



DIRECT ACCESS DESIGN 8

Benefit Highlights

Medford Township Board of Education

Plan	Office Visit Copayment	Deductible		Maximum Out-of-Pocket*	
		In-Network	Out-of-Network	In-Network	Out-of-Network
DIRECT ACCESS DESIGN 8 100/70	\$5	None	\$100 per indiv./ \$200 per family	\$400 per indiv./ \$800 per family	\$2000 per indiv./ \$4000 per family
		In-Network		Out-of-Network	
Coinsurance		100%		70%	
Maximums					
Benefit Period		Unlimited		\$5,000,000	
Lifetime		Unlimited		\$5,000,000	
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 \$25 copay (\$25 copay applies to facility charges)	
Skilled Nursing Facility		100%		70% after deductible up to 240 days per benefit period	
Home Health Care		100%		70% after deductible	
Hospice Care (Eligibility requires a confirmed diagnosis of terminal illness with a life expectancy of 6 months or less)		100%		70% after deductible	
PHYSICIAN SERVICES		In-Network		Out-of-Network	
Inpatient Services					
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	
Outpatient/Out-of-Hospital Services					
Office Visits (including related diagnostic/therapy services) when medically necessary		100% after \$5 copay		70% after deductible	
Medical and Surgical Care (including related diagnostic/therapy services)		100% after \$5 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 \$5 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 \$5 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)**					
Gyn Exam & Pap Exam (per NJ Mandate)					
Mammography (per NJ Mandate)**		One baseline between ages 35 and 39; Annual mammogram age 40 and over***			
Short Term Therapies: Physical, Speech, Occupational, Respiratory/Inhalation, Cognitive (Limit of 3 modalities per visit - out of network only)		100% after \$5 copay		70% after deductible	
Therapeutic Manipulations		100% after \$5 copay		70% after deductible	
Diabetic Education (per NJ Mandate)		100% after \$5 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 (per NJ Mandate)	100%	70% after deductible
Durable Medical Equipment	100%	70% after deductible
Physical Rehabilitation Facility Inpatient Services	100%	70% after deductible
Prescription Drugs	Covered under a freestanding program	
Routine Vision Exam (Limited to 1 per benefit period, if covered)	100% after \$5 copay	70% after deductible
Vision Hardware	\$100 in a 2 calendar year period	
MENTAL HEALTH ¹	In-Network	Out-of-Network
Inpatient Physician Services	100%	70% after deductible
Inpatient Facility Services	100% up to 35 days per benefit period	70% after deductible up to 60 days per benefit period
Outpatient Services	100% after \$5 copay up to 30 visits per benefit period	70% after deductible up to 30 visits per benefit period
Inpatient Detoxification	100%	70% after deductible up to 7 days
Outpatient Detoxification	100% after \$5 copay 100% up to 30 days per benefit period	70% after deductible up to 30 days per benefit period
Inpatient Rehabilitation		90 days per lifetime
Outpatient Rehabilitation	100% up to 60 visits per benefit period	70% after deductible up to 30 visits per benefit period, 120 visits per lifetime
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 non-compliance
ELIGIBILITY		

Children are covered to the end of the calendar year in which they turn age 23. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to age 23. Under certain conditions, coverage may be extended for qualified dependents up to age 30.

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. 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. Non-network services are reimbursed at the 90th of 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.

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.

*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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