Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work®

Horizon Direct Access Value Select

Benefit Highlights*

Selection of a PCP is not a requirement to receive network benefits.**

PCP Office Visit Copayment	All Other Physicians Copayment	Maternity Copayment	Deductible†	Maximum Out of Pocket† Network	Maximum Out of Pocket† Non-Network
$30	$50	$25	$2,500	$4,500	$6,750

	Network***	Non-Network***
Coinsurance	100% for office visits and non-hospital laboratory; 80% for hospital and other services; 60% for prescription drugs	60% for all services

Practitioner Services	**Network*****	**Non-Network*****
Office Visits	100% after copayment	60% after deductible
Preventive Care	$750 each year per covered dependent child through end of calendar year in which child attains age one; $500 maximum per covered person per calendar year. Not subject to deductible or coinsurance.	
Surgery In physician's office Not in physician's office	 100% after copayment 80% after deductible	 60% after deductible 60% after deductible
Radiology *(May require preapproval)*	100%; deductible does not apply	60% after deductible
Laboratory	100% when provided by a participating laboratory or in a physician's office	60% after deductible

Hospital Services	**Network*****	**Non-Network*****
Inpatient Care Semi-Private Room or Intensive Care Unit *(All inpatient admissions require preapproval from Horizon BCBSNJ)*	80% after deductible	60% after deductible

(Continues)

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Hospital Services *(continued)*	Network***	Non-Network***
Maternity Practitioner Services *(Total obstetrical care includes pre/post-natal visits and delivery)*	80% after deductible; $25 copayment per pregnancy for initial office visit only	60% after deductible
Hospital Outpatient Care *(Some services require preapproval)*	80% after deductible	60% after deductible
Emergency Room *(Copayment waived if admitted within 24 hours)*	$100 copayment then 80% coinsurance; No deductible applies to the emergency room facility charge	$100 copayment, then deductible and 60% coinsurance
Pre-Admission Testing	80% after deductible	60% after deductible
Rehabilitation *(Requires preapproval)*	80% after deductible Must begin within 14 days of preceding hospital stay	60% after deductible Must begin within 14 days of preceding hospital stay
Hospice Care *(Requires preapproval)*	80% after deductible	60% after deductible

Other Services	Network***	Non-Network***
Therapeutic Manipulations *(Limit of 30 visits per calendar year)*		
In practitioner's office	100% after copayment	60% after deductible
Not in practitioner's office	80% after deductible	60% after deductible
Speech/Cognitive Rehabilitation Therapy *(Combined limit of 30 visits per calendar year)*		
In practitioner's office	100% after copayment	60% after deductible
Not in practitioner's office	80% after deductible	60% after deductible
Physical/Occupational Therapy *(Combined limit of 30 visits per calendar year)*		
In practitioner's office	100% after copayment	60% after deductible
Not in practitioner's office	80% after deductible	60% after deductible

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Other Services (*continued*)	**Network*** **	**Non-Network*** **
Alcoholism		
In practitioner's office	100% after copayment	60% after deductible
Not in practitioner's office	80% after deductible	60% after deductible
Non-Biologically Based Mental Illness and Substance Abuse		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Limited to 30 inpatient days per calendar year combined network and non-network; Limited to 20 outpatient visits per calendar year combined network and non-network; One inpatient day may be exchanged for two outpatient visits.	*For Non-Biologically Based Mental Illness/Substance Abuse and Alcoholism services, you must call Magellan Behavioral Health™ at* ***1-800-626-2212*** *to obtain authorization for inpatient care and a referral for outpatient care to receive the network level of benefits.*	
Biologically Based Mental Illness		
Inpatient	80% after deductible	60% after deductible
Outpatient		
In practitioner's office	100% after copayment	
Not in practitioner's office	80% after deductible	60% after deductible
Durable Medical Equipment/Medical Supplies (including diabetic supplies) *(Requires preapproval)*	50% coinsurance Combined limit of $2,500 per person per calendar year	50% after deductible
Prescription Drugs *Prior authorization may be required. Other prescription options are available. Contact your broker or Horizon BCBSNJ representative for details.*	60% after deductible	60% after deductible
Lifetime Maximum	**Unlimited**	**Unlimited**

(Continues)

* This is not a contract. These benefit highlights are only a summary of the standard Small Employer Health (SEH) Plan B in a Point of Service format with an office rider offered by Horizon BCBSNJ. **Prior authorization may be required for certain services.** This does not describe all plan designs available. If you are interested in other plan designs, please call **1-800-466-BLUE (2583)**.

** Selection of a PCP is not a requirement to receive network benefits. Though the requirement to select a PCP has been eliminated for most services, Horizon BCBSNJ encourages members to select a PCP to coordinate their medical care.

***All payments based on our allowable amounts.

† Amounts shown represent individual cost-sharing; family amounts are two times the individual amount.

All payments are based on medical necessity and appropriateness of services. For complete information and verification of all your benefits, refer to your group health benefits policy. In the event of a conflict 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 also call Member Services at **1-800-355-BLUE (2583).**

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

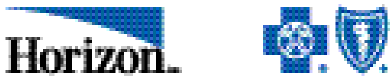
1. We will continue to renew coverage at the option of the plan sponsor except for the following reasons: Nonpayment of premiums, fraud, violation of contribution or participation rules, termination of the plan by us or enrollees move outside the service area.

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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