



**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/usw1086](http://www.HorizonBlue.com/usw1086) or by calling 1-888-444-8014.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	<b>\$150</b> person / <b>\$300</b> family for in-network services and <b>\$300</b> person / <b>\$600</b> family for out-of-network services. Does not apply to preventive care.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. For in-network services <b>\$500</b> person/ <b>\$1,000</b> family. For out-of-network services <b>\$1,000</b> person/ <b>\$2,000</b> family.	The <b>out-of-pocket limit</b> 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 <b>out-of-pocket limit</b> ?	Premiums, deductibles, copayments, balanced-billed charges and 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 <b>out-of-pocket limit</b> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list on In-Network providers, see <a href="http://www.HorizonBlue.com/usw1086">www.HorizonBlue.com/usw1086</a> or call 1-888-444-8014.	If you use an In-Network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No. You don't need a written referral to see a specialist.	You can see the <b>specialist</b> 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 <b>excluded services</b> .

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- **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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$10 Copay/visit	30% coinsurance after deductible	—————none—————
	Specialist visit	\$10 Copay/visit	30% coinsurance after deductible	—————none—————
	Other practitioner office visit	\$15 Copay/Short term therapy visit; \$15 Copay/Therapeutic manipulations (chiropractic care) visit	30% coinsurance after deductible	Short term therapies: physical, occupational speech, cognitive and respiratory are limited to 30 visits maximum in and out-of-network per therapy per benefit period. Therapeutic Manipulations (chiropractic care) are limited to 30 visits maximum in and out-of-network per benefit period.
	Preventive care/screening/immunization	\$10 Copay/visit	30% coinsurance after deductible	One routine physical per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance after deductible	—————none—————.
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	30% coinsurance after deductible	Requires pre-approval.

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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
<p><b>If you need drugs to treat your illness or condition</b></p> <p><b>More information about prescription drug coverage is available at 1-800-711-0917 or <a href="http://www.express-scripts.com">www.express-scripts.com</a></b></p>	Generic drugs	\$10 Copay/Retail \$20 Copay/Mail order	\$10/\$20 co-pay plus cost above PAR provider UCR	Retail- 30-day supply (\$10) Mail – up to 90 day supply (\$20)
	Preferred brand drugs	\$15 Copay/Retail \$30 Copay/Mail order.	\$15/\$30 co-pay plus cost above PAR provider UCR	Retail- 30-day supply (\$15) Mail – up to 90 day supply (\$30)
	Merck and Schering-Plough <b>manufactured</b> Brand Name Drugs	\$0 Copay/Retail \$0 Copay/Mail order.	\$0/\$0 co-pay plus cost above PAR provider UCR	Retail- 30-day supply (\$0) Mail – up to 90 day supply (\$0)
	Specialty drugs	\$15 Copay/Retail \$30 Copay/Mail order.	\$15/\$30 co-pay plus cost above PAR provider UCR	Retail- 30-day supply (\$15) Mail – up to 90 day supply (\$30)
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance after deductible	30% coinsurance after deductible	—————none—————
	Physician/surgeon fees	10% Coinsurance after deductible	30% coinsurance after deductible	—————none—————
<p><b>If you need immediate medical attention</b></p>	Emergency room services	\$25 Copay/visit	\$25 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	No Charge	No Charge	—————none—————
	Urgent care	\$15 Copay/Primary visit/Specialist visit	30% coinsurance after deductible	—————none—————

