

## HORIZON POS DESIGN AM

| Benefit   | In-Network  | Out-of-Network                    |
|---|---|-----------------------------------|
| <b>Benefit Period</b>   | Calendar year   |                                   |
| <b>Deductible</b>   |   |                                   |
| Individual  | None  | \$2000                            |
| Family  | None  | <b>Two deductibles per family</b> |
| Deductible is Calendar year.  |   |                                   |
| <b>Coinsurance</b>  | 80%   | 60%                               |
| <b>Maximum Out of Pocket</b>  |   |                                   |
| Individual  | \$5000  | \$10000                           |
| Family  | \$10,000  | \$20,000                          |
| Maximum Out of Pocket is Calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket.<br>Balances from non-participating providers over our allowance are not eligible towards the Maximum Out of Pocket.  |   |                                   |
| <b>Benefit Period Maximum</b>   | Unlimited   | Unlimited                         |
| <b>Lifetime Maximum</b>   | Unlimited   | Unlimited                         |
| <b>Primary Care Physician Selection</b>   | Required  |                                   |
| <b>Doctor's Office Visits</b>   |   |                                   |
| Primary Care Office Visit   | 100% after \$20 copay<br>A primary care physician is a general or family practitioner, internist or pediatrician                                | 60% after deductible              |
| Specialist Office Visit   | 80% after \$40 copay<br><b>A referral is required to visit a specialist.</b>  | 60% after deductible              |
| Maternity Visits  | 80% after \$40 copay<br>Copay applies to 1st visit only<br>Female child dependents are ineligible for maternity/obstetrical benefits.           | 60% after deductible              |
| Allergy Testing and Treatment   | 100% after \$20 copay for PCP and<br>80% after \$40 copay for specialists   | 60% after deductible              |
| <b>Preventive Care</b>  |   |                                   |
| Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations   | 100% after \$20 copay for PCP and<br>100% after \$40 copay for specialists<br><br>Note: A copay will only apply when an office visit is billed. | 60% (no deductible)               |
| Well Child Exams  | 100% after \$20 copay for PCP and<br>100% after \$40 copay for specialists  | 60% (no deductible)               |
| Well Child Immunizations and Lead Screening   | 100%  | 60% (no deductible)               |
| <b>Diagnostic Procedures</b>  |   |                                   |
| Laboratory  | 100% when rendered by PCP or Labcorp<br>80% when rendered by a specialist<br>or in Outpatient facility  | 60% after deductible              |
| Outpatient X-ray/Radiology Services   | 100% when rendered by PCP<br>80% when rendered by a specialist<br>or in Outpatient facility   | 60% after deductible              |
| 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 <b>1-866-496-6200</b> and providing the necessary clinical information. Once the authorization number is received, the member may call CCN at <b>1-866-969-1234</b> to schedule an appointment. |   |                                   |
| <i>Note: Managed Care members can call <b>1-866-969-1234</b> to obtain a confirmation number for non-Advanced Imaging diagnostic procedures. Confirmation numbers from CCN replace the need for a paper referral.</i>   |   |                                   |
| <b>Hospital Care</b>  |   |                                   |
| Inpatient Admission (including maternity)   | 80%   | 60% after deductible              |
| Room and Board  | 80%   | 60% after deductible              |
| Pre-admission Testing   | 80%   | 60% after deductible              |
| Surgery in Hospital   | 80%   | 60% after deductible              |
| Inpatient Physician Services  | 80%   | 60% after deductible              |
| Outpatient Dept. Services   | 80%   | 60% after deductible              |

