### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$200 person/$500 family for out-of network services only.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>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.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. In-network coinsurance limit $800 person/$2,000 family; Active employee medical out-of-pocket limit $5,480 person/$10,960 family. Retiree medical out-of-pocket limit $5,499 person/$10,998 family. Out-of-network providers $5,000 person/$12,500 family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance billed charges and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of in-network providers, see <a href="http://www.HorizonBlue.com/shbp">www.HorizonBlue.com/shbp</a> or call 1-800-414-SHBP (7427).</td>
<td>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.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No. You don’t need a written referral to see a specialist.</td>
<td>You can see the in-network specialist you choose without permission for this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 5 &amp; 6. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

Questions: Call 1-609-292-7524 or visit us at [www.state.nj.us/treasury/pensions/health-benefits.shtml](http://www.state.nj.us/treasury/pensions/health-benefits.shtml).

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Horizon BCBSNJ: NJ DIRECT2030  
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016 - 12/31/2016
Coverage for: All Coverage Types  | Plan Type: PPO
New Jersey State Health Benefits Program

- **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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay/visit</td>
<td>30% coinsurance after deductible</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30 copay/visit (adult) $20 copay/visit (child)</td>
<td>30% coinsurance after deductible</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$30 copay/visit (adult) $20 copay/visit (child)</td>
<td>30% coinsurance after deductible</td>
<td>Chiropractic care is limited to 30 visits combined per calendar year. Out-of-network coverage for chiropractic and acupuncture services are limited to no more than $35 a visit for chiropractic and $60 a visit for acupuncture or 75% of the in network cost per visit, whichever is less.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>One routine physical per calendar year.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge</td>
<td>30% coinsurance after deductible</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No Charge</td>
<td>30% coinsurance after deductible</td>
<td>Requires pre-approval</td>
</tr>
</tbody>
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### Common Medical Event

#### If you need drugs to treat your illness or condition
- **Generic drugs**
- **Preferred brand drugs**
- **Non-preferred brand drugs**
- **Specialty drugs**

More information about [prescription drug coverage](#) is available through your employer.

#### Your Cost If You Use an In-network Provider
See separate Prescription Drug Plan SBC

#### Limitations & Exceptions

________ none ________

#### If you have outpatient surgery
- **Facility fee (e.g., ambulatory surgery center)**
  - **Your Cost If You Use an In-network Provider**: No Charge
  - **Your Cost If You Use an Out-of-network Provider**: 30% coinsurance after deductible

- **Physician/surgeon fees**
  - **Your Cost If You Use an In-network Provider**: No Charge
  - **Your Cost If You Use an Out-of-network Provider**: 30% coinsurance after deductible

________ none ________

#### If you need immediate medical attention
- **Emergency room services**
  - **Your Cost If You Use an In-network Provider**: $125 copay/visit
  - **Your Cost If You Use an Out-of-network Provider**: $125 copay/visit

- **Emergency medical transportation**
  - **Your Cost If You Use an In-network Provider**: 10% coinsurance
  - **Your Cost If You Use an Out-of-network Provider**: 30% coinsurance after deductible

- **Urgent care**
  - **Your Cost If You Use an In-network Provider**: $30 copay/visit (adult);
    $20 copay/visit (child)
  - **Your Cost If You Use an Out-of-network Provider**: 30% coinsurance after deductible

- **Limitations & Exceptions**
  - If admitted within 24 hours, the copayment is waived. Payment at the in-network level applies only to true Medical Emergencies & Accidental Injuries.
  - Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.

________ none ________

#### If you have a hospital stay
- **Facility fee (e.g., hospital room)**
  - **Your Cost If You Use an In-network Provider**: No Charge
  - **Your Cost If You Use an Out-of-network Provider**: 30% coinsurance after deductible

- **Physician/surgeon fee**
  - **Your Cost If You Use an In-network Provider**: No Charge
  - **Your Cost If You Use an Out-of-network Provider**: 30% coinsurance after deductible

- **Limitations & Exceptions**
  - Requires pre-approval. There is a separate $500 deductible per inpatient stay for out-of-network facilities.
  - Requires pre-approval.

