



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HorizonBlue.com or by calling 1-800-355-BLUE (2583).

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$2,500 person / \$5,000 family for in-network services. \$7,500 person/ \$15,000 family for out-of-network. Does not apply to preventive care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For in-network providers \$5,000 person/ \$10,000 family and out-of- network providers \$15,000 person/ \$30,000 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, prescription drugs, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of in-network providers, see www.HorizonBlue.com or call 1-800-355-BLUE (2583).	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 co-pay/visit if PCP is selected; \$50 co-pay/visit if PCP is not selected	50% coinsurance after deductible	Primary Care Physician (PCP) selection recommended for maximum benefits.
	Specialist visit	\$50 co-pay/visit.	50% coinsurance after deductible	_____none_____
	Other practitioner office visit	\$30 copay/visit for therapeutic manipulation & therapies	50% coinsurance after deductible	30 visit limit per calendar year for therapeutic manipulation; 30 visit limit per calendar year per therapy for speech, physical, occupational & cognitive therapies.
	Preventive care/screening/immunization	No charge.	No charge.	Out-of-network: Maximum of \$500 per individual (except newborns) per calendar year; Newborns: maximum of \$750 per calendar year up to age 1.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible	50% coinsurance after deductible	Plan pays 100% when provided by a network lab.
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____

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Horizon BCBSNJ: Direct Access Plan A/50 70/50 (G2148-G2161) Coverage Period: 01/01/2012 – 12/31/2012

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: All Coverage Types | Plan Type: DA

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.HorizonBlue.com	Generic drugs	50% coinsurance	50% coinsurance	Prior authorization may be required. Covers up to a 90 day supply (retail only).
	Preferred brand drugs	50% coinsurance	50% coinsurance	Prior authorization may be required. Covers up to a 90 day supply (retail only).
	Non-preferred brand drugs	50% coinsurance	50% coinsurance	Prior authorization may be required. Covers up to a 90 day supply (retail only).
	Specialty drugs	50% coinsurance	50% coinsurance	Prior authorization may be required. Covers up to a 90 day supply (retail only).
	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____
If you have outpatient surgery	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____
	Emergency room services	30% coinsurance after \$100 copay and deductible	30% coinsurance after \$100 copay and deductible	Payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries. Copayment waived if admitted within 24 hours.
If you need immediate medical attention	Emergency medical transportation	30% coinsurance after deductible	50% coinsurance after deductible	Payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries
	Urgent care	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: All Coverage Types | Plan Type: DA

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	50% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance.
	Physician/surgeon fee	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____
	Mental/Behavioral health outpatient services	30% coinsurance after deductible	50% coinsurance after deductible	Maximum 20 visits/calendar year.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	30% coinsurance after deductible	50% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance. maximum 30 days inpatient care/calendar year.. Unused Inpatient days may be exchanged for additional Outpatient visits, where each Inpatient day may be exchanged for two Outpatient visits.
	Substance use disorder outpatient services	30% coinsurance after deductible	50% coinsurance after deductible	Maximum 20 visits/calendar year.
	Substance use disorder inpatient services	30% coinsurance after deductible	50% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance. maximum 30 days inpatient care/calendar year.. Unused Inpatient days may be exchanged for additional Outpatient visits, where each Inpatient day may be exchanged for two Outpatient visits.
If you are pregnant	Prenatal and postnatal care	\$25 co-pay/initial visit.	50% coinsurance after deductible	Prenatal and postnatal visits are included in the delivery charge.
	Delivery and all inpatient services	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: All Coverage Types | Plan Type: DA

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	50% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance.
	Rehabilitation services	30% coinsurance after deductible	50% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance. Limited to 120 days combined in-network and out-of-network.
	Habilitation services	30% coinsurance after deductible	50% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance. Limited to 120 days combined in-network and out-of-network.
	Skilled nursing care	30% coinsurance after deductible	50% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance. Limited to 120 days combined in-network and out-of-network.
	Durable medical equipment	30% coinsurance after deductible	50% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance.
	Hospice service	30% coinsurance after deductible	50% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance.
If your child needs dental or eye care	Eye exam	Not covered.	Not covered.	_____none_____
	Glasses	Not covered.	Not covered.	_____none_____
	Dental check-up	Not covered.	Not covered.	_____none_____

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)	
- Cosmetic surgery - Dental care (Adult) - Eyeglasses - Hearing aids (Only covered for Members age 15 or younger, maximums apply)	- Infertility treatment - Long-term care - Weight loss programs - Private Duty Nursing - Routine eye care (Adult) - Routine foot care
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
- Acupuncture when used as a substitute for other forms or anesthesia - Non-emergency care when traveling outside the U.S.(www.HorizonBlue.com)	- Chiropractic care - Bariatric surgery

Your Rights to Continue Coverage:

“Federal and State laws may provide protections that allow you to keep health coverage as long as you pay your **premium**. There are no exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-355-BLUE (2583). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.”

Your Grievance and Appeals Rights:

For questions about your rights, this notice, or assistance, you can contact: Horizon Blue Cross Blue Shield of New Jersey Member Services at 1-800-355-BLUE (2583). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebda/healthreform.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-355- BLUE (2583).

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-355-BLUE (2583).

[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-800-355-BLUE (2583).

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-355- BLUE (2583).

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$3,600
- Patient pays \$3,940

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$2500
Copays	\$0
Coinsurance	\$1,280
Limits or exclusions	\$160
Total	\$3,940

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$570
- Patient pays \$4,830

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2500
Copays	\$30
Coinsurance	\$240
Limits or exclusions	\$2,060
Total	\$4,830

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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