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?	**$1,000** person/**$2,000** family for Out-of-Network services. Doesn't apply to preventive care	You must pay all of 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 **deductibles.**
Are there other deductibles for specific services?	No	You don't have to meet all deductibles for specific services, but see the chart starting on pg2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, For In-Network/Out-of-Network providers **$3,000** person **$6,000** 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, penalties for failure to obtain pre-authorization for services balanced-billed charges 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**, 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 specialist?	No. A written referral is not required 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 page 7. 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	$20 copay/visit	30% coinsurance after deductible	————————none————————
	Specialist visit	$40 copay/visit	30% coinsurance after deductible	————————none————————
	Other practitioner office visit	$20 copay/visit for Therapist/ Chiropractors all other specialist a $40 copay	30% coinsurance after deductible	Combined In-Network/Out-of-Network Therapist Limited to 30 visits per benefit period, Chiropractic Care limited to 25 visits per benefit period. Requires pre-approval; 20% penalty applies for non-compliance.
	Preventive care/screening/immunization	No charge	30% coinsurance after deductible	One per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	No charge in office/ Outpatient facility.	30% coinsurance after deductible	

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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
	Imaging (CT/PET scans, MRIs)	No charge in office/ Outpatient facility.	30% coinsurance 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 not yet drug coverage** is available at www.HorizonBlue.com.	Generic drugs	$15 copay / retail $30 copay / 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	$35 copay /retail $70 copay / mail order	Not covered	
	Non-preferred brand drugs	$50 copay / retail $100 copay / mail order	Not covered	
	Specialty drugs	At retail benefit in above applicable tiers	Not covered	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)	No charge for Hospital Outpatient surgery/Surgery in an Ambulatory surgicenter	30% coinsurance after deductible	————————none————————
	Physician/surgeon fees	No charge	30% coinsurance after deductible	————————none————————
If you need immediate medical attention	Emergency room services	$50 copay	$50 copay	Payment at the In-Network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.
	Emergency medical transportation	No charge	30% coinsurance after deductible	

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
	Urgent care	$20 or 40 copay/visit	30% coinsurance after deductible	Copay will be assessed based on provider type.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay per admission	30% coinsurance after deductible and $200 copay/admission	365 days Inpatient Hospital care; requires pre-approval; 20% penalty applies for non-compliance
	Physician/surgeon fee	No charge	30% coinsurance after deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge for Outpatient Department/Office setting	30% coinsurance after deductible	
	Mental/Behavioral health inpatient services	$200 copay/admission	30% coinsurance after deductible and $200 copay/admission	365 days Inpatient Hospital care; Requires pre-approval; 20% penalty applies for non-compliance
	Substance use disorder outpatient services	No charge for Outpatient Department/Office setting	30% coinsurance after deductible	
	Substance use disorder inpatient services	$200 copay/admission	30% coinsurance after deductible and $200 copay/admission	365 days Inpatient Hospital care; Requires pre-approval; 20% penalty applies for non-compliance
If you are pregnant	Prenatal and postnatal care	$40 copay/1st visit	30% coinsurance after deductible	Copay applies to initial visit only
	Delivery and all inpatient services	No charge	30% coinsurance 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	No charge	30% coinsurance after deductible	Out-of-Network benefits limited to a 100 day visit maximum per benefit period; Requires pre-approval; 20% penalty applies for non-compliance.
	Rehabilitation services	$200 copay/admission	30% coinsurance after deductible and $200 copay/admission	Combined In-Network/Out-of-Network limited to 60days per benefit period; Requires pre-approval; 20% penalty applies for non-compliance.
	Habilitation services	No charge	30% coinsurance after deductible	
	Skilled nursing care	No charge	30% coinsurance after deductible	In-Network limited to 100 days per benefit period /Out-of-Network limited to 60 days per benefit period; Requires pre-approval; 20% penalty applies for non-compliance.
	Durable medical equipment	No charge	30% coinsurance after deductible	Requires pre-approval; 20% penalty applies for non-compliance.
	Hospice service	No charge	30% coinsurance after deductible	Requires pre-approval; 20% penalty applies for non-compliance.
If your child needs dental or eye care	Eye exam	$40 copay/visit	30% coinsurance after deductible	Combined In-Network/Out-of-Network limited to one exam per calendar year
	Glasses	Reimbursed $50	Reimbursed $50	Limited to one pair per 2 calendar year period; Reimbursed $50
	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)
- Hearing aids(Only covered for Members age 15 or younger, maximums apply)
- Long-term care
- 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.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.HorizonBlue.com
- Private-duty nursing
- Routine eye care (Adult)

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 or www.cciio.cms.gov.

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: Horizon Blue Cross BlueShield 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/ebsa/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** $7,130
- **Patient pays** $410

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$300
Radiology	$300
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$260
Coinsurance	$0
Limits or exclusions	$150
Total	**$410**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,820
- **Patient pays** $2,580

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	$580
Coinsurance	$0
Limits or exclusions	$2,000
Total	**$2,580**

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.