**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?** | **$1,500.00** Individual / **$3,000.00** Family per contract for combined in and out-of-network. True family aggregate. | 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 policy, the overall family deductible must be met before the plan begins to pay. |
| **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 **$6,350.00** Individual/**$12,700.00** family per contract. | 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**, the overall family **out-of-pocket limit** must be met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, 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 **out-of-pocket limit**. |
| **Will you pay less if you use a network provider?** | Not Applicable | This plan does not use a provider network. You can receive covered services from any provider. |
| **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 | 25% Coinsurance after deductible. | 25% Coinsurance after deductible. | _____none_____ |
| | Specialist visit | 25% Coinsurance after deductible. | 25% Coinsurance after deductible. | _____none_____ |
| | Other practitioner office visit | 25% Coinsurance after deductible. | 25% Coinsurance after deductible | Chiropractic care therapeutic manipulation visit limit coverage is unlimited per benefit period. |
| | Preventive care/screening/immunization | No Charge, Deductible does not apply. | No Charge, Deductible does not apply. | 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) | 25% Coinsurance for Office, Outpatient Hospital, Independent Laboratory after deductible. | 25% Coinsurance for Office, Outpatient Hospital, Independent Laboratory after deductible. | Labcorp. Applies only to non routine diagnostic radiology, laboratory, and pathology services. |
| | Imaging (CT/PET scans, MRIs) | 25% Coinsurance for Outpatient Hospital after deductible. | 25% Coinsurance for Outpatient Hospital after deductible. | _____none_____ |
| **If you need drugs to treat your illness or condition** | Generic drugs | 25% coinsurance after deductible | Not Covered | _____none_____ |
| | Preferred brand drugs | 25% coinsurance after deductible | Not Covered | |
| | Non-preferred brand drugs | 25% coinsurance after deductible | Not Covered | |
| | Specialty drugs | 25% coinsurance after deductible | Not Covered. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 25% Coinsurance for Outpatient Hospital, Ambulatory Surgical Center after deductible. | 25% Coinsurance for Outpatient Hospital, Ambulatory Surgical | Procedures related to spine surgery are subject to pre-service and post-service utilization management review. |

| 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) | |
| | | | Center after deductible. | |
| | Physician/surgeon fees | 25% Coinsurance for Outpatient Hospital, Ambulatory Surgical Center after deductible. | 25% Coinsurance for Outpatient Hospital, Ambulatory Surgical Center after deductible. | Procedures related to spine surgery are subject to pre-service and post-service utilization management review. 25% Coinsurance after deductible for anesthesia. |
| **If you need immediate medical attention** | Emergency room care | 25% Coinsurance for Outpatient Hospital after deductible. | 25% Coinsurance for Outpatient Hospital after deductible. | The listed benefits apply only to true medical emergencies and accidental injuries rendered in the emergency room only. |
| | Emergency medical transportation | 25% Coinsurance after deductible. | 25% Coinsurance after deductible. | _____none_____ |
| | Urgent care | 25% Coinsurance for Office after deductible. | 25% Coinsurance for Office after deductible. | _____none_____ |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 25% Coinsurance for Inpatient Hospital after deductible. | 25% Coinsurance for Inpatient Hospital after deductible. | Requires pre-approval; 20% cutback penalty for non-compliance, up to $1000 maximum. |
| | Physician/surgeon fees | 25% Coinsurance for Inpatient Hospital after deductible. | 25% Coinsurance for Inpatient Hospital after deductible. | Procedures related to spine surgery are subject to pre-service and post-service utilization management review. 25% Coinsurance after deductible for anesthesia. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 25% Coinsurance for Outpatient Hospital after deductible. | 25% Coinsurance for Outpatient Hospital after deductible. | _____none_____ |
| | Inpatient services | 25% Coinsurance for Inpatient Hospital after deductible. | 25% Coinsurance for Inpatient Hospital after deductible. | Requires pre-approval; 20% cutback penalty for non-compliance, up to $1000 maximum. |

