Washington Township Board of Education

Horizon Blue Cross Blue Shield of NJ Plan Design Comparisons Current PPO Design 1 vs. Omnia Design 3 vs. Advantage EPO Design 1

Benefit In-Network Calendar Year Courside NJ: Blue Card PPO Network Network Courside NJ: Blue Card PPO Network Network Calendar Year Coles Calendar Year Cale		Current Plan - Blue Card PPO Design 1		OMNIA Design 3		Advantage EPO Design 1		
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Well Child Immunizations and Lead Screening 100% 80% (no deductible) 100% in Office or Labcorp 100% in Office 100%	Child Evams	100%	80% (no deductible)	100%	100%	100%		
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100% in Outpatient facility Outpatient X-ray/Radiology Services 100% in Office 100% after 515 copay in Outpatient facility Outpatient Facility Outpatient Facility 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) a and providing necessary clinical information. Once the authorizaton number is received, the member may call CCN at 1-866-969-1234 to schedule an appointment. Hospital Care Inpatient Admission (including maternity) 100% 80% after deductible 100%		10011 200		1000/1 000	1001/1 (0)	10011 200		
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100% in Outpatient facility 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(CN) a and providing necessary clinical information. Once the authorization number is received, the member may call CCN at 1-866-969-1234 to schedule an appointment. Hospital Care Inpatient Admission (including maternity) 100% 80% after deductible 100% 100	estiont V roy/Padialogy Convices	1009/ in Office				1009/ in Office		
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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) a and providing necessary clinical information. Once the authorizaton number is received, the member may call CCN at 1-866-969-1234 to schedule an appointment. Hospital Care Inpatient Admission (including maternity) 100% 80% after deductible \$250 per day up to 5 day maximum 80% after deductible 100% Surgery in Hospital 100% 80% after deductible 100%		100% in Outpatient facility	80% after deductible			100% in Outpatient facility		
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Inpatient Admission (including maternity) 100% 80% after deductible 100% Pre-admission Testing 100% 80% after deductible 100%	ital Care		and providing necessary chinical informa	I once the authorizaton number is rece	lived, the member may can CCN at 1-866-965	- 1234 to schedule all appointment.		
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Ambulance 80% after deductible 80% after deductible 100% 80% after deductible 100%	ulance				· · ·	-		
Outpatient Surgery								

