



## Garden State Plan

### VERY IMPORTANT New Jersey Providers Only

Benefit (Excludes BlueCard)	In-Network	Out-of-Network
<b>Benefit Period</b>	Calendar Year	
<b>Deductible</b>	Deductible is Calendar Year.	
Individual	None	\$350
Family	None	\$700
<b>Coinsurance</b>	100%	70%
<b>Maximum Out of Pocket</b>	Deductible is Calendar Year.	
Individual	\$500	\$2,000
Family	\$1,000	\$5,000
Split Maximum Out of Pocket is Calendar Year . The deductible, coinsurance, 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.		
<b>Benefit Period Maximum</b>	Unlimited	
<b>Lifetime Maximum</b>	Unlimited	
<b>Primary Care Physician Selection</b>	Not Required	
<b>Doctor's Office Visits</b>	A referral is not required to visit a specialist.	
Primary Care Office Visit	100% after \$10 copay A primary care physician is a general or family practitioner, internist or pediatrician	70% after deductible
Specialist Office Visit	100% after \$15 copay	70% after deductible
Maternity Visits	100% after \$15 copay Copay applies to 1st visit only Dependent children are eligible for Maternity/Obstetrical Benefits.	70% after deductible
Allergy Testing and Treatment	100%	70% after deductible
<b>Preventive Care</b>	Dependent children are eligible for Maternity/Obstetrical Benefits.	
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)
<b>Diagnostic Procedures</b>	Dependent children are eligible for Maternity/Obstetrical Benefits.	
Laboratory	100% in office or in a Preferred Lab 100% in Outpatient facility	70% after deductible
Outpatient X-ray/Radiology Services	100% in office 100% 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 <b>1-866-496-6200</b> and providing the necessary clinical information. Once the authorization number is received, the member may call eviCore healthcare at <b>1-866-969-1234</b> to schedule an appointment.		
<i>Note: Managed Care members can call <b>1-866-969-1234</b> to obtain a confirmation number for non-Advanced Imaging diagnostic procedures. Confirmation numbers from eviCore healthcare replace the need for a paper referral.</i>		
<b>Hospital Care</b>	Dependent children are eligible for Maternity/Obstetrical Benefits.	
Inpatient Admission (including maternity)	100%	70% after deductible
Pre-admission Testing	100%	70% after deductible
Surgery in Hospital	100%	70% after deductible
Inpatient Physician Services	100%	70% after deductible
Outpatient Dept. Services	100%	70% after deductible
<b>Emergency Care</b>	100% after \$125 copay	
Emergency Room	Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.	
Ambulance	90%	70% after deductible



## Garden State Plan

Outpatient Surgery		
Hospital Outpatient Surgery	100%	70% after deductible
Surgery in an Ambulatory SurgiCenter	100%	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	100%	70% after deductible
Outpatient department	100%	70% after deductible
Office setting	100% after \$15 copay	70% after deductible
Substance Abuse Services		
Inpatient	100%	70% after deductible
Outpatient department	100%	70% after deductible
Office setting	100% after \$15 copay	70% after deductible
Alcohol Abuse Services		
Inpatient	100%	70% after deductible
Outpatient department	100%	70% after deductible
Office setting	100% after \$15 copay	70% 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		
	100% after \$15 copay	70% after deductible maximum allowance per visit up to \$60
Acupuncture	Unlimited	
Bariatric Surgery	100%	70% after deductible
Diabetic Education	100% after \$15 copay	70% after deductible
Diabetic Supplies	100%	70% after deductible
Durable Medical Equipment	90%	70% after deductible
Home Health Care	100%	70% after deductible
Hospice Care	100%	70% after deductible
Infertility (including in-vitro fertilization)	100% after \$15 copay Limited to 4 egg retrievals per lifetime	70% after deductible
Nutritional Counseling	100% after \$15 copay Limited to 3 visits per benefit period	70% after deductible
Orthotics and Prosthetics	100% after \$10 copay	70% after deductible
Physical Rehabilitation Facility Inpatient Services	100%	70% after deductible
Private Duty Nursing	90% Unlimited	70% after deductible
Physical Therapy	100% after \$15 copay Unlimited	70% after deductible maximum allowance per visit up to \$52
Short-term Therapies: Occupational, Speech, Respiratory	100% after \$15 copay	70% after deductible
Skilled Nursing Facility/Extended Care Center	100% up to 120 days The overall maximum per benefit period is 120 days combined in and out of network.	70% after deductible up to 60 days
Therapeutic Manipulation (Chiropractic Care)	100% after office copay 30 visit maximum per benefit period	70% after deductible
Vision - Routine Eye Exam	100% after \$15 copay	Not Covered
Vision Hardware	Not Covered	
Telemedicine	100% after \$15 copay	Not Covered
Prescription Drugs		
Covered under a freestanding Rx program		

The out-of-network reasonable and customary allowance is only 200% of Medicare. This is the same allowance as the NJEHP but considerable less than your other Horizon Plans. If you see any out-of-state providers they will not be covered.