Horizon Blue Cross Blue Shield of New Jersey
Making Healthcare Work.

NJ TRANSIT Rail Agreement

Benefit	HMO	Advantage EPO
	In-Network Benefits Only (no out-of-state network)	In-Network Benefits Only **(Includes Bluecard network for out of state access)**
Benefit Period	Calendar Year	Calendar Year
Deductible		
Individual	None	None
Family	None	None
Coinsurance	100%	100%
Maximum Out of Pocket		
Individual	$8,550	$8,550
Family	$17,100	$17,100
	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 the allowance are not eligible towards the Maximum Out of Pocket.	Consolidated Maximum Out of Pocket is Calendar year. The deductible, coinsurance, prescription and copayments apply to the Maximum Out of Pocket.
Benefit Period Maximum	Unlimited	Unlimited
Lifetime Maximum	Unlimited	Unlimited
Primary Care Physician Selection	Required	**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	100% after $5 copay A primary care physician is a general or family practitioner, internist or pediatrician
Specialist Office Visit	100% after $5 copay A referral is required to visit a specialist.	100% after $5 copay **A referral is not required to visit a specialist.**
Maternity Visits	100% after $5 copay Copay applies to 1st visit only Dependent children are ineligible for Maternity/Obstetrical Benefits.	100% after $5 copay Copay applies to 1st visit only Dependent children are ineligible for Maternity/Obstetrical Benefits.
Allergy Testing and Treatment	100% Note: A copay will only apply when an office visit is billed.	100% Note: A copay will only apply when an office visit is billed.
Preventive Care		
Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations	100% Routine Physical Covered by PCP Only	100%
Well Child Exams	100% Covered by PCP Only	100%
Well Child Immunizations and Lead Screening	100%	100%
Diagnostic Procedures		
Laboratory	100% in office setting or in a Preferred Lab $35 copay in outpatient facility	100% in office setting or in a Preferred Lab $35 copay in outpatient facility
Outpatient X-ray/Radiology Services	100% after applicable copay in office setting $35 copay in outpatient facility	100% in office setting $35 copay in outpatient facility
Hospital Care		
Inpatient Admission (including maternity)	100%	100%
Room and Board	100%	100%
Pre-admission Testing	100% after $35 copay	100% after $35 copay
Surgery in Hospital	100%	100%
Inpatient Physician Services	100%	100%
Outpatient Dept. Services	100% after $35 copay	100% after $35 copay
Emergency Care		
Emergency Room	100% after $35 facility copay	100% after $35 facility copay
Ambulance	100%	100%
Outpatient Surgery		
Hospital Outpatient Surgery	100% after $35 facility copay	100% after $35 facility copay
Surgery in an Ambulatory SurgiCenter	100% after $35 facility copay	100% after $35 facility copay
	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.	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%	100%
Outpatient department	100% after $35 copay	100% after $35 copay
Office setting	100% after $5 copay	100% after $5 copay
Substance Abuse Services		

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Inpatient	100%	100%
Outpatient department	100% after $35 copay	100% after $35 copay
Office setting	100% after $5 copay	100% after $5 copay
Alcohol Abuse Services		
Inpatient	100%	100%
Outpatient department	100% after $35 copay	100% after $35 copay
Office setting	100% after $5 copay	100% after $5 copay
	Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Horizon Behavioral Health at 1-800-626-2212.	Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Horizon Behavioral Health at 1-800-626-2212.
Other Services		
Acupuncture	Excluded	Excluded
Bariatric Surgery	100% after $35 copay	100% after $35 copay
Diabetic Education	100% after applicable copay in office setting	100% after office copayment
Diabetic Supplies	100%	100%
Durable Medical Equipment	80%	80%
Orthotics and Prosthetics	80% One pair per benefit period	**80%**
Home Health Care	100% up to 100 days per benefit period	100% up to 100 days per benefit period
Hospice Care	100% Respite Care limited to 7 days	100% Respite Care limited to 7 days
Infertility Basic Coverage Only	100% after applicable copay in office setting ($35 copay if OPD is used) $5,000 lifetime maximum (Combined for subscriber & spouse) Does not cover IVF	100% after applicable copay in office setting ($35 copay if OPD is used) **$5,000 lifetime maximum per person** Does not cover IVF
Physical Rehabilitation Facility Inpatient Services	100% Limited to 60 days per benefit period	100% Limited to 60 days per benefit period
Private Duty Nursing	80% 60 8-hour shift visits per year (out-of-hospital only)	80% 60 8-hour shift visits per year (out-of-hospital only)
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after $5 copay Limited to 25 visits per benefit period	100% after office copayment 25 visit maximum per therapy, per benefit period
Skilled Nursing Facility/Extended Care Center	100% Limited to 60 visits per benefit period	100% Limited to 60 visits per benefit period
Therapeutic Manipulation (Chiropractic Care)	Visits 1 to 6: 50% after copay Visits 7 to 12: 25% after copay Limited to 12 visits per benefit period	**100% after $5 office copay** **Limited to 25 visits per benefit period**
Vision - Routine Eye Exam	1 routine exam per benefit period - no referral required	1 routine exam per benefit period - no referral required
Vision Hardware	$50 every two years	$50 every two years
Telemedicine	100% after $5 copay	100% after $5 copay