $50 copayment. Limited to 60 visits per calendar year if pre-approved.
Hospice Care	100% after deductible. Unlimited days if pre-approved.
Infertility *Certain fertility services are excluded.*	100% after deductible and copayment. (Requires pre-approval.)

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Benefit	In-network
Speech and Cognitive Therapy (*30 visit limit combined per year*)	100% after deductible and physician copayment.
Physical, Occupational Therapy (*30 visit limit combined per year*)	100% after deductible and physician copayment.
Skilled Nursing Facility/Extended Care Center (*Copayment waived if admitted directly from hospital*)	100% after deductible and $500 copayment; unlimited days. (Requires pre-approval.)
Therapeutic Manipulation (*30 visit maximum per calendar year*)	100% after deductible and physician copayment.
Vision Exam (*Routine physical examinations, including eye examinations*)	100% after physician copayment.
Vision Hardware	Not covered.
Prescription Drugs	50% 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 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**>.

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.

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Additional Prescription Plan Options

Advantage formulary applies
For Small Employers with two to 50 eligible employees
Benefit Highlights*

Option 1	Retail Copayment	Mail-Order Copayment
Generic-Preferred**	$10	$20
Brand-Preferred**	$25	$50
Brand-Non-Preferred**	$50	$100
Option 2	**Retail Copayment**	**Mail-Order Copayment**
Generic-Preferred**	$10	$20
Brand-Preferred**	$35	$70
Brand-Non-Preferred**	$70	$140
50% Coinsurance Option (payable at purchase)	**Available for Horizon Blue Cross Blue Shield of New Jersey small employer health plans except Horizon HMO Plans.**	
Participating Pharmacy	Show your Horizon BCBSNJ ID card and pay 50 percent of the discounted price of the prescription. The pharmacist electronically sends the remaining 50 percent of the charges to CVS Caremark for payment to the pharmacist.	
Nonparticipating Pharmacy	You pay 100 percent of the regular prescription cost. You submit the claims to Horizon BCBSNJ and receive 50 percent reimbursement. **(Mail-order is not available with this option.)**	

* **Please note:** This is not a contract. These benefit highlights are only a summary of the additional Small Employer Health (SEH) Prescription Plans offered by Horizon BCBSNJ. Prescription drug plans are not available with HSA-compatible, high-deductible plan options, Horizon MSA or Horizon Comprehensive Health Plan A. This does not describe all plan designs available. If you are interested in other plan designs, please call **1-800-466-BLUE (2583)**.

** Covered medications are categorized into one of the three tiers described below:

Tier One: Generic-Preferred Drugs (lowest copayment) - Approved by the U.S. Food and Drug Administration, generic drugs contain the same active ingredients as brand-name medications. Generics are chemically and therapeutically equivalent to brand drugs, but are available at a lower price.

Tier Two: Brand-Preferred Drugs (middle copayment) - These brand-name drugs have been identified as the most therapeutically safe and effective options for treatment of most medical conditions. These drugs do not have less-costly generic equivalents because they are sold under a trademarked name.

Tier Three: Brand-Non-Preferred Drugs (highest copayment) - These brand drugs often have either a generic equivalent or a Preferred brand drug alternative.

A prescription drug guide is available, which lists all Preferred drugs under our three-tier prescription plans. You can also visit our Web site at **www.HorizonBlue.com** for more information. Contact your Horizon BCBSNJ representative for more information on these prescription plans.

For complete information and verification of your benefits, refer to your group health benefits policy. In the event a conflict exists between the information contained in these benefit highlights and the actual terms of your group policy, the terms of the policy will prevail. For further information on your policy, you may call Member Services at **1-800-355-BLUE (2583)**. This product has exclusions beyond the standard drug plan exclusions, including drugs for weight control, erectile dysfunction, smoking cessation, antihistamines, prescription vitamins and acne agents. Please refer to your contract for a complete list of exclusions.

Disclosure of information as required by the Health Insurance Portability and Accountability Act (HIPAA):

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; termination of the plan by us; or, with respect to Health Maintenance Organization plans, movement of the employer's employees out of our service area.
2. We require the employer to contribute a minimum of 10 percent of 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 an illness or injury which manifests itself in the six months before a covered person's enrollment date and medical advice, diagnosis, care or treatment was recommended or received during the six months before the enrollment date. 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 a pre-existing condition 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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