

Horizon BCBSNJ: OMNIA HEALTH PLAN

Coverage for: All Coverage Types | Plan Type: EPOSummary of Benefits and Coverage: What this Plan Covers & What it Costs

New Jersey State Health Benefits Program



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HorizonBlue.com/shbp or by calling 1-800-414-SHBP (7427).

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0 for OMNIA Tier 1 providers. \$1,500 person/ \$3,000 family for Tier 2 providers.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the Common Medical Events chart for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see Common Medical Events chart for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For Health OMNIA Tier 1 providers \$2,500 person/ \$5,000 family. For Health Tier 2 providers \$4,500 person/ \$9,000 family.	The <u>out-of-pocket</u> limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The Common Medical Events chart describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of in-network providers, see www.HorizonBlue.com/shbp or call 1-800-414-SHBP (7427).	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their network. See the Common Medical Events chart for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. A written referral is not required to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on the Services Your Plan Does Not Cover chart. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	\$5 Copay/visit	\$20 Copay/visit	Not Covered.	—————none—————
	Specialist visit	\$15 Copay/visit	\$30 Copay/visit	Not Covered.	—————none—————
	Other practitioner office visit	\$15 Copay/visit	\$30 Copay/visit.	Not Covered.	In-network chiropractic care therapeutic manipulation visit limit is 30 visits.
	Preventive care/screening/Immunization	No Charge.	No Charge.	Not Covered.	One per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for Office or Inpatient Hospital. \$15 Copay/visit for Outpatient Hospital.	No charge for Office or Inpatient Hospital. 20% Coinsurance after deductible for Outpatient Hospital.	Not Covered.	—————none—————

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	Imaging (CT/PET scans, MRIs)	\$15 Copay/visit for Office, Outpatient Hospital. No charge for Inpatient Hospital.	20% Coinsurance after deductible for Office, Outpatient Hospital. No charge for Inpatient Hospital.	Not Covered.	Requires pre-approval.
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available through your employer.	Generic drugs	See separate Prescription Drug Plan SBC.			_____none_____
	Preferred brand drugs				
	Non-preferred brand drugs				
	Specialty drugs				
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 Copay/visit	20% Coinsurance after deductible.	Not Covered.	_____none_____
	Physician/surgeon fees	No charge	20% Coinsurance after deductible.	Not Covered.	_____none_____
If you need immediate medical attention	Emergency room services	\$100 Copay/visit	\$100 Copay/visit	\$100 Copay/visit	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.	20% Coinsurance after deductible.	20% Coinsurance after deductible.	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.

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	Urgent care	\$15 Copay/visit	\$30 Copay/visit	Not Covered.	Applies only to out of hospital urgently needed care.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 Copay/admission	20% Coinsurance after deductible.	Not Covered.	Requires pre-approval.
	Physician/surgeon fee	No charge.	20% Coinsurance after deductible.	Not covered.	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 Copay/visit	20% Coinsurance after deductible for outpatient hospital. \$30 copay/visit for Office Visit	Not Covered.	—————none—————
	Mental/Behavioral health inpatient services	No Charge.	20% Coinsurance after deductible.	Not Covered.	Requires pre-approval.
	Substance use disorder outpatient services	\$15 Copay/visit	20% Coinsurance after deductible for outpatient hospital. \$30 copay/visit for Office Visit	Not Covered.	—————none—————
	Substance use disorder inpatient services	No Charge.	20% Coinsurance after deductible.	Not Covered.	Requires pre-approval.
If you are pregnant	Prenatal and postnatal care	No Charge.	20% Coinsurance after deductible.	Not Covered.	—————none—————
	Delivery and all inpatient services	No charge.	20% Coinsurance after deductible.	Not Covered.	Requires pre-approval.

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If you need help recovering or have other special health needs	Home health care	\$5 Copay/visit	\$5 Copay/visit	Not Covered.	Requires pre-approval.
	Rehabilitation services (inpatient)	\$150 Copay/admission	20% Coinsurance after deductible.	Not Covered.	Requires pre-approval.
	Habilitation services (inpatient)	\$150 Copay/admission	20% Coinsurance after deductible.	Not Covered.	Requires pre-approval.
	Skilled nursing care	\$150 Copay/admission	20% Coinsurance after deductible.	Not Covered.	In-network inpatient skilled nursing facility day limit is 100 days in-network.
	Durable medical equipment	No Charge.	No Charge.	Not Covered.	Items over \$500.00 require pre-approval.
	Hospice service	No charge.	No charge.	Not Covered.	Requires pre-approval.
If your child needs dental or eye care	Eye exam	\$15 Copay	\$30 Copay	Not Covered.	In-network routine vision exam visit limit is 1 visit in-network.
	Glasses	Not Covered.	Not Covered.	Not Covered.	—————none—————
	Dental check-up	Not Covered.	Not Covered.	Not Covered.	—————none—————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Long Term Care 	<ul style="list-style-type: none"> • Most coverage provided outside the United States. (tier 1 level of benefit) • Non-emergency care when traveling outside the U.S. (tier 1 level of benefit) 	<ul style="list-style-type: none"> • Private-duty nursing (Inpatient) • Routine foot care • Weight loss programs

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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (substitute for anesthesia only)
- Bariatric surgery (requires pre-approval)
- Chiropractic care
- Hearing aids (Only covered for Members age 15 or younger) Infertility treatment (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)
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-414-SHBP (7427). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

For questions about your rights, this notice, or assistance, you can 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/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-414-SHBP (7427).

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,220
- Patient pays \$320

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$150
Coinsurance	\$0
Limits or exclusions	\$170
Total	\$320

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,270
- Patient pays \$3,130

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$200
Coinsurance	\$0
Limits or exclusions	\$2,930
Total	\$3,130

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

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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