

## DIRECT ACCESS DESIGN AP Benefit Highlights

Plan	Office Visit Copayment	Deductible		Maximum Out-of-Pocket*	
		In-Network	Out-of-Network	In-Network	Out-of-Network
<b>DIRECT ACCESS DESIGN AP 100/80/60</b>	<b>\$20/\$40</b>	<b>None</b>	<b>\$2000 per indiv./ two ded. per family</b>	<b>\$5000 per indiv./ \$10000 per family</b>	<b>\$10000 per indiv./ \$20000 per family</b>
		In-Network		Out-of-Network	
Coinsurance					
Hospital/Facility		80%		60%	
Professional					
Services rendered in Office		100%		60%	
All other Services		80%		60%	
Supplemental		80%		60%	
Maximums					
Benefit Period				Unlimited	
Lifetime				Unlimited	
<b>HOSPITAL/FACILITY SERVICES</b>		In-Network		Out-of-Network	
<b>Hospital Services Copay</b>					
Inpatient (per admission)		\$500		\$0	
<b>Inpatient Services</b>					
Room & Board		80%		60% after deductible	
Semi-Private Room					
Intensive Care & Other Hospital Services					
Organ Transplants (Includes ABMT)		80%		60% after deductible	
<b>Outpatient Services</b>					
Hospital Services (operating room, blood administration, general nursing, therapy/ diagnostic services, etc.)		80%		60% after deductible	
Pre-Admission Testing		80%		60% after deductible	
Medical Emergency/Accidental Injury				80% after \$100 copay (\$100 copay applies to facility charges)	
Ambulatory Surgical Center		80% after \$300 copay		60% after deductible	
Surgery in Hospital Outpatient Department		80% after \$500 copay		60% after deductible	
Skilled Nursing Facility		80% up to 100 days		60% after deductible up to 60 days	
Home Health Care		80%		60% after deductible up to 100 visits	
Hospice Care (Eligibility requires a confirmed diagnosis of terminal illness with a life expectancy of 6 months or less)		80%		60% after deductible	
				Combined \$9,000 lifetime maximum	
<b>PHYSICIAN SERVICES</b>		In-Network		Out-of-Network	
<b>Inpatient Services</b>					
Medical Care (including consultations)		80%		60% after deductible	
Surgical Services (including assistant surgeon and anesthesia)		80%		60% after deductible	
Diagnostic/Therapy Services		80%		60% after deductible	
<b>Outpatient/Out-of-Hospital Services</b>		Office		All Other	
Office Visits (including related diagnostic/therapy services) when medically necessary		100% after \$20 copay, \$40 for specialists		60% after deductible	
Medical and Surgical Care (including related diagnostic/therapy services)		100% after \$20 copay, \$40 for specialists		80%	
Diagnostic X-ray and Lab		100%		80% (LabCorp @ 100%)	
Allergy Testing, Treatment & Injections		100%**		80%	
Maternity Care (Employee & Spouse)		100% after \$20 copay, \$40 for specialists (copay on 1st visit only)		80%	
		100%**		80%	
Infertility (includes in-vitro fertilization per NJ Mandate)				4 egg retrievals per lifetime	
Preventive Care		100% after \$20 copay, \$40 for specialists		60% (no deductible)	
Well Child Care (through age 19)					
Child Immunizations/Lead Testing**					
Annual Routine Physicals (beginning at age 20 per NJ Mandate)					
Annual Prostate Screening (men age 40 and over)**					
Annual Routine Gyn Exam & Pap (per NJ Mandate)					
Mammography (per NJ Mandate)**				1 baseline between ages 35 and 39; 1 per benefit period age 40 and older***	
Short Term Therapies: Physical, Speech, Occupational, Respiratory/Inhalation Therapy (Limit of 3 modalities per visit - out of network only)		100% after \$20 copay		80%	
				60% after deductible	
				\$1,000 Ind./\$2,000 family maximum for each therapy	
				30 visit maximum per benefit period	
		100% after \$40 copay		80%	
				60% after deductible	
				\$1,000 Ind./\$2,000 family maximum per benefit period	
				25 visit maximum per benefit period	
Therapeutic Manipulations					
Diabetic Education (per NJ Mandate)		100% after \$20 copay, \$40 for specialists		80%	
				60% after deductible	

