**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit Member Online Services at www.HorizonBlue.com/members or by calling 1-800-355-BLUE(2583). If you do not currently have coverage with Horizon BCBSNJ you can view a sample policy here, HorizonBlue.com/sample-benefit-booklets. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-355-BLUE(2583) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible**? | **$500.00** Individual / **$1,000.00** Family for out-of-network. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care is covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Yes, For Health/Pharmacy providers **$2,000.00** Individual/**$4,000.00** family. Combined in and out of network benefits. Aggregate family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. For a list of in-network provider, see www.HorizonBlue.com or call 1-800-355-BLUE(2583). | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you 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 a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider(You will pay the most) | |
| **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 for Office. | 30% Coinsurance for Office. | ————none———— |
| | Specialist visit | $40.00 Copayment per visit for Office; Specialist. | 30% Coinsurance for Office. | |
| | Preventive care/screening/immunization | No Charge. | 30% Coinsurance for Office. Deductible does not apply. | One per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge for Office. Independent Laboratory. Outpatient Hospital. | 30% Coinsurance for Office, Outpatient Hospital, Independent Laboratory. | Molecular and genomic testing is subject to pre-service and post-service medical necessity review. |
| | Imaging (CT/PET scans, MRIs) | No Charge for Outpatient Hospital. | 30% Coinsurance for Outpatient Hospital. | Requires pre-approval; 20% penalty applies for non-compliance. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at Prime Therapeutics LLC (Prime) Service Center www.MyPrime.com or 1-800-370-5088 | Generic drugs | $10.00 Copayment/Retail; $20.00 Copayment/Mail Order. | $10.00 Copayment/Retail; $20.00 Copayment/Mail Order. | Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order) |
| | Preferred brand drugs | $25.00 Copayment/Retail; $50.00 Copayment/Mail Order. | $25.00 Copayment/Retail; $50.00 Copayment/Mail Order. | |
| | Non-preferred brand drugs | $50.00 Copayment/Retail; $100.00 Copayment/Mail Order. | $50.00 Copayment/Retail; $100.00 Copayment/Mail Order. | |
| | Specialty drugs | Covered at retail benefit in above applicable categories. | Covered at retail benefit in above applicable categories. | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider(You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $300.00 Copayment per visit for Outpatient Hospital. No Charge for Ambulatory Surgical Center. | 30% Coinsurance for Outpatient Hospital, Ambulatory Surgical Center. | Procedures related to spine surgery are subject to pre-service and post-service utilization management review. |
| | Physician/surgeon fees | No Charge for Outpatient Hospital. | 30% Coinsurance for Outpatient Hospital. | Procedures related to spine surgery are subject to pre-service and post-service utilization management review. 30% Coinsurance for anesthesia. |
| **If you need immediate medical attention** | Emergency room care | $100.00 Copayment per visit for Outpatient Hospital. | $100.00 Copayment per visit for Outpatient Hospital. Deductible does not apply. | Copay waived if admitted within 24 hours. Applies only to emergency room medical emergency and accidental injury. |
| | Emergency medical transportation | No Charge. | 30% Coinsurance. | ———none——— |
| | Urgent care | $40.00 Copayment per visit for Specialist. | 30% Coinsurance for Office. | ———none——— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $100.00 Copayment per admission for Inpatient Hospital. | $100.00 Copayment per admission and 30% Coinsurance for Inpatient Hospital. | Requires pre-approval; 20% penalty applies for non-compliance. In-network & Out-of-network inpatient separation period is limited to 90 days. |
| | Physician/surgeon fees | No Charge for Inpatient Hospital. | 30% Coinsurance for Inpatient Hospital. | Procedures related to spine surgery are subject to pre-service and post-service utilization management review. 30% Coinsurance for out-of-network anesthesia. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No Charge for Outpatient Hospital. | 30% Coinsurance for Outpatient Hospital. | ———none——— |
| | Inpatient services | $100.00 Copayment per admission for Inpatient Hospital. | $100.00 Copayment per admission and 30% Coinsurance for Inpatient Hospital. | Requires pre-approval; 20% penalty applies for non-compliance. In-network & Out-of-network inpatient separation period is limited to 90 days. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider(You will pay the most) | |
| **If you are pregnant** | Office visits | $20.00 Copayment per visit for Office. $40.00 Copayment per visit for Specialist. | 30% Coinsurance for Office. | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound.) Not covered - for child. |
| | Childbirth/delivery professional services | No Charge for Inpatient Hospital. | 30% Coinsurance for Inpatient Hospital. | Not covered - for child. |
| | Childbirth/delivery facility services | $100.00 Copayment per admission for Inpatient Hospital. | $100.00 Copayment per admission and 30% Coinsurance for Inpatient Hospital. | Not covered - for child. In-network & Out-of-network inpatient separation period is limited to 90 days. |
| **If you need help recovering or have other special health needs** | Home health care | No Charge. | 30% Coinsurance. | Requires pre-approval; 20% penalty applies for non-compliance. Out-of-network home health care visits are limited to 100 visits. |
| | Rehabilitation services | $100.00 Copayment per admission for Inpatient Hospital. | $100.00 Copayment per admission and 30% Coinsurance for Inpatient Hospital. | Requires pre-approval; 20% penalty applies for non-compliance. In-network & Out-of-network separation period is limited to 90 days. In-network & Out-of-network physical rehabilitation days are limited to 60 days. |
| | Habilitation services | $100.00 Copayment per admission for Inpatient Hospital. | $100.00 Copayment per admission and 30% Coinsurance for Inpatient Hospital. | |
| | Skilled nursing care | No Charge for Inpatient Facility. | 30% Coinsurance for Inpatient Facility. | Requires pre-approval; 20% penalty applies for non-compliance. In-network inpatient skilled nursing facility days limited to 100 days. Out-of-network inpatient skilled nursing facility days limited to 60 days. |
| | Durable medical equipment | No Charge. | 30% Coinsurance. | Prior authorization required for DME purchases over $500. 20% penalty applies for non-compliance. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider(You will pay the most) | |
| | Hospice services | No Charge for Inpatient Facility. | 30% Coinsurance for Inpatient Facility. | Requires pre-approval. 20% penalty applies for non-compliance. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered. | Not Covered. | ———none——— |
| | Children's glasses | Not Covered. | Not Covered. | ———none——— |
| | Children's dental check-up | Not Covered. | Not Covered. | ———none——— |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

