



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.** Benefits may change upon renewal. 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](http://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](http://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](http://www.cciio.cms.gov) or call 1-800-355-BLUE(2583) to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<b>\$500.00</b> Individual/ <b>\$1,000.00</b> Family for out-of-network.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Yes, For Health providers <b>\$3,000.00</b> Individual/ <b>\$6,000.00</b> Family. Combined in and out of network benefits. For Pharmacy providers <b>\$1,500.00</b> Individual/ <b>\$3,000.00</b> Family. Aggregate family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. For a list of in-network <u>providers</u> , see <a href="http://www.HorizonBlue.com">www.HorizonBlue.com</a> or call 1-800-355-BLUE (2583).	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No. You don't need a <u>referral</u> to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20.00 Copayment per visit.	30% Coinsurance.	—none—
	Specialist visit	\$20.00 Copayment per visit.	30% Coinsurance.	
	Preventive care/screening/immunization	No Charge.	30% Coinsurance. 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.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	No Charge for Office, Outpatient Hospital, Independent Laboratory.	30% Coinsurance for Office, Outpatient Hospital, Independent Laboratory.	Molecular and genomic testing are 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.
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at Prime Therapeutics LLC (Prime) Service Center <a href="http://www.MyPrime.com">www.MyPrime.com</a> or 1-800-370-5088.	Generic drugs	\$15.00 Copayment/Retail. \$30.00 Copayment/Mail Order.	\$15.00 Copayment/Retail. \$30.00 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	\$40.00 Copayment/Retail. \$80.00 Copayment/Mail Order.	\$40.00 Copayment/Retail. \$80.00 Copayment/Mail Order.	
	Non-preferred brand drugs	\$40.00 Copayment/Retail. \$80.00 Copayment/Mail Order.	\$40.00 Copayment/Retail. \$80.00 Copayment/Mail Order.	
	Specialty drugs	Covered at mail order benefit in above applicable categories.	Covered at mail order benefit in above applicable categories.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150.00 Copayment for Outpatient Hospital, 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. Surgical procedure performed in out-of-network ambulatory surgical center requires pre-approval.

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)	
	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% <u>Coinsurance</u> for out-of-network anesthesia.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$100.00 Copayment per visit for Outpatient Hospital.	\$100.00 Copayment per visit for Outpatient Hospital. <u>Deductible</u> does not apply.	Copayment waived if admitted within 24 hours. Payment at the in-network level of benefits applies only to true accidental injuries and medical emergencies.
	<u>Emergency medical transportation</u>	No Charge.	30% Coinsurance.	— none —
	<u>Urgent care</u>	\$20.00 Copayment per visit for Office.	30% Coinsurance for Office.	— none —
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$200.00 Copayment for Inpatient Hospital.	\$200.00 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.	30% <u>Coinsurance</u> for out-of-network anesthesia.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No Charge for Outpatient Hospital.	30% Coinsurance for Outpatient Hospital.	— none —
	Inpatient services	\$200.00 Copayment for Inpatient Hospital.	\$200.00 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.
<b>If you are pregnant</b>	Office visits	\$20.00 Copayment per visit for Office.	30% Coinsurance for Office.	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound.)
	Childbirth/delivery professional services	No Charge for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	— none —
	Childbirth/delivery facility services	\$200.00 Copayment for Inpatient Hospital.	\$200.00 Copayment per admission and 30% Coinsurance for Inpatient Hospital.	In-network & Out-of-network inpatient separation period is limited to 90 days.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	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.

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)	
	<u>Rehabilitation services</u>	\$200.00 Copayment for Inpatient Hospital.	\$200.00 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. In-network & Out-of-network physical rehabilitation day limit is 60 days.
	<u>Habilitation services</u>	\$200.00 Copayment for Inpatient Hospital.	\$200.00 Copayment per admission and 30% Coinsurance for Inpatient Hospital.	
	<u>Skilled nursing care</u>	No Charge for Inpatient Facility.	30% Coinsurance for Inpatient Facility.	
	<u>Durable medical equipment</u>	No Charge.	30% Coinsurance.	
	<u>Hospice services</u>	No Charge for Inpatient Facility.	30% Coinsurance for Inpatient Facility.	
<b>If your child needs dental or eye care</b>	Children's eye exam	\$20.00 Copayment for Specialist.	30% Coinsurance for Office.	In-network & Out-of-network routine vision exam is limited to 1 visit.
	Children's glasses	\$50.00 Reimbursement.	\$50.00 Reimbursement. <u>Deductible</u> does not apply.	In-network & Out-of-network routine vision hardware dollar limit is every 2 years.
	Children's dental check-up	No Charge.	No Charge. <u>Deductible</u> does not apply.	In-network & out-of-network prophylaxis frequency limit is 3 services per calendar year. In-network & out-of-network benefit period maximum (excluding ortho) is \$1,500. per calendar year.

