DIRECT ACCESS Design EO
Centenary University

Benefit	In-Network	Out-of-Network
Benefit Period	Calendar Year	
Deductible		
Individual	$500	$2,000
Family	Two deductibles per family	Two deductibles per family
	Deductible is Calendar Year.	
Coinsurance	90%	70%
Maximum Out of Pocket		
Individual	$3,000	$7,000
Family	$6,000	$14,000
Consolidated Maximum Out of Pocket is Calendar Year. The deductible, coinsurance, prescription, 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 $25 copay A primary care physician is a general or family practitioner, internist or pediatrician	70% after deductible
Specialist Office Visit	100% after $50 copay A referral is not required to visit a specialist.	70% after deductible
Maternity Visits	100% after $50 copay Copay applies to 1st visit only Dependent children are ineligible for maternity/obstetrical benefits.	70% after deductible
Allergy Testing and Treatment	100% in office setting Note: A copay will only apply when an office visit if billed.	70% after deductible
Preventive Care		
Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations	100%	70% (no deductible)
Well Child Exams	100%	70% (no deductible)
Well Child Immunizations and Lead Screening	100%	70% (no deductible)
Diagnostic Procedures		
Laboratory	100% in office or in a Preferred Lab 90% after deductible in outpatient facility	70% after deductible
Outpatient X-ray/Radiology Services	100% in office 90% after deductible in outpatient facility	70% after deductible
CT/CTA Scans, Pet Scans, MRIs/MRAs, Nuclear Medicine studies (including Nuclear Cardiology) require prior authorization. Advanced/Complex Radiology may pay at a different benefit level than listed above. 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)	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

DIRECT ACCESS Design EO
Centenary University

Emergency Care		
Emergency Room	90% after $100 facility copay Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.	
Ambulance	90% after deductible	70% after deductible
Outpatient Surgery		
Hospital Outpatient Surgery	90% after deductible	70% after deductible
Surgery in an Ambulatory SurgiCenter	90% after deductible	70% 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	90% after deductible	70% after deductible
Outpatient department	90% after deductible	70% after deductible
Office setting	100% after $50 copay	70% after deductible
Substance Use Disorder Services		
Inpatient	90% after deductible	70% after deductible
Outpatient department	90% after deductible	70% after deductible
Office setting	100% after $50 copay	70% after deductible
Alcoholism Treatment		
Inpatient	90% after deductible	70% after deductible
Outpatient department	90% after deductible	70% after deductible
Office setting	100% after $50 copay	70% after deductible
Inpatient and Outpatient Mental Health/Substance Use Disorder Services/Alcoholism Treatment must be coordinated through Horizon Behavioral Health at 1-800-626-2212.		
Other Services		
Bariatric Surgery	Not Covered	Not Covered
Diabetic Education	100% after office copayment	70% after deductible
Diabetic Supplies	90% after deductible	70% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible
Orthotics and Prosthetics (Per NJ mandate)	100% after $25 copay	70% after deductible
Home Health Care	90% after deductible	70% after deductible up to 100 visits
Hospice Care	90% after deductible	70% after deductible
Infertility (including in-vitro fertilization)	100% after $50 copay 90% after deductible in outpatient facility	70% after deductible
	Limited to 4 egg retrievals per lifetime	
Physical Rehabilitation Facility Inpatient Services	90% after deductible	70% after deductible
	Limited to 60 days per benefit period	
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after $25 copay 90% after deductible in outpatient facility	70% after deductible
	30 visit maximum per therapy, per benefit period	
Private Duty Nursing	90% after deductible	70% after deductible
	Limited to 30 visits per benefit period (8-hour shifts)	
Skilled Nursing Facility/Extended Care Center	90% after deductible Limited to 100 days per benefit period	70% after deductible Limited to 60 days per benefit period
Therapeutic Manipulation (Chiropractic Care)	100% after $25 copay	70% after deductible
	25 visit maximum per benefit period	
Vision - Routine Eye Exam	100% after $50 copay	70% after deductible
Vision Hardware	$100 every two years	
Telemedicine	100% after $15 copay	Not covered
Prescription Drugs	Covered under freestanding prescription program	

DIRECT ACCESS Design EO
Centenary University

Eligibility	Dependent children who are eligible are covered to until the 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.
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**.