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</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$30 copay/visit (adult) $20 copay/visit (child)</td>
<td>30% coinsurance after deductible</td>
<td>Some specialty outpatient services require pre-approval. Inpatient services require pre-approval. There is a separate $500 deductible per inpatient stay for out-of-network facilities.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>No Charge</td>
<td>30% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>No Charge</td>
<td>30% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>No Charge</td>
<td>30% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$30 copay/visit (adult) $20 copay/visit (child)</td>
<td>30% coinsurance after deductible</td>
<td>Copayment applies to initial visit only.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>No Charge</td>
<td>30% coinsurance after deductible</td>
<td>Requires pre-approval. There is a separate $500 deductible per inpatient stay for out-of-network facilities.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No Charge</td>
<td>30% coinsurance after deductible</td>
<td>Requires pre-approval.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$30 copay/visit (adult) $20 copay/visit (child)</td>
<td>30% coinsurance after deductible</td>
<td>Requires pre-approval.</td>
</tr>
<tr>
<td></td>
<td>Habilitative services</td>
<td>$30 copay/visit (adult) $20 copay/visit (child)</td>
<td>30% coinsurance after deductible</td>
<td>Requires pre-approval.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No Charge</td>
<td>30% coinsurance after deductible</td>
<td>Requires pre-approval. Limited to 120 days in-network and 60 out-of-network facility days for a combined maximum of 120 days per calendar year. There is a separate $500 deductible per inpatient stay for out-of-network facilities.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance after deductible</td>
<td>Requires pre-approval for all rentals and some purchases.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No Charge</td>
<td>30% coinsurance after deductible</td>
<td>Requires pre-approval. There is a separate $500 deductible per inpatient stay for out-of-network facilities.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>$30 copay/visit (adult) $20 copay/visit (child)</td>
<td>Not Covered</td>
<td>Limited to one exam every 12 months.</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

### Common Medical Event

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<tr>
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<th>Your Cost If You Use an In-network Provider</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>none</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>none</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing (inpatient)
- Routine foot care
- Weight loss programs

#### Other Covered Services

- Acupuncture (for pain management only)
- Bariatric surgery (requires pre-approval)
- Chiropractic care (limited to 30 visits/year)
- Hearing aids (Only covered for members age 15 or younger, maximums apply)
- Infertility treatment (requires pre-approval)
- Non-emergency care when traveling outside the U.S. (subject to deductible/coinsurance and balance billing.)
- 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 1-800-414-SHBP (7427). 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.ecriio.cms.gov.

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Horizon Blue Cross Blue Shield of New Jersey Member Services at 1-800-414-

### Questions:

Call 1-609-292-7524 or visit us at [www.state.nj.us/treasury/pensions/health-benefits.shtml](http://www.state.nj.us/treasury/pensions/health-benefits.shtml).

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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:

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

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Horizon BCBSNJ: NJ DIRECT2030
Coverage Examples

Coverage Period: 01/01/2016 - 12/31/2016
Coverage for: All Coverage Types | Plan Type: PPO
New Jersey State Health Benefits Program

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.

Having a baby (normal delivery)

- Amount owed to providers: $7,540
- Plan pays $7,340
- Patient pays $200

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 $0
- Copays $30
- Coinsurance $0
- Limits or exclusions $170

Total $200

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

- Amount owed to providers: $5,400
- Plan pays $1,000
- Patient pays $4,400

Sample care costs:

- Prescriptions $2,900
- Medical Equipment and Supplies $1,300
- Office Visits and Procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive $100

Total $5,400

Patient pays:

- Deductibles $0
- Copays $200
- Coinsurance $0
- Limits or exclusions $4,200

Total $4,400

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.

Please note that some of the Limits or Exclusions listed above may be covered under the Prescription Plan.

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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.

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