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, http://www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html. 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?	**$1,000.00** Individual/**$2,000.00** Family for OMNIA Tier 1 providers. **$1,500.00**/Individual or **$3,000.00**/ Family for Tier 2 providers. OMNIA Tier 1 accumulates to Tier 2.	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 OMNIA Tier 1 providers **$5,000.00** Individual/ **$10,000.00** Family and for Tier 2 providers **$7,000.00** Individual/ **$14,000.00** Family. Aggregate family. OMNIA Tier 1 accumulates to Tier 2.	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. See www.HorizonBlue.com or call 1-800-355-BLUE (2583) for a list of network providers. Benefits provided by in-network providers other than OMNIA Tier 1 providers are at the Tier 2 level of benefits, such as Tier 2 and BlueCard PPO providers.	You pay the least if you use a provider in OMNIA Tier 1. You pay more if you use a provider in Tier 2. 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
		OMNIA Tier 1 Provider(You will pay the least)	Tier 2 Network Provider	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. $10.00 Copayment per visit applies only to Horizon CareOnline. Deductible does not apply.	$30.00 Copayment per visit. $10.00 Copayment per visit applies only to Horizon CareOnline. Deductible does not apply.	Not Covered.	_____none_____
	Specialist visit	$40.00 Copayment per visit. $10.00 Copayment per visit applies only to Horizon CareOnline. Deductible does not apply.	$50.00 Copayment per visit. $10.00 Copayment per visit applies only to Horizon CareOnline. Deductible does not apply.	Not Covered.	
	Preventive care/ screening/ immunization	No Charge. Deductible does not apply.	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)	No charge for Office, Independent Laboratory. Deductible does not apply. 20% Coinsurance for Outpatient Hospital.	No charge for Office, Independent Laboratory. Deductible does not apply. 40% Coinsurance for Outpatient Hospital.	Not Covered.	Molecular and genomic testing are subject to pre-service and post-service medical necessity review.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance for Outpatient Facility.	40% Coinsurance for Outpatient Facility.	Not Covered.	Requires pre-approval.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider(You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
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. View the formulary at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/HIM/2019/2019_NJ_3T_HealthInsuranceMarketplaceClassicDL.pdf	Generic drugs	$10.00 Copayment/ Retail. $20.00 Copayment Mail order.	$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 per copayment, up to a 90 day supply applying separate copayments (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.	$40.00 Copayment/ Retail. $80.00 Copayment Mail order.	
	Non-preferred brand drugs	$75.00 Copayment/ Retail. $150.00 Copayment Mail order.	$75.00 Copayment/ Retail. $150.00 Copayment Mail order.	$75.00 Copayment/ Retail. $150.00 Copayment Mail order.	
	Specialty drugs	$75.00 Copayment/ Retail. $150.00 Copayment Mail order.	$75.00 Copayment/ Retail. $150.00 Copayment Mail order.	$75.00 Copayment/Retail. $150.00 Copayment Mail order.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance for Ambulatory Surgical Center, Outpatient Hospital.	40% Coinsurance for Ambulatory Surgical Center, Outpatient Hospital.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review.
	Physician/surgeon fees	20% Coinsurance for Ambulatory Surgical Center, Outpatient Hospital.	40% Coinsurance for Ambulatory Surgical Center, Outpatient Hospital.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review. 20% Coinsurance for OMNIA Tier 1 anesthesia. 40% Coinsurance for Tier 2 anesthesia.
If you need immediate medical attention	Emergency room care	$100.00 Copayment and 20% Coinsurance for Outpatient Hospital.	$100.00 Copayment and 20% Coinsurance for Outpatient Hospital.	$100.00 Copayment and 20% Coinsurance for Outpatient Hospital.	Copayment waived if admitted within 24 hours. Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries. Accumulates to OMNIA Tier 1 deductible.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider(You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	Deductible applies.	Deductible applies.	Deductible applies.	Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Urgent care	$75.00 Copayment. Deductible does not apply.	$75.00 Copayment. Deductible does not apply.	$75.00 Copayment. Deductible does not apply.	No coverage for non-urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance for Inpatient Hospital.	40% Coinsurance for Inpatient Hospital.	Not Covered.	Requires pre-approval.