| 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 | 25% Coinsurance for Office after deductible. | 25% Coinsurance for Office after deductible. | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound.) |
| | Childbirth/delivery professional services | 25% Coinsurance after deductible. | 25% Coinsurance after deductible. | BAYADA does not cover newborns for the first 30 days, unless they are later enrolled in the plan as a dependent. |
| | Childbirth/delivery facility services | 25% Coinsurance for Inpatient Hospital after deductible. | 25% Coinsurance for Inpatient Hospital after deductible. | Requires pre-approval; 20% cutback, and up to a $1000 maximum penalty applies for non-compliance. |
| **If you need help recovering or have other special health needs** | Home health care | 25% Coinsurance after deductible. | 25% Coinsurance after deductible. | Requires pre-approval; 20% cutback penalty for non-compliance, up to $1000 maximum. |
| | Rehabilitation services | 25% Coinsurance after deductible. | 25% Coinsurance after deductible. | Requires pre-approval; 20% cutback penalty for non-compliance, up to $1000 maximum. |
| | Habilitation services | 25% Coinsurance after deductible. | 25% Coinsurance after deductible. | |
| | Skilled nursing care | 25% Coinsurance for Inpatient Hospital after deductible. | 25% Coinsurance for Inpatient Hospital. Deductible does not apply. | Requires pre-approval; 20% cutback penalty for non-compliance, up to $1000 maximum. |
| | Durable medical equipment | 25% Coinsurance after deductible. | 25% Coinsurance after deductible. | Prior authorization required for DME purchases over $500. 20% penalty applies for non-compliance. |
| | Hospice services | 25% Coinsurance for Inpatient Hospital after deductible. | 25% Coinsurance for Inpatient Hospital. Deductible does not apply. | Requires pre-approval; 20% cutback penalty for non-compliance, up to $1000 maximum. |
| **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.)**

- Cosmetic Surgery
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- 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.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- 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.

## 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? No

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 | $1,500.00 |
| Specialist *Copayment* | $0.00 |
| Hospital (facility) *Coinsurance* | 25% |
| Other *Coinsurance* | 25% |

**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 | $1,500.00 |
| Copayments | $0.00 |
| Coinsurance | $2,770.00 |
| *What isn't covered* | |
| Limits or exclusions | $100.00 |
| **The total Peg would pay is** | **$4,370.00** |

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

| | |
|---|---|
| The plan's overall deductible | $1,500.00 |
| Specialist *Copayment* | $0.00 |
| Hospital (facility) *Coinsurance* | 25% |
| Other *Coinsurance* | 25% |

**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 | $1,500.00 |
| Copayments | $0.00 |
| Coinsurance | $360.00 |
| *What isn't covered* | |
| Limits or exclusions | $4,310.00 |
| **The total Joe would pay is** | **$6,170.00** |

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

| | |
|---|---|
| The plan's overall deductible | $1,500.00 |
| Specialist *Copayment* | $0.00 |
| Hospital (facility) *Coinsurance* | 25% |
| Other *Coinsurance* | 25% |

**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 | $830.00 |
| Copayments | $0.00 |
| Coinsurance | $70.00 |
| *What isn't covered* | |
| Limits or exclusions | $810.00 |
| **The total Mia would pay is** | **$1,710.00** |

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 bąąh ílíní 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.



An Independent Licensee of the
Blue Cross and Blue Shield Association.

Horizon
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 on the basis of race, color, national origin, age, disability or sex. Horizon BCBSNJ does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Horizon BCBSNJ provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Information written in other languages

If you need these services, contact Horizon BCBSNJ's Director of Regulatory Compliance at the phone number, fax or email listed below.

If you believe that Horizon BCBSNJ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

**Horizon BCBSNJ – Director, Regulatory Compliance**
**Three Penn Plaza East, PP-16C**
**Newark, NJ 07105**
**Phone: 1-800-658-6781**
**Fax: 1-973-466-7759**
**Email: ComplianceAndEthicsOffice@HorizonBlue.com**

You can file a grievance in person, or by mail, fax or email. If you need help filing a grievance, Horizon BCBSNJ's Director of Regulatory Compliance is available to help you.

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)

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