HorizonBlue.com

Brief Notes

News for Brokers and Consultants

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Applies to: Small Group market

Two New Horizon Patient-Centered Advantage EPO Plans Available

Premiums for our new Silver and Bronze plans average 15% less than our current offerings

Beginning **July 1, 2014**, Horizon Blue Cross Blue Shield of New Jersey will offer two new Horizon Patient-Centered Advantage EPO plans to customers in the Small Group market:

- **Horizon Patient-Centered Advantage EPO Silver.**
- **Horizon Patient-Centered Advantage EPO Bronze.**

These off-exchange plans offer customers access to the state's largest network of patient-centered practices and the lowest-premium Silver and Bronze plans we offer in the Small Group market.

What's New?

Like our other Horizon Advantage EPO plans, our new Horizon Patient-Centered Advantage EPO Silver and Bronze plans incorporate our patient-centered programs, which are designed to deliver more effective, efficient and affordable health care.

What's unique about the Horizon Patient-Centered Advantage EPO Silver and Bronze plans is that they use lower member cost sharing to encourage enrolled members to preselect and use a Primary Care Physician (PCP) affiliated with one of our established PCMH and/or ACO practices:

- Horizon Patient-Centered Advantage EPO members incur a lower out-of-pocket expense when they preselect and use a PCP who participates in one of our patient-centered programs.
- Horizon Patient-Centered Advantage EPO members incur a greater out-of-pocket expense when they receive care from a participating Horizon Managed Care Network PCP who does not participate in one of our patient-centered programs.

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Horizon BCBSNJ is offering a
Special Broker Incentive Program
for the new Horizon Patient-Centered Advantage EPO Silver and Bronze plans.
Learn more *here.*

Horizon Blue Cross Blue Shield of New Jersey

Plan Highlights

- Members have access to all doctors, facilities and other health care professionals in the Horizon Managed Care Network.
- No PCP selection is required. However, when a member preselects and uses a PCP who participates in our patient-centered programs, the member pays only the plan copayment ($20 for Silver, $40 for Bronze) for a PCP office visit. The deductible does not apply.
- Preventive services, screenings and immunizations are covered with no member cost share when services are received from an in-network provider.
- One routine physical per calendar year.
- No referrals are required.
- No out-of-network benefits, except in the event of an emergency.
- Emergency coverage while traveling outside of New Jersey.

The Summary of Benefits and Coverage (SBC) for the **Horizon Patient-Centered Advantage EPO Silver** plan is available *here*.

The Summary of Benefits and Coverage (SBC) for the **Horizon Patient-Centered Advantage EPO Bronze** plan is available *here*.

Lower Costs for Customers

Premiums for our new Horizon Patient-Centered Advantage EPO Silver plan are approximately 15 percent lower than our current Horizon Patient-Centered Advantage EPO plan, which has been available since January 1, 2014.

Premiums for our new Horizon Patient-Centered Advantage EPO Bronze plan are approximately 15 percent lower than Horizon BCBSNJ's current lowest-priced small group plan.

Members' out-of-pocket costs are as follows:

Horizon Patient-Centered Advantage EPO Silver

Health Care Professional Status	***Cost-Sharing Amounts***
Preselected PCMH/ACO PCP	Copayment: $20 per visit, then covered 100%
Preselected Horizon Managed Care Network PCP	Deductible: $2,000 Person/$4,000 Family Copayment: $30 per visit
Nonselected Horizon Managed Care Network PCP and Participating Specialists	Deductible: $2,000 Person/$4,000 Family Coinsurance: 30%
Maximum Out-of-Pocket (MOOP) Limit for In-Network Providers	$5,000 Person/$10,000 Family

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Horizon Patient-Centered Advantage EPO Bronze

Health Care Professional Status	*Cost-Sharing Amounts*
Preselected PCMH/ACO PCP	Copayment: $40 per visit, then covered 100%
Preselected Horizon Managed Care Network PCP	Deductible: $2,500 Person/$5,000 Family Coinsurance: 50%
Nonselected Horizon Managed Care Network PCP and Participating Specialists	Deductible: $2,500 Person/$5,000 Family Coinsurance: 50%
Maximum Out-of-Pocket (MOOP) Limit for In-Network Providers	$6,350 Person/$12,700 Family

Quote Our Plans for Your Clients

These new plans are available off exchange only, and are available to quote through the Horizon Broker Portal and HealthConnect now. Consider one of our new Horizon Patient-Centered Advantage EPO plans for your clients' health insurance needs.

