New Jersey Transit / Rail Agreement

BENEFIT COMPARISON

	Blue Card PPO		Direct Access 10		Horizon HMO	Traditional
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only REFERRALS REQUIRED	*Closed to new enrollments*
GENERAL PROVISIONS						
Deductible Individual Family	None None None	None None $500 each non-emergency admission	$250 $500	$500 $1000	None None	$100 $300
Employee Coinsurance Basic Hospital	0% 10%	30% 30%	0% 0%	40% 40%	0% 0%	Basic Hospital 0% Major Medical 20%
Catastrophic Coverage / Coinsured Charge limit (Plan Pays 100%)	N/A (In-patient Hospital) After $5,000 of eligible claims for all Outpatient Hospital, Professional, and Supplemental.	After $5,000 of eligible claims for all Hospital, Professional, and Supplemental (after in-patient deductible).	N/A	N/A	Major Medical (Supplemental only), after $2,000 of eligible claims. Two per family	Basic Hospital (N/A) Major Medical, after $2,000 of eligible claims
Employee Maximum Out of Pocket Individual Family	$7,350 $14,700	N/A - no maximum N/A - no maximum	$7,350 $14,700	$12,700 $31,750	$7,350 $14,700	$7,350 $14,700
Maximum Payment Level	Horizon BCBSNJ Allowance	Usual, Customary & Reasonable (UCR)	Horizon BCBSNJ Allowance	Usual, Customary & Reasonable (UCR)	Horizon BCBSNJ Allowance	PACE Schedule/UCR
Benefit Period Maximum	None, Unless otherwise specified	None, Unless otherwise specified	None, Unless otherwise specified	None, Unless otherwise specified	None, Unless otherwise specified	None, Unless otherwise specified
Pre-Existing Conditions	None	None	Covered	Covered	Covered	Covered
PHYSICIAN SERVICES	*plan pays*	*plan pays*	*plan pays*	*plan pays*	*plan pays*	*plan pays*
Primary Doctors Office Visit	100% after $10 copay	70%	100% after $10 copay	60% after deductible	100% after $5 copay	80% after deductible
Specialist Doctors Office Visit	100% after $10 copay	70%	100% after $20 copay	60% after deductible	100% after $5 copay	80% after deductible
Preventive Care	100%	No Benefit	100%	60%	100%	100%, no deductible
Well Baby Care	100%	No Benefit	100%	60%	100%	100%, no deductible
Surgery	90%	70%	100%	60% after deductible	100%	80% after deductible
Maternity (Pre & Post Natal Care)	90%	70%	100% after $20 copay	60% after deductible	100% after $5 copay	80% after deductible
X-Ray and Lab	90%	70%	100%	60% after deductible	100% ($35 copay if OPD used)	80% after deductible
Emergency Care	90%	90%	100% after $100 facility copay	100% after $100 facility co-pay	100%	80% after deductible
PHYSICIAN SERVICES (cont.)						
Short Term Therapies (Physical, Speech, Occupational)	90%; 30 visits/year/person	70%; 30 visits/year/person	100% after office copayment; 30 visit maximum per benefit period	60% after deductible; 30 visit maximum per benefit period	100% after $5 copay 25 visits per benefit period	80% after deductible
Chiropractic Care	90%;12 visits/year/person	70%;12 visits/year/person	100% after office copayment; 25 visit maximum per benefit period	60% after deductible; 25 visit maximum per benefit period	First 6 visits paid at 50%, last 6 visits paid at 25% after office copay; 12 visit per benefit period	Deductible; then 80% if medically necessary

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FACILITY SERVICES						
Pre-Admission Review	Hospital responsible for obtaining approval	Mandatory; $1,000 benefit reduction for non-compliance	Hospital responsible for obtaining approval	Mandatory; $1,000 benefit reduction for non-compliance	Hospital responsible for obtaining approval	Mandatory; 20% benefit reduction for non-compliance
Inpatient Care - Medical Non-Emergency - Emergency	100% - 100% - 100%	70% - Deductible, then 70% - 100%	$100 copay then 100% - $100 copay then 100% - $100 copay then 100%	60% after deductible and $100 copay - 60% after deductible - 60% after deductible	100% - 100% - 100%	100% - 100% - 80% after deductible
Pre-Admission Testing	100%	70%	100% after deductible	60% after deductible	100% after $35 copay	80% after deductible
Outpatient Surgery	100%	70%	100% after deductible	60% after deductible	100% after $35 copay	100%
Outpatient Accidental Injury	100%	100%	100% after deductible	60% after deductible	100% after $35 copay	80% after deductible
Outpatient Medical Emergency*	90% after $100 copay	90% after $100 copay	100% after $100 copay	100% after $100 copay	100% after $35 copay	80% after deductible
Inpatient X-Ray & Lab	100%	70%	100% after deductible	60% after deductible	100%	100%
Outpatient X-Ray and Lab	100%	70%	100%	60% after deductible	100% after $35 copay	80% after deductible
Skilled Nursing Facility	100%; 120 days/year/person	Deductible, then 70% 120 days/year/person	100% after deductible; limited to 100 days per benefit period	60% after deductible; limited to 60 days per benefit period	100% limited to 60 days per benefit period	100% up to 60 days/year/person
Home Health Care	100%; 90 visits	70%; 90 visits	100% after deductible	60% after deductible; up to 100 visits	100% up to 100 days per benefit period	80% after deductible; 60 visits per benefit period
Hospice Care	100%	70%	100% after deductible (Respite limited to 10 days)	60% after deductible	100% (Respite limited to 7 days)	Deductible, then 80%
Birthing Centers	100%	Deductible; then 70%	100% after deductible	60% after deductible and $100 copay	100%	100%
SUPPLEMENTAL SERVICES						
Durable Medical Equipment	80%		100% after deductible	60% after deductible	80%	Deductible, then 80%
Ambulance	80%		100% after deductible	60% after deductible	100%	Deductible, then 80%
Blood	80% *(emergent Dx only)*		100% after deductible	60% after deductible	80%	Deductible, then 80%
Private Duty Nursing	80% to $10,000/year/person		100% after deductible; limited to 30 visits per benefit period (8hr shifts)	60% after deductible; limited to 30 visits per benefit period (8hr shifts)	80%; 60 visits per benefit period (8hr shifts), $100k lifetime max	Deductible, then 80% to $10,000/year/person
MENTAL HEALTH/SUBSTANCE						
Mental Inpatient	100%	Deductible; then 70%	100% after $100 copay	60% after deductible and $100 copay	100%	100%
Substance Abuse Inpatient	100%	Deductible; then 70%	100% after $100 copay	60% after deductible and $100 copay	100%	100%
Outpatient Mental Health and Substance Abuse	100%	70%	100% after deductible	60% after deductible	100% after $35 copay	Visit 1-3 100% 4+ $5/$15 (Group/Individual)
Office Setting	Visit 1-3 100% 4+ $5/$15 (Group/Individual)	70%	100% after office copayment	60% after deductible	100% after $5 copay	$5 copay up to $200 maxium then 100%

The Benefits listed are intended to provide a general overview of the indicated programs. Please refer to the SPD or contact your Benefitis Specialist for additional information.

* Payment at in-network level across the board only applies to true Medical Emergencies & Accidental Injuries