

DIRECT ACCESS DESIGN 3 CENTENARY COLLEGE

Benefit	In-Network	Out-of-Network
Benefit Period	Calendar year	
Deductible		
Individual	None	\$300
Family	None	Two deductibles per family
	Deductible is Calendar year.	
Coinsurance	80%	60%
Maximum Out of Pocket		
Individual	\$5,000	\$5,000
Family	\$10,000	\$12,500
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	Not Required	
Doctor's Office Visits		
Primary Care Office Visit	100% after \$15 copay A primary care physician is a general or family practitioner, internist or pediatrician	60% after deductible
Specialist Office Visit	100% after \$15 copay A referral is not required to visit a specialist.	60% after deductible
Maternity Visits	100% after \$15 copay Copay applies to 1st visit only Dependent children are ineligible 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% after office copayment Note: A copay will only apply when an office visit is billed.	60% (no deductible)
Well Child Exams	100% after \$15 copay	60% (no deductible)
Well Child Immunizations and Lead Screening	100%	60% (no deductible)
Diagnostic Procedures		
Laboratory	100% in office or Labcorp 80% in Outpatient facility	60% after deductible
Outpatient X-ray/Radiology Services	100% in office 80% 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 CareCore National, LLC (CCN) at 1-866-496-6200 and providing the necessary clinical information. Once the authorization number is received, the member may call CCN at 1-866-969-1234 to schedule an appointment.		
<i>Note: Managed Care members can call 1-866-969-1234 to obtain a confirmation number for non-Advanced Imaging diagnostic procedures. Confirmation numbers from CCN replace the need for a paper referral.</i>		
Hospital Care		
Inpatient Admission (including maternity)	80%	60% after deductible
Room and Board	80%	60% after deductible
Pre-admission Testing	80%	60% after deductible
Surgery in Hospital	80%	60% after deductible
Inpatient Physician Services	80%	60% after deductible
Outpatient Dept. Services	80%	60% after deductible
Emergency Care		
Emergency Room	80% after \$50 facility copayment Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.	
Ambulance	80%	60% after deductible

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Outpatient Surgery		
Hospital Outpatient Surgery	80%	60% after deductible
Surgery in an Ambulatory SurgiCenter	80%	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 Biologically-Based Mental Illness (treated the same as general illnesses)	80%	60% after deductible
Outpatient Biologically-Based Mental Illness (treated the same as general illnesses)	100% after office copayment 80% in outpatient facility	60% after deductible
Inpatient Non-Biologically Based Mental Illness/Substance Abuse	80%	60% after deductible
	45 days per benefit period 90 days per lifetime	30 days per benefit period 90 days per lifetime
Outpatient Non-Biologically Based Mental Illness/Substance Abuse	80% after office copayment 80% in outpatient facility 50 visits per benefit period 150 visits per lifetime	60% after deductible 20 visits per benefit period 60 visits per lifetime
Inpatient Mental Health/Substance Abuse Services must be coordinated through Magellan Behavioral Health at 1-800-626-2212.		
Alcohol Abuse Services		
Inpatient	80%	60% after deductible
Outpatient department	80%	60% after deductible
Office setting	100% after office copayment	60% after deductible
Alcohol abuse is treated the same as any other illness.		
Other Services		
Bariatric Surgery	80%	60% after deductible
Diabetic Education	100% after office copayment	60% after deductible
Diabetic Supplies	80%	60% after deductible
Durable Medical Equipment	80%	60% after deductible
	Combined \$5000 maximum	
Orthotics and Prosthetics (Per NJ mandate)	100% after office copayment	60% after deductible
Home Health Care	80%	60% after deductible up to 100 visits
Hospice Care	80%	60% after deductible
	Combined \$9,000 maximum per lifetime	
Infertility (including in-vitro fertilization)	100% after office copayment	60% after deductible
	Limited to 4 egg retrievals per lifetime	
Short-term Therapies: Physical, Occupational, Speech, Respiratory (Limit of 3 modalities per visit - out of network only)	100% after office copayment	60% after deductible \$1,000 Ind./\$2,000 Family max for each therapy 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.	
Physical Rehabilitation Facility Inpatient Services	80%	60% after deductible
	Limited to 60 days per benefit period	
Private Duty Nursing	80%	60% after deductible
	Limited to 30 visits per benefit period (8-hour shifts)	
Skilled Nursing Facility/Extended Care Center	80%	60% after deductible
	Limited to 100 days per benefit period	Limited to 60 days per benefit period
Therapeutic Manipulation (Chiropractic Care)	100% after office copayment	60% after deductible
	\$1,000 Individual/\$2,000 Family maximum per benefit period 25 visit maximum per benefit period	
Vision - Routine Eye Exam	100% after \$15 copay	60% after deductible
Vision Hardware	\$50 in a 2 calendar year period	



Horizon Blue Cross Blue Shield of New Jersey

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Prescription Drugs	Covered under freestanding program
Eligibility	Children are covered to the end of the calendar year in which they turn age 19. Full-time students are covered until the end of the calendar year in which they reach age 23 or until the end of the month during which their full-time student status ends. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to the age of 19. Under certain conditions, coverage may be extended for qualified dependents up to age 31.
Pre-Existing Conditions	Employees and Dependents who have continuous coverage under the prior group contract and/or other previous health coverage, with no break in coverage of 63 days or more, will not be subject to the pre-existing condition exclusion. 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.
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 .

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 benefit booklet for more information.

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Rate Structure

Tier 4	Non-carveout	Carveout
Single	\$ 686.87	
2 Adult	\$ 1,100.76	
Family	\$ 1,487.55	
Parent/Child	\$ 1,068.23	

Commissions

Rates include commissions of 4%.

Effective 01/01/09, Horizon's Standard Broker Commission is 4%.

Please note that any deviations from Horizon BCBSNJ's standard commission rates will require approval from Horizon BCBSNJ and the group.

Group Official:

Signature: _____

Print: _____

Title: _____

Date: _____