Special Broker Incentive Program

Horizon BCBSNJ will offer a special broker incentive program* for all new business sales of the Horizon Patient-Centered Advantage EPO Silver and Bronze plans with effective dates of July 2014 through October 2014. This program rewards incentive payouts of **$100 per contract** for the new plans.

The existing broker incentive program for new business sales offering $60 per contract for sales of plans in our existing product portfolio, and $15 per contract for Dental plan sales remains in effect.

* To be eligible for this program, brokers must be licensed and contracted with Horizon BCBSNJ, and must be the Broker of Record on the effective date of the sale.

How to Find a Participating Patient-Centered Practice

Horizon BCBSNJ has the state's largest network of patient-centered practices. There are more than 3,700 doctors in more than 900 patient-centered practice locations throughout the state.

Customers can use our online *Provider Directory* at **HorizonBlue.com/Directory** to find out which doctors participate in a patient-centered practice. The Advanced Physician Search capability enables users to search specifically for PCPs participating in our patient-centered practices.

What Makes a Patient-Centered Practice Special?

The quality of care patients receive and the vital role doctors and care teams play in care coordination are the hallmarks of patient-centered programs, which reward value rather than volume. Patients can expect:

- Quality, personalized and team-based care led by a doctor.
- Coordinated care from start to finish.
- To receive follow-up primary care immediately after an Emergency Room (ER) visit or hospital discharge.
- Improved access to care when needed most.

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- Enhanced communications with their care team by phone, email and in person.
- Wellness and preventive care based on national guidelines.
- Extra support and resources – including health education.

These services will benefit members who require routine or preventive care, and they are especially important for patients who have chronic conditions or extra health care needs. Patient-centered practices also have a Care Coordinator to provide information and point patients to additional resources for taking care of their health.

How can I help my clients understand the value of patient-centered care?

"Patient-centered" care is an innovative approach that provides incentives to doctors based upon the quality of patient care, rather than the quantity of care under the traditional approach. Patient-centered practices are paid more when they improve patient satisfaction and improve patient care based upon national clinical guidelines.

Your clients can read *real-world success stories* of how practices that are part of New Jersey's largest PCMH program are delivering more coordinated and effective care for Horizon BCBSNJ's members.

Delivering Better, Cost-effective Care

Our PCMH results from the 2012 January through December plan year show that patient-centered practices are improving the coordination of care and reducing unnecessary complications for their patients.

In fact, Horizon BCBSNJ compared how health care was delivered to 70,000 members in patient-centered practices to the health care delivered to members in other primary care practices. The results showed impressive improvements in care and reduced costs to those members in the patient-centered program, including:

- *Providing better care:*
  - 5 percent higher rate in improved diabetes control (HbA1c).
  - 3 percent higher rate in breast cancer screenings.
  - 11 percent higher rate in pneumonia vaccinations.

- *Utilization and cost measures:*
  - 23 percent lower rate in hospital inpatient admissions.
  - 12 percent lower rate in ER visits.
  - 9 percent lower cost of care for patients with diabetes.

Horizon BCBSNJ will distribute a press release announcing our new Horizon Patient-Centered Advantage EPO Silver and Bronze plan during the week of June 9, 2014.

Horizon BCBSNJ will also host online broker training sessions during the week of June 16, 2014. Watch your email for details.

Horizon BCBSNJ is dedicated to providing you and your clients with market-leading benefit solutions. For more information, please contact your Horizon BCBSNJ sales executive or account manager.

