

**DIRECT ACCESS DESIGN 5**  
**Benefit Highlights**  
**Porky Products, Inc.**

- HIGH PLAN

Plan	Office Visit Copayment	Deductible		Maximum Out-of-Pocket*	
		In-Network	Out-of-Network	In-Network	Out-of-Network
<b>DIRECT ACCESS DESIGN 5</b> 100/70	\$15/30	None	\$500 per indiv./two ded. per family	\$3000 per indiv./\$6000 per family	
		<b>In-Network</b>		<b>Out-of-Network</b>	
Coinsurance		100%		70%	
Maximums		Unlimited		Unlimited	
Benefit Period		Unlimited		Unlimited	
Lifetime		Unlimited		Unlimited	
<b>HOSPITAL/FACILITY SERVICES</b>		<b>In-Network</b>		<b>Out-of-Network</b>	
<b>Hospital Services Copay</b>					
Inpatient (per admission)		\$300		\$300	
<b>Inpatient Services</b>					
Room & Board		100%		70% after deductible	
Semi-Private Room					
Intensive Care & Other Hospital Services					
Organ Transplants (Includes ABMT)		100%		70% after deductible	
<b>Outpatient Services</b>					
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)		70% after deductible	
Ambulatory Surgical Center		100% after \$100 copay		70% after deductible	
Surgery in Hospital Outpatient Department		100% after \$100 copay		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	
		Unlimited lifetime maximum			
<b>PHYSICIAN SERVICES</b>		<b>In-Network</b>		<b>Out-of-Network</b>	
<b>Inpatient Services</b>					
Medical Care (including consultations)		100%		70% after deductible	
Surgical Services (including assistant surgeon and anesthesia)		100%		70% after deductible	
Diagnostic/Therapy Services		100%		70% after deductible	
<b>Outpatient/Out-of-Hospital Services</b>					
Office Visits (including related diagnostic/therapy services) when medically necessary		100% after \$15/30 copay		70% after deductible	
Medical and Surgical Care (including related diagnostic/therapy services)		100% after \$15/30 copay		70% after deductible	
Diagnostic X-ray and Lab		100%		70% after deductible	
Allergy Testing, Treatment & Injections		100%**		70% after deductible	
Maternity Care		100% after \$15/30 copay (Copay applies to 1st visit only)		70% after deductible	
		100%**		70% after deductible	
Infertility (includes in-vitro fertilization per NJ Mandate)		4 egg retrievals per lifetime		70% (no deductible)	
Preventive Care		100% after \$15/30 copay		70% (no deductible)	
Well Child Care (through age 19)					
Child Immunizations/Lead Testing (per NJ Mandate)**					
Annual Routine Physicals (beginning at age 20)					
Annual Prostate Screening (men age 40 and over)**					
Annual Routine Gyn Exam & Pap (per NJ Mandate)					
Mammography Mandate (per NJ Mandate)**		One baseline between ages 35 and 39; 1 per benefit period age 40 and older***		70% after deductible	
Short Term Therapies: Physical, Speech, Occupational, Respiratory/Inhalation		100% after \$15/30 copay		\$1,000 Ind./\$2,000 Family max for each therapy	
(Limit of 3 modalities per visit - out of network only)		30 visit maximum per benefit period		70% after deductible	
		100% after \$15/30 copay		70% after deductible	
Therapeutic Manipulations		30 visit maximum per benefit period			
Diabetic Education		100% after \$15/30 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	Not Covered	Not Covered
Diabetic Supplies	100%	70% after deductible
Durable Medical Equipment	100%	70% after deductible
Physical Rehabilitation Facility Inpatient Services	Combined \$5000 maximum (no maximum on prosthetics)	
Prescription Drugs	100%	70% after deductible
Private Duty Nursing	Limited to 60 days per benefit period	
Routine Vision Exam (Limited to 1 per benefit period, if covered)	Covered under freestanding program	Covered under freestanding program
Vision Hardware	100%	70% after deductible
	Limited to 30 visits per benefit period (8-hour shifts)	
	100% after \$15/30 copay	70% after deductible
	\$50 in a 2 calendar year period	
MENTAL HEALTH/SUBSTANCE ABUSE <sup>1</sup>	In-Network	Out-of-Network
	100%	70% after deductible
Inpatient Services	45 days per benefit period 90 days per lifetime	30 days per benefit period 90 days per lifetime
Outpatient Services	100% after \$15/30 copay 25 visits per benefit period Unlimited per lifetime	70% after deductible 25 visits per benefit period Unlimited per lifetime
Group Therapy	100% after \$15/30 copay	70% after deductible
Partial Hospitalization	3 sessions = 1 outpatient visit	
	100%	70% after deductible
	45 days per benefit period	
COST MANAGEMENT	In-Network	Out-of-Network
Catastrophic Case Management	Covered	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 23 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 the child removal age. 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 pays 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. Direct Access provides the highest level of benefits for in-network services and the member does not have to file claims. If this is a split copay program, the lower copayment applies to office services for the following providers: General Practice, Family Practice, Internal Medicine, Pediatricians and all short term therapies. 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 the 80th HIAA schedule 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.

\*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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