	Current Plan - Blue Card PPO Design 1		OMNIA Design 3		Advantage EPO Design 1
Benefit	In-Network	Out-of-Network	TIER 1	TIER 2	In-Network ONLY
Hopital Outpatient Surgery	100%	80% after deductible	\$150 copayment	80% after deductible	100% after \$200 copay
Surgery in an Ambulatory SurgiCenter	100%	80% after deductible	\$100 copayment	80% after deductible	100% after \$100 copay
Mental Health Services	100,0	50% arter deddetible	\$100 copuşment	50% urter deddetisie	20070 diter \$200 copus
Inpatient	100%	80% after deductible	\$250 per day up to 5 day maximum	80% after deductible	100% after \$250 copay per day /up to 5 days
Outpatient department	100%	80% after deductible	100% after \$15 copay	80% after deductible	100%
Office Setting	100% after \$15 copay	80% after deductible	100% after \$25 copay	100% after \$30 copay	100% after \$40 copay
Substance Abuse Services	20071 0.100. \$200 00\$007	50% arter deddetible		100% diter \$50 copay	20070 2000 4 10 00 00 00
Inpatient	100%	80% after deductible	\$250 per day up to 5 day maximum	80% after deductible	100% after \$250 copay per day /up to 5 days
Outpatient department	100%	80% after deductible	100% after \$15 copay	80% after deductible	100%
Office Setting	100% after \$15 copay	80% after deductible	100% after \$25 copay	100% after \$30 copay	100% after \$40 copay
Alcohol Abuse Services	100% arter \$15 copay	50% arter deddetible	10070 01101 \$25 00004	100% unter \$50 copay	100% ditel \$ 10 copus
Inpatient	100%	80% after deductible	\$250 per day up to 5 day maximum	80% after deductible	100% after \$250 copay per day/(up to 5 days
Outpatient department	100%	80% after deductible	100% after \$15 copay	80% after deductible	100% arter 3230 copay per day/ (up to 3 day)
Office Setting	100% after \$15 copay	80% after deductible	100% after \$25 copay	100% after \$30 copay	100% after \$40 copay
office Setting					DUGH VALUE OPTIONS AT 1-800-626-2212.
Other Services	ALL INFA	AID OOT ATEN MENTALTE		THE COOK DIVINITION OF	
Bariatric Surgery	100%	80% after deductible	100%	80% after deductible	100%
Diabetic Education	100% 100% after \$15 copay	80% after deductible	100% 100% after office copay	100% after deductible	100% after office copayment
Diabetic Supplies	80% after deductible	80% after deductible	100% after office copay	100% after office copay 100%	100% after office copayment
Durable Medical Equipment	80% after deductible			100%	50%
Durable Medical Equipment	80% after deductible	80% after deductible	100%	100%	50%
Home Health Care	100%	80% after deductible	100% after \$5 copay	100% after \$5 copay	100%
Hospice Care	100%	80% after deductible	\$250 per day up to 5 day maximum	\$250 per day up to 5 day maximum	100%
Infartility (including in vitro forilization)	100% after \$15 copay	80% after deductible	100% after \$15 copay office	100% after \$30 copay office	100% after copayment in office setting,
Infertility (including in-vitro ferilization)	100% after \$15 copay	30% arter deductible	100% after \$15 copay outpatient	80% after deductible outpatient	100% in outpatient facility
	Limited to 4 egg ret	•	Limited to 4 egg retrievals per lifetime.		Limited to 4 egg retrievals per lifetime.
Orthotics and Prosthetics	100% after \$15 copay	80% after deductible	100% after \$20 copay	100% after \$20 copay	100% after \$20 copay
Physical Rehabilitation Facility Inpatient Services	100%	80% after deductible	\$250 per day up to 5 day maximum	80% after deductible	100% Limited to 60 days per benefit period.
Private Duty Nursing	80% after deductible	80% after deductible	100% 80% after deductible Limited to 30 visits per benefit period (8-hours shifts)		100%
	Limited to 240 hour	s per benefit period			Limited to 30 visit per benefit period
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% limited to 60 visits per benefit period, combined in and out of network	80% after deductible limited to 60 visits per benefit period, combined in and out of network	100% after \$5 copay-office 100% after deductible-outpatient 30 Visit maximum per therapy, per benefit period, combined in and out of network	100% after \$20 copay-office 80% after deductible-outpatient 30 Visit maximum per therapy, per benefit period, combined in and out of network	100% after \$20 copay 30 visit maximum per therapy per BP.
Skilled Nursing Facility/Extended Care Center	100% up to 120 days with up to 120 days combined in & out of network	80% after deductible up to 120 days combined in & out of network	\$250 per day up to 5 day maximum Limited to 100 days per benefit period combined in and out of network	\$250 per day up to 5 day maximum Limited to 100 days per benefit period combined in and out of network	100% Limited to 100 days per benefit period.
Therapeutic Manipulation	100%	80% after deductible	100% after \$15 copay	100% after \$30 copay	100% after \$20 copay
Chiropractic Care)	60 visit maximum	per benefit period	25 visit maximum per benefit period		25 visit maximum per benefit period.
Vision - Routine Eye Exam	Not Covered Not Covered		Adult - Not Covered Pediatric - 1 Routine vision per year		100% after \$40 copay
Vision Hardware	Not Covered		Adult - Not Covered Pediatric - Hardware Services up to \$120 per year		\$50 every two years
Prescription Drugs	Covered under freestanding program		Covered under freestanding program		Covered under freestanding progeram
Coordination of Benefits	Yes		Yes		Yes

^{*}This summary highlights the major features of the above health benefit programs. 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.