Plan Provisions	Premium Plus		
	Hackensack Meridian *Health* Inner Circle	**Horizon PPO Network**	**Out-of-Network**
Annual Deductible Individual/Family	$0/$0	$1,500/$3,000	$2,000/$4,000
Coinsurance	Plan Pays 100%	Plan Pays 70%	Plan Pays 50%
Out-Of-Pocket Maximum Individual/Family	$1,000/$2,000 (Medical & Rx)	$4,000/$8,000 (Medical & Rx)	$5,000/$10,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Precertification Requirements	$400 Penalty Applies For Each Failure To Precert		
HMH Annual HSA Contribution	N/A	N/A	N/A
Maximum Team Member HSA Contributions	N/A	N/A	N/A
Inpatient Covered Services			
Hospital Copay Applied Before Deductible, Per Admission	None	None	None
Semi-Private Room	100%	70% After Deductible	50% After Deductible
Inpatient Physician	100%	70% After Deductible	50% After Deductible
Surgery Direct	100%	70% After Deductible	50% After Deductible
Outpatient Covered Services			
Primary Care Office Visit	100% After $5 Copay	100% After $50 Copay	50% After Deductible
Specialist Visit	100% After $15 Copay	100% After $100 Copay	50% After Deductible
Outpatient Surgery	100%	70% After Deductible	Surgi-Center – Not Covered All Other Facilities - 50% After Deductible
Preventive Care, Including Routine Physicals & Immunizations Frequency Limits May Apply	100%	100%	Not Covered
Chiropractic Care	100% After $15 Copay	100% After $100 Copay	50% After Deductible
	30 Visits Per Year		
Diagnostic X-Ray, Lab Services And Treatments	100%	70% After Deductible	50% After Deductible
Mental Health/Substance Abuse			
Inpatient Care	100%	70% After Deductible	50% After Deductible
Outpatient Mental Health/Substance Abuse	100% After $15 Copay	100% After $100 Copay	50% After Deductible
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
Ambulance Service (Medically Necessary)	100%	100%	100%
Urgent Care	100% After $15 Copay	100% After $30 Copay	50% After Deductible
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
	60 Visits Per Year		
Radiation, Chemotherapy And Cardiac Therapy	100%	70% After Deductible	50% After Deductible
Dialysis	100% After $15 Copay	70% After Deductible	Not Covered
Home Health Care	100%	70% After Deductible	50% After Deductible
	120 Visits Per Year		
Extended Care/ Skilled Nursing	100%	70% After Deductible	50% After Deductible
	120 Visits Per Year		
Hospice Care	100%	70% After Deductible	50% After Deductible
Durable Medical Equipment	100%	70% After Deductible	50% After Deductible
Acupuncture Includes Coverage For Pain Management	100% After $15 Copay	100% After $100 Copay	Not Covered