Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

HORIZON POS DESIGN 10
Pittsgrove Township Board of Education

Benefit	In-Network	Out-of-Network
Benefit Period	Calendar year	
Deductible		
Individual	None	$500
Family	None	Two deductibles per family
	Deductible is Calendar year.	
Coinsurance	100%	60%
Maximum Out of Pocket		
Individual	$4,000	
Family	$8,000	
Split Maximum Out of Pocket is Calendar year. The deductible, coinsurance and copayments apply to the Maximum Out of Pocket. Balances from non-participating providers over our allowance are not eligible towards the Maximum Out of Pocket.		
Benefit Period Maximum	Unlimited	Unlimited
Lifetime Maximum	Unlimited	Unlimited
Primary Care Physician Selection	Required	
Doctor's Office Visits		
Primary Care Office Visit	100% after $10 copay A primary care physician is a general or family practitioner, internist or pediatrician	60% after deductible
Specialist Office Visit	100% after $10 copay **A referral is required to visit a specialist.**	60% after deductible
Maternity Visits	100% after $10 copay Copay applies to 1st visit only Dependent children are eligible for Maternity/Obstetrical Benefits.	60% after deductible
Allergy Testing and Treatment	100%	60% after deductible
Preventive Care		
Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations	100%	60% (no deductible)
Well Child Exams	100%	60% (no deductible)
Well Child Immunizations and Lead Screening	100%	60% (no deductible)
Diagnostic Procedures		
Laboratory	100% in office or Labcorp 100% in Outpatient facility	60% after deductible
Outpatient X-ray/Radiology Services	100% in office 100% 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 eviCore Healthcare at **1-866-496-6200** and providing the necessary clinical information. Once the authorization number is received, the member may call eviCore Healthcare 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 eviCore Healthcare replace the need for a paper referral.*		
Hospital Care		
Inpatient Admission (including maternity)	100%	60 after deductible
Pre-admission Testing	100%	60% after deductible
Surgery in Hospital	100%	60% after deductible
Inpatient Physician Services	100%	60% after deductible
Outpatient Dept. Services	100%	60% after deductible
Emergency Care		
Emergency Room	100% after $35 facility copayment Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.	
Ambulance	100%	60% after deductible

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Outpatient Surgery		
Hospital Outpatient Surgery	100%	60% after deductible
Surgery in an Ambulatory SurgiCenter	100%	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	100%	60 after deductible
Outpatient department	100%	60% after deductible
Office setting	100% after $10 copay	60% after deductible
Substance Abuse Services		
Inpatient	100%	60 after deductible
Outpatient department	100%	60% after deductible
Office setting	100% after $10 copay	60% after deductible
Alcohol Abuse Services		
Inpatient	100%	60 after deductible
Outpatient department	100%	60% after deductible
Office setting	100% after $10 copay	60% after deductible
Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Horizon Behavioral Health at 1-800-626-2212.		
Other Services		
Acupuncture	Not Covered	Not Covered
Bariatric Surgery	100%	60% after deductible
Diabetic Education	100% after office copayment	60% after deductible
Diabetic Supplies	100%	60% after deductible
Durable Medical Equipment	100% after deductible	60% after deductible
Orthotics and Prosthetics (Per NJ mandate)	100% after office copayment	60% after deductible
Home Health Care	100%	60% after deductible up to 100 visits
Hospice Care	100%	60% after deductible
Infertility (including in-vitro fertilization)	100% after office copayment Limited to 4 egg retrievals per lifetime	60% after deductible
Physical Rehabilitation Facility Inpatient Services	100% Limited to 60 days per benefit period	60% after deductible
Private Duty Nursing	100% Limited to 30 visits per benefit period (8-hour shifts)	60% after deductible
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after office copayment 30 visit maximum per therapy, per benefit period Note: If specialist copay is higher than PCP copay, the lower copay will apply to short-term therapies. Also, if PCP copay is $30, the STT copay will default to $20.	60% after deductible
Skilled Nursing Facility/Extended Care Center	100% Limited to 100 days per benefit period	60% after deductible Limited to 60 days per benefit period
Therapeutic Manipulation (Chiropractic Care)	100% after office copayment 25 visit maximum per benefit period	60% after deductible
Vision - Routine Eye Exam	100% after $10 copay	60% after deductible
Vision Hardware	$100 in a 2 calendar year period	
Telemedicine	100% after $10 copay	Not Covered
Prescription Drugs	Covered under freestanding program	

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Eligibility	Dependent children, including full-time students are covered until the end of the calendar year in which they reach the age of 26. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to the age of 26. Under certain conditions, coverage may be extended for qualified dependents up to age 31.
Grandfathered	Not applicable
Pre-Existing Conditions	Not applicable
Prior Authorization	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 **www.HorizonBlue.com**.
24/7 Nurse Line	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.

Please note that the benefit highlights are provided for informational purposes. Horizon BCBSNJ makes every effort to provide clear and accurate information pertaining to these benefit highlights. However, because Horizon BCBSNJ generally expects continued guidance from regulators on issues pertaining to Federal health care reform, the information that has been provided is subject to change. Horizon BCBSNJ will provide notice of such changes to members pursuant to State and Federal requirements.

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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Rate Structure

Tier 4	Non-carveout	Carveout
Single		
2 Adult		
Family		
Parent/Child		

Commissions

The above rates include a 3.5 % broker commission which includes adjustment for ACA taxes, assessments and fees. This may differ slightly from the standard commission due to the required ACA taxes, assessments and fees which are not included in the commission calculation.

Horizon BCBSNJ administers payment of broker commissions on Contract Holder's behalf to Contract Holder's commissioned broker. Broker commission noted herein is specifically directed, approved, and authorized by Contract Holder and Horizon BCBSNJ provides only administrative services in making broker payment and does not independently make commission payments. Contract Holder acknowledges that broker commissions are paid by its own funds and that it remains responsible to fund such commissions either as included in the premium rates or self-funded fees. Where Contract Holder approval is not received within 45 days of the effective/renewal date, Horizon BCBSNJ shall cease all administration of broker commission payments on behalf of Contract Holder and premium rates or self-funded fees shall be reduced accordingly. Additionally, Contract Holder is solely responsible for contracting with its commissioned broker and Horizon BCBSNJ is not a party to such relationship between Contract Holder and its commissioned broker.

I represent that by signing this document that I have the legal authority to accept these terms.

Group Official:

Signature:

Print:

Title:

Date: