Horizon BCBSNJ: State Health Benefits Program- NJ DIRECT15 (PPO)

Coverage for: All Coverage Types



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 http://www.nj.gov/treasury/pensions/index.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, http://www.nj.gov/treasury/pensions/index.shtml. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, coinsurance, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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:
<u>deductible</u> ?	\$100.00 Individual / \$250.00 Family per calendar year for out-of-network providers. Aggregate family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network <u>Coinsurance</u> limit \$400.00 Individual/\$1,000.00 Family; Active employee in-network Health <u>providers</u> \$8,480.00 Individual / \$16,960.00 Family. Retiree in-network Health <u>providers</u> \$9,249.00 Individual/ \$18,498.00 Family. Out-of-network <u>providers</u> \$2,000.00 Individual/ \$5,000.00 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> <u>limit</u> .
a <u>network provider</u> ?	www.HorizonBlue.com/shbp or	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u>

Plan Type: PPO

		might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common		What You Will Pay		
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider(You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	injury or illness	\$15.00 <u>Copayment</u> per visit.	30% <u>Coinsurance</u> .	Out-of-network allowances for Chiropractic, Acupuncture and Physical Therapy services are limited to no more than \$35.00 per visit for Chiropractic,
		\$15.00 <u>Copayment</u> per visit.	30% <u>Coinsurance</u> .	\$60.00 per visit for Acupuncture and \$52.00 per visit for Physical Therapy or 75% of the in network cost per visit, whichever is less.
	Preventive care/screening/immunization	No Charge.		One per calendar year. You may have to pay for services that aren't <u>Preventive</u> . Ask your <u>provider</u> if the services needed are <u>Preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge.	30% <u>Coinsurance</u> .	none
	Imaging (CT/PET scans, MRIs)	No Charge.	30% <u>Coinsurance</u> .	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
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge.	30% <u>Coinsurance</u> .	none
	Physician/surgeon fees	No Charge.	30% <u>Coinsurance</u> .	30% <u>Coinsurance</u> for out-of-network anesthesia.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at http://www.nj.gov/treasury/pensions/index.shtml

Common		What You Will Pay		
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider(You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	\$100.00 <u>Copayment</u> per visit for Outpatient Hospital.		\$50 <u>Copayment</u> /visit for physician referrals or pediatric (under age 19) ER visits; and if admitted within 24 hours, the <u>Copayment</u> is waived. Payment at the innetwork level applies only to true Medical Emergencies & Accidental Injuries.
	Emergency medical transportation	10% <u>Coinsurance</u> .	30% <u>Coinsurance</u> .	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.
	<u>Urgent care</u>	\$15.00 <u>Copayment</u> per visit for Specialist.	30% <u>Coinsurance</u> for Specialist.	none
If you have a hospital stay	, (6, 1	No Charge.	30% <u>Coinsurance</u> .	Requires pre-approval. There is a separate \$200 <u>Deductible</u> per inpatient stay for out-of-network facilities.
	Physician/surgeon fees	No Charge.	30% <u>Coinsurance</u> .	Requires pre-approval. 30% <u>Coinsurance</u> for out-of-network anesthesia.
If you need mental health, behavioral health, or substance abuse services		No Charge for Outpatient Hospital. \$15.00 <u>Copayment</u> per Office visit for Mental Health and Behavioral Health. No Charge for Substance abuse Office visit.	30% <u>Coinsurance</u> .	Some specialty outpatient services require pre-approval. 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
	Inpatient services	No Charge.	30% <u>Coinsurance</u> .	Requires pre-approval. There is a separate \$200 <u>Deductible</u> per inpatient stay for out-of-network facilities.
If you are pregnant		\$15.00 <u>Copayment</u> per visit for Office.	30% <u>Coinsurance</u> .	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.	30% <u>Coinsurance</u> .	none

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at http://www.nj.gov/treasury/pensions/index.shtml

Common		What You Will Pay		
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider(You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery facility services	No Charge.	30% <u>Coinsurance</u> .	Requires pre-approval. There is a separate \$200 <u>Deductible</u> per inpatient stay for out-of-network facilities.
If you need help recovering or have	Home health care	No Charge.	30% Coinsurance.	Requires pre-approval.
other special health needs	Rehabilitation services	No Charge for Inpatient and Outpatient Facility. \$15.00 Copayment per visit for Office.	30% <u>Coinsurance</u> .	Requires pre-approval. There is a separate \$200 <u>Deductible</u> per inpatient stay for out-of-network facilities.
	Habilitation services	No Charge for Inpatient and Outpatient Facility. \$15.00 Copayment per visit for Office.	30% <u>Coinsurance</u> .	
	Skilled nursing care	No Charge.	30% <u>Coinsurance</u> .	Requires pre-approval. Limited to 120 days in-network and 60 out-of-network facility days for a combined maximum of 120 days per calendar year. There is a separate \$200 <u>Deductible</u> per inpatient stay for out-of-network facilities.
	Durable medical equipment	10% <u>Coinsurance</u> .	30% <u>Coinsurance</u> .	Requires pre-approval for all rentals and some purchases.
	Hospice services	No Charge.	30% <u>Coinsurance</u> .	Requires pre-approval. There is a separate \$200 <u>Deductible</u> per inpatient stay for out-of-network facilities.
If your child needs dental or eye care	Children's eye exam	\$15.00 <u>Copayment</u> per visit.	Not Covered.	Coverage is limited to 1 visit.
	Children's glasses	Not Covered.	Not Covered.	none
	Children's dental check-up	Not Covered.	Not Covered.	none

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Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded</u> <u>services</u>.)

