

DIRECT ACCESS DESIGN DZ

Benefit Highlights

Plan	Office Visit Copayment	Deductible		Maximum Out-of-Pocket*	
		In-Network	Out-of-Network	In-Network	Out-of-Network
DIRECT ACCESS DESIGN DZ 100/70	\$15	None	\$500 per indiv./two ded. per family	\$3000 per indiv./\$6000 per family	
		In-Network	Out-of-Network		
Coinsurance		100%	70%		
Maximums			Unlimited		
Benefit Period			Unlimited		
Lifetime			Unlimited		
HOSPITAL/FACILITY SERVICES		In-Network	Out-of-Network		
Hospital Services Copay					
Inpatient (per admission)		None	None		
Inpatient Services					
Room & Board		100%	70% after deductible		
Semi-Private Room					
Intensive Care & Other Hospital Services					
Organ Transplants (Includes ABMT)		100%	70% after deductible		
Outpatient Services					
Hospital Services (operating room, blood administration, general nursing, therapy/ diagnostic services, etc.)		100%	70% after deductible		
Pre-Admission Testing		100%	70% after deductible		
Medical Emergency/Accidental Injury			100% after \$50 copay (\$50 copay applies to facility charges)		
Ambulatory Surgical Center		100%	70% after deductible		
Surgery in Hospital Outpatient Department		100%	70% after deductible		
Skilled Nursing Facility		100% up to 100 days	70% after deductible up to 60 days		
Home Health Care		100%	70% 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)		100%	70% after deductible Combined \$9,000 lifetime max.		
PHYSICIAN SERVICES		In-Network	Out-of-Network		
Inpatient Services					
Medical Care (including consultations)		100%	70% after deductible		
Surgical Services (including assistant surgeon & anesthesia)		100%	70% after deductible		
Diagnostic/Therapy Services		100%	70% after deductible		
Outpatient/Out-of-Hospital Services					
Office Visits (including related diagnostic/therapy services) when medically necessary		100% after \$15 copay	70% after deductible		
Medical and Surgical Care (including related diagnostic/therapy services)		100% after \$15 copay	70% after deductible		
Diagnostic X-ray and Lab		100%	70% after deductible		
Allergy Testing, Treatment & Injections		100%**	70% after deductible		
Maternity Care (Employee & Spouse)		100% after \$15 copay (Copay on 1st visit only)	70% after deductible		
Infertility (includes in-vitro fertilization per NJ Mandate)			4 egg retrievals per lifetime		
Preventive Care		100% after \$15 copay	70% (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 (beginning at age 20 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)		100% after \$15 copay	70% after deductible \$1,000 Ind./\$2,000 Family max for each therapy 30 visit maximum per benefit period		
Therapeutic Manipulations		100% after \$15 copay	70% after deductible \$1,000 Individual/\$2,000 Family maximum per benefit period 25 visit maximum per benefit period		
Diabetic Education		100% after \$15 copay	70% after deductible		

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OTHER SERVICES	In-Network	Out-of-Network
Ambulance (Ground Transport & Air Transport)	100%	70% after deductible
Bariatric Surgery	100%	70% after deductible
Diabetic Supplies	100%	70% after deductible
Durable Medical Equipment	100%	70% after deductible
Physical Rehabilitation Facility Inpatient Services	100%	70% after deductible
Prescription Drugs	Not Covered	Not Covered
Routine Vision Exam	1 per benefit period	1 per benefit period
Vision Hardware	\$100 every two years	\$100 every two years
MENTAL HEALTH/SUBSTANCE ABUSE ¹	In-Network	Out-of-Network
Inpatient Services	100%	70% after deductible
	45 days per benefit period	30 days per benefit period
	90 days per lifetime	90 days per lifetime
Outpatient Services	100% after \$15 copay	70% after deductible
	50 visits per benefit period	20 visits per benefit period
	150 visits per lifetime	60 visits per lifetime
Group Therapy	100% after \$15 copay	70% after deductible
	3 sessions = 1 outpatient visit	3 sessions = 1 outpatient visit
Partial Hospitalization	100%	70% after deductible
	2 partial days = 1 inpatient day	2 partial days = 1 inpatient day
COST MANAGEMENT	In-Network	Out-of-Network
Catastrophic Case Management	Covered	Covered
Pre-Admission Review	Physician Network 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 on a fee for service basis. 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. 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. Horizon BCBSNJ reimburses participating providers at the applicable allowance. Non-network providers are reimbursed at 80th percentile HIAA and may balance bill to 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.

¹ 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.

*The Out-of-Pocket Maximum is combined in and out of network and is combined for Hospital/Facility, Professional and Supplemental services. 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.

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Three Penn Plaza East, Newark, New Jersey 07105