



BLUECARD PPO DESIGN 5
Benefit Highlights
Centenary College - Pa. Only

Plan	Office Visit Copayment	Deductible		Maximum Out-of-Pocket*	
		In-Network	Out-of-Network	In-Network	Out-of-Network
BLUECARD PPO DESIGN 5 100/80/60	\$15	None	\$300 per indiv./ two per family	\$5000 per indiv./ \$10000 per family	\$3000 per indiv./\$6000 per family
		In-Network		Out-of-Network	
Coinsurance		80%		60%	
Catastrophic Limit (Services are reimbursed at 100% after catastrophic limit is reached)					
Hospital/Facility				\$5000 per indiv./two indiv. per family	
Professional				\$5000 per indiv./two indiv. per family	
Supplemental				\$5000 per indiv./two indiv. per family	
Maximums				Unlimited	
Benefit Period				Unlimited	
Lifetime				Unlimited	
HOSPITAL/FACILITY SERVICES		In-Network		Out-of-Network	
Hospital Services Copay					
Inpatient (per admission)		None		None	
Inpatient Services					
Room & Board					
Semi-Private Room					
Intensive Care & Other Hospital Services		80%		60% after deductible	
Organ Transplants (Includes ABMT)		80%		60% after deductible	
Outpatient Services					
General Medical Care		80%		60% after deductible	
Hospital Services (operating room, blood administration, general nursing, therapy/ diagnostic services, etc.)		80%		60% after deductible	
Pre-Admission Testing		80%		60% after deductible	
Medical Emergency/Accidental Injury				80% after \$50 copay	
Ambulatory Surgical Center		80%		60% after deductible	
Surgery in Hospital Outpatient Department		80%		60% after deductible	
		80%		60% after deductible	
Skilled Nursing Facility		120 days per benefit period, following a 3 or more day prior hospital stay			
		80%		60% after deductible	
Home Health Care		90 visits, up to \$4,500 per benefit period, with direct admission			
Hospice Care (Eligibility requires a confirmed diagnosis of terminal illness with a life expectancy of 6 months or less)		80%		\$10000 lifetime maximum 60% after deductible	
PHYSICIAN SERVICES		In-Network		Out-of-Network	
Inpatient Services					
Medical Care (including consultations)		80%		60% after deductible	
Surgical Services (including assistant surgeon and anesthesia)		80%		60% after deductible	
Diagnostic/Therapy Services		80%		60% after deductible	
Outpatient/Out-of-Hospital Services					
Office Visits (including related diagnostic/therapy services) when medically necessary		100% after \$15 copay		60% after deductible	
Medical and Surgical Care (including related diagnostic/therapy services)		80%		60% after deductible	
Diagnostic X-ray and Lab		80%		60% after deductible	
Allergy Testing, Treatment & Injections		80%**		60% after deductible	
Maternity Care		100% after \$15 copay (Copay on 1st visit only)		60% after deductible	
		80%**		60% after deductible	
Infertility (includes in-vitro fertilization per NJ Mandate)				4 egg retrievals per lifetime	
Preventive Care		100% after \$15 copay		60% (no deductible)	
Well Child Care (through age 19)				\$300 maximum per child per calendar year	
Child Immunizations/Lead Testing (per NJ Mandate)**					
Annual Routine Physicals (beginning at age 20 per NJ Mandate)					
Annual Prostate Screening (men age 40 and over per NJ Mandate)**					
Gyn Exam & Pap Exam (per NJ Mandate)					
Mammography (per NJ Mandate)		One baseline between ages 35 and 39; Annual mammogram age 40 and over***			
Short Term Therapies:		80%		60% after deductible	
Physical, Speech, Occupational, Cognitive Rehabilitation (Limit of 3 modalities per visit - out of network only)				30 visit maximum per benefit period	
		100% after \$15 copay		60% after deductible	
Therapeutic Manipulations				30 visit maximum per benefit period	
Diabetic Education		100% after \$15 copay		60% after deductible	
Bariatric Surgery		80%		60% after deductible	
		100%		60% after deductible	
Vision Care (Exam and Hardware)				\$35 maximum per exam; scheduled allowances for frames and lenses	



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OTHER SERVICES	In-Network	Out-of-Network
Ambulance (Ground Transport & Air Transport)	80%	60% after deductible
Diabetic Supplies	80%	60% after deductible
Durable Medical Equipment	80%	60% after deductible
Prescription Drugs	Unlimited	Unlimited
Private Duty Nursing	Covered under freestanding Rx plan	Covered under freestanding Rx plan
	80%	60% after deductible
	Limited to 240 hours per benefit period	
MENTAL HEALTH/SUBSTANCE ABUSE ¹	In-Network	Out-of-Network
Inpatient Services	80%	60% after deductible
	16 days maximum	per benefit period
Outpatient Services	50% after deductible	50% after deductible
	Limited to 50 visits	per benefit period
COST MANAGEMENT	In-Network	Out-of-Network
Catastrophic Case Management	Included	Included
Pre-Admission Review	20% reduction for noncompliance	
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 the age of 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 age of 19.

Under certain conditions, coverage may be extended for qualified dependents up to age 30. Dependent children are ineligible for Maternity/Obstetrical Benefits.

In-Network

The payment for eligible expenses when services are provided by a BlueCard PPO Hospital or Physician. BlueCard PPO Hospitals include those in the Horizon Hospital Network, as well as those that other BCBS organizations have identified as in their BlueCard network. Likewise, BlueCard PPO Physicians include those in Horizon's Traditional Network, as well as those who participate in other BCBS organization's BlueCard network. BlueCard PPO provides a higher level of benefits for in-network care and members do not have to file claims. Horizon BCBSNJ reimburses at the applicable allowance after any deductible, coinsurance, or copay. Once a member reaches the out of pocket maximum, Horizon BCBSNJ pays 100% of the applicable allowance for the rest of the year. Network providers accept this allowance as payment in full. No referrals are required.

Out-of-Network

The payment for eligible services that are not provided by a BlueCard PPO Hospital or Physician. The member may see any physician if he/she is willing to pay a greater share of the costs. Horizon BCBSNJ reimburses up to the allowance level after any applicable deductible, coinsurance or copay. The non-participating reimbursement schedule for Professional Services is: 80th TOR. Once the member reaches the out of pocket maximum, Horizon BCBSNJ pays 100% of the allowance for eligible services for the rest of that year. The member is responsible for complying with all utilization review and cost containment programs. Out-of-network providers may balance bill the member up to their charges.

Pre-Existing Condition Exclusion

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.

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 booklet for more information.

¹ Inpatient Mental Health/Substance Abuse Care Services must be coordinated through the Horizon BCBSNJ/Magellan Behavioral Health Program. Alcoholism and Biologically Based Mental Illnesses will be paid as any other medical condition pursuant to the NJ state mandates.

*The Out-of-Pocket Maximum is combined for Hospital/Facility, Professional and Supplemental services. All copayments, deductibles and coinsurance count towards the Out-of-Pocket maximum.

**Copayment will apply when an office visit procedure code is billed separately.

***More frequent mammograms are covered if under age 40 with a family history of breast cancer or other breast cancer risk factors.

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