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?	**$0.**	See the chart starting on page 2 for your costs for services this plan covers.
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 and services this plan covers.
Is there an out–of–pocket limit 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 out–of–pocket limit?	Premiums 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 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	$30 co-pay/visit.	Not covered.	————————none————————
	Specialist visit	$30 co-pay/visit.	Not covered.	————————none————————
	Other practitioner office visit	$30 co-pay/visit; outpatient physical therapy $20 co-pay/visit	Not covered.	Requires pre-approval; 30 visits per calendar year for outpatient physical therapy.
	Preventive care/screening/immunization	No charge.	Not covered.	One per calendar year. Wellness visits covered up to $600 per covered person per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	Not covered.	Maximum includes Imaging (CT/PET scans, MRIs) and Diagnostic test (x-ray). For diagnostic services rendered in the office, freestanding or an outpatient facility. $500 shared maximum for diagnostic tests and imaging 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
	Imaging (CT/PET scans, MRIs)	No charge.	Not covered.	Maximum includes Imaging (CT/PET scans, MRIs) and Diagnostic test (x-ray). For diagnostic services rendered in the office, freestanding or an outpatient facility. $500 shared maximum for diagnostic tests and imaging per covered person per calendar year.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.HorizonBlue.com	Generic drugs	$15 co-pay /retail and mail order.	Not covered.	Prior authorization may be required; covers up to a 30 day supply (retail) and a 90 day supply (mail order).
	Preferred brand drugs	50% coinsurance.	Not covered.	Prior authorization may be required; covers up a 90 day supply (retail only). $500 maximum per covered person per calendar year.
	Non-preferred brand drugs	50% coinsurance.	Not covered.	Prior authorization may be required; covers up to a 90 day supply (retail only). $500 maximum per covered person per calendar year.
	Specialty drugs	50% coinsurance.	Not covered.	Prior authorization may be required; covers up to a 90 day supply (retail only). $500 maximum per covered person per calendar year.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 co-pay/visit per surgery.	Not covered.	——————none——————
	Physician/surgeon fees	$30 co-pay/visit.	Not covered.	——————none——————
If you need immediate medical	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.

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
attention	Emergency medical transportation	Not covered.	Not covered.	——————none——————
	Urgent care	$30 co-pay/visit.	Not covered.	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 co-pay 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	$30 co-pay/visit.	Not covered.	——————none——————
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 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
	Substance use disorder inpatient services	30% coinsurance after $500 hospital confinement	Not covered.	Requires pre-approval; 50% penalty applies for non-compliance; 30 visits per covered person per calendar year.
If you are pregnant	Prenatal and postnatal care	$30 co-pay/initial visit.	Not covered.	——————none——————
	Delivery and all inpatient services	$500 co-pay per period of confinement.	Not covered.	——————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	50% coinsurance.	Not covered.	Requires pre-approval; 50% penalty applies for non-compliance; $2,500 maximum per covered person per calendar year.
	Rehabilitation services	$500 co-pay per covered person per period of confinement	Not covered.	Requires pre-approval; 50% penalty applies for non-compliance; Co-pay does not apply if admission is preceded by a hospital confinement; maximum 90 days per calendar year.
	Habilitation services	$500 co-pay per covered person per period of confinement	Not covered.	Requires pre-approval; 50% penalty applies for non-compliance; Co-pay does not apply if admission is preceded by a hospital confinement; maximum 90 days per calendar year.
	Skilled nursing care	Not covered.	Not covered.	——————none——————
	Durable medical equipment	50% coinsurance.	Not covered.	$2,500 maximum per covered person per calendar year.
	Hospice service	50% coinsurance.	Not covered.	Requires pre-approval; 50% penalty applies for non-compliance; $2,500 maximum per covered person per calendar year.
If your child needs dental or eye care	Eye exam	Not covered.	Not covered.	——————none——————
	Glasses	Not covered.	Not covered.	——————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
	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
- Non-emergency care when traveling outside the U.S.
- Chiropractic care
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot 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.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** $6,840
- **Patient pays** $700

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	$540
Coinsurance	$0
Limits or exclusions	$160
Total	**$700**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,220
- **Patient pays** $3,180

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	$480
Coinsurance	$640
Limits or exclusions	$2,060
Total	**$3,180**

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.