## DIRECT ACCESS DESIGN AP Benefit Highlights

OTHER SERVICES	In-Network	Out-of-Network
Ambulance (Ground Transport & Air Transport)	80%	60% after deductible
Bariatric Surgery	Not Covered	Not Covered
Diabetic Supplies	80%	60% after deductible
Durable Medical Equipment	50%	50% after deductible
	80%	60% after deductible
Physical Rehabilitation Facility Inpatient Services	Limited to 60 days	per benefit period
Prescription Drugs	Not Covered	Not Covered
	80%	60% after deductible
Private Duty Nursing	Limited to 30 visits per benefit period (8-hour shifts)	
Routine Vision Exam	Not Covered	
Vision Hardware	Not Covered	
MENTAL HEALTH/SUBSTANCE ABUSE <sup>1</sup>	In-Network	Out-of-Network
	80%	60% after deductible
Inpatient Services	45 days per benefit period 90 days per lifetime	30 days per benefit period 90 days per lifetime
	80% after \$40 copay	60% after deductible
Outpatient Services	50 visits per benefit period 150 visits per lifetime	20 visits per benefit period 60 visits per lifetime
	80% after \$40 copay	60% after deductible
Group Therapy	3 sessions = 1 outpatient visit	
Partial Hospitalization	80%	60% after deductible
	2 partial days = 1 inpatient day	
COST MANAGEMENT	In-Network	Out-of-Network
Catastrophic Case Management	Covered	
Pre-Admission Review	Network Physician's Responsibility In State Member Responsibility Out of State	Member Responsibility 20% reduction for noncompliance
ELIGIBILITY		
Children are covered to the end of the calendar year in which they turn age 19. Full-time students are covered until the end of the calendar year in which they reach age 25 or until the end of the month during which their full-time student status ends. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to age 19. Under certain conditions, coverage may be extended for qualified dependents up to age 30. Dependent children are ineligible for Maternity/Obstetrical Benefits.		

**In-Network** - Horizon BCBSNJ's payment for eligible expenses when services are obtained from one of the providers in our Managed Care Network. Horizon BCBSNJ reimburses both Primary Care physicians and Specialists at the applicable allowance and the member will not be responsible for any balance bill after payment of any applicable copayment or coinsurance. Direct Access provides the highest level of benefits for in-network services and the member does not have to file claims. This is a split copay program. The lower copayment applies to office services for the following providers: General Practice, Family Practice, Internal Medicine, and Pediatricians. The higher copayment applies to all other provider types, including OB/GYNs. No referrals are required.

**Out-of-Network** - Horizon BCBSNJ's payment for eligible services that are not obtained from one of the providers in our Managed Care Network. The member may see any physician if he/she is willing to pay a greater share of the costs. Non-network services are reimbursed at 150% CMS (Medicare) and providers may balance bill up to their charges. An annual deductible and a coinsurance applies to all eligible medical and most supplemental services. Once the member reaches the out of pocket maximum, the Plan pays 100% of the appropriate allowance for eligible services for the rest of the year. The member is responsible for complying with all utilization review and cost containment programs.

#### Pre-Existing Condition Exclusion

Employees and Dependents who have continuous coverage under the prior group contract and/ or other previous health coverage, with no break in coverage of 63 days or more, will not be subject to the pre-existing condition exclusion. If the exclusion applies, for the first twelve months after an eligible person's enrollment under the contract, no benefits will be provided for services incident to, resulting from, or relating to any disease, injury or condition, which was treated or diagnosed by a health care professional within the six month period prior to enrollment for that person. Note, this does not apply to children who enroll within 30 days of birth or adoption.

This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract. Please refer to your booklet for more information.

<sup>1</sup> All Mental Health/Substance Abuse Care Services must be coordinated through the Horizon BCBSNJ/Magellan Behavioral Health Program. Alcoholism and Biologically Based Mental Illnesses will be paid as any other medical condition pursuant to the NJ state mandates.

\*All copayments, deductibles and coinsurance count towards the Out-of-Pocket maximum.

\*\*Copay will apply when an office visit procedure code is billed separately.

\*\*\*More frequent mammograms are covered if under age 40 with a family history of breast cancer or other breast cancer risk factors.

Services and products provided through Horizon Healthcare of New Jersey or Horizon Blue Cross Blue Shield of New Jersey. Each of which is an independent licensee of the Blue Cross and Blue Shield Association.

® Registered marks of the Blue Cross and Blue Shield Association.

® and SM Registered and service marks of Horizon Blue Cross Blue Shield of New Jersey.

© 2006 Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza East, Newark, New Jersey 07105

www.HorizonBlue.com