Cosmetic Surgery

Long Term Care

Routine foot care

Dental care

Private-duty nursing

• Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

• Acupuncture (for pain management only)

Hearing Aids

 Non-emergency care when traveling outside the U.S. (Subject to deductible/coinsurance and balance billing.)

Bariatric surgery (requires pre-approval)

Most covered provided outside the United

Infertility treatment (requires pre-approval)

Chiropractic care (limited to 30 visits/year)

Most coverage provided outside the United States. (Subject to deductible/coinsurance and balance billing.)

Routine eye care (Adult)

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at http://www.nj.gov/treasury/pensions/index.shtml

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.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 <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 <u>www.dol.gov/ebda/healthreform</u>.

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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

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

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at http://www.nj.gov/treasury/pensions/index.shtml

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.

\$0.00

\$15.00

0%

10%

Peg is Having a Baby
(9 months of in-network pre-natal care
and a hospital delivery)
■ The plan's overall deductible \$0.00

\$15.00 ■ Hospital (facility) *Coinsurance*

Other Coinsurance

Specialist Copayment

0%10%

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

■ The plan's overall deductible Specialist Copayment

■ Hospital (facility) *Coinsurance*

Other Coinsurance

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 10%

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)

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)

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 \$12,700.00

Total Example Cost \$5,600.00 Total Example Cost \$2,800.00

In this example, Peg would pay:

Cost Sharing			
Deductibles	\$0.00		
Copayments	\$20.00		
Coinsurance	\$0.00		
What isn't covered			
Limits or exclusions	\$70.00		
The total Peg would pay is	\$90.00		

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0.00
Copayments	\$200.00
Coinsurance	\$80.00
What isn't covered	
Limits or exclusions	\$3,500.00
The total Joe would pay is	\$3,780.00
-	

In this example Mia would pave

in this example, wha would pay.			
Cost Sharing			
Deductibles	\$0.00		
Copayments	\$200.00		
Coinsurance	\$100.00		
What isn't covered			
Limits or exclusions	\$10.00		
The total Mia would pay is	\$310.00		

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 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 (e.g. qualified sign language interpreters and information in other formats) and to those whose primary language is not English (e.g. information in other languages) to communicate effectively with us.

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.

Filing a Section 1557 Grievance

If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated against you for one of the reasons described above, 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.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201or by phone at 1-800-368-1019 or 1-800-537-7697 (TDD). OCR Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language assistance

Si habla un idioma diferente al inglés, hay ayuda disponible gratis. Llame al número que aparece al reverso de su tarjeta de identificación. 如果您讲英语以外的语言,可获取免费帮助。请拨打您的身份证背面的号码。

영어 이외의 언어를 사용하는 경우, 무료 지원 서비스를 받을 수 있습니다. ID 카드 뒷면에 있는 번호로 전화하십시오.

Se você fala um idioma diferente do inglês, a ajuda está disponível gratuitamente. Ligue para o número no verso do seu bilhete de identidade.

જો તમે અંગ્રેજ સિવાયની ભાષા બોલતા હોવ. તો મકતમાં મદદ ઉપલબ્ધ છે. તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર પર કૉલ.

Jeśli mówisz w języku innym niż angielski, pomoc udzielana jest bezpłatnie. Zadzwoń pod numer podany na odwrocie dowodu osobistego. Se parli una lingua diversa dall'inglese, è disponibile un servizio di assistenza gratuito. Chiama il numero sul retro della tua carta d'identificaz ione.

Kung nagsasalita ka ng isang wika maliban sa Ingles, magagamit ang tulong nang walang bayad. Tumawag sa numerong nasa likod ng iyong ID card.

Если вы не говорите по-английски, вам помогут бесплатно. Позвоните по телефону, указанному на обратной стороне вашей ID-карты.

Si ou pale on lòt lang ke Anglè, gen èd ki disponib gratis. Rele nan nimewo ki ekri nan do kat idantifyan w lan.

यदि आप अंग्रेज़ी से भिन्न कोई अन्य भाषा बोलते हैं, तो निःशुल्क सहायता उपलब्ध है। अपने आईडी कार्ड के पीछे दिए गए नंबर पर .

Nếu bạn nói ngôn ngữ khác ngoài tiếng Anh, thì chúng tôi có thể giúp bạn miễn phí. Hãy gọi số ở mặt sau thẻ ID của bạn.

Si vous parlez une langue autre que l'anglais, l'aide est gratuite. Appelez le numéro au dos de votre carte d'identité.

إذا كنت تتحدث لغة أخرى غير الإنجليزية، نوفر لك المساعدة مجانًا. يُمكنك الاتصال بالرقم الموجُود على ظهر بطاقة الهوية

اگر آپ انگریزی کے علاوہ کوئی دوسری زبان بول سکتے ہیں تو مفت مدد دستیاب ہے۔ براہ مہربانی شناختی کارڈ کی پچھلی طرف درج شدہ نمبر پر کال کریں۔

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