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). If you do not currently have coverage with Horizon and wish to view a sample plan document, they are available at http://www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html. Starting in January of 2016, once you have enrolled in coverage with Horizon, you may sign into our Member Services portal at www.HorizonBlue.com/Member to view your plan document. (Please note that document viewing availability is subject to NJDOBI regulatory procedures, enrollment and/or billing activities or other procedures preventing the display.)

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** person /**$3,000** family for in-network and **$2,500** person/**$5,000** family for out-of network services.	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 in-network health/pharmacy providers **$3,000** person/**$6,000** family and out-of- network health providers **$8,000** person/ **$16,000** 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, balance-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 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. 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 the Services Your Plan Does Not Cover chart. 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	40% coinsurance after deductible	Applies to selected PCP.
	Specialist visit	$40 copay/visit.	40% coinsurance after deductible	————————none————————
	Other practitioner office visit	Outpatient facility: 20% coinsurance after deductible for Short term therapy Office: $20 copay/visit for Short term therapy and Therapeutic manipulation (Chiropractic care)	40% coinsurance after deductible	Therapeutic manipulations limited to combined 30 visits per calendar year for in-network and out-of-network care. Speech & Cognitive Therapy limited to 30 visits combined per calendar year & Physical & Occupational Therapy limited to 30 visits combined per calendar year for in-network and out-of-network care.

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
	Preventive care/screening/immunization	No Charge	Subject to $750 per child up to 1 year and $500 per covered person maximum; subject to limitations and exceptions.	One routine physical per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	Outpatient facility: 20% coinsurance after deductible Office: No Charge	40% coinsurance after deductible	————————none————————
	Imaging (CT/PET scans, MRIs)	Outpatient facility: 20% coinsurance after deductible Office: No Charge	40% coinsurance after deductible	Requires pre-approval; 50% 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	Generic drugs	$15 copay/retail $30 copay/mail order	$15 copay/retail $30 copay/mail order	Prior authorization may be required. Covered up to a 90 day supply at retail and a 90 day supply at mail order.
	Preferred brand drugs	$40 copay/retail $80 copay/mail order	$40 copay/retail $80 copay/mail order	Prior authorization may be required. Covered up to a 90 day supply at retail and a 90 day supply at mail order.
	Non-preferred brand drugs	$75 copay/retail $150 copay/mail order	$75 copay/retail $150 copay/mail order	Prior authorization may be required. Covered up to a 90 day supply at retail and a 90 day supply at mail order.

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
(Prime) Service Center www.MyPrime.com or 1-800-370-5088. View the formulary at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2016/2016_NJ_3T_HealthInsuranceMarketplaceAdvantage.pdf	Specialty drugs	Covered at retail benefit in above applicable tiers	Covered at retail benefit in above applicable tiers	Prior authorization may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-network Ambulatory Surgical Centers benefit maximum of $2,000 per person per calendar year.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible after $100 copay/visit	20% coinsurance after deductible after $100 copay/visit	Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Emergency medical transportation	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Urgent care	$40 copay/visit	40% coinsurance after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance.

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	40% coinsurance after deductible	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Outpatient facility: 20% coinsurance after deductible Office: $40 copay/specialist	40% coinsurance after deductible	————————none————————
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance.
	Substance use disorder outpatient services	Outpatient facility: 20% coinsurance after deductible Office: $40 copay/specialist	40% coinsurance after deductible	————————none————————
	Substance use disorder inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance.
If you are pregnant	Prenatal and postnatal care	No Charge	40% coinsurance after deductible	————————none————————
	Delivery and all inpatient services	20% coinsurance after deductible	40% 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	20% coinsurance after deductible	40% coinsurance after deductible	Limited to a combined maximum of 60 visits per calendar year for in-network and out-of-network services. Requires pre-approval; 50% penalty applies for non-compliance.
	Rehabilitation services (Inpatient)	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance.
	Habilitative services (Inpatient)	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance.
	Durable medical equipment	50% coinsurance	50% coinsurance after deductible	Items over $500 require pre-approval; 50% penalty applies for non-compliance.
	Hospice service	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval; 50% penalty applies for non-compliance.
If your child needs dental or eye care More information about **vision coverage** is available at www.HorizonBlue.com or 1-800-278-7753.	Eye exam	No Charge	Not Covered	Limited to one exam per 12 months.
	Glasses	No Charge	Not Covered	Vision hardware reimbursement limited to once per calendar year.
	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)
- Hearing Aids (Only covered for Members age 15 or younger)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult, Optometrist/Ophthalmologist office. For verification of coverage on routine vision services, please see your policy or plan document.)
- 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
- Chiropractic care
- Infertility treatment (requires pre-approval)
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.

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:

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/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 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** $5,280
- **Patient pays** $2,260

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	$1,500
Copays	$20
Coinsurance	$590
Limits or exclusions	$150
Total	**$2,260**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,140
- **Patient pays** $2,260

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	$1,130
Copays	$600
Coinsurance	$450
Limits or exclusions	$80
Total	**$2,260**

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.