



DIRECT ACCESS 50% EPO \$2500 - Plan 866

BENEFIT DESCRIPTION

Benefit	Network	Non-Network
Deductible (Calendar year)	\$2,500 single coverage / \$5,000 multiple coverage	No Benefit
Hospital Pre Certification and Utilization Review is required for all hospital admissions.		
Hospital		
Medical Emergency/Accidental Injury	50% after \$150 Co-Pay: Co-Pay Waived if admitted.	No Benefit for non-emergency diagnosis, true emergency diagnosis covered at the In-Network level
Facility Charges	50% after deductible, Subject to Pre-Approval and Per Admission Co-Pay	No Benefit
Professional Office Care	Up to \$50 Co-Pay	No Benefit
Professional Care (Out-Patient)	50% after deductible	No Benefit
Skilled Nursing Facility	50% after deductible	No Benefit
Home Health Agency Care	50% after deductible	No Benefit
Hospice Care	50% after deductible	No Benefit
Physician Services		
Surgical Services	\$50 Co-Pay	No Benefit
In-Patient Services	50% after deductible	No Benefit
Primary Care Physician	\$35 Co-Pay	No Benefit
Specialist Services	\$50 Co-Pay	No Benefit
Preventive Care		
Immunizations, out-patient well baby care and periodic health exams	100% covered	No Benefit
Therapy Services		
Therapeutic Manipulation	\$35 Co-Pay 30 Visits a year	No Benefit
Respiratory	50% after deductible 30 Visits a year	No Benefit
Cognitive, Occupational, Physical, Speech	50% after deductible 60 Visits a year for each therapy	No Benefit
Chelation, Chemotherapy, Dialysis, Infusion, Radiation Treatment	50% after deductible	No Benefit

Benefit	Network	Non-Network
Mental Health/Substance Abuse		
All Mental Health/Substance Abuse Care services must be coordinated through the Horizon BCBSNJ/Value Options. Mental Illness and Substance Abuse will be paid as any other medical condition pursuant to the NJ State mandate.		
In-Patient Services	50% after deductible, Subject to Pre-Approval and Per Admission Co-Pay	No Benefit
Out-Patient Services	\$50 Co-Pay	No Benefit
In-Patient Medical Visits	50% after deductible	No Benefit
Other Services		
Anesthesia	50% after deductible	No Benefit
Ambulance (Air & Ground transportation only)	50% after deductible	No Benefit
Durable Medical Equipment	50% after deductible	No Benefit
Infertility (Excludes In-Vitro Fertilization)	50% after deductible	No Benefit
Diagnostic X-Ray and Lab	50% after deductible	No Benefit
Private Duty Nursing	50% after deductible 30 Visits a year	No Benefit
Nutrition Counseling	\$50 Co-Pay 3 Visits per year	No Benefit
Vision Care	\$50 Co-Pay 1 Eye Examination and 1 Vision Survey per year	No Benefit
Vision Hardware Coverage	\$50 allowance in a 2-calendar year period	No Benefit
Prescription Drug Card (Generic/Brand/Non-Preferred)	Deductible does not apply. \$15/\$35/\$50 co-pay for 30-day supply. Up to 90-day supplies are available through the mail order service subject to up to 3 times the applicable co-payment amount. Prior authorization may be required. Additional charges apply when using an out-of-network pharmacy.	
NETWORK	Horizon BCBSNJ's payment for eligible expenses when services are obtained from one of the providers in the Managed Care Network. Horizon BCBSNJ reimburses both Primary Care physicians and Specialist at the applicable allowance on a fee for service basis.	
NON-NETWORK	No Benefit	
PER-ADMISSION CO-PAY	\$500 Co-Pay per day up to 5 days per admission 2 admission Co-Pay max per year	
COINSURANCE	In Network Eligible Expenses - 50%.	
MAXIMUM OUT OF POCKET (MOOP)	In-Network MOOP - \$6,250 per person / \$12,500 per family. 100% thereafter.	
For complete information & verification of all your benefits, refer to your benefits certificate. In the event a conflict exists between the information contained on this benefit description and the actual terms of the group contract, the terms of the contract will prevail. For further information on your contract, you may call customer service at (973) 379-1090.		
Plan 866		Effective Date: 11-01-2025