# *Midsize Advantage EPO DESIGN FE*
# *Centenary University*

| Benefit | In-Network Benefits Only (Includes Bluecard network) |
|---|---|
| **Benefit Period** | Calendar year |
| **Deductible** | |
| Individual | $2,000 |
| Family | $4000 (2 individuals per family) |
| **Coinsurance** | 100/70% |
| **Maximum Out of Pocket** | |
| Individual | $7,000 |
| Family | $14,000 |
| Consolidated Maximum Out of Pocket is Calendar year. The deductible, coinsurance, prescription, and copayments apply to the Maximum Out of Pocket. | |
| **Benefit Period Maximum** | Unlimited |
| **Lifetime Maximum** | Unlimited |
| **Primary Care Physician Selection** | Not Required |
| **Doctor's Office Visits** | |
| Primary Care Office Visit | 100% after $30 copay<br>A primary care physician is a general or family practitioner, internist or pediatrician |
| Specialist Office Visit | 100% after $60 copay<br>A referral is not required to visit a specialist. |
| Maternity Visits | 100% after $60 copay<br>Copay applies to 1st visit only<br>Dependent children are ineligible for Maternity/Obstetrical Benefits. |
| Allergy Testing and Treatment | 100%<br>Note: A copay will only apply when an office visit is billed. |
| **Preventive Care** | |
| Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations | 100% |
| Well Child Exams | 100% |
| Well Child Immunizations and Lead Screening | 100% |
| **Diagnostic Procedures** | |
| Laboratory | 100% in office setting or in a Preferred Lab<br>70% after deductible in outpatient facility |
| Outpatient X-ray/Radiology Services | 100% in office setting<br>70% after deductible in outpatient facility |
| 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.<br><br>*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) | 70% after deductible |
| Surgery in Hospital | 70% after deductible |
| Inpatient Physician Services | 70% after deductible |
| Outpatient Dept. Services | 70% after deductible |
| **Emergency Care** | |
| Emergency Room | 70% after $100 facility copay |
| Ambulance | 70% after deductible |

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|---|---|
| **Outpatient Surgery** | |
| Hospital Outpatient Surgery | 70% after deductible |
| Surgery in an Ambulatory SurgiCenter | 70% after deductible |
| **Mental Health Services** | |
| Inpatient | 70% after deductible |
| Outpatient department | 70% after deductible |
| Office setting | 100% after $60 copay |
| **Substance Use Disorder Services** | |
| Inpatient | 70% after deductible |
| Outpatient department | 70% after deductible |
| Office setting | 100% after $60 copay |
| **Alcoholism Treatment** | |
| Inpatient | 70% after deductible |
| Outpatient department | 70% after deductible |
| Office setting | 100% after $60 copay |
| | 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 |
| Diabetic Education | 100% after office copayment |
| Diabetic Supplies | 70% after deductible |
| Durable Medical Equipment | 50% |
| Orthotics and Prosthetics (Per NJ mandate) | 100% after $30 copay |
| Home Health Care | 70% after deductible |
| Hospice Care | 70% after deductible |
| Infertility (including in-vitro fertilization) | 100% after copayment in office setting<br>70% after deductible in outpatient facility<br>Limited to 4 egg retrievals per lifetime |
| Physical Rehabilitation Facility Inpatient Services | 70% after deductible<br>Limited to 60 days per benefit period |
| Private Duty Nursing | 70% after deductible<br>Limited to 30 visits per benefit period (8-hour shifts) |
| Short-term Therapies: Physical, Occupational, Speech, Respiratory | 100% after $30 copayment<br>70% after deductible in outpatient facility<br>30 visit maximum per therapy, per benefit period |
| Skilled Nursing Facility/Extended Care Center | 70% after deductible<br>Limited to 100 days per benefit period |
| Therapeutic Manipulation (Chiropractic Care) | 100% after $30 copayment<br>25 visit maximum per benefit period |
| Vision - Routine Eye Exam | 100% after $60 copay |
| Vision Hardware | $100 every 2 years |
| Telemedicine | 100% after $15 copay |
| **Prescription Drugs** | Available under a freestanding program (optional) |
| | |
| **Eligibility** | Dependent children who are eligible 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. |
| | |
| **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**. |
| | |
| **24/7 Nurse Line** | Not Applicable |

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The Advantage EPO plans cover eligible expenses rendered by providers in Horizon's Managed Care network. When you utilize participating providers, you generally only pay your copayment and any applicable in-network coinsurance or deductible. No benefits are available out-of-network, except in emergency situations.

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.