**Important Questions** | **Answers** | **Why This Matters:**
---|---|---
What is the overall deductible? | $2,200.00 Individual / $4,400.00 Family for in-network providers. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

Are there services covered before you meet your deductible? | Yes. Preventive care is covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/).

Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services.

What is the out-of-pocket limit for this plan? | Yes, For in-network Health/Pharmacy providers $8,150.00 Individual / $16,300.00 Family. Aggregate family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out-of-pocket limit? | Premiums, balance-billing 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.

Will you pay less if you use a network provider? | Yes. For a list of in-network providers, see [www.HorizonBlue.com](http://www.HorizonBlue.com) or call 1-800-355-BLUE (2583) | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you 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 a referral.
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30.00 Copayment per visit.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$60.00 Copayment per visit.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge for Office, Independent Laboratory. $100.00 Copayment per visit for Outpatient Hospital.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100.00 Copayment per visit for Outpatient Facility.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$20.00 Copayment/ Retail $40.00 Copayment/Mail Order.</td>
<td>$20.00 Copayment/ Retail $40.00 Copayment/Mail Order.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at Prime Therapeutics LLC (Prime) Service Center <a href="http://www.MyPrime.com">www.MyPrime.com</a> or 1-800-370-5088.</td>
<td>Preferred brand drugs</td>
<td>50% Coinsurance Retail/Mail order.</td>
<td>50% Coinsurance Retail/Mail order.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>50% Coinsurance Retail/Mail order.</td>
<td>50% Coinsurance Retail/Mail order.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>View the formulary at <a href="https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/HIM/2020/2020_NJ_3T_HealthInsuranceMarketplaceClassicDL.pdf">https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/HIM/2020/2020_NJ_3T_HealthInsuranceMarketplaceClassicDL.pdf</a></strong></td>
<td>Specialty drugs</td>
<td>Covered at retail benefit in above applicable categories.</td>
<td>Covered at retail benefit in above applicable categories.</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>50% Coinsurance for Ambulatory Surgical Center, Outpatient Facility.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>50% Coinsurance for Ambulatory Surgical Center, Outpatient Facility.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$100.00 Copayment and 50% Coinsurance for Outpatient Hospital.</td>
<td>$100.00 Copayment and 50% Coinsurance for Outpatient Hospital.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>50% Coinsurance.</td>
<td>50% Coinsurance.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$75.00 Copayment. Deductible does not apply.</td>
<td>$75.00 Copayment.</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>50% Coinsurance for Inpatient Hospital.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>50% Coinsurance for Inpatient Hospital.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>50% Coinsurance for Outpatient Hospital.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>50% Coinsurance for Inpatient Hospital.</td>
<td>Not Covered.</td>
</tr>
</tbody>
</table>

- Procedures related to spine surgery are subject to pre-service and post-service utilization management review.
- Procedures related to spine surgery are subject to pre-service and post-service utilization management review. 50% Coinsurance for anesthesia.
- Copayment waived if admitted within 24 hours. Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
- Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
- No coverage for non-urgent care.
- Requires pre-approval.
- Requires pre-approval.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$30.00 Copayment per visit for Office. $60.00 Copayment per visit for Specialist. Deductible does not apply.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>50% Coinsurance for Inpatient Hospital.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>50% Coinsurance for Inpatient Hospital.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>$30.00 Copayment for Outpatient Facility. Deductible does not apply.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>50% Coinsurance for Inpatient Hospital.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>50% Coinsurance for Inpatient Hospital.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>50% Coinsurance for Inpatient Facility.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>50% Coinsurance. Deductible does not apply.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>50% Coinsurance for Inpatient Facility.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>If your child needs dental or eye care.</td>
<td>Children’s eye exam</td>
<td>No Charge for Office. Deductible does not apply.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Amounts greater than $150.00 for non-collection frames. Deductible does not apply.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered.</td>
<td>Not Covered.</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)*

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids (Only covered for Members age 15 and younger)
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- 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 (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)*

- Acupuncture when used as a substitute for other forms of anesthesia
- Bariatric surgery
- Chiropractic care
- Infertility treatment (limited to artificial insemination; requires pre-approval)
Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 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. You may also contact the NJ Department of Banking and Insurance Consumer Protection Services at 1-888-393-1062 ext 50998.

Does this plan provide Minimum Essential Coverage? Yes

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----------------------------------------
To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----------------------------------------
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $2,200.00
- Specialist Copayment: $60.00
- Hospital (facility) Coinsurance: 50%
- Other Coinsurance: 0%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

Total Example Cost: $12,800.00

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,200.00</td>
<td>$1,160.00</td>
<td>$4,480.00</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions: $60.00
- The total Peg would pay is: $7,900.00

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $2,200.00
- Specialist Copayment: $60.00
- Hospital (facility) Coinsurance: 50%
- Other Coinsurance: 50%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

Total Example Cost: $7,400.00

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0.00</td>
<td>$1,660.00</td>
<td>$1,791.00</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions: $55.00
- The total Joe would pay is: $3,506.00

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $2,200.00
- Specialist Copayment: $60.00
- Hospital (facility) Coinsurance: 50%
- Other Coinsurance: 50%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost: $1,900.00

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$675.00</td>
<td>$300.00</td>
<td>$693.00</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions: $0.00
- The total Mia would pay is: $1,667.00

The plan would be responsible for the other costs of these EXAMPLE covered services.
Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Horizon BCBSNJ provides free aids and services to people with disabilities (e.g. qualified sign language interpreters and information in other formats) and to those whose primary language is not English (e.g. information in other languages) to communicate effectively with us.

Contacting Member Services

Please call Member Services at 1-800-355-BLUE (2583) (TTY 711) or the phone number on the back of your member ID card, if you need the free aids and services noted above and for all other Member Services issues.

Filing a Section 1557 Grievance

If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated against you for one of the reasons described above, you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ’s Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address: Horizon BCBSNJ Civil Rights Coordinator PO Box 820, Newark, NJ 07101.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at 1-800-368-1019 or 1-800-537-7697 (TDD). OCR Complaint forms are available at www.hhs.gov/ocr/office/index.html.

Language assistance

Si habla un idioma diferente al inglés, hay ayuda disponible gratis. Llame al número que aparece al reverso de su tarjeta de identificación.

 usted puede obtener el servicio gratuito. Llame al número que aparece en su tarjeta de identificación.

Kung nagsasaalita ka ng isang wika maliban sa Ingles, magagamit ang tulong nang walang bayad. Tumawag sa numerong nasa likod ng iyong ID card.

Si ou parlez une langue autre que l'anglais, l'aide est gratuite. Appelez le numéro au dos de votre carte d'identité.

Если вы не говорите по-английски, вам помогут бесплатно. Позвоните по телефону, указанному на обратной стороне вашей ID-карты.

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如果您讲英语以外的语言，可获取免费帮助。请拨打您的身份证背面的号码。

영어 이외의 언어를 사용하는 경우, 무료 지원 서비스를 받을 수 있습니다. ID 카드 뒷면에 있는 번호로 전화하십시오.

Se você fala um idioma diferente do inglês, a ajuda está disponível gratuitamente. Ligue para o número no verso do seu bilhete de identidade.

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语言服务

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