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.state.nj.us/treasury/pensions/health-benefits.shtml or by calling 1-609-292-7524. If you do not currently have coverage with Horizon BCBSNJ you can view a sample policy here, www.state.nj.us/treasury/pensions/health-benefits.shtml. 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 1-609-292-7524 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500.00** Individual/**$3,000.00** Family for Tier 2 providers. 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 Health OMNIA Tier 1 providers **$2,500.00** Individual/ **$5,000.00** Family. For Health Tier 2 providers **$4,500.00** Individual/ **$9,000.00** 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. See www.HorizonBlue.com/shbp **or call 1-800-414-SHBP (7427)** 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.	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	$5.00 Copayment per visit for Office.	$20.00 Copayment per visit for Office. Deductible does not apply.	Not Covered.	_____none_____
	Specialist visit	$15.00 Copayment per visit; Specialist.	$30.00 Copayment per visit for Office; Specialist. Deductible does not apply.	Not Covered.	
	Preventive care /screening/immunization	No Charge.	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. $15.00 Copayment per visit for Outpatient Hospital.	No Charge for Office, Independent Laboratory. 20% Coinsurance for Outpatient Hospital after deductible.	Not Covered.	Applies only to non -routine diagnostic radiology, laboratory, and pathology services.
	Imaging (CT/PET scans, MRIs)	$15.00 Copayment per visit for Outpatient Hospital.	20% Coinsurance for Outpatient Hospital after deductible.	Not Covered.	Requires pre-approval.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available through your employer.	Generic drugs Preferred brand drugs Non-preferred brand drugs Specialty drugs	See separate Prescription Drug Plan SBC			_____none_____

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150.00 Copayment per visit for Ambulatory Surgical Center and Outpatient Hospital.	20% Coinsurance for Ambulatory Surgical Center, Outpatient Hospital after deductible.	Not Covered.	_____none_____
	Physician/surgeon fees	No Charge for Ambulatory Surgical Center, Outpatient Hospital.	20% Coinsurance for Ambulatory Surgical Center, Outpatient Hospital after deductible.	Not Covered.	$15 Copayment for anesthesia. (Tier1). 20% Coinsurance after deductible for anesthesia (Tier 2).
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.	$100.00 Copayment per visit for Outpatient Hospital.	Copayment waived if admitted within 24 hours. Payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Emergency medical transportation	No Charge.	No Charge.	Not Covered.	_____none_____
	Urgent care	$15.00 Copayment per visit for Office; Specialist.	$30.00 Copayment per visit for Office; Specialist. Deductible does not apply.	Not Covered.	Applies only to out of hospital urgently needed care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150.00 Copayment per admission for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	Requires pre-approval.
	Physician/surgeon fees	No Charge for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	20% Coinsurance after deductible for anesthesia (Tier 2).
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15.00 Copayment per visit for Outpatient Hospital.	20% Coinsurance for Outpatient Hospital after deductible.	Not Covered.	_____none_____
	Inpatient services	No Charge for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital after deductible.	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 are pregnant	Office visits	$5.00 Copayment per visit for Office. $15.00 Copayment per visit for Office; Specialist.	$20.00 Copayment per visit for Office. $30.00 Copayment per visit for Office; 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	No Charge.	20% Coinsurance after deductible.	Not Covered.	_____none_____
	Childbirth/delivery facility services	No Charge for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	_____none_____
If you need help recovering or have other special health needs	Home health care	$5.00 Copayment.	$5.00 Copayment.	Not Covered.	Requires pre-approval.
	Rehabilitation services	$150.00 Copayment per admission for Inpatient Facility. No Charge for Outpatient Facility. $15.00 Copayment per visit for Office	20% Coinsurance after deductible for Inpatient and Outpatient Facility.	Not Covered.	Requires pre-approval.
	Habilitation services	$150.00 Copayment per admission for Inpatient Facility. No Charge for Outpatient Facility. $15.00 Copayment per visit for Office	20% Coinsurance after deductible for Inpatient and Outpatient Facility.	Not Covered.	
	Skilled nursing care	$150.00 Copayment per admission for Inpatient Facility.	20% Coinsurance for Inpatient Facility after deductible.	Not Covered.	Requires pre-approval. In-network inpatient skilled nursing facility days are limited to 100 days.
	Durable medical equipment	No Charge.	No Charge.	Not Covered.	Prior authorization required for DME purchases over $500.
	Hospice services	No Charge for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital after deductible.	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 your child needs dental or eye care	Children's eye exam	$15.00 Copayment for Office; Specialist.	$30.00 Copayment for Office; Specialist. Deductible does not apply.	Not Covered.	This benefit is administered by Davis Vision. In-network routine vision exam for is limited to 1 visit.
	Children's glasses	Not Covered.	Not Covered.	Not Covered.	_____none_____
	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)
- Long Term Care
- Most coverage provided outside the United States (tier 1 level of benefits)
- Non-emergency care when traveling outside the U.S. (tier 1 level of benefits)
- Private-duty nursing (Inpatient)
- 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
- Hearing Aids (Only covered for Members age 15 or younger)
- Infertility treatment (requires pre-approval)
- Non-emergency care when traveling outside the U.S. See www.HorizonBlue.com (tier 2 level of benefits)

- Bariatric surgery (requires pre-approval)
- Chiropractic care
- Most coverage provided outside the United States. See www.HorizonBlue.com (tier 2 level of benefits)
- 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: the plan at 1-800-414-7427 (SHBP), the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. 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: Horizon Blue Cross Blue Shield of New Jersey Member Services at 1-800-414-SHBP (7427). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebda/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*	**$15.00**
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	$440.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$100.00
The total Peg would pay is	**$540.00**

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*	**$15.00**
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	$310.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$6,040.00
The total Joe would pay is	**$6,350.00**

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

The plan's overall deductible	**$0.00**
Specialist *Copayment*	**$15.00**
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	$120.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$120.00**

Please note that some of the Limits or Exclusions listed above may be covered under the Prescription Plan.

This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.
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.

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.

CMC0007942 (0516)

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**.

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