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| Emergency Care  |  |  |
|---|--|--|
| Emergency Room  | 80% after \$100 facility copay<br>Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.                         |  |
| Ambulance   | 80%  | 60% after deductible   |
| Outpatient Surgery  |  |  |
| Hospital Outpatient Surgery   | 80% after \$300 copay  | 60% after deductible   |
| Surgery in an Ambulatory SurgiCenter  | 80% after \$100 copay  | 60% after deductible   |
| Services performed at a non-participating ambulatory surgery center are reimbursed at Horizon BCBSNJ's Payment Allowance and therefore may result in significant out of pocket costs. |  |  |
| Mental Health Services  |  |  |
| Inpatient <b>Biologically-Based</b> Mental Illness (treated the same as general illnesses)  | 80%  | 60% after deductible   |
| Outpatient <b>Biologically-Based</b> Mental Illness (treated the same as general illnesses)   | 100% after \$10 copay for PCP and<br>80% after \$40 copay for specialists<br>80% in outpatient facility  | 60% after deductible   |
| Inpatient <b>Non-Biologically Based</b> Mental Illness/Substance Abuse  | 80%<br>45 days per benefit period<br>90 days per lifetime  | 60% after deductible<br>30 days per benefit period<br>90 days per lifetime   |
| Outpatient <b>Non-Biologically Based</b> Mental Illness/Substance Abuse   | 80% after \$40 copay<br>80% in outpatient facility<br>50 visits per benefit period<br>150 visits per lifetime  | 60% after deductible<br>20 visits per benefit period<br>60 visits per lifetime   |
| Inpatient Mental Health/Substance Abuse Services must be coordinated through Magellan Behavioral Health at 1-800-626-2212.  |  |  |
| Alcohol Abuse Services  |  |  |
| Inpatient   | 80%  | 60% after deductible   |
| Outpatient department   | 80%  | 60% after deductible   |
| Office setting  | 100% after \$20 copay for PCP and<br>80% after \$40 copay for specialists  | 60% after deductible   |
| Alcohol abuse is treated the same as any other illness.   |  |  |
| Other Services  |  |  |
| Bariatric Surgery   | Not Covered  | Not Covered  |
| Diabetic Education  | 100% after \$20 copay for PCP and<br>80% after \$40 copay for specialists  | 60% after deductible   |
| Diabetic Supplies   | 80%  | 60% after deductible   |
| Durable Medical Equipment   | 50%  | 50% after deductible   |
| Orthotics and Prosthetics<br>(Per NJ mandate)   | Combined \$2500 maximum  |  |
| Home Health Care  | 100% after \$20 copay  | 60% after deductible   |
| Hospice Care  | 80%  | 60% after deductible up to 100 visits  |
| Infertility (including in-vitro fertilization)  | 80%<br>100% after \$20 copay for PCP and<br>80% after \$40 copay for specialists<br>80% in outpatient facility   | 60% after deductible   |
| Private Duty Nursing  | Limited to 4 egg retrievals per lifetime   |  |
| Physical Rehabilitation Facility<br>Inpatient Services  | 80%  | 60% after deductible   |
| Short-term Therapies:<br>Physical, Occupational, Speech,<br>Respiratory (Limit of 3 modalities per visit - out of network only)   | 80%<br>100% after \$20 copay for PCP and<br>80% after \$40 copay for specialists   | 60% after deductible<br>\$1,000 Ind./\$2,000 Family max for each therapy<br>30 visit maximum per therapy, per benefit period |
| Skilled Nursing Facility/Extended Care Center   | Note: If specialist copay is higher than PCP copay, the lower copay will apply to short-term therapies.<br>Also, if PCP copay is \$30, the STT copay will default to \$20. |  |
|   | 80%<br>Limited to 100 days per benefit period  | 60% after deductible<br>Limited to 60 days per benefit period  |



# HORIZON POS DESIGN AM

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

|   |  |                      |
|---|--|----------------------|
| Therapeutic Manipulation<br>(Chiropractic Care) | 100% after \$20 copay copay for PCP and<br>80% after \$40 copay for specialists<br>\$1,000 Individual/\$2,000 Family maximum per benefit period<br>25 visit maximum per benefit period<br>No referral required   | 60% after deductible |
| Vision - Routine Eye Exam                       | 100% after \$40 copay  | 60% after deductible |
| Vision Hardware                                 | \$100 every two years  |                      |
| <b>Prescription Drugs</b>                       | Not Covered  |                      |
| <b>Eligibility</b>                              | 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 the age of 19. Under certain conditions, coverage may be extended for qualified dependents up to age 30.   |                      |
| <b>Pre-Existing Conditions</b>                  | 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. |                      |
| <b>Prior Authorization</b>                      | Some services/procedures require prior authorization. For a complete list, contact our customer service number at 1-800-355-BLUE (2583) or refer to our website at <a href="http://www.HorizonBlue.com">www.HorizonBlue.com</a> .  |                      |
| <b>Care Wise</b>                                | Not Applicable   |                      |

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. Generally, 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.

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Group Official: \_\_\_\_\_  
Signature

\_\_\_\_\_  
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Title: \_\_\_\_\_

Date: \_\_\_\_\_