## 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
- Long Term Care
- 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
- Dental Care (Adult)
- Hearing Aids (Only covered for Members age 15 or younger)
- Infertility treatment
- Most coverage provided outside the United States. See [www.HorizonBlue.com](http://www.HorizonBlue.com)
- Non-emergency care when traveling outside the U.S. See [www.HorizonBlue.com](http://www.HorizonBlue.com)
- Private-duty nursing
- Routine eye care (Adult)

## 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](http://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](http://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](http://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](http://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 \$20.00
- 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:**

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$450.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$60.00
<b>The total Peg would pay is</b>	<b>\$510.00</b>

**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 \$20.00
- 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:**

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$1,180.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$60.00
<b>The total Joe would pay is</b>	<b>\$1,240.00</b>

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

- The plan's overall deductible \$0.00
- Specialist Copayment \$20.00
- 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:**

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$140.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$220.00
<b>The total Mia would pay is</b>	<b>\$360.00</b>

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



## 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 (e.g. qualified sign language interpreters and information in other formats) and to those whose primary language is not English (e.g. information in other languages) to communicate effectively with us.

### Contacting Member Services

Please call Member Services at **1-800-355-BLUE (2583) (TTY 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**.

### Filing a Section 1557 Grievance

If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated against you for one of the reasons described above, 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.**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail at **U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201** or by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**. OCR Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).

### Language assistance

Si habla un idioma diferente al inglés, hay ayuda disponible gratis. Llame al número que aparece al reverso de su tarjeta de identificación.

如果您讲英语以外的语言，可获取免费帮助。请拨打您的身份证背面的号码。

영어 이외의 언어를 사용하는 경우, 무료 지원 서비스를 받을 수 있습니다. ID 카드 뒷면에 있는 번호로 전화하십시오.

Se você fala um idioma diferente do inglês, a ajuda está disponível gratuitamente. Ligue para o número no verso do seu bilhete de identidade.

જો તમે અંગ્રેજી સિવાયની ભાષા બોલતા હોવ, તો મફતમાં મદદ ઉપલબ્ધ છે. તમારા આઈડી કાર્ડની પાછળ આપેલા નંબર પર કોલ.

Jeśli mówisz w języku innym niż angielski, pomoc udzielana jest bezpłatnie. Zadzwoń pod numer podany na odwrocie dowodu osobistego.

Se parli una lingua diversa dall'inglese, è disponibile un servizio di assistenza gratuito. Chiama il numero sul retro della tua carta d'identità.

Kung nagsasalita ka ng isang wika maliban sa Ingles, magagamit ang tulong nang walang bayad. Tumawag sa numerong nasa likod ng iyong ID card.

Если вы не говорите по-английски, вам помогут бесплатно. Позвоните по телефону, указанному на обратной стороне вашей ID-карты.

Si ou pale on lòt lang ke Anglè, gen èd ki disponib gratis. Rele nan nimewo ki ekri nan do kat idantifyan w lan.

यदि आप अंग्रेज़ी से भिन्न कोई अन्य भाषा बोलते हैं, तो निःशुल्क सहायता उपलब्ध है। अपने आईडी कार्ड के पीछे दिए गए नंबर पर।

Nếu bạn nói ngôn ngữ khác ngoài tiếng Anh, thì chúng tôi có thể giúp bạn miễn phí. Hãy gọi số ở mặt sau thẻ ID của bạn.

Si vous parlez une langue autre que l'anglais, l'aide est gratuite. Appelez le numéro au dos de votre carte d'identité.

إذا كنت تتحدث لغة أخرى غير الإنجليزية، نوفر لك المساعدة مجاناً. يُمكنك الاتصال بالرقم الموجود على ظهر بطاقة الهوية  
اگر آپ انگریزی کے علاوہ کوئی دوسری زبان بول سکتے ہیں تو مفت مدد دستیاب ہے۔ براہ مہربانی شناختی کارڈ کی پچھلی طرف درج شدہ نمبر پر کال کریں۔