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?	**$2,000** person/**$4,000** family for in-network services. Does not apply to preventive care.	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 chart starting on page 2 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 the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For in-network providers **$5,000** person/**$10,000** 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, 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 on 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. You don't need a written 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 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	PCMH/ACO PCP: $20 copay/visit PCP: $30 copay after deductible/visit	Not Covered	Lowest copayment will apply for pre-selected PCMH/ACO PCP.
	Specialist visit	30% coinsurance after deductible/visit	Not Covered	————————none————————
	Other practitioner office visit	$30 copay after deductible/visit	Not Covered	Therapeutic manipulations limited to 30 visits per calendar year. Speech & Cognitive Therapy limited to 30 visits combined per calendar year & Physical & Occupational Therapy limited to 30 visits combined per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	One routine physical 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
If you have a test	Diagnostic test (x-ray, blood work)	Outpatient facility: 30% coinsurance after deductible/visit for lab and radiology No Charge in a participating lab or office	Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	Outpatient facility: 30% coinsurance after deductible/visit for lab and radiology No Charge in a participating lab or office	Not Covered	Requires pre-approval.
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 copay /retail $20 copay /mail order After deductible	Not Covered	May require authorization. Covered up to a 90 day supply at retail and a 90 day supply at mail order.
	Preferred brand drugs	$35 copay /retail $70 copay /mail order After deductible	Not Covered	May require authorization. Covered up to a 90 day supply at retail and a 90 day supply at mail order.
	Non-preferred brand drugs	$70 copay /retail $140 copay /mail order After deductible	Not Covered	May require authorization. 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
	Specialty drugs	Covered at retail benefit in above applicable categories	Not Covered	May require authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	Not Covered	————————none————————
	Physician/surgeon fees	30% coinsurance after deductible	Not Covered	————————none————————
If you need immediate medical attention	Emergency room services	30% coinsurance after deductible after $100 copay/visit	30% 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	30% coinsurance after deductible	Not Covered	————————none————————.
	Urgent care	30% coinsurance after deductible/ visit	Not Covered	Copayment will be assessed based on the provider type.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	Not Covered	Requires pre-approval.
	Physician/surgeon fee	30% coinsurance after deductible	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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Outpatient facility: 30% coinsurance after deductible	Not Covered	————————none————————
	Mental/Behavioral health inpatient services	30% coinsurance after deductible	Not Covered	Requires pre-approval.
	Substance use disorder outpatient services	Outpatient facility: 30% coinsurance after deductible	Not Covered	————————none————————
	Substance use disorder inpatient services	30% coinsurance after deductible	Not Covered	Requires pre-approval.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	————————none————————
	Delivery and all inpatient services	30% coinsurance after deductible	Not Covered	Requires pre-approval.

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	30% coinsurance after deductible	Not Covered	Requires pre-approval. Limited to 60 visits per calendar year.
	Rehabilitation services (inpatient)	30% coinsurance after deductible	Not Covered	Requires pre-approval.
	Habilitative services (inpatient)	30% coinsurance after deductible	Not Covered	Requires pre-approval.
	Skilled nursing care	30% coinsurance after deductible	Not Covered	Requires pre-approval.
	Durable medical equipment	50% coinsurance after deductible	Not Covered	Items over $500.00 require pre-approval.
	Hospice service	30% coinsurance after deductible	Not Covered	Requires pre-approval.
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 benefit period.
	Glasses	No Charge	Not Covered	Vision Hardware is 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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult, Optometrist/ Ophthalmogist office)
- 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 of anesthesia
- Bariatric surgery
- Chiropractic care
- Infertility treatment (Requires Pre-approval)

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: 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." The Affordable Care Act establishes a minimum value standard of benefits of a health plan. **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** $4,630
- **Patient pays** $2,910

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	$2,000
Copays	$20
Coinsurance	$740
Limits or exclusions	$150
Total	**$2,910**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,480
- **Patient pays** $2,920

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	$2,000
Copays	$400
Coinsurance	$440
Limits or exclusions	$80
Total	**$2,920**

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.

