Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work®

DSM USA High Retiree PPO

Benefit	In-Network	Out-of-Network
Deductible		
Employee	$350	$700
Employee + 1	$700	$1,400
Family	$1,050	$2,100
	Deductible is per Calendar Year	
Coinsurance	90%	70%
Maximum Out of Pocket		
Employee	$1,850	$3,700
Employee + 1	$3,700	$7,400
Family	$5,500	$11,100
Maximum Out of Pocket is per Calendar Year. The coinsurance, copayments (excludes Rx copayments) and deductible 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	$2,000,000	$2,000,000
Doctor's Office Visits		
Primary Care Office Visit	$20 Copayment	70% after Deductible
	A primary care physician is a general or family practitioner, internist, obstetrician/gynecologist or pediatrician	
Specialist Office Visit	$30 Copayment: Physical Therapy and Chiropractic Care $40 Copayment: for all other specialists	70% after Deductible
	A referral is not required to visit a specialist	
Maternity Visits	90% after Deductible (initial visit covered at 100% after copay)	70% after Deductible
Allergy Testing and Treatment	100% Copay applies to office visit charge only	70% after Deductible
Preventive Care		
Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations	100%	70% after Deductible
	Visit Limitations apply	
Well Child Exams	100%	70% after Deductible
	Visit Limitations apply	
Routine Laboratory, X-ray/ Radiology Services	100%	70% after Deductible
Hospital Care		
Facility fee (e.g., hospital room)	90% after Deductible	70% after Deductible
Physician/surgeon fee	90% after Deductible	70% after Deductible
Emergency Care		
Emergency Room	$100 Copayment	$100 Copayment
	Emergency Room Copay waived if admitted	
Ambulance	90% after Deductible	90% after Deductible
Outpatient Surgery		
Hospital Outpatient Surgery	90% after Deductible	70% after Deductible
Surgery in an Ambulatory SurgiCenter	90% after Deductible	70% after Deductible
Mental Health Services		
Inpatient	90% after Deductible	70% after Deductible
Outpatient department	90% after Deductible	70% after Deductible
	*In-network outpatient/out of hospital Mental Health and Substance Abuse professional visits are covered at 100% after PCP copay	
Substance Abuse Services		
Inpatient	90% after Deductible	70% after Deductible
Outpatient department	90% after Deductible	70% after Deductible
	*In-network outpatient/out of hospital Mental Health and Substance Abuse professional visits are covered at 100% after PCP copay	

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Other Services		
Durable Medical Equipment	90% after Deductible	70% after Deductible
	Durable medical equipment over $500 requires pre-approval	
Home Health Care	90% after Deductible	70% after Deductible
	Limited to 100 visits maximum per Calendar year for in-network & out-of network services combined	
Hospice Care	90% after Deductible	70% after Deductible
	Limited to 180 days maximum per lifetime for in-network & out-of-network services combined	
Skilled Nursing	90% after Deductible	70% after Deductible
	Limited to 60 days maximum per calendar year for in-network & out-of-network services combined	
Routine Vision Care (Exam)	Not Covered	
Vision Care (Hardware)	Not Covered	
Infertility	90% after Deductible	70% after Deductible
	Limited to $15,000 maximum per lifetime for in-network & out-of-network services combined	
Non-routine Laboratory, X-ray/ Radiology Services	90% after Deductible	70% after Deductible
Prescription Drugs	Coverage is with Express Scripts	
Eligibility	Children Eligible To Age 26 and removed at the End of the Calendar Month they turn 26	
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 **HorizonBlue.com**.	

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 Benefits Enrollment Guide for more information.