



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

DIRECT ACCESS DESIGN 8

Carlstadt BOE 82760-03, 04, 05 & 51

Benefit	In-Network	Out-of-Network
Benefit Period	Calendar Year	
Deductible		
Individual	None	\$100
Family	None	\$250
	Deductible is Calendar Year.	
Coinsurance	100%	70%
Maximum Out of Pocket		
Individual	\$400	\$2,000
Family	\$800	\$5,000
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.		
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 \$5 copay A primary care physician is a general or family practitioner, internist or pediatrician	70% after deductible
Specialist Office Visit	100% after \$5 copay A referral is not required to visit a specialist.	70% after deductible
Maternity Visits	100% after \$5 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
Preventive Care		
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)
Diagnostic Procedures		
Laboratory	100% in Office or Labcorp 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. The ordering physician should request the prior authorization by calling CareCore National, LLC (CCN) at 1-866-496-6200 and providing the necessary clinical information. Once the authorization number is received, the member may call CCN at 1-866-969-1234 to schedule an appointment.		
Note: Managed Care members can call 1-866-969-1234 to obtain a confirmation number for non-Advanced Imaging diagnostic procedures. Confirmation numbers from CCN replace the need for a paper referral.		
Hospital Care		
Inpatient Admission (including maternity)	100%	70% after deductible and \$200 copay
Room and Board	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
Emergency Care		
Emergency Room	100% after \$25 facility copayment Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.	
Ambulance	100%	70% after deductible



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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 and \$200 copay
Outpatient department	100%	70% after deductible
Office setting	100% after \$10 copay	70% after deductible
Substance Abuse Services		
Inpatient	100%	70% after deductible and \$200 copay
Outpatient department	100%	70% after deductible
Office setting	100% after \$10 copay	70% after deductible
Alcohol Abuse Services		
Inpatient	100%	70% after deductible and \$200 copay
Outpatient department	100%	70% after deductible
Office setting	100% after \$10 copay	70% after deductible
Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Magellan Behavioral Health at 1-800-626-2212.		
Other Services		
Acupuncture	100%	70% after deductible
Bariatric Surgery	100%	70% after deductible
Diabetic Education	100% after \$10 copay	70% after deductible
Diabetic Supplies	100%	70% after deductible
Durable Medical Equipment	100%	70% after deductible
Home Health Care	100%	70% after deductible
Hospice Care	100%	70% after deductible
	100% after \$10 copay	70% after deductible
Infertility (including in-vitro fertilization)	Limited to 4 egg retrievals per lifetime	
	100%	70% after deductible
Nutritional Counseling	Limited to 3 visits per benefit period	
Orthotics and Prosthetics	100% after \$10 copay	70% after deductible
Physical Rehabilitation Facility Inpatient Services	100%	70% after deductible
Private Duty Nursing	100%	70% after deductible
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after \$10 copay	70% after deductible
Skilled Nursing Facility/Extended Care Center	100% up to 120 days	70% after deductible up to 60 days
	100% after \$10 copay	70% after deductible
Therapeutic Manipulation (Chiropractic Care)	30 visit maximum per benefit period No referral required	
Vision - Routine Eye Exam	100% after \$10 copay	70% after deductible
Vision Hardware	Not covered	
Prescription Drugs	Covered under a freestanding program	
Eligibility	Dependent children, including full-time students are covered until their 26th birthday. 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 age 31.	
Grandfathered	Not applicable	
Pre-Existing Conditions	Not applicable	