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, including coverage details and out-of-pocket costs at **HorizonBlue.com/members** or by calling **1-800-355-BLUE (2583)** or the number on the back of your ID card. If you do not currently have coverage with Horizon BCBSNJ you can view a sample policy here, **HorizonBlue.com/sample-benefit-booklets.** For effective dates on and after November 1, 2015, your benefit booklet will be distributed by your employer or will be made available through Horizon BCBSNJ's Member Online Services. The benefit booklet availability is subject to New Jersey Department of Banking and Insurance regulatory procedures, enrollment, billing and/or activities that may delay the availability of the actual benefit booklet.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500.00** person / **$1,000.00** family for out-of-network.	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 Common Medical Events chart 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 Common Medical Events chart for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, For Health/Pharmacy providers **$2,000.00** person/**$4,000.00** family. Combined in and out-of-network benefits. Aggregate 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, 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 Common Medical Events chart 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**, or participating for **providers** in their network. See the Common Medical Events chart for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	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 the Services Your Plan Does Not Cover chart. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20.00 Copayment per visit.	30% Coinsurance after deductible.	_____none_____
	Specialist visit	$40.00 Copayment per visit. Specialist.	30% Coinsurance after deductible.	_____none_____
	Other practitioner office visit	$20.00 Copayment per visit. Specialist.	30% Coinsurance after deductible.	In-network & Out-of-network chiropractic care therapeutic manipulation visit limit. Coverage is limited to 25 visits.
	Preventive care/screening/immunization	No Charge	30% Coinsurance for Office.	One per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for Office, Outpatient Hospital, Independent Laboratory.	30% Coinsurance for Office, Outpatient Hospital, Independent Laboratory after deductible.	Applies only to out of hospital diagnostic services non routine laboratory and pathology cardiovascular disease testing, non-routine laboratory and pathology pap smear, non-routine laboratory and pathology.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	No charge for Outpatient Hospital.	30% Coinsurance for Outpatient Hospital after deductible.	Requires pre-approval; 20% penalty applies for non-compliance.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Prime Therapeutics LLC (Prime) Service Center www.MyPrime.com or 1-800-370-5088	Generic drugs	$10.00 Copayment/Retail; $20.00 Copayment/Mail Order.	$10.00 Copayment/Retail; $20.00 Copayment/Mail Order.	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order)
	Preferred brand drugs	$25.00 Copayment/Retail; $50.00 Copayment/Mail Order.	$25.00 Copayment/Retail; $50.00 Copayment/Mail Order.	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order)
	Non-preferred brand drugs	$50.00 Copayment/Retail; $100.00 Copayment/Mail Order.	$50.00 Copayment/Retail; $100.00 Copayment/Mail Order.	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order)
	Specialty drugs	Covered at retail benefit in above applicable categories.	Covered at retail benefit in above applicable categories.	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300.00 Copayment per visit for Outpatient Hospital. No charge for Ambulatory Surgical Center.	30% Coinsurance for Outpatient Hospital, Ambulatory Surgical Center after deductible.	_____none_____
	Physician/surgeon fees	No charge for Outpatient Hospital, Ambulatory Surgical Center.	30% Coinsurance for Outpatient Hospital, Ambulatory Surgical Center after deductible.	_____none_____
If you need immediate medical attention	Emergency room services	$100.00 Copayment per visit for Outpatient Hospital.	$100.00 Copayment per visit for Outpatient Hospital.	Copay waived if admitted within 24 hours. Applies only to emergency room medical emergency and accidental injury.
	Emergency medical transportation	No charge.	30% Coinsurance after deductible.	_____none_____