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

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric surgery
- Chiropractic care
- Hearing Aids (Only covered for Members age 15 or younger)
- 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

## Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

## Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 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. You may also contact the NJ Department of Banking and Insurance Consumer Protection Services at 1-888-393-1062 ext 50998.

## Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

**About these Coverage Examples:**

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

## Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0.00**
- **Specialist *Copayment*** **$40.00**
- **Hospital (facility) *Coinsurance*** **0%**
- **Other *Coinsurance*** **0%**

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | $12,800.00 |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0.00 |
| Copayments | $200.00 |
| Coinsurance | $0.00 |
| *What isn't covered* | |
| Limits or exclusions | $60.00 |
| **The total Peg would pay is** | **$260.00** |

## Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0.00**
- **Specialist *Copayment*** **$40.00**
- **Hospital (facility) *Coinsurance*** **0%**
- **Other *Coinsurance*** **0%**

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | $7,400.00 |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0.00 |
| Copayments | $500.00 |
| Coinsurance | $0.00 |
| *What isn't covered* | |
| Limits or exclusions | $60.00 |
| **The total Joe would pay is** | **$560.00** |

## Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0.00**
- **Specialist *Copayment*** **$40.00**
- **Hospital (facility) *Coinsurance*** **0%**
- **Other *Coinsurance*** **0%**

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | $1,900.00 |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0.00 |
| Copayments | $120.00 |
| Coinsurance | $0.00 |
| *What isn't covered* | |
| Limits or exclusions | $810.00 |
| **The total Mia would pay is** | **$930.00** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

Horizon Blue Cross Blue Shield of New Jersey

If you need help understanding this Horizon Blue Cross Blue Shield of New Jersey information, you have the right to get help in your language at no cost to you. To talk to an interpreter, please call **1-800-355-BLUE (2583)** during normal business hours.