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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
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance after deductible	30% coinsurance after deductible	Limited to 70 day maximum for IP out-of-network services. Requires pre-approval. 100% penalty applies up to \$1000 maximum for non-compliance.
	Physician/surgeon fee	10% coinsurance after deductible	30% coinsurance after deductible	—————none—————
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Office: \$10 Copay/visit. Outpatient facility: 10% coinsurance after deductible	30% coinsurance after deductible	—————none—————
	Mental/Behavioral health inpatient services	10% coinsurance after deductible	30% coinsurance after deductible	Limited to 70 day maximum for IP out-of-network services. Requires pre-approval. 100% penalty applies up to \$1000 maximum for non-compliance.
	Substance use disorder outpatient services	Office: \$10 Copay/visit. Outpatient facility: 10% coinsurance after deductible	30% coinsurance after deductible	—————none—————
	Substance use disorder inpatient services	10% coinsurance after deductible	30% coinsurance after deductible	Limited to 70 day maximum for IP out-of-network services. Requires pre-approval. 100% penalty applies up to \$1000 maximum for non-compliance.
<b>If you are pregnant</b>	Prenatal and postnatal care	\$10 Copay/Initial visit	30% coinsurance after deductible	Office visit copay for the initial visit only. The benefit listed is specific to the maternity prenatal and postnatal office visits, charges for other services and supplies may be subject to member out-of-pocket.
	Delivery and all inpatient services	10% Coinsurance after deductible	30% coinsurance after deductible	Requires pre-approval. 100% penalty applies up to \$1000 maximum for non-compliance.

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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
<b>If you need help recovering or have other special health needs</b>	Home health care	10% Coinsurance after deductible	30% coinsurance after deductible	Requires pre-approval; 20% penalty applies for non-compliance.
	Rehabilitation services (Inpatient)	10% Coinsurance after deductible	30% coinsurance after deductible	Limited to 30 day maximum for in and out-of-network services. Requires pre-approval. 100% penalty applies up to \$1000 maximum for non-compliance.
	Habilitation services (Inpatient)	10% Coinsurance after deductible	30% coinsurance after deductible	Limited to 30 day maximum for in and out-of-network services. Requires pre-approval. 100% penalty applies up to \$1000 maximum for non-compliance
	Skilled nursing care	10% Coinsurance after deductible	30% coinsurance after deductible	Requires pre-approval. 100% penalty applies up to \$1000 maximum for non-compliance.
	Durable medical equipment	10% Coinsurance after deductible	30% coinsurance after deductible	Items over \$500.00 require pre-approval; 20% penalty applies for non-compliance.
	Hospice service	10% Coinsurance after deductible	30% coinsurance after deductible	Requires pre-approval. 100% penalty applies up to \$1000 maximum for non-compliance.
<b>If your child needs dental or eye care</b>	Eye exam	No Charge	Member is refunded per Non Par Reimbursement schedule	One exam per every 12 months
	Glasses	No Charge	Member is refunded per Non Par Reimbursement schedule	Limited to one pair of glasses per year. Optional upgrades available at a discount
	Dental check-up	No Charge	Member is refunded per Non Par Reimbursement schedule	Routine exams, x-rays, cleanings, fluoride treatments (two per calendar year)

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**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
- Hearing aids (Only covered for Members age 15 or younger, maximums apply)
- Routine foot care
- Cosmetic surgery
- Infertility treatment
- Weight loss programs
- Dental care (Adult) – Covered separately
- Long-term care

**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.)

- Bariatric surgery
- Non-emergency care when traveling outside the U.S. See [www.HorizonBlue.com](http://www.HorizonBlue.com)
- Private-duty nursing
- Chiropractic care
- Orthotics
- Routine eye care (Adult)
- Dental care (Children)

**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-EBSA (3272) or [www.dol.gov/ebsa](http://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](http://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](http://www.dol.gov/ebsa/healthreform).

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## 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, kwijigo 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.* —————

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## 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 \$6,870
- Patient pays \$670

**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
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$150
Copays	\$10
Coinsurance	\$340
Limits or exclusions	\$170
<b>Total</b>	<b>\$670</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$2,110
- Patient pays \$3,290

**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
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$150
Copays	\$0
Coinsurance	\$210
Limits or exclusions	\$2,930
<b>Total</b>	<b>\$3,290</b>



## 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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