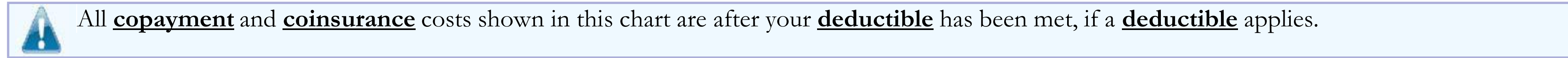
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. 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?	**$400.00** Individual / **$800.00** Family per contract for out-of-network. Aggregate family.	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 in-network Health providers **$5,000.00** Individual/ **$10,000.00** Family per contract. For out-of-network Health providers **$5,000.00** Individual/**$10,000.00** Family per contract. 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	$10.00 Copayment per visit.	Not Covered.	———none———
	Specialist visit	$10.00 Copayment per visit; Specialist.	Not Covered.	
	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, Outpatient Hospital, Independent Laboratory.	30% Coinsurance for Office, Outpatient Hospital, Independent Laboratory.	———none———
	Imaging (CT/PET scans, MRIs)	No Charge for Outpatient Hospital.	30% Coinsurance for Outpatient Hospital.	Requires pre-approval. 30% penalty applies for non-compliance
If you need drugs to treat your illness or condition	Generic drugs	Not Covered.	Not Covered.	———none———
	Preferred brand drugs	Not Covered.	Not Covered.	
	Non-preferred brand drugs	Not Covered.	Not Covered.	
	Specialty drugs	Not Covered.	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge 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.
	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 out-of-network anesthesia.

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 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 accidental injury and medical emergency.
	Emergency medical transportation	No Charge.	30% Coinsurance.	———none———
	Urgent care	$10.00 Copayment per visit for Office.	30% Coinsurance for Office.	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	Requires pre-approval; 30% penalty applies for non-compliance. In-network & Out-of-network inpatient separation period is 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	No Charge for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	Requires pre-approval; 30% penalty applies for non-compliance. In-network & Out-of-network inpatient separation period is 90 days.
If you are pregnant	Office visits	$10.00 Copayment per visit for Office.	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.)
	Childbirth/delivery professional services	No Charge for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	———none———
	Childbirth/delivery facility services	No Charge for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	In-network & Out-of-network inpatient separation period is 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 need help recovering or have other special health needs	Home health care	No Charge.	30% Coinsurance.	Requires pre-approval. 30% penalty applies for non-compliance. Out-of-network home health care visit limit is limited to 100 visits per contract.
	Rehabilitation services	No Charge for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	Requires pre-approval. 30% penalty applies for non-compliance.
	Habilitation services	No Charge for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	
	Skilled nursing care	No Charge for Inpatient Facility.	30% Coinsurance for Inpatient Facility.	Requires pre-approval. 30% penalty applies for non-compliance. Out-of-network inpatient skilled nursing facility day limit is limited to 60 days per contract out-of-network.
	Durable medical equipment	No Charge.	30% Coinsurance.	Applies only to supplemental durable medical equipment (DME) DME rental. 30% penalty applies for non-compliance.
	Hospice services	No Charge for Inpatient Facility.	30% Coinsurance for Inpatient Facility.	Requires pre-approval. 30% penalty applies for non-compliance.
If your child needs dental or eye care	Children's eye exam	$10.00 Copayment for Office.	30% Coinsurance for Office.	In-network & Out-of-network routine vision exam visit limit. Coverage is limited to 1 visit.
	Children's glasses	$50.00 Reimbursement.	$50.00 Reimbursement. Deductible does not apply.	In-network & Out-of-network routine Vision hardware dollar limit. Coverage is limited to every 2 years.
	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
- 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
- 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
- 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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? 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	**$10.00**
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	$0.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$60.00**

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	**$10.00**
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	$90.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$60.00
The total Joe would pay is	**$150.00**

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

The plan's overall deductible	**$0.00**
Specialist Copayment	**$10.00**
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	$50.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$810.00
The total Mia would pay is	**$860.00**

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 (Espafiol): Si necesita ayuda para comprender esta informacion de Horizon Blue Cross Blue Shield ofNew Jersey, usted tiene el derecho de obtener ayuda en su idioma sin costo alguno. Para hablar con un interprete, sirvase Hamar al 1-855-477-AZUL (2985) durante el horario normal de trabajo.

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Portuguese (Portugues): Se precisar de ajuda para entender estas informas:oes da Horizon Blue Cross Blue Shield ofNew Jersey, voce tern o direito de receber gratuitamente assistencia no seu idioma. Para falar com urn interprete, ligue para: 1-800-355-BLUE (2583) no honirio normal de trabalho.

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Polish (Polski): Jezeli potrzebujesz pomocy, aby zrozumiec informacje planu Horizon Blue Cross Blue Shield ofNew Jersey, masz prawo poprosic o bezplatn(lpomoc w jzyku ojczystym. Aby skorzystac z pomocy trumacza, zadzwoii pod numer 1-800-355-BLUE (2583) podczas normalnych godzin pracy.

Russian (PyccKHii 3biK): Ecm1 BaM Heo6xo.D.HMa noMOb B pa3'b CHeHHH 3Toi1 »H<PopMaU.HH, npe.D.OCTaBJieHHOH KOMnaHHeii Horizon Blue Cross Blue Shield of New Jersey, y sac ecTb npaso Ha nOJI)""eHHe nOMOI..U11 Ha BameM pO,ll,HOM .ll3bTKe 6eCnJiaTHO. ,[(JUI CB.ll311 C nepeBO,ll,'ii1KOM 3BOHHTe no HOMepy Tene<PoHa 1-800-355-BLUE {2583) s o6brqHbie pa6oq11e 'iaCbi.

Haitian Creole (Kreyol ayisyen): Si ou bezwen ed pou konprann enfomasyon sou Horizon Blue Cross Blue Shield of New Jersey, ou gen dwa pou jwenn ed nan lang natifnatal ou gratis. Pou pale avek yon entepret, tanpri rele nimewo 1-800-355-BLUE {2583) pandan le noma! biznis.

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Vietnamese (Ti ng Vi t): N u d.n duqc giup dodhiu ro thOng tin nay cua Horizon Blue Cross Blue Shield ofNew Jersey, quyvj c6 quySn duqc giup do b ng ng6n ngfr cua minh min phi. Xin goi s6 1-800-355-BLUE (2583) trong *gia* lam vic dn6i chuyn v&i ngucri thong dich.

French (Franyais): Si vous avez besoin d'assistance pour comprendre ces informations au sujet de Horizon Blue Cross Blue Shield ofNew Jersey, vous avez le droit d'obtenir de !'aide dans votre langue, sans aucun frais. Pourparler avec un interprete, veuillez appeler le 1-800-355-BLUE {2583) pendant les heures normales de bureau.

Navajo (Dine): *Dii* New Jersey bil hahoodzo Horizon Blue Cross Blue Shield, t'aa ninizaad k'ehji baa hane'ii bik'i diitiih bee shika' a'doowol ninizingo ei bee na'ahoot'i' d66 doo bh ilini da. Ata' halne'e 1a' bich'i' hadeesdzih ninizingo t'aa shQQdi 1-800-355-BLUE (2583)ji' nida'anishgo oolkilii bik'ehgo hodiilnih.

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Italian (Italiano): Se vi serve aiuto per capire queste inforrnazioni della Horizon Blue Cross Blue Shield ofNew 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 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, ifyou 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 ofrace, 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 BCBSN.T'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/portalllobby.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.

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