Plan Provisions	Premium Plus			Premium		Basic			Out of New Jersey Plan (option available for team members who reside outside New Jersey)	
	Hackensack Meridian *Health* Inner Circle	Horizon PPO Network	Out-of-Network	Hackensack Meridian *Health* Inner Circle	Horizon PPO Network	Hackensack Meridian *Health* Inner Circle	Horizon PPO Network	Out-of-Network	Hackensack Meridian *Health* Inner Circle	Horizon PPO Network
Annual Deductible Individual/Family	$0/$0	$1,500/$3,000	$2,000/$4,000	$0/$0	$3,000/$6,000	$1,500/$3,000	$1,500/$3,000	$3,000/$6,000	$0/$0	$1,500/$3,000
Coinsurance	Plan Pays 100%	Plan Pays 70%	Plan Pays 50%	Plan Pays 100%	Plan Pays 50%	Plan Pays 100%	Plan Pays 60%	Plan Pays 50%	Plan Pays 100%	Plan Pays 80%
Out-Of-Pocket Maximum Individual/Family	$1,000/$2,000 (Medical & Rx)	$4,000/$8,000 (Medical & Rx)	$5,000/$10,000 (Medical & Rx)	$1,500/$3,000 (Medical & Rx)	$5,000/$10,000 (Medical & Rx)	$2,000/$4,000 (Medical & Rx)	$6,650/$13,300 (Medical & Rx)	$6,650/$13,300 (Medical & Rx)	$4,000/$8,000 (Medical & Rx)	$4,000/$8,000 (Medical & Rx)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Precertification Requirements	$400 Penalty Applies For Each Failure To Precert			$400 Penalty Applies For Each Failure To Precert		$400 Penalty Applies For Each Failure To Precert			$400 Penalty Applies For Each Failure To Precertify	
HMH Annual HSA Contribution	N/A	N/A	N/A	N/A	N/A	HSA Funding Varies By Salary Band And Coverage Tier: Under $40K Team Member: $570 Team Member +Spouse: $1,140 Team Member +Child: $1,000 Team Member +Family: $1,570 $40K - $60K Team Member: $410 Team Member +Spouse: $810 Team Member +Child: $710 Team Member +Family: $1,120 $60K - $120K Team Member: $70 Team Member +Spouse: $130 Team Member +Child: $110 Team Member +Family: $180 Over $120K None			N/A	N/A
Maximum Team Member HSA Contributions	N/A	N/A	N/A	N/A	N/A	Your And HMH's Matching Contribution Cannot Exceed $3,550 (Individual) / $7,100 (Family) In 2020			N/A	N/A
Inpatient Covered Services										
Hospital Copay Applied Before Deductible, Per Admission	None	None	None	None	None	None	None	None	None	None
Semi-Private Room	100%	70% After Deductible	50% After Deductible	100%	50% After Deductible	100% After Deductible	60% After Deductible	50% After Deductible	100%	80% After Deductible
Inpatient Physician	100%	70% After Deductible	50% After Deductible	100%	50% After Deductible	100% After Deductible	60% After Deductible	50% After Deductible	100%	80% After Deductible
Surgery Direct	100%	70% After Deductible	50% After Deductible	100%	50% After Deductible	100% After Deductible	60% After Deductible	50% After Deductible	100%	80% After Deductible
Outpatient Covered Services										
Primary Care Office Visit	100% After $5 Copay	100% After $50 Copay	50% After Deductible	100% After $5 Copay	100% After $50 Copay	100% After Deductible	60% After Deductible	50% After Deductible	100% After $5 Copay	100% After $5 Copay
Specialist Visit	100% After $15 Copay	100% After $100 Copay	50% After Deductible	100% After $15 Copay	100% After $100 Copay	100% After Deductible	60% After Deductible	50% After Deductible	100% After $15 Copay	100% After $15 Copay
Outpatient Surgery	100%	70% After Deductible	Surgi-Center – Not Covered All Other Facilities - 50% After Deductible	100%	50% After Deductible	100% After Deductible	60% After Deductible	Surgi-Center – Not Covered All Other Facilities - 50% After Deductible	100%	80% After Deductible
Preventive Care, Including Routine Physicals & Immunizations Frequency Limits May Apply	100%	100%	Not Covered	100%	100%	100%	100%	Not Covered	100%	100%
Chiropractic Care	100% After $15 Copay	100% After $100 Copay	50% After Deductible	100% After $15 Copay	100% After $100 Copay	100% After Deductible	60% After Deductible	50% After Deductible	100% After $15 Copay	100% After $15 Copay