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?	**$2,500** person/**$5,000** family for in-network services. Does not apply to preventive care.	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 chart starting on page 2 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 the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For in-network providers **$6,350** person/**$12,700** 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, 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 on 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. You don't need a written 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 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	PCMH/ACO PCP: $40 copay/visit PCP: 50% coinsurance after deductible/visit	Not Covered	Lowest copayment will apply for pre-selected PCMH/ACO PCP.
	Specialist visit	50% coinsurance after deductible/visit	Not Covered	————————none————————
	Other practitioner office visit	50% coinsurance after deductible/visit	Not Covered	Therapeutic manipulations limited to 30 visits per calendar year. Speech & Cognitive Therapy limited to 30 visits combined per calendar year & Physical & Occupational Therapy limited to 30 visits combined per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	One routine physical 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
If you have a test	Diagnostic test (x-ray, blood work)	Outpatient facility: 50% coinsurance after deductible/visit for lab and radiology No Charge in a participating lab or office	Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	Outpatient facility: 50% coinsurance after deductible/visit for lab and radiology No Charge in a participating lab or office	Not Covered	Requires pre-approval.
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	$25 copay /retail $50 copay /mail order After deductible	Not Covered	May require authorization. Covered up to a 90 day supply at retail and a 90 day supply at mail order.
	Preferred brand drugs	$50 copay /retail $100 copay /mail order After deductible	Not Covered	May require authorization. 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 After deductible	Not Covered	May require authorization. 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
	Specialty drugs	Covered at retail benefit in above applicable categories	Not Covered	May require authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance after deductible	Not Covered	————————none————————
	Physician/surgeon fees	50% coinsurance after deductible	Not Covered	————————none————————
If you need immediate medical attention	Emergency room services	50% coinsurance after deductible after $100 copay/visit	50% 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	50% coinsurance after deductible	Not Covered	————————none————————.
	Urgent care	50% coinsurance after deductible/ visit	Not Covered	Copayment will be assessed based on the provider type.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/per day after deductible	Not Covered	Requires pre-approval. Maximum $2,500 per admission.
	Physician/surgeon fee	50% coinsurance after deductible	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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Outpatient facility: 50% coinsurance after deductible	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	$500 copay/per day after deductible	Not Covered	Requires pre-approval. Maximum $2,500 per admission.
	Substance use disorder outpatient services	Outpatient facility: 50% coinsurance after deductible	Not Covered	——————none——————
	Substance use disorder inpatient services	$500 copay/per day after deductible	Not Covered	Requires pre-approval. Maximum $2,500 per admission.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	——————none——————
	Delivery and all inpatient services	$500 copay/per day after deductible	Not Covered	Requires pre-approval. Maximum $2,500 per admission.

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 after deductible	Not Covered	Requires pre-approval. Limited to 60 visits per calendar year.
	Rehabilitation services (inpatient)	$500 copay/per day after deductible	Not Covered	Requires pre-approval. Maximum $2,500 per admission.
	Habilitative services (inpatient)	$500 copay/per day after deductible	Not Covered	Requires pre-approval. Maximum $2,500 per admission.
	Skilled nursing care	$500 copay/per day after deductible	Not Covered	Requires pre-approval. Maximum $2,500 per admission.
	Durable medical equipment	50% coinsurance after deductible	Not Covered	Items over $500.00 require pre-approval.
	Hospice service	50% coinsurance after deductible	Not Covered	Requires pre-approval.
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 benefit period.
	Glasses	No Charge	Not Covered	Vision Hardware is 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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Routine eye care (Adult, Optometrist/ Ophthalmogist office)
- 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 of anesthesia
- Bariatric surgery
- Chiropractic care
- Infertility treatment (Requires Pre-approval)

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: 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." The Affordable Care Act establishes a minimum value standard of benefits of a health plan. **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** $4,370
- **Patient pays** $3,170

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	$2,500
Copays	$520
Coinsurance	$0
Limits or exclusions	$150
Total	**$3,170**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,700
- **Patient pays** $3,700

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	$2,500
Copays	$750
Coinsurance	$370
Limits or exclusions	$80
Total	**$3,700**

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.