HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY
HORIZON POS DESIGN JJ BENEFITS
Delva Tool

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

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. Horizon BCBSNJ reimburses network providers at the applicable allowance. Non-network providers are reimbursed up to the allowance level and may balance bill to 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, the Horizon POS pays 100% of the appropriate allowance for eligible services for the rest of that year. There is a lifetime maximum for each member. The member is responsible for complying with all utilization review and cost containment programs.

	In-Network	Out-of-Network
ALL SERVICES		
Benefit Period	Calendar Year	
Deductible (Total combined per year)		
Hospital/Facility	None	$1,000 per indiv./two ded. per family
Professional	None	$1,000 per indiv./two ded. per family
Supplemental	None	$1,000 per indiv./two ded. per family
Coinsurance		
Hospital/Facility	80%	60%
Professional		
Primary Care Physician	100%	60%
Specialist	80%	60%
Supplemental	80%	60%
Out of Pocket Maximum (excluding deductible)		
Hospital/Facility	$1,000 per ind./$2,000 per family	$4,000 per ind./$8,000 per family
Professional	$1,000 per ind./$2,000 per family	$4,000 per ind./$8,000 per family
Supplemental	$1,000 per ind./$2,000 per family	$4,000 per ind./$8,000 per family
Maximums		
Benefit Period	Unlimited	
Lifetime	Unlimited	
HOSPITAL/FACILITY SERVICES		
Inpatient Services		
Room & Board (semi-private room)	80%	60% after deductible
Intensive Care & Other Hospital Services (therapy/diagnostic services, blood administration, general nursing, operating room, etc.)	80%	60% after deductible
Maternity Benefits	80%	60% after deductible
Organ Transplants (Includes ABMT)	80%	60% after deductible
Outpatient Services		
Hospital Services (operating room, blood administration, general nursing, therapy/ diagnostic services, etc.)	80%	60% after deductible
Pre-Admission Testing	100%	100%
Medical Emergency/Accidental Injury	80% after $50 copay ($50 copay applies to facility charges)	
Surgical Center	80%	60% after deductible

	In-Network		Out-of-Network
Outpatient Services			
Skilled Nursing Facility	80% up to 100 days		60% after deductible up to 60 days
Home Health Care	80%		60% after deductible up to 100 visits
Hospice Care	80% combined $9,000 Lifetime Max		60% after deductible
PHYSICIAN SERVICES			
	PCP	**Specialist**	
Inpatient Services			
Medical Care (including consultations)	100%	80%	60% after deductible
Surgical Services (including assistant surgeon and anesthesia)	100%	80%	60% after deductible
Obstetrical Services (i.e., normal delivery, cesarean section, abortion)	100%	80%	60% after deductible
Diagnostic/Therapy Services	100%	80%	60% after deductible
Outpatient/Out-of-Hospital Services			
Office Visits (including related diagnostic/therapy services) when medically necessary	100% after $30 copay	80% after $30 copay	60% after deductible
Medical and Surgical Care (including related diagnostic/therapy services)	100% after $30 copay	80% after $30 copay	60% after deductible
Diagnostic X-ray and Lab	100%	80%	60% after deductible
Allergy Testing, Treatment & Injections	100% after $30 copay	80% after $30 copay	No Benefit
Maternity Care	80% after $30 copay (first visit only)		60% after deductible
Infertility (includes in-vitro fertilization per NJ Mandate)	80% after $30 copay 4 egg retrievals per lifetime		60% after deductible
Well Child Care (through age 19)	100% after $30 copay	No Benefit	No Benefit
Child Immunizations/Lead Testing (NJ Mandate)	100% after $30 copay	No Benefit	60% (no deductible)
Routine Physicals (beginning at age 20) (Health Wellness NJ Mandate)	100% after $30 copay 1 per year	80% after $30 copay	60% (no deductible) 1 per year
Prostate Screening (NJ Mandate)	100% after $30 copay Men age 40 and over, 1 per year		60% (no deductible)
Annual Routine Ob/Gyn Exam	100% after $30 copay No referral needed - 1 per benefit period		60% (no deductible)
NJ Pap and Mammography (NJ Mandates)	100% after $30 copay 1 per benefit period		60% (no deductible)
Short Term Therapies: Physical, Speech, Occupational, Respiratory/Inhalation Therapy. (Limit of 3 modalities per visit)	100% after $20 copay 30 visit maximum	80% after $20 copay	60% after deductible $1,000Ind./$2,000 Family maximum for each therapy
Therapeutic Manipulations	100% after $30 copay $1,000Individual/$2,000 Family maximum per benefit period 25 visits within a 60 day period maximum	80% after $30 copay	60% after deductible
Routine Vision Exam	80% after $30 copay 1 per benefit period, no referral		60% after deductible
SUPPLEMENTAL SERVICES			
Ambulance (Ground Transport Only)	80%		60% after deductible
Air Ambulance	80%		60% after deductible
Private Duty Nursing*	80% limited to 30 visits		No Benefit
Durable Medical Equipment*	80% Combined $5,000 maximum (no maximum on prosthetics)		60% after deductible
Diabetic Supplies (NJ Mandate)*	80%		60% after deductible
Diabetic Education (NJ Mandate)	80% after applicable copayment		60% after deductible
Prescription Drugs*	Covered under freestanding prescription drug program		Covered under freestanding prescription drug program
Physical Rehabilitation Facility Inpatient Services*	80% limited to 60 days		No Benefit
Oxygen & Administration*	80%		60% after deductible
Nutrition	100% after $30 copay 3 visits per year		No Benefit
Vision Hardware	$100 every two years		

Blood Charges*	80%	60% after deductible

	In-Network	Out-of-Network
MENTAL HEALTH/SUBSTANCE ABUSE **		
Inpatient Services	80% 45 days per benefit period 90 days per lifetime	60% after deductible 30 days per benefit period 90 days per lifetime
Outpatient Services	80% after $30 copay 50 visits per benefit period 150 visits per lifetime	60% after deductible 20 visits per benefit period 60 visits per lifetime
Group Therapy	80% after $30 copay 3 sessions = 1 visit	No Benefit
Partial Hospitalization	2 partial days = 1 inpatient day 45 days per benefit period	No Benefit
**All Mental Health/Substance Abuse Care services must be coordinated through the Horizon BCBSNJ/Magellan Behavioral Health Program. Biologically Based Mental Illnesses will be paid as any other medical condition pursuant to NJ state mandate. The Catastrophic Limit does not apply to Mental Health/Substance Abuse.		
COST MANAGEMENT		
Catastrophic Case Management	Included as PCP management	Covered
Pre-Admission Review	Included as PCP management	20% reduction for noncompliance
ELIGIBILITY		
Children covered to the end of the calendar year in which they turn age 19. Full-time students 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 covered beyond the child removal age, if handicap occurred prior to age 19. Dependent children are ineligible for Maternity/Obstetrical Benefits.		

Pre-Existing Condition Exclusion

Employees and Dependents who have continuous coverage under the prior group contract and/ or other previous health coverage will not be subject to the pre-existing condition exclusion. The exclusion applies to new hires and late entrants only. 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.