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 deductible?	**$2,500** person **/$5,000** family for in-network services. **$5,000** person / **$10,000** family for out-of-network. Doesn't 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 deductibles 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 out–of–pocket limit on my expenses?	Yes. For in-network providers **$5,000** person/**$10,000** family and out-of- network providers **$10,000** person/**$20,000** 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 out–of–pocket limit?	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	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**, of 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 specialist?	No.	You can see the in-network **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 4. See your policy or plan document for additional information about **excluded services**.

- **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	30% co-insurance after deductible.	Primary Care Physician (PCP) selection recommended for maximum benefits, but not required and no referral is needed.
	Specialist visit	$50 co-pay/visit	30% co-insurance after deductible.	————————none————————
	Other practitioner office visit	$30 copay/visit for Therapeutic manipulations & therapies	30% co-insurance 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)	20% coinsurance after deductible.	30% co-insurance after deductible	Plan pays 100% when provided by a network lab.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible.	30% co-insurance after deductible	————————none————————

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.
	Preferred brand drugs	50% coinsurance.	50% coinsurance.	Prior authorization may be required.
	Non-preferred brand drugs	50% coinsurance.	50% coinsurance.	Prior authorization may be required
	Specialty drugs	50% coinsurance.	50% coinsurance.	Prior authorization may be required
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible.	30% co-insurance after deductible	————————none————————
	Physician/surgeon fees	20% coinsurance after deductible.	30% co-insurance after deductible	————————none————————
If you need immediate medical attention	Emergency room services	20% coinsurance after $100 copay & deductible.	20% coinsurance after $100 copay & 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.
	Emergency medical transportation	20% coinsurance after deductible.	20% coinsurance after deductible.	Payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Urgent care	20% coinsurance after deductible.	30% co-insurance after deductible	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible.	30% co-insurance after deductible	Requires pre-approval; 50% penalty applies for noncompliance

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
	Physician/surgeon fee	20% coinsurance after deductible.	30% co-insurance after deductible.	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible.	30% co-insurance after deductible.	Maximum 20 visits/calendar year.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible.	30% co-insurance 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	20% coinsurance after deductible.	30% co-insurance after deductible.	Maximum 20 visits/calendar year.
	Substance use disorder inpatient services	20% coinsurance after deductible.	30% co-insurance 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	30% co-insurance after deductible.	Prenatal and postnatal visits are included in the delivery charge.
	Delivery and all inpatient services	20% coinsurance after deductible.	30% co-insurance after deductible.	————————none————————

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	20% coinsurance after deductible.	30% co-insurance after deductible.	Requires pre-approval; 50% penalty applies for noncompliance.
	Rehabilitation services	20% coinsurance after deductible.	30% co-insurance after deductible.	Limited to 120 days per calendar year; must start within 14 days of a hospital stay; must be due to the same or a related condition that necessitated the hospital stay; Requires pre-approval; 50% penalty applies for noncompliance
	Habilitation services	20% coinsurance after deductible.	30% co-insurance after deductible.	Limited to 120 days per calendar year. Requires pre-approval; 50% penalty applies for noncompliance
	Skilled nursing care	20% coinsurance after deductible.	30% co-insurance after deductible.	Limited to 120 days per calendar year/Must begin within 14 days of proceeding hospital stay; Requires pre-approval; 50% penalty applies for noncompliance.
	Durable medical equipment	20% coinsurance after deductible.	30% co-insurance after deductible.	Replacements and repairs not covered; Requires pre-approval; 50% penalty applies for noncompliance
	Hospice service	20% coinsurance after deductible.	30% co-insurance after deductible.	Requires pre-approval; 50% penalty applies for noncompliance.
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——————

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 excluded services.)**

- 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 plan 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, kwiijigo 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.

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** $4,560
- **Patient pays** $2,980

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	$250
Coinsurance	$70
Limits or exclusions	$160
Total	**$2,980**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $530
- **Patient pays** $4,870

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	$280
Limits or exclusions	$2,060
Total	**$4,870**

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.