

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY
DIRECT ACCESS DESIGN E
Delva Tool

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. Direct Access provides the highest level of benefits for in-network services and the member does not have to file claims.

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 up to our applicable allowance 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 catastrophic limit, the Plan pays 100% of the appropriate allowance for eligible services for the rest of the year. There is a lifetime maximum for each member. The member is responsible for complying with all utilization review and cost containment programs.

	In-Network	Out-of-Network
ALL SERVICES		
Benefit Period	Calendar Year	
Deductible (Total combined per year)		
Hospital/Facility	None	\$1,000 per indiv./two ded. per family
Professional	None	\$1,000 per indiv./two ded. per family
Supplemental	None	\$1,000 per indiv./two ded. per family
Coinsurance		
Hospital/Facility	100%	60%
Professional	100%	60%
Supplemental	100%	60%
Catastrophic Limit (Services are reimbursed at 100% after cata. limit is reached)		
Hospital/Facility	None	\$10,000 per ind./\$25,000 per family
Professional	None	\$10,000 per ind./\$25,000 per family
Supplemental	None	\$10,000 per ind./\$25,000 per family
Maximums		
Benefit Period		Unlimited
Lifetime		Unlimited
HOSPITAL/FACILITY SERVICES		
Inpatient Services		
Room & Board (semi-private room)	100%	60% after deductible
Intensive Care & Other Hospital Services (therapy/diagnostic services, blood administration, general nursing, operating room, etc.)	100%	60% after deductible
Maternity Benefits	100%	60% after deductible
Organ Transplants (Includes ABMT)	100%	60% after deductible
Outpatient Services		
Hospital Services (operating room, blood administration, general nursing, therapy/diagnostic services, etc.)	100%	60% after deductible
Pre-Admission Testing	100%	60% after deductible
Medical Emergency/Accidental Injury	100% after \$50 copay if notified within 48 hours If not notified within 48 hours, 60% after deductible \$50 copay applies to facility charges	
Surgical Center	100%	60% after deductible
Skilled Nursing Facility	100% up to 100 days	60% after deductible up to 60 days
Home Health Care	100%	60% after deductible up to 100 visits
Hospice Care	100%	60% after deductible combined \$9,000

	In-Network	Out-of-Network
PHYSICIAN SERVICES		
Inpatient Services		
Medical Care (including consultations)	100%	60% after deductible
Surgical Services (including assistant surgeon and anesthesia)	100%	60% after deductible
Obstetrical Services (i.e., normal delivery, cesarean section, abortion)	100%	60% after deductible
Diagnostic/Therapy Services	100%	60% after deductible
Outpatient/Out-of-Hospital Services		
Office Visits (including related diagnostic/therapy services) when medically necessary	100% after \$20 copay	60% after deductible
Medical and Surgical Care (including related diagnostic/therapy services)	100% after \$20 copay	60% after deductible
Diagnostic X-ray and Lab	100%	60% after deductible
Allergy Testing, Treatment & Injections	100% after \$20 copay	No Benefit
Maternity Care	100% after \$20 copay (first visit only)	60% after deductible
Infertility (excludes in-vitro fertilization)	100% after \$20 copay \$5,000 lifetime maximum	60% after deductible
Well Child Care (through age 19)	100% after \$20 copay	No Benefit
Child Immunizations/Lead Testing (NJ Mandate)	100% after \$20 copay	60% (no deductible)
Routine Physicals (beginning at age 20) (Health Wellness NJ Mandate)	100% after \$20 copay 1 per year	60% (no deductible)
Prostate Screening (NJ Mandate)	100% after \$20 copay 1 per year	60% (no deductible) Men age 40 and over, 1 per year
Annual Routine Ob/Gyn Exam	100% after \$20 copay No referral needed - 1 per ben. period	60% (no deductible)
NJ Pap and Mammography Mandates	100% after \$20 copay 1 per benefit period	60% (no deductible)
Short Term Therapies: Physical, Speech, Occupational, Respiratory/Inhalation Therapy	100% after \$20 copay 30 visit maximum	60% after deductible \$1,000Ind./\$2,000 Family max for each therapy
Therapeutic Manipulations	100% after \$20 copay \$1,000 Individual/\$2,000 Family maximum per benefit period 25 visits within a 60 day period maximum	60% after deductible
Routine Vision Exam	100% after \$20 copay 1 per benefit period	60% after deductible
SUPPLEMENTAL SERVICES		
Ambulance (Ground Transport Only)	100%	60% after deductible
Private Duty Nursing	100% limited to 30 visits	No Benefit
Durable Medical Equipment	100% Combined \$5,000 maximum (no maximum on prosthetics)	60% after deductible
Diabetic Supplies (NJ mandate)	100%	60% after deductible
Diabetic Education (NJ mandate)	100% after applicable copayment	60% after deductible
Prescription Drugs	Covered under freestanding rx plan	
Physical Rehabilitation Facility Inpatient Services	100% limited to 60 days	No Benefit
Oxygen & Administration	100%	60% after deductible
Nutrition	100% after \$20 copay 3 visits per year	No Benefit
Vision Hardware	\$100 every two years	
Blood Charges	100%	60% after deductible

	In-Network	Out-of-Network
MENTAL HEALTH/SUBSTANCE ABUSE **		
Inpatient Services	100% 45 days per benefit period 90 days per lifetime	60% after deductible 30 days per benefit period 90 days per lifetime
Outpatient Services	100% after \$20 copay 50 visits per benefit period 150 visits per lifetime	60% after deductible 20 visits per benefit period 60 visits per lifetime
Group Therapy	100% after \$20 copay 3 sessions = 1 visit	No Benefit
Partial Hospitalization	2 partial days = 1 inpatient day 45 days per benefit period	No Benefit
** All Mental Health/Substance Abuse Care Services must be coordinated through the Horizon BCBSNJ/Magellan Behavioral Health Program. Biologically Based Mental Illnesses will be paid as any other medical condition pursuant to the NJ state mandate. The Catastrophic limit does not apply to Mental Health/Substance Abuse.		
COST MANAGEMENT		
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 covered to the end of the calendar year in which they turn age 19. Full-time students 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 covered beyond the child removal age, if handicap occurred prior to age 19. Dependent children are ineligible for Maternity/Obstetrical Benefits		

Pre-Existing Condition Exclusion

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 eligible person. Note: This does not apply to children who enroll within 30 days of birth or adoption or employees and dependents who have satisfied a pre-existing condition exclusion under their prior group contracts.

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.