	30 Visits Per Year			30 Visits Per Year		30 Visits Per Year			30 Visits Per Year	
Diagnostic X-Ray, Lab Services And Treatments	100%	70% After Deductible	50% After Deductible	100%	50% After Deductible	100% After Deductible	60% After Deductible	50% After Deductible	100%	80% After Deductible
Mental Health/Substance Abuse										
Inpatient Care	100%	70% After Deductible	50% After Deductible	100%	50% After Deductible	100% After Deductible	60% After Deductible	50% After Deductible	100%	80% After Deductible
Outpatient Mental Health/Substance Abuse	100% After $15 Copay	100% After $100 Copay	50% After Deductible	100% After $15 Copay	100% After $100 Copay	100% After Deductible	60% After Deductible	50% After Deductible	100% After $15 Copay	100% After $15 Copay
Emergency Services										
Emergency Room	$0 Copay For True Emergencies. $200 Copay For Non-Emergencies	$0 Copay For True Emergencies. $200 Copay For Non-Emergencies	$0 Copay For True Emergencies. $200 Copay For Non-Emergencies	$0 Copay For True Emergencies. $200 Copay For Non-Emergencies	$0 Copay For True Emergencies. $200 Copay For Non-Emergencies	100% After Deductible	100% After Deductible	100% After Deductible	$0 Copay For True Emergencies; $200 Copay For Non-Emergencies	$0 Copay For True Emergencies; $200 Copay For Non-Emergencies
Ambulance Service (Medically Necessary)	100%	100%	100%	100%	100%	100% After Deductible	100% After Deductible	100% After Deductible	100%	Emergent 100% Non Emergent - 80% After Deductible
Urgent Care	100% After $15 Copay	100% After $30 Copay	50% After Deductible	100% After $15 Copay	100% After $30 Copay	100% After Deductible	60% After Deductible	50% After Deductible	100% After $15 Copay	100% After $15 Copay
Other Services										
Physical, Occupational, Speech and Cognitive Therapy	Facility - 100% Office - 100% After $15 Copay	Facility - 70% After Deductible Office - 100% After $100 Copay	50% After Deductible	Facility - 100% Office - 100% After $15 Copay	Facility - 50% After Deductible Office - 100% After $100 Copay	100% After Deductible	60% After Deductible	50% After Deductible	Facility - 100% Office - 100% After $15 Copay	Facility - 80% After Deductible; Office - 100% After $15 Copay
	60 Visits Per Year			60 Visits Per Year		60 Visits Per Year			60 Visits Per Year	
Radiation, Chemotherapy And Cardiac Therapy	100%	70% After Deductible	50% After Deductible	100%	50% After Deductible	100% After Deductible	60% After Deductible	50% After Deductible	100%	80% After Deductible
Dialysis	100% After $15 Copay	70% After Deductible	Not Covered	100% After $15 Copay	50% After Deductible	100% After Deductible	60% After Deductible	Not Covered	100% After $15 Copay	80% After Deductible
Home Health Care	100%	70% After Deductible	50% After Deductible	100%	50% After Deductible	100% After Deductible	60% After Deductible	50% After Deductible	100%	80% After Deductible
	120 Visits Per Year			120 Visits Per Year		120 Visits Per Year			120 Visits Per Year	
Extended Care/ Skilled Nursing	100%	70% After Deductible	50% After Deductible	100%	50% After Deductible	100% After Deductible	60% After Deductible	50% After Deductible	100%	80% After Deductible
	120 Visits Per Year			120 Visits Per Year		120 Visits Per Year			120 Visits Per Year	
Hospice Care	100%	70% After Deductible	50% After Deductible	100%	50% After Deductible	100% After Deductible	60% After Deductible	50% After Deductible	100%	80% After Deductible
Durable Medical Equipment	100%	70% After Deductible	50% After Deductible	100%	50% After Deductible	100% After Deductible	60% After Deductible	50% After Deductible	100%	80% After Deductible
Acupuncture Includes Coverage For Pain Management	100% After $15 Copay	100% After $100 Copay	Not Covered	100% After $15 Copay	100% After $100 Copay	100% After Deductible	60% After Deductible	Not Covered	100% After $15 Copay	100% After $15 Copay