Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

DIRECT ACCESS
Georgian Court University
Plan Option #1

Benefit	In-Network	Out-of-Network*
Benefit Period	Calendar year	
Deductible		
Individual	$2,000	$2,000
Family	Two deductibles per family	Two deductibles per family
	Deductible is Calendar year.	
**ONLY Horizon's USUAL AND CUSTOMARY allowance for services will be paid, nothing more than that will be paid nor go towards the MOOP & the participant will be balanced billed for everything above this. The out of network MOOP is irrelevant for charges above usual and customary, no matter how high the costs are.*		
Coinsurance	80%	60%
Maximum Out of Pocket		
Individual	$4,000	$4,000
Family	$8,000	$8,000
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 $40 copay A primary care physician is a general or family practitioner, internist or pediatrician	60% after deductible
Specialist Office Visit	100% after $60 copay A referral is not required to visit a specialist.	60% after deductible
Maternity Visits	100% after $60 copay; Copay applies to 1st Visit only Dependent children are ineligible for Maternity/Obstetrical Benefits.	60% after deductible
Allergy Testing and Treatment	100% in office setting* *Copay only applies if office visit is billed	60% after deductible
Preventive Care		
Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations	100%	60% (no deductible)
Well Child Exams	100%	60% (no deductible)
Well Child Immunizations and Lead Screening	100%	60% (no deductible)
Diagnostic Procedures		
Laboratory	100% in office or Labcorp/Quest 80% after deductible in Outpatient facility	60% after deductible
Outpatient X-ray/Radiology Services	100% in office 80% after deductible in Outpatient facility	60% after deductible
Hospital Care		
Inpatient Admission (including maternity)	80% after deductible	60% after deductible
Room and Board	80% after deductible	60% after deductible
Pre-admission Testing	80% after deductible	60% after deductible
Surgery in Hospital	80% after deductible	60% after deductible
Inpatient Physician Services	80% after deductible	60% after deductible
Outpatient Dept. Services	80% after deductible	60% after deductible
Emergency Care		
Emergency Room	80% after $100 facility copayment Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.	
Ambulance	80% after deductible	60% after deductible
Outpatient Surgery		
Hospital Outpatient Surgery	80% after deductible	60% after deductible
Surgery in an Ambulatory SurgiCenter	80% after deductible	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	80% after deductible	60% after deductible
Outpatient department	80% after deductible	60% after deductible
Office setting	100% after $60 copay	60% after deductible
Substance Abuse Services		
Inpatient	80% after deductible	60% after deductible
Outpatient department	80% after deductible	60% after deductible
Office setting	100% after $60 copay	60% after deductible

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Alcohol Abuse Services		
Inpatient	80% after deductible	60% after deductible
Outpatient department	80% after deductible	60% after deductible
Office setting	100% after $60 copay	60% after deductible
Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Horizon Behavioral Health at 1-800-626-2212.		
Other Services		
Acupuncture	Not Covered	Not Covered
Bariatric Surgery	80% after deductible	60% after deductible
Diabetic Education	100% after office copayment	60% after deductible
Diabetic Supplies	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Orthotics and Prosthetics	100% after office copayment	60% after deductible
Home Health Care	80% after deductible	60% after deductible up to 100 visits
Hospice Care	80% after deductible	60% after deductible
Infertility	80% after deductible	60% after deductible
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after $20 office copayment 80% after deductible in Outpatient facility	60% after deductible
	30 visit maximum per therapy, per benefit period	
Physical Rehabilitation Facility Inpatient Services	80% after deductible	60% after deductible
	Limited to 60 days per benefit period	
Private Duty Nursing	80% after deductible	60% after deductible
	Limited to 30 visits per benefit period (8-hour shifts)	
Skilled Nursing Facility/Extended Care Center	80% after deductible Limited to 100 days per benefit period	60% after deductible Limited to 60 days per benefit period
Therapeutic Manipulation (Chiropractic Care)	100% after office copayment	60% after deductible
	25 visit maximum per benefit period	
Vision - Routine Eye Exam	Not covered	Not covered
Vision Hardware	Not covered	
Telemedicine	100% ($0 Copay)	Not Covered
Prescription Drugs	Covered under freestanding program	
Eligibility	Dependent children, including full-time students are covered until the end of the month in which they reach age 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 the age 31.	
Pre-Existing Conditions*	Not applicable	
Grandfathered	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	24/7 Nurse Line is a health information service that includes a toll free 24 hour health information line staffed by registered nurses. 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.	

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.

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.