

HORIZON POS DESIGN EM Benefit Highlights

Plan	Office Visit Copayment	Deductible		Maximum Out-of-Pocket*	
		In-Network	Out-of-Network	In-Network	Out-of-Network
HORIZON POS DESIGN EM 100/60	\$20/\$40	None	\$2000 per indiv./ two ded. per family	\$3000 per indiv./ \$6000 per family	\$6000 per indiv./ \$12000 per family
		In-Network		Out-of-Network	
Coinsurance		100%		60%	
Maximums				Unlimited	
Benefit Period				Unlimited	
Lifetime					
HOSPITAL/FACILITY SERVICES		In-Network		Out-of-Network	
Hospital Services Copay					
Inpatient (per admission)		None		None	
Inpatient Services					
Room & Board		100%		60% after deductible	
Semi-Private Room					
Intensive Care & Other Hospital Services					
Organ Transplants (Includes ABMT)		100%		60% after deductible	
Outpatient Services					
Hospital Services (operating room, blood administration, general nursing, therapy/ diagnostic services, etc.)		100%		60% after deductible	
Pre-Admission Testing		100%		60% after deductible	
Medical Emergency/Accidental Injury		100% after \$100 copay (\$100 copay applies to facility charges)			
Ambulatory Surgical Center		100% after \$100 copay		60% after deductible	
Surgery in Hospital Outpatient Department		100% after \$300 copay		60% after deductible	
Skilled Nursing Facility		100% up to 100 days		60% after deductible up to 60 days	
Home Health Care		100%		60% after deductible up to 100 visits	
Hospice Care (Eligibility requires a confirmed diagnosis of terminal illness with a life expectancy of 6 months or less)		100%		60% after deductible	
				Combined \$9,000 lifetime maximum	
PHYSICIAN SERVICES		In-Network		Out-of-Network	
Inpatient Services					
Medical Care (including consultations)		100%		60% after deductible	
Surgical Services (including assistant surgeon & anesthesia)		100%		60% after deductible	
Diagnostic/Therapy Services		100%		60% after deductible	
Outpatient/Out-of-Hospital Services					
Office Visits (including related diagnostic/therapy services) when medically necessary		100% after \$20 copay, \$40 for specialists		60% after deductible	
Medical and Surgical Care (including related diagnostic/therapy services)		100% after \$20 copay, \$40 for specialists		60% after deductible	
Diagnostic X-ray and Lab		100%		60% after deductible	
Allergy Testing, Treatment & Injections		100%**		60% after deductible	
Maternity Care (Employee & Spouse)		100% after \$40 copay (Copay on first visit only)		60% after deductible	
		100%**		60% after deductible	
Infertility (includes in-vitro fertilization per NJ Mandate)		4 egg retrievals per lifetime			
Preventive Care		100% after \$20 copay, \$40 for specialists		60% (no deductible)	
Well Child Care (through age 19)					
Child Immunizations/Lead Testing**					
Annual Routine Physicals (beginning at age 20 per NJ Mandate)					
Annual Prostate Screening (men age 40 and over)**					
Annual Routine Gyn Exam & Pap (per NJ Mandate)					
Mammography (per NJ Mandate)**		1 baseline between ages 35 and 39; 1 per benefit period age 40 and older***			
Short Term Therapies: Physical, Speech, Occupational, Respiratory/Inhalation (Limit of 3 modalities per visit - out of network only)		100% after \$20 copay		60% after deductible	
				\$1,000 Ind./\$2,000 Family max for each therapy	
				30 visit maximum per benefit period	
		100% after \$40 copay		60% after deductible	
		\$1,000 Individual/\$2,000 Family maximum per benefit period			
Therapeutic Manipulations		25 visit maximum per benefit period			
Diabetic Education		100% after \$20 copay, \$40 for specialists		60% after deductible	

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OTHER SERVICES	In-Network	Out-of-Network
Ambulance (Ground Transport & Air Transport)	100%	60% after deductible
Bariatric Surgery	Not Covered	Not Covered
Diabetic Supplies	100%	60% after deductible
	50%	50% after deductible
Durable Medical Equipment	Combined \$2500 maximum	
	100%	60% after deductible
Physical Rehabilitation Facility Inpatient Services	Limited to 60 days per benefit period	
Prescription Drugs	Not Covered	Not Covered
	100%	60% after deductible
Private Duty Nursing	Limited to 30 visits per benefit period (8-hour shifts)	
Routine Vision Exam (1 per benefit period)	100% after \$40 copay	60% after deductible
Vision Hardware	\$100 every two years	
MENTAL HEALTH/SUBSTANCE ABUSE ¹	In-Network	Out-of-Network
	100%	60% after deductible
Inpatient Services	45 days per benefit period 90 days per lifetime	30 days per benefit period 90 days per lifetime
	100% after \$40 copay	60% after deductible
Outpatient Services	50 visits per benefit period 150 visits per lifetime	20 visits per benefit period 60 visits per lifetime
	100% after \$40 copay	60% after deductible
Group Therapy	3 sessions = 1 outpatient visit	
	100%	60% after deductible
Partial Hospitalization	2 partial days = 1 inpatient day	
COST MANAGEMENT	In-Network	Out-of-Network
Catastrophic Case Management	Covered	
Pre-Admission Review	Included as PCP management	Member Responsibility 20% reduction for noncompliance
ELIGIBILITY		
Children are covered to the end of the calendar year in which they turn age 19. Full-time students are covered until the end of the calendar year in which they reach age 25 or until the end of the month during which their full-time student status ends. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to age 19. Under certain conditions, coverage may be extended for qualified dependents up to age 30. Dependent children are ineligible for Maternity/Obstetrical Benefits.		

In-Network - Horizon BCBSNJ's payment for eligible expenses when services are provided or coordinated by the Primary Care Physician (PCP). The member will not be responsible for any balance bill after payment of any applicable copayment or coinsurance. Horizon POS provides the highest level of benefits for in-network services, and the member does not have to file claims. Referrals are required.

Out-of-Network - Horizon BCBSNJ's payment for eligible services that are not provided or coordinated by the Primary Care Physician. The member may see any physician if he/she is willing to pay a greater share of the costs. Non-network services are reimbursed at the 70th percentile HIAA reimbursement schedule and providers may balance bill up to their charges. An annual deductible and a coinsurance applies to all eligible medical and most supplemental services. Once the member reaches the out of pocket maximum, Horizon POS pays 100% of the appropriate allowance for eligible services for the rest of that year. The member is responsible for complying with all utilization review and cost containment programs.

Pre-Existing Condition Exclusion

Employees and Dependents who have continuous coverage under the prior group contract and/ or other previous health coverage, with no break in coverage of 63 days or more, will not be subject to the pre-existing condition exclusion. If the exclusion applies, for the first twelve months after an eligible person's enrollment under the contract, no benefits will be provided for services incident to, resulting from, or relating to any disease, injury or condition, which was treated or diagnosed by a health care professional within the six month period prior to enrollment for that person. Note, this does not apply to children who enroll within 30 days of birth or adoption.

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 booklet for more information.

¹ All Mental Health/Substance Abuse Care Services must be coordinated through the Horizon BCBSNJ/Magellan Behavioral Health Program. Alcoholism and Biologically Based Mental Illness will be paid as any other medical condition pursuant to the NJ state mandates.

*All copayments, deductibles and coinsurance count towards the Out-of-Pocket maximum.

**Copay will apply when an office visit procedure code is billed separately.

***More frequent mammograms are covered if under age 40 with a family history of breast cancer or other breast cancer risk factors.

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