HORIZON BCBS OF NJ Summary of Benefits

USW LOCAL 10-00086 MERCK EMPLOYEE'S HEALTH & WELFARE PLAN

Member Portal - www.horizonblue.com/usw1086

Benefit	In-Network	Out-of-Network*
Benefit Period	Calendar Year	
Deductible	Deductible is Calendar Year	
Individual	$150	$300
Family	$300	$600
Coinsurance	90%	70%
Maximum Out of Pocket		
Individual	$500	$1,000
Family	$1,000	$2,000
Maximum Out of Pocket is Calendar Year. The Coinsurances apply to the Maximum Out of Pocket. Balances from non-participating providers over the allowance are not eligible towards the Maximum Out of Pocket.		
Benefit Period Maximum	Not Applicable	Not Applicable
Lifetime Maximum	Unlimited	$1,000,000
Primary Care Physician Selection	Not Required	
Doctor's Office Visits		
Primary Care Office Visit	100% after $10 copay	70% after deductible
Specialist Office Visit	100% after $10 copay	70% after deductible
Urgent Care Visit	100% after $10 copay	70% after deductible
Telemedicine Care Visit - Horizon CareOnline [1]	100% after $0 copay	70% after deductible
Virtual Office Visit	100% after $10 copay	70% after deductible
Maternity Visits [2]	100% after $10 copay Copay applies to 1st visit only	70% after deductible
Allergy Testing and Treatment (Office) [3]	100% after $10 copay	70% after deductible
Preventive Care		
Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations [4]	100% after office copay Note: A copay will only apply when an office visit is billed.	70% after deductible

Benefit	In-Network	Out-of-Network*
Well Child Exams [5]	100% after office copy	70% after deductible
	Unlimited benefit period maximum	
Well Child Immunizations and Lead Screening	100% (no deductible)	70% after deductible
Diagnostic Procedures		
Laboratory	100% (no deductible)	70% after deductible
Outpatient - X-ray/Radiology Services Advanced Radiology may require review under the Advance Imaging Mgt Program (AIM)	90% after deductible	70% after deductible
Hospital Care		
Inpatient Admission (including maternity)	90% after deductible	70% after deductible
Room and Board	90% after deductible	70% after deductible
Pre-admission Testing	90% after deductible	70% after deductible
Surgery in Hospital	90% after deductible	70% after deductible
Inpatient Physician Services	90% after deductible	70% after deductible
Outpatient Department Services	90% after deductible	70% after deductible
Emergency Care		
Emergency Room	100% after $25 facility copay	
	Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries	
Ambulance	100% no deductible	100% no deductible
Outpatient Surgery		
Hospital Outpatient Surgery	90% after deductible	70% after deductible
Surgery in an Ambulatory Surgical Center	90% after deductible	70% after deductible
Services performed at a non-participating ambulatory surgery center are reimbursed at 250% of CMS and therefore may result in significant out of pocket costs.		
Mental Health and Substance Abuse Services		
Inpatient	90% after deductible	70% after deductible
Outpatient department	90% after deductible	70% after deductible
Office setting	100% after office copay	70% after deductible

Benefit	In-Network	Out-of-Network*
Other Services		
Bariatric Surgery (medical necessity)	90% after deductible	70% after deductible
Durable Medical Equipment - Contraceptive devices (i.e., IUD or Diaphragm) are NOT covered by the plan	90% after deductible	70% after deductible
Prosthetics	90% after deductible	70% after deductible
Orthotics - Limits are combined in and out-of-network up to $500.00 maximum per year.	80% no deductible	80% no deductible
Home Health Care	90% after deductible	70% after deductible
	Unlimited visits with direct admission.	
Hospice Care	90% after deductible	70% after deductible
Infertility	Not Covered	Not Covered
Private Duty Nursing - Outpatient Private Duty Nursing - Inpatient	90% after deductible Not Covered	70% after deductible
Short-term Therapies: Physical, Occupational, Speech, Cognitive	100% after $15 copay	70% after deductible
	Claims will pend for letter of medical necessity from provider after 10 visits and will deny after 30 visits if medical necessity is not established.	
Respiratory Therapy	100% after $15 copay	70% after deductible
Skilled Nursing Facility/Extended Care Center ***Authorization Required**	90% after deductible	70% after deductible
Therapeutic Manipulation (Chiropractic Care)	100% after $15 copay	70% after deductible
	Claims will pend for letter of medical necessity from provider after 10 visits and will deny after 30 visits if medical necessity is not established.	
Routine Vision Care (Exam and Hardware)	Covered through Vision Benefits of America	
Prescription Drugs	Covered through Express Scripts	
Eligibility	Children are covered to the end of the month in which they turn age 26. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to the age of 26.	
Pre-Existing Conditions	Not Applicable	
Prior Authorization	Some services/procedures require prior authorization. For a complete list, contact our customer service number 1-888-444-8014.	
Note: Out-of-Network Claims **Plan pays 70% of the Horizon Allowance after deductible. Claims are subject to Balance Billing from Provider.**		

24/7 Nurse Line

24/7 Nurse Line is a health information service that includes a toll free 24 hour health information line staffed by registered nurses at 1-888-624-3096. 24/7 Nurse Line nurses do not diagnose or recommend any treatment. Instead, they provide the member with the necessary health information needed to make informed medical decisions. This helps members determine if their health ailment requires a doctor's visit.

Inpatient Mental Health/Substance Abuse/Alcohol Abuse Services must be coordinated through Horizon Behavioral Health at 1-800-626-2212.

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 copay 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.

[1] **Telemedicine Care Visit –** Horizon CareOnline Telemedicine for Medical and Behavioral Health services.

[2] **Maternity Visits –** In-Network 90% coinsurance after deductible. $10 copay applies to first visit only.

[3] **Allergy Testing and Treatment (Office)**-Office visit copay only applies when an actual office visit is charged. If injections are rendered without an office visit, then no separate copayment is charged (INN would pay at 100% not subject to deductible if no office visit is rendered).

[4] **Preventive –** Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations: In-network 100% after $10 copay. Routine OB/GYN – the plan covers charges for one routine OB/GYN exam per year.

[5] **Preventive** - Well Child Exams: In-network 100% after $10 copay.

Note: This information is an overview of your health plan medical benefit. Benefits and co-payments are subject to change by your Fund Trustees. Any discrepancy between this Summary and the Plan, The Plan Document will govern.