Spanish (Español): Si necesita ayuda para comprender esta información de Horizon Blue Cross Blue Shield of New Jersey, usted tiene el derecho de obtener ayuda en su idioma sin costo alguno. Para hablar con un intérprete, sírvase llamar al **1-855-477-AZUL (2985)** durante el horario normal de trabajo.

Chinese (中文)：如果您需要幫助來理解這份新澤西州地平線藍十字藍盾 (Horizon Blue Cross Blue Shield of New Jersey)資料，您有權免費獲得以您的語言提供的協助。欲聯絡翻譯人員，請於上班時間致電 **1-800-355-BLUE (2583)**。

Korean (한국어): 가입자는 Horizon Blue Cross Blue Shield of New Jersey에 관한 정보를 이해하기 위해 주로 사용하는 언어로 무료로 도움을 받을 권리가 있습니다. 통역사의 도움을 받으려면 정상 업무 시간 동안에 **1-800-355-BLUE (2583)**로 전화해 주십시오.

Portuguese (Português): Se precisar de ajuda para entender estas informações da Horizon Blue Cross Blue Shield of New Jersey, você tem o direito de receber gratuitamente assistência no seu idioma. Para falar com um intérprete, ligue para: **1-800-355-BLUE (2583)** no horário normal de trabalho.

Gujarati (ગુજરાતી): જો તમને આ ન્યુ જર્સી માહિતીનાં હોરાઈઝન્સ બ્લૂ ક્રોસ બ્લૂ શીલ્ડને સમજવા મદદની જરૂર હોય તો, તમને તમારી ભાષામાં કોઈ પણ ખર્ચ વગર મદદ મેળવવાનો અધિકાર છે. કોઈ દુભાષિયા સાથે વાત કરવા, કૃપા કરીને સામાન્ય બિઝનેસ કલાકો દરમિયાન **1-800-355-BLUE (2583)** પર ફોન કરો .

Polish (Polski): Jeżeli potrzebujesz pomocy, aby zrozumieć informacje planu Horizon Blue Cross Blue Shield of New Jersey, masz prawo poprosić o bezpłatną pomoc w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer **1-800-355-BLUE (2583)** podczas normalnych godzin pracy.

Russian (Русский язык): Если вам необходима помощь в разъяснении этой информации, предоставленной компанией Horizon Blue Cross Blue Shield of New Jersey, у вас есть право на получение помощи на вашем родном языке бесплатно. Для связи с переводчиком звоните по номеру телефона **1-800-355-BLUE (2583)** в обычные рабочие часы.

Haitian Creole (Kreyòl ayisyen): Si ou bezwen èd pou konprann enfòmasyon sou Horizon Blue Cross Blue Shield of New Jersey, ou gen dwa pou jwenn èd nan lang natifnatal ou gratis. Pou pale avèk yon entèprèt, tanpri rele nimewo **1-800-355-BLUE (2583)** pandan lè nòmal biznis.

Hindi (हिंदी): यदि आपको न्यू जर्सी की इस होराइज़न ब्लू क्रॉस ब्लू शील्ड सूचना को समझने में सहायता की ज़रूरत है, तो आपके पास मुफ्त में अपनी भाषा में सहायता पाने का अधिकार है। किसी दुभाषिए से बात करने के लिए, कृपया सामान्य कार्य समय के दौरान **1-800-355-BLUE (2583)** पर कॉल करें।

Vietnamese (Tiếng Việt): Nếu cần được giúp đỡ để hiểu rõ thông tin này của Horizon Blue Cross Blue Shield of New Jersey, quý vị có quyền được giúp đỡ bằng ngôn ngữ của mình miễn phí. Xin gọi số **1-800-355-BLUE (2583)** trong giờ làm việc để nói chuyện với người thông dịch.