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Urgent care	$20.00 Copayment per visit for Office. $40.00 Copayment per visit for Office. Specialist.	30% Coinsurance for Office after deductible.	Applies only to out of hospital urgently needed care. Copayment will be assessed based on the provider type.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100.00 Copayment per admission for Inpatient Hospital.	$100.00 Copayment per admission and 30% Coinsurance for Inpatient Hospital after deductible.	Requires pre-approval; 20% penalty applies for non-compliance. In-network & Out-of-network inpatient day limit is 365 days. In-network & Out-of-network inpatient separation period is 90 days.
	Physician/surgeon fee	No charge for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital after deductible.	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge for Outpatient Hospital.	30% Coinsurance for Outpatient Hospital after deductible.	_____none_____
	Mental/Behavioral health inpatient services	$100.00 Copayment per admission for Inpatient Hospital.	$100.00 Copayment per admission and 30% Coinsurance for Inpatient Hospital after deductible.	Requires pre-approval; 20% penalty applies for non-compliance. In-network & Out-of-network inpatient day limit is 365 days. In-network & Out-of-network inpatient separation period is 90 days.
	Substance use disorder outpatient services	No charge for Outpatient Hospital.	30% Coinsurance for Outpatient Hospital after deductible.	_____none_____
	Substance use disorder inpatient services	$100.00 Copayment per admission for Inpatient Hospital.	$100.00 Copayment per admission and 30% Coinsurance for Inpatient Hospital after deductible.	Requires pre-approval; 20% penalty applies for non-compliance. In-network & Out-of-network inpatient day limit is 365 days. In-network & Out-of-network inpatient separation period is 90 days.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$20.00 Copayment per visit for Office. $40.00 Copayment per visit for Office. Specialist.	30% Coinsurance for Office after deductible.	Copay applies to initial visit only. Not covered - for child.
	Delivery and all inpatient services	$100.00 Copayment per admission for Inpatient Hospital.	$100.00 Copayment per admission and 30% Coinsurance for Inpatient Hospital after deductible.	Not covered - for child. In-network & Out-of-network inpatient day limit is 365 days. In-network & Out-of-network inpatient separation period is 90 days.
If you need help recovering or have other special health needs	Home health care	No charge for Freestanding Facility.	30% Coinsurance for Freestanding Facility after deductible.	Requires pre-approval; 20% penalty applies for non-compliance. Out-of-network home health care visit is limited to 100 visits per benefit period.
	Rehabilitation services	$100.00 Copayment per admission.	$100.00 Copayment per admission and 30% Coinsurance after deductible.	Requires pre-approval; 20% penalty applies for non-compliance. In-network and Out-of-Network inpatient separation period is 90 days. In-network and Out-of-network physical rehabilitation day limit is 60 days.
	Habilitative services	$100.00 Copayment per admission.	$100.00 Copayment per admission and 30% Coinsurance after deductible.	Requires pre-approval; 20% penalty applies for non-compliance. In-network and Out-of-Network inpatient separation period is 90 days. In-network and Out-of-network physical rehabilitation day limit is 60 days.
	Skilled nursing care	No charge for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital after deductible.	Requires pre-approval; 20% penalty applies for non-compliance. In-network inpatient skilled nursing facility day limit is 100 days. Out-of-network inpatient skilled nursing facility day limit is 60 days.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Durable medical equipment	No charge.	30% Coinsurance after deductible.	Prior authorization required for DME purchases over $500. 20% penalty applies for non-compliance.
	Hospice service	No charge for Inpatient Hospital, Freestanding Facility.	30% Coinsurance for Inpatient Hospital, Freestanding Facility after deductible.	Requires pre-approval; 20% 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_____

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.)

- Acupuncture
- Cosmetic Surgery
- Dental care (Adult)
- Long Term Care
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy for plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing Aids(Only covered for members age 15 and younger)
- Infertility treatment
- Most coverage provided outside the United States. See www.HorizonBlue.com
- Non-emergency care when traveling outside the U.S. See www.HorizonBlue.com
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Call **1-800-355-BLUE (2583)** or visit **www.HorizonBlue.com**. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as 'minimum essential coverage.' **This plan or policy does provide minimum essential coverage**.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 three 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 also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

Amount owed to providers: $7,540.00
Plan pays $7,270.00
You pay $270.00

Sample care costs:

Hospital charges (mother)	$2,700.00
Routine obstetric care	$2,100.00
Hospital charges (baby)	$900.00
Anesthesia	$900.00
Laboratory tests	$500.00
Prescriptions	$200.00
Radiology	$200.00
Vaccines, other preventive	$40.00
Total	**$7,540.00**

Patient pays:

Deductibles	$0.00
Co-pays	$120.00
Co-insurance	$0.00
Limits or exclusions	$150.00
Total	**$270.00**

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

Amount owed to providers: $5,400.00
Plan pays $5,120.00
You pay $280.00

Sample care costs:

Prescriptions	$2,900.00
Medical Equipment and Supplies	$1,300.00
Office Visits and Procedures	$700.00
Education	$300.00
Laboratory tests	$100.00
Vaccines, other preventive	$100.00
Total	**$5,400.00**

Patient pays:

Deductibles	$0.00
Co-pays	$200.00
Co-insurance	$0.00
Limits or exclusions	$80.00
Total	**$280.00**

Questions and answers about 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.
- 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**, **co-payments**, and **co-insurance** 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 for 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 **co-payments**, **deductibles**, and **co-insurance**. You should consider also 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.