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 (150% of CMS) 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.

Prescription Drug Program
Centenary University

The Prescription Drug Program covers FDA approved legend drugs. A prescription order from a physician is required for drugs to be eligible. Prescriptions may be refilled within one year of the original prescription date, when authorized by the physician and permitted by law. Any limitations that apply to an original prescription also apply to the refills.

The Horizon Prescription Formulary is a list of prescription medications developed by an independent Pharmacy and Therapeutics (P&T) Committee comprised of practicing physicians and pharmacists in New Jersey. The Horizon P&T Committee determines which drugs will be placed into preferred and non-preferred status within our open formulary. The priority consideration is clinical efficacy and safety, followed by other considerations such as second line therapies, and availability of commonly used and safe generics. At least two drugs from each therapeutic class are placed in the preferred status on the formulary. Once a quality review has determined that two or more drugs are equal to other therapeutic alternatives, the P&T Committee may place the most cost effective drug(s) into preferred status.

Type of Program	Preferred Generic Drugs	Preferred Brand Name Drugs	Non-Preferred Brand Name Drugs
Three Tier Copayment Plan:			
Retail: Up to a 90 day supply (1 retail copay applies per 30-day supply)	$15	$50	$75
Mail Order: Up to 90 day supply (1 mail order copay applies for the 90-day supply)	$35	$125	$200
Front End Deductible (applies to retail and mail): Amount excluding copayments/co-insurance, which must be incurred per member in a benefit period before benefits are paid.	Not Applicable		
Benefit Period Maximum:	Unlimited		

Plan includes:

- Contraceptive (self-administered or injectible) drugs & devices obtained at a pharmacy
- Diabetic Supplies
- Fertility Drugs
- DAW1 Program (Dispense as Written) - If **prescriber** requests brand drug when generic equivalent is available, prior authorization will be required and the non-preferred copay is charged.
- DAW2 Program - If **member** requests brand drug when generic equivalent is available, the generic copay PLUS the cost difference between the brand and generic will be assessed.
- Prior Authorization - Certain medications that have medical utility for only a select group of patients require PA before coverage is approved. Specific guidelines, developed and approved by physicians and pharmacists, have to be met for these drugs to be approved and covered under your prescription drug benefits. See Horizon BCBSNJ's website for the PA drug list.

Specialty Pharmacy Program:

Certain specialty pharmaceuticals must be obtained from one of the contracted pharmacies. Specialty pharmaceuticals are typically used to treat conditions such as: Adenosine Deaminase Deficiency, Allergic Asthma, Alpha-1 Proteinase Inhibitor Deficiency, Anemia, Crohn's Disease, Cytomegalovirus, Fabry's Disease, Gaucher Disease, Hypercalcemia of Malignancy, Neutropenia, Prostate Cancer, Psoriasis, Pulmonary Hypertension, Respiratory Synctial Virus, and Rheumatoid Arthritis.

- Personal attention from a pharmacist-led team that provides condition-specific education, medication administration instruction and expert advice to help manage therapy.
- Claims assistance to help determine individual coverage and file the necessary paperwork.
- Easy access to pharmacists and other health experts 24 hours a day, seven days a week.
- Single, reliable source for specialty medication needs.
- Easy ordering with a dedicated toll-free number.
- Confidential and convenient delivery to the location of choice (i.e., home, physician's office.)
- Helpful follow-up care calls to remind when it's time to refill a prescription, check on therapy progress and answer any questions.
- NOTE: Specialty pharmacies are considered "retail" pharmacies and are always subject to the retail copayment levels, even if the specialty pharmaceutical is obtained through the mail.

Exclusions:

Anti-Obesity Drugs
Over The Counter Vitamins & Minerals
Growth Hormones (unless prior authorized)
Drugs for Cosmetic Purposes
Immunization Agents and Allergy Serum
Lifestyle Drugs

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.

For more information about your prescription drug plan, please refer to our website at www.HorizonBlue.com under Member Information. Should you have any additional questions, please feel free to contact Member Services at the phone number listed on your identification card.