**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?** | $0 | See the Common Medical Events chart for your costs for services this plan covers. |
| **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 providers **$2,500.00** person/**$5,000.00** family. Aggregate family. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums, penalties for failure to obtain pre-authorization for services and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out–of–pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The Common Medical Events chart describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of in-network **providers**, see www.HorizonBlue.com **or call** 1-800-355-BLUE (2583) | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. See the Common Medical Events chart for how this plan pays different kinds of **providers.** |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a **specialist**. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on the Services Your Plan Does Not Cover chart. See your policy or plan document for additional information about **excluded services**. |

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20.00 Copayment per visit. | Not Covered. | _____none_____ |
| | Specialist visit | $40.00 Copayment per visit. Specialist. | Not Covered. | _____none_____ |
| | Other practitioner office visit | $20.00 Copayment per visit. | Not Covered. | In-network chiropractic care therapeutic manipulation visit limit. Coverage is limited to 25 visits in-network. |
| | Preventive care/screening/immunization | No Charge | Not Covered. | One per calendar year. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge for Office, Inpatient Hospital, Outpatient Hospital, Independent Laboratory. | Not Covered | _____none_____ |
| | Imaging (CT/PET scans, MRIs) | No charge for Office, Inpatient Hospital, Outpatient Hospital. | Not Covered. | Requires pre-approval; 20% penalty applies for non-compliance. |

| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition** | Generic drugs | Not Covered | Not Covered | _____none_____ |
| | Preferred brand drugs | Not Covered | Not Covered | _____none_____ |
| | Non-preferred brand drugs | Not Covered | Not Covered | _____none_____ |
| | Specialty drugs | Not Covered | Not Covered | _____none_____ |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $100.00 Copayment per visit for Ambulatory Surgical Center. $200.00 Copayment per visit for Outpatient Hospital. | Not Covered. | _____none_____ |
| | Physician/surgeon fees | No charge for Ambulatory Surgical Center and Outpatient Hospital. | Not Covered. | _____none_____ |
| **If you need immediate medical attention** | Emergency room services | $100.00 Copayment per visit for Outpatient Hospital. | $100.00 Copayment per visit for Outpatient Hospital. | Applies only to emergency room accidental injury and medical emergency. |
| | Emergency medical transportation | No charge. | Not Covered. | _____none_____ |
| | Urgent care | $20.00 Copayment per visit for Office. $40.00 Copayment per visit for Office. Specialist. | Not Covered. | Applies only to out of hospital urgently needed care. Copayment will be assessed based on the provider type. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $100.00 Copayment per day (up to 5 days) for Inpatient Hospital. | Not Covered. | Requires pre-approval; 20% penalty applies for non-compliance. Copay per day applies for 5 days per admission. $2,500.00 Copayment maximum for Inpatient Hospital per benefit year. In-network inpatient separation period is limited to 90 days. In-network inpatient day limit is 365 days. |

| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Physician/surgeon fee | No charge for Inpatient Hospital. | Not Covered. | _____none_____ |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | No charge for Outpatient Hospital. | Not Covered. | _____none_____ |
| | Mental/Behavioral health inpatient services | $100.00 Copayment per day (up to 5 days) for Inpatient Hospital. | Not Covered. | Requires pre-approval; 20% penalty applies for non-compliance. Copay per day applies for 5 days per admission. $2,500.00 Copayment maximum for Inpatient Hospital per benefit year. In-network inpatient separation period is limited to 90 days. In-network inpatient day limit is 365 days. |
| | Substance use disorder outpatient services | No charge for Outpatient Hospital. | Not Covered. | _____none_____ |
| | Substance use disorder inpatient services | $100.00 Copayment per day (up to 5 days) for Inpatient Hospital. | Not Covered. | Requires pre-approval; 20% penalty applies for non-compliance. Copay per day applies for 5 days per admission. $2,500.00 Copayment maximum for Inpatient Hospital per benefit year. In-network inpatient separation period is limited to 90 days. In-network inpatient day limit is 365 days. |
| **If you are pregnant** | Prenatal and postnatal care | $40.00 Copayment per Initial visit for Office. Specialist. | Not Covered. | Copay applies to initial visit only. Not covered - for child. |
| | Delivery and all inpatient services | $100.00 Copayment per day (up to 5 days) for Inpatient Hospital. | Not Covered. | Not covered - for child. Copay per day applies for 5 days per admission. $2,500.00 Copayment maximum for Inpatient Hospital per benefit year. In-network inpatient separation period is limited to 90 days. In-network inpatient day limit is 365 days. |

| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | No charge for Freestanding Facility. | Not Covered. | Requires pre-approval; 20% penalty applies for non-compliance. |
| | Rehabilitation services | $100.00 Copayment per day (up to 5 days). | Not Covered. | Requires pre-approval; 20% penalty applies for non-compliance. Copay per day applies for 5 days per admission. $2,500.00 Copayment maximum for Inpatient Hospital per benefit year. In-network inpatient separation period is limited to 90 days. In-network inpatient rehabilitation day limit is 60 days. |
| | Habilitative services | $100.00 Copayment per day (up to 5 days). | Not Covered. | Requires pre-approval; 20% penalty applies for non-compliance. Copay per day applies for 5 days per admission. $2,500.00 Copayment maximum for Inpatient Hospital per benefit year. In-network inpatient separation period is limited to 90 days. In-network inpatient rehabilitation day limit is 60 days. |
| | Skilled nursing care | $100.00 Copayment per day for Inpatient Hospital. | Not Covered. | Requires pre-approval; 20% penalty applies for non-compliance. $2,500.00 Copayment maximum for Inpatient Hospital per benefit year. In-network inpatient skilled nursing facility day limit is100 days in-network. |
| | Durable medical equipment | No charge. | Not Covered. | Prior authorization required for DME purchases over $500. 20% penalty applies for non-compliance. |
| | Hospice service | No charge for Inpatient Hospital, Freestanding Facility. | Not Covered. | Requires pre-approval; 20% penalty applies for non-compliance. |

| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If your child needs dental or eye care** | Eye exam | $40.00 Copayment for Office. Specialist. | Not Covered. | In-network routine vision exam visit limit. Coverage is limited to 1 visit in-network. |
| | Glasses | $50.00 Reimbursement. | Not Covered. | In-network routine vision hardware dollar limit. Coverage is limited to every 2 years. |
| | Dental check-up | Not Covered | Not Covered | _____none_____ |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

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

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

- Chiropractic care
- Hearing Aids(Only covered for Members age 15 or younger)
- Bariatric surgery
- Infertility treatment
- Most coverage provided outside the United States. See www.HorizonBlue.com
- Non-emergency care when traveling outside the U.S. See www.HorizonBlue.com
- Private-duty nursing
- 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: Call **1-800-355-BLUE (2583)** or visit **www.HorizonBlue.com**. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**.

## Does this Coverage Provide Minimum Essential Coverage?

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

## Does this Coverage Meet the Minimum Value Standard?

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

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-355-BLUE (2583)**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-355-BLUE (2583)**.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码**1-800-355-BLUE (2583).**
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-355-BLUE (2583)**.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page*

## About these Coverage Examples:

These examples show how this plan might cover medical care in three situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers: $7,540.00**
- **Plan pays** $7,080.00
- **You pay** $460.00

**Sample care costs:**

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

**Patient pays:**

| | |
|---|---|
| Deductibles | $0.00 |
| Co-pays | $290.00 |
| Co-insurance | $0.00 |
| Limits or exclusions | $170.00 |
| **Total** | **$460.00** |

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

- **Amount owed to providers: $5,400.00**
- **Plan pays** $2,070.00
- **You pay** $3,330.00

**Sample care costs:**

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

**Patient pays:**

| | |
|---|---|
| Deductibles | $0.00 |
| Co-pays | $400.00 |
| Co-insurance | $0.00 |
| Limits or exclusions | $2,930.00 |
| **Total** | **$3,330.00** |

# Questions and answers about Coverage Examples:

**What are some of the assumptions behind the Coverage Examples?**

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

**What does a Coverage Example show?**

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

**Does the Coverage Example predict my own care needs?**

- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

**Does the Coverage Example predict my future expenses?**

- **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

**Can I use Coverage Examples to compare plans?**

- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

**Are there other costs I should consider when comparing plans?**

- **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should consider also contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.