	Physician/surgeon fees	20% Coinsurance for Inpatient Hospital.	40% Coinsurance for Inpatient Hospital.	Not Covered.	20% Coinsurance for OMNIA Tier 1 anesthesia. 40% Coinsurance for Tier 2 anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance for Outpatient Hospital.	40% Coinsurance for Outpatient Hospital.	Not Covered.	_____none_____
	Inpatient services	20% Coinsurance for Inpatient Hospital.	40% Coinsurance for Inpatient Hospital.	Not Covered.	Requires pre-approval.
If you are pregnant	Office visits	$20.00 Copayment per visit for Office. $40.00 Copayment per visit for Specialist. Deductible does not apply.	$30.00 Copayment per visit for Office. $50.00 Copayment per visit for Specialist. Deductible does not apply.	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.)
	Childbirth/delivery professional services	20% Coinsurance for Inpatient Hospital.	40% Coinsurance for Inpatient Hospital.	Not Covered.	_____none_____
	Childbirth/delivery facility services	20% Coinsurance for Inpatient Hospital.	40% Coinsurance for Inpatient Hospital.	Not Covered.	_____none_____
If you need help recovering or have other special health needs	Home health care	$20.00 Copayment per visit for Outpatient Facility. Deductible does not apply.	$30.00 Copayment per visit for Outpatient Facility. Deductible does not apply.	Not Covered.	Requires pre-approval. Private-duty nursing is only covered under the Home health care benefit when required by a Home health care plan. Coverage is limited to 60 visits per calendar year.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider(You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
	Rehabilitation services	20% Coinsurance for Inpatient Hospital.	40% Coinsurance for Inpatient Hospital.	Not Covered.	Requires pre-approval.
	Habilitation services	20% Coinsurance for Inpatient Hospital.	40% Coinsurance for Inpatient Hospital.	Not Covered.	
	Skilled nursing care	20% Coinsurance for Inpatient Facility.	40% Coinsurance for Inpatient Facility.	Not Covered.	
	Durable medical equipment	50% Coinsurance.	50% Coinsurance.	Not Covered.	
	Hospice services	20% Coinsurance for Inpatient Facility.	40% Coinsurance for Inpatient Facility.	Not Covered.	
If your child needs dental or eye care	Children's eye exam	No Charge. Deductible does not apply.	No Charge. Deductible does not apply.	Not Covered.	This benefit is administered by Davis Vison. In-network routine vision exam child visit limit is 1 visit in-network.
	Children's glasses	Amounts greater than $150.00 for non-collection frames. Deductible does not apply.	Amounts greater than $150.00 for non-collection frames. Deductible does not apply.	Not Covered.	This benefit is administered by Davis Vison. Lenses and Hardware are covered once every 12 months. Limit includes 1 pair of frames from the select Davis Vision collection or $150.00 allowance for non-collection frames.
	Children's dental check-up	Not Covered.	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 (Only covered for Members age 15 and younger)
- Long-term care
- Most coverage provided outside the United States. (OMNIA Tier 1 level benefit)
- Non-emergency care when traveling outside the U.S. (OMNIA Tier 1 level benefit)
- Private-duty nursing
- Routine eye care (Adult, Optometrist/ Ophthalmologist office. For verification of coverage on routine vision services, please see your policy or plan document.)
- 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 when used as a substitute for other forms of anesthesia
- Bariatric surgery
- Chiropractic care
- Infertility treatment (limited to artificial insemination; requires pre-approval)
- Most coverage provided outside the United States. See www.HorizonBlue.com (Tier 2 level of benefit)
- Non-emergency care when traveling outside the U.S. See www.HorizonBlue.com (Tier 2 level of benefit)

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** **$1,000.00**
- **Specialist *Copayment*** **$40.00**
- **Hospital (facility) *Coinsurance*** **20%**
- **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	$1,000.00
Copayments	$760.00
Coinsurance	$1,7920.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$3,612.00**

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

- **The plan's overall deductible** **$1,000.00**
- **Specialist *Copayment*** **$40.00**
- **Hospital (facility) *Coinsurance*** **20%**
- **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	$7,400.00

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$1,410.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$55.00
The total Joe would pay is	**$1,465.00**

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

- **The plan's overall deductible** **$1,000.00**
- **Specialist *Copayment*** **$40.00**
- **Hospital (facility) *Coinsurance*** **20%**
- **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	$1,900.00

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000.00
Copayments	$200.00
Coinsurance	$137.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$1,337.00**

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