



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> ?	\$0.	See the chart starting on page 2 for your costs for services this plan covers.
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 and services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance billed charges, 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 , 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 <u>specialist</u> ?	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 6. 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 Specialist visit	No charge. No charge.	Not covered. Not covered.	\$700 maximum per covered person per calendar year. \$700 maximum per covered person per calendar year.
If you have a test	Other practitioner office visit Preventive care / screening / immunization Diagnostic test (x-ray, blood work)	\$20 co-pay/visit for outpatient physical therapy. No charge. No charge.	Not covered. Not covered. Not covered.	Outpatient physical therapy requires pre-approval; 30 visit limit per benefit period. \$700 maximum per covered person per calendar year. One per calendar year. Wellness visits covered up to \$600 per covered person per calendar year. \$500 shared maximum per covered person per calendar year.

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
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.HorizonBlue.com</p>	Imaging (CT/PET scans, MRIs)	No charge.	Not covered.	\$500 shared maximum per covered person per calendar year. Required pre-approval; 50% penalty applies for non-compliance.
	Generic drugs	Not covered.	Not covered.	_____none_____
	Preferred brand drugs	Not covered.	Not covered.	_____none_____
	Non-preferred brand drugs	Not covered.	Not covered.	_____none_____
	Specialty drugs	Not covered.	Not covered.	_____none_____
	<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	\$250 co-pay/visit per surgery.	Not covered.
Physician/surgeon fees		No charge.	Not covered.	\$700 maximum per covered person per calendar year.
<p>If you need immediate medical attention</p>	Emergency room services	\$100 co-pay/visit (waived if admitted within 24 hours).	\$100 co-pay/visit (waived if admitted within 24 hours).	Out-of-network payment at the in-network level of benefits applies only to true medical emergencies.
	Emergency medical transportation	Not covered.	Not covered.	_____none_____
	Urgent care	No charge.	Not covered.	\$700 maximum per covered person per calendar year.

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary

at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov to request a copy.

Horizon BCBSNJ: Basic and Essential EPO (B1017-B4335)

Coverage Period: 01/01/2012 – 12/31/2012

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

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)	\$500 co-pay/visit per period of confinement.	Not covered.	Requires pre-approval; 50% penalty applies for non-compliance; 90 days per covered person per calendar year.
	Physician/surgeon fee	No charge.	Not covered.	\$700 maximum per covered person per calendar year.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% coinsurance.	Not covered.	30 visits per covered person per calendar year.
	Mental/Behavioral health inpatient services	\$500 co-pay per covered person per period of confinement.	Not covered.	Requires pre-approval; 50% penalty applies for non-compliance; 90 days per covered person per calendar year.
	Substance use disorder outpatient services	30% coinsurance.	Not covered.	30 visits per covered person per calendar year.
If you are pregnant	Substance use disorder inpatient services	30% coinsurance after \$500 confinement deductible.	Not covered.	Requires pre-approval; 50% penalty applies for non-compliance; 30 visits per covered person per calendar year.
	Prenatal and postnatal care	Covered when included in the delivery charge.	Not covered.	_____none_____
	Delivery and all inpatient services	No charge for delivery.	Not covered.	_____none_____

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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	Not covered.	Not covered.	_____none_____
	Rehabilitation services	Not covered.	Not covered.	_____none_____
	Habilitation services	Not covered.	Not covered.	_____none_____
	Skilled nursing care	Not covered.	Not covered.	_____none_____
	Durable medical equipment	Not covered.	Not covered.	_____none_____
	Hospice service	Not covered.	Not covered.	_____none_____
	Eye exam	Not covered.	Not covered.	_____none_____
If your child needs dental or eye care	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 excluded services.)**

- | | | |
|---|--|----------------------------|
| • Cosmetic surgery | • Infertility treatment | • Private Duty Nursing |
| • Dental care (Adult) | • Long-term care | • Routine eye care (Adult) |
| • Eyeglasses | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Hearing aids (Only covered for Members age 15 or younger, maximums apply) | • Chiropractic care | • Weight loss programs |

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
- 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.ccoio.cms.gov.”

Your Grievance and Appeals Rights:

Questions: Call 1-800-355-BLUE (2583) or visit us at www.HorizonBlue.com.

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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 \$6,870
- Patient pays \$670

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	\$0
Copays	\$500
Coinsurance	\$0
Limits or exclusions	\$170
Total	\$670

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$1,200
- Patient pays \$4,200

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	\$0
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$4,200
Total	\$4,200

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.