SHIF Garden State Plan

NJ Garden State Plans provide services performed by providers located within the state of New Jersey Only. Services performed by a provider located outside the state of New Jersey is not covered.

	In-Network Designated	Out-Of-Network/Non Designated Providers
REPLACING CURRENT PLAN	**Horizon Garden State**	**Horizon Garden State**
Is a PCP Selection required? (*Yes or No)*	No	No
Are Referrals required? *(Yes or No)*	No	No
Deductible - Individual/Family	None	$350/$700
Max Out of Pocket In Network - Individual/Family	$500/$1000	$2000/$5000
Routine Well Adult Exam	No deductible 100%	not covered
Routine Gyn Exam	No deductible 100%	After deductible 70%
Routine Mammography	No deductible 100%	After deductible 70%
Routine Well Child Exams	100% - per age/frequency schedule	not covered - immunizations 70% no deductible for children under 12 months
Routine Eye Exam	$15 copay	not covered
Routine Eye Exam Frequency	1 per calendar year	not covered
Vision Eyewear Reimbursement Allowance and Frequency	not covered	not covered
PCP Office Visit	$10 copay	After deductible 70%
Specialist Office Visit	$15 copay	After deductible 70%
Maternity Prenatal Care	$15 copay for initial visit then 100%	After deductible 70%
Diagnostic X-Ray/Lab in Office	No deductible 100% but if billed as part of an Office Visit, copay will apply	After deductible 70%
Diagnostic X-Ray/Lab in Facility	No deductible 100%	After deductible 70%
Complex Imaging in Facility	No deductible 100%	After deductible 70%
Urgent Care	$15 copay	After deductible 70%
Emergency Room - In Network & Out of Network	$125 copay	$125 copay
Is Non-Emergency care at ER covered?	No	No
Ambulance	No deductible 90%	After deductible 70%
Is Non-Emergency Ambulance transport covered?	No	No
Inpatient Hospital Services	No deductible 100%	After deductible 70%
Per Confinement Copay	N/A	N/A
Outpatient Hospital Services	No deductible 100%	After deductible 70%
Outpatient Surgery	No deductible 100%	After deductible 70%
Skilled Nursing Facility	No deductible 100%	After deductible 70%
Skilled Nursing Facility - Limits *(# of days per calendar year)*	120	60
Home Health Care	100%	After deductible 70%
Home Health Care Limits *(# of visits per calendar year)*	No limit	No limit
Hospice	No deductible 100%	After deductible 70%
Durable Medical Equipment	No deductible 90%	After deductible 70%
Orthotics / Prosthetics	$15 copay	After deductible 70%
Diabetic Supplies	No deductible 90%	After deductible 70%
Acupuncture	$15 copay	Lesser of $60/visit or 75% of In-network cost/visit
Short Term Rehab - Physical Therapy	$15 copay	Lesser of $52/visit or 75% of In-network cost/visit
Physical Therapy Limits *(# of visits per calendar year)*	no limit	no limit
Short Term Rehab - Occupational Therapy	$15 copay	After deductible 70%
Occupational Therapy Limits? *(# of visits per calendar year)*	no limit	no limit
Short Term Rehab - Speech Therapy	$15 copay	After deductible 70%
Speech Therapy Limits *(# of visits per calendar year)*	no limit	no limit
Spinal Manipulation/Chiro	$15 copay	Lesser of $35/visit or 75% of in-network cost/visit
Spinal Manipulation/Chiro Limits *(# visits per calendar year)*	30 visits	30 visits
Mental Health Inpatient	100%	After deductible 70%
Mental Health Outpatient - Office Setting	$15 copay	After deductible 70%