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.amt-nj.com or by calling 973-379-1090. 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?	$2,500.00 Individual / $5,000.00 Family per calendar year for in-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?	For in-network Health/Pharmacy providers $6,250.00 Individual/ $12,500.00 Family. 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).** Benefits provided by in-network providers and BlueCard PPO providers are at the in-network level of benefits.	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 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	$35.00 Copayment per visit. Deductible does not apply.	Not Covered.	_____none_____
	Specialist visit	$50.00 Copayment per visit. Deductible does not apply.	Not Covered.	
	Preventive care/screening/immunization	No Charge, Deductible does not apply.	Not Covered.	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)	50% Coinsurance for Office, Outpatient Hospital, Independent Laboratory.	Not Covered.	_____none_____
	Imaging (CT/PET scans, MRIs)	50% Coinsurance for Outpatient Hospital.	Not Covered.	_____none_____
If you need drugs to treat your illness or condition 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	$15.00 Copayment/Retail; $30.00 Copayment/Mail Order. Deductible does not apply.	$15.00 Copayment/Retail; $30.00 Copayment/Mail Order. Deductible does not apply.	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order). Additional charges apply when using an out-of-network pharmacy.
	Preferred brand drugs	$35.00 Copayment/Retail; $70.00 Copayment/Mail Order. Deductible does not apply.	$35.00 Copayment/Retail; $70.00 Copayment/Mail Order. Deductible does not apply.	
	Non-preferred brand drugs	$50.00 Copayment/Retail; $100.00 Copayment/Mail Order. Deductible does not apply.	$50.00 Copayment/Retail; $100.00 Copayment/Mail Order. Deductible does not apply.	
	Specialty drugs	Covered at retail benefit in above applicable categories.	Not Covered.	

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)	50% Coinsurance for Outpatient Hospital, Ambulatory Surgical Center.	Not Covered.	_____none_____
	Physician/surgeon fees	50% Coinsurance for Outpatient Hospital, Ambulatory Surgical Center.	Not Covered.	50% Coinsurance for anesthesia in an Outpatient Hospital, Ambulatory Surgical Center.
If you need immediate medical attention	Emergency room care	$150.00 Copayment per visit and 50% Coinsurance. Deductible does not apply.	$150.00 Copayment per visit and 50% Coinsurance. Deductible does not apply.	Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Emergency medical transportation	50% Coinsurance.	Not Covered.	Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Urgent care	$50.00 Copayment per visit. Deductible does not apply.	Not Covered.	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	$500.00 Copayment per day and 50% Coinsurance for Inpatient Hospital.	Not Covered.	Copayment per day applies for 5 days per admission. $2,500 max per admission. Annual Copayment max is 2 admissions. Requires pre-approval; 20% penalty applies for non-compliance.
	Physician/surgeon fees	50% Coinsurance for Inpatient Hospital.	Not Covered.	50% Coinsurance for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% Coinsurance for Outpatient Hospital.	Not Covered.	The Integrated System of Care (ISC) program is available to members with a serious mental illness or substance use disorder. Services must be rendered by a contracted ISC provider to be eligible for reimbursement. Locate a provider www.Horizonblue.com/member-ISC.

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)	
	Inpatient services	$500.00 Copayment per day and 50% Coinsurance for Inpatient Hospital.	Not Covered.	Copayment per day applies for 5 days per admission. $2,500 max per admission. Annual Copayment max is 2 admissions. Requires pre-approval; 20% penalty applies for non-compliance.
If you are pregnant	Office visits	$35.00 Copayment per visit for Office and 50% Coinsurance.	Not Covered.	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound.). Copayment applies to initial office visit only. The benefit listed is specific to the maternity prenatal and postnatal office visits, charges for other services and supplies may be subject to member out-of-pocket.
	Childbirth/delivery professional services	50% Coinsurance for Inpatient Hospital.	Not Covered.	_____none_____
	Childbirth/delivery facility services	$500.00 Copayment per day and 50% Coinsurance for Inpatient Hospital.	Not Covered.	Copayment per day applies for 5 days per admission. $2,500 max per admission. Annual Copayment max is 2 admissions. Requires pre-approval for maternity care that exceeds 48 hours for normal delivery or 96 hours for Cesarean birth.
If you need help recovering or have other special health needs	Home health care	50% Coinsurance.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance.
	Rehabilitation services	$500.00 Copayment per day and 50% Coinsurance for Inpatient Hospital.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. Copayment per day applies for 5 days per admission. $2,500 max per admission. Annual Copayment max is 2 admissions.
	Habilitation services	$500.00 Copayment per day and 50% Coinsurance for Inpatient Hospital.	Not Covered.	
	Skilled nursing care	50% Coinsurance for Inpatient Facility.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance.
	Durable medical equipment	50% Coinsurance.	Not Covered.	Requires pre-approval for items 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	50% Coinsurance for Inpatient Facility.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance.
If your child needs dental or eye care	Children's eye exam	$50.00 Copayment for Office. Specialist. Deductible does not apply.	Not Covered.	In-network routine vision exam visit limit. Coverage is limited to 1 visit in-network per year.
	Children's glasses	$50.00 Reimbursement. Deductible does not apply.	$50.00 Reimbursement. Deductible does not apply.	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.)

- Acupuncture
- Cosmetic Surgery
- Dental care
- Long Term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- 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, including coverage for Cochlear implants
- Infertility treatment (Basic only)
- 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;. To contact the issuer call 1-800-355-BLUE(2583). 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.getcovered.nj.gov or call 1-833-677-1010.