French (Français): Si vous avez besoin d'assistance pour comprendre ces informations au sujet de Horizon Blue Cross Blue Shield of New Jersey, vous avez le droit d'obtenir de l'aide dans votre langue, sans aucun frais. Pour parler avec un interprète, veuillez appeler le **1-800-355-BLUE (2583)** pendant les heures normales de bureau.

Navajo (Diné): Díí New Jersey bił hahoodzo Horizon Blue Cross Blue Shield, t'áá ninizaad k'ehjí baa hane'íí bik'i diitįįh bee shiká' a'doowoł nínízingo éí bee ná'ahoot'i' dóó doo bą́ą́h íllíní da. Ata' halne'é ła' bich'į' hadeesdzih nínízingo t'áá shǫǫdí **1-800-355-BLUE (2583)**jį' nida'anishgo oolkiłíí bik'ehgo hodíílnih.

Arabic (عربي): إذا كنت بحاجة إلى المساعدة في فهم معلومات Horizon Blue Cross Blue Shield of New Jersey، لديك الحق في الحصول على المساعدة بلغتك دون تحملك أية تكلفة. للتكلم مع مترجم، يرجى الاتصال خلال ساعات العمل العادية بالرقم **1-800-355-BLUE (2583)**.

Urdu (**اردو**): اگر آپ کو نیوجرسی انفارمیشن کے اس آسمانی نیلے رنگ والے تیز نیلے رنگ والے شیلڈ کو سمجھنے میں مدد کی ضرورت ہے تو، آپ کو اپنی زبان میں بغیر کسی خرچ کے مدد حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، براہ کرم، معمول کے کاروباری اوقات میں **1-800-355-BLUE (2583)** پر کال کریں۔

Italian (Italiano): Se vi serve aiuto per capire queste informazioni della Horizon Blue Cross Blue Shield of New Jersey, avete diritto ad assistenza gratis nella vostra lingua. Per parlare con un interprete, siete pregati di telefonare al numero **1-800-355-BLUE (2583)** durante le normali ore d'ufficio.

Tagalog (Tagalog): Kung kailangan mo ng tulong sa pag-unawa nitong impormasyon ng Horizon Blue Cross Blue Shield of New Jersey, may karapatan kang humingi ng tulong sa iyong wika nang walang gastos sa iyo. Upang makipag-usap sa isang taga-interpret, mangyaring tumawag sa **1-800-355-BLUE (2583)** sa loob ng karaniwang mga oras ng negosyo.

CMC0007942 (0516)

Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza East
Newark, NJ 07105-2200
HorizonBlue.com

## Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon BCBSNJ provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information written in other languages.

**Contacting Member Services**
Please call Member Services at **1-800-355-BLUE (2583)** (TTY/TDD **711**) **or the phone number on the back of your member ID card**, if you need the free aids and services noted above and for **all other Member Services issues, including:**

- **Claim, benefits or enrollment inquiries**
- **Lost/stolen ID cards**
- **Address changes**
- **Any other inquiry related to your benefits or health plan**

**Filing a Section 1557 Grievance**
If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin, age or disability you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address:

**Horizon BCBSNJ – Civil Rights Coordinator**
**PO Box 820**
**Newark, NJ 07101**

If you are not a Horizon BCBSNJ member, you may contact Horizon BCBSNJ's Civil Rights Coordinator by calling **1-866-660-6528** (TTY/TDD **711**) or by writing to Horizon BCBSNJ's Civil Rights Coordinator at the above-referenced address.You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

**Office for Civil Rights Headquarters**
**U.S. Department of Health and Human Services**
**200 Independence Avenue, SW**
**Room 509F, HHH Building**
**Washington, D.C. 20201**
**1-800-368-1019** or **1-800-537-7697** (TDD)

OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.