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**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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** **$2,500.00**
- **Specialist *Copayment*** **$50.00**
- **Hospital (facility) *Coinsurance*** **50%**
- **Other *Coinsurance*** **50%**

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	$12,700.00

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500.00
Copayments	$500.00
Coinsurance	$200.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$3,260.00**

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

- **The plan's overall deductible** **$2,500.00**
- **Specialist *Copayment*** **$50.00**
- **Hospital (facility) *Coinsurance*** **50%**
- **Other *Coinsurance*** **50%**

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	$5,600.00

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100.00
Copayments	$1,300.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$20.00
The total Joe would pay is	**$1,420.00**

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

- **The plan's overall deductible** **$2,500.00**
- **Specialist *Copayment*** **$50.00**
- **Hospital (facility) *Coinsurance*** **50%**
- **Other *Coinsurance*** **50%**

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	$2,800.00

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700.00
Copayments	$400.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$2,100.00**

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

* For more information about limitations and exceptions, see the plan or policy document at www.amt-nj.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 (including limited English proficiency and primary language), age, disability, pregnancy, gender identity, sex, sexual orientation, sex characteristics or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon provides language assistance services and appropriate auxiliary aids and services at no cost 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 **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 has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin (including limited English proficiency and primary language), 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 member, you may contact Section 1557 Coordinator by calling **1-866-660-6528** (TTY **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**https://ocrportal.hhs.gov/ocr/portal/lobby.jsf opens a dialog window, 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.**

Notice of Availability

If you speak English, free language assistance services and auxiliary aids are available to provide information in accessible formats. Call the number on the back of your member ID card for help.

Si habla español, hay servicios gratuitos de asistencia lingüística y ayudas auxiliares disponibles para proporcionar información en formatos accesibles. Llame al número que figura en el reverso de su tarjeta de identificación de miembro para obtener ayuda.

如果您說中文，我們提供免費的語言協助服務和輔助工具，以無障礙格式提供資訊。請撥打您的會員 ID 卡背面的電話號碼尋求協助。

한국어를 사용하시는 경우, 무료 언어 지원 서비스 및 보조 기구를 통해 접근 가능한 형식으로 정보를 제공받을 수 있습니다. 도움이 필요하시면 가입자 ID 카드 뒷면에 있는 번호로 전화하시기 바랍니다.

Se fala português, estão disponíveis serviços de assistência linguística e auxiliares gratuitos para fornecer informações em formatos acessíveis. Telefone para o número no verso do seu cartão de identificação de associado para obter ajuda.

જો તમે ગુજરાતી બોલતા હોવ, તો સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે નિઃશુલ્ક ભાષા સહાય સેવાઓ અને પૂરક સહાયો ઉપલબ્ધ છે. મદદ માટે તમારા સભ્ય આઈડી કાર્ડની પાછળના નંબર પર કૉલ કરો.

Jeśli posługujesz się językiem polski, dostępne są bezpłatne usługi wsparcia językowego i materiały pomocnicze w celu przekazania informacji w przystępnym formacie. Aby uzyskać pomoc, zadzwoń pod numer podany na odwrocie identyfikacyjnej karty członkowskiej.

Se parlate italiano, sono disponibili servizi gratuiti di assistenza linguistica e ausili aggiuntivi per fornire informazioni in formati accessibili. Chiamate il numero sul retro della Vostra tessera identificativa per ricevere assistenza.

إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية المجانية والمساعدات الإضافية لتوفير المعلومات بصيغ يسهل الوصول إليها. اتصل بالرقم الموجود على ظهر بطاقة هوية العضو للحصول على المساعدة.

Kung nagsasalita ka ng Tagalog, handang magamit ang mga libreng tulong na serbisyo sa wika at mga auxiliary na tulong para magbigay ng impormasyon sa mga naa-access na format. Tawagan ang numero sa likod ng iyong kard ng pagkakakilanlan bilang miyembro para sa tulong.

Если вы говорите на Русский язык, мы готовы бесплатно предоставить услуги переводчика и вспомогательные средства для получения информации в доступных форматах. Для получения помощи позвоните по номеру, указанному на обратной стороне вашей карточки участника.

Si w pale Kreyòl Ayisyen, sèvis asistans lang gratis ak èd oksilyè disponib pou bay enfòmasyon nan fòma ki aksesib. Rele nimewo ki sou do kat manm ou a pou èd.

यदि आप हिंदी बोलते हैं, तो सुलभ प्रारूपों में जानकारी प्रदान करने के लिए निःशुल्क भाषा सहायता सेवाएं और सहायक साधन उपलब्ध हैं। मदद के लिए अपने सदस्य आईडी कार्ड के पीछे दिए गए नंबर पर कॉल करें।

Nếu bạn nói tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí và công cụ hỗ trợ để cung cấp thông tin ở các định dạng có thể truy cập. Hãy gọi số điện thoại ở mặt sau thẻ nhận dạng thành viên của bạn để được trợ giúp.

Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition, ainsi que des outils auxiliaires fournissant des informations dans des formats accessibles. Pour recevoir de l'aide, appelez le numéro indiqué au dos de votre carte de membre.

اگر آپ اردو بولتے ہیں، تو مفت زبان کی مدد کی خدمات اور معاون امداد ایک قابل رسائی شکل میں معلومات کی فراہمی کے لیے دستیاب ہیں۔ مدد کے لیے اپنے ممبر آئی ڈی کارڈ کی پشت پر موجود نمبر پر کال کریں۔

আপনি যদি বাংলায় ভাষায় কথা বলেন, তাহলে সহজলভ্য ফরম্যাটে তথ্য প্রদানের জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা ও সহায়ক উপকরণ উপলব্ধ রয়েছে। সাহায্যের জন্য আপনার সদস্য আইডি কার্ডের পিছনে দেওয়া **নম্বরে** কল করুন।

ECNA0023235 (0125)