

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 10/01 - 09/30**

Horizon BCBSNJ: County of Monmouth

Coverage for: All Coverage Types

Plan Type: EPO




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, 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?	\$1,500.00 Individual / \$3,000.00 Family per contract for Tier 2 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 deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Yes, 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 per contract. Aggregate 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 limit</u> .
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 <u>provider</u> . Benefits provided by in-network <u>providers</u> other than OMNIA Tier 1 <u>providers</u> are at the Tier 2 level of benefits, such	You pay the least if you use a <u>provider</u> in OMNIA Tier 1. You pay more if you use a <u>provider</u> in Tier 2. 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> 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.

	as Tier 2 and BlueCard PPO providers.	
Do you need a <u>referral</u> to see a <u>specialist</u>?	No. You don't need a <u>referral</u> to see a specialist.	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 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.	\$20.00 Copayment per visit. <u>Deductible</u> does not apply.	Not Covered.	—none—
	<u>Specialist</u> visit	\$15.00 Copayment per visit; Specialist.	\$30.00 Copayment per visit; Specialist. <u>Deductible</u> does not apply.	Not Covered.	
	<u>Preventive care/screening/immunization</u>	No Charge.	No Charge, <u>Deductible</u> does not apply.	Not Covered.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge for Office, Independent Laboratory, Outpatient Hospital.	No Charge for Office, Independent Laboratory. <u>Deductible</u> does not apply. 20% Coinsurance for Outpatient Hospital.	Not Covered.	—none—
	Imaging (CT/PET scans, MRIs)	\$15.00 Copayment per visit for Outpatient Hospital.	20% Coinsurance for Outpatient Hospital.	Not Covered.	Requires pre-approval. 20% penalty applies for non-compliance
If you need drugs to	Generic drugs	Not Covered.	Not Covered.	Not Covered.	—none—
	Preferred brand drugs	Not Covered.	Not Covered.	Not Covered.	

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)	
treat your illness or condition	Non-preferred brand drugs	Not Covered.	Not Covered.	Not Covered.	
	Specialty drugs	Not Covered.	Not Covered.	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150.00 Copayment per visit for Outpatient Hospital, Ambulatory Surgical Center.	20% Coinsurance for Outpatient Hospital, Ambulatory Surgical Center.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review.
	Physician/surgeon fees	No Charge for Outpatient Hospital.	20% Coinsurance for Outpatient Hospital.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review. No Charge for (OMNIA Tier 1) anesthesia. 20% <u>Coinsurance</u> 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 and 20% Coinsurance for Outpatient Hospital.	\$100.00 Copayment per visit and 20% Coinsurance for Outpatient Hospital.	Copay waived if admitted within 24 hours. Out of network pays at tier 2. Applies only to emergency room medical emergency and accidental injury.
	Emergency medical transportation	No Charge.	Deductible applies.	Not Covered.	—none—
	Urgent care	\$15.00 Copayment per visit for Specialist.	\$30.00 Copayment per visit for Specialist. <u>Deductible</u> does not apply.	Not Covered.	—none—
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.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. In-network OMNIA Tier 1 Tier 2 inpatient separation period is limited to 90 days in-network.
	Physician/surgeon fees	No Charge for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization

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)	
					management review. No Charge for (OMNIA Tier 1) anesthesia. 20% <u>Coinsurance</u> 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.	Not Covered.	—none—
	Inpatient services	No Charge for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. In-network OMNIA Tier 1 Tier 2 inpatient separation period is limited to 90 days in-network.
If you are pregnant	Office visits	\$5.00 Copayment per visit for Office. \$15.00 Copayment per visit for Specialist.	\$20.00 Copayment per visit for Office. \$30.00 Copayment per visit for Specialist. <u>Deductible</u> does not apply.	Not Covered.	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound.)
	Childbirth/delivery professional services	No Charge for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital.	Not Covered.	—none—
	Childbirth/delivery facility services	No Charge for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital.	Not Covered.	In-network OMNIA Tier 1 Tier 2 inpatient separation period is limited to 90 days in-network.
If you need help recovering or have other special health needs	<u>Home health care</u>	\$5.00 Copayment per visit.	\$20.00 Copayment per visit.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance.
	<u>Rehabilitation services</u>	\$150.00 Copayment per admission for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. In-network OMNIA Tier 1 Tier 2 inpatient separation period is limited to 90 days in-network.
	<u>Habilitation services</u>	\$150.00 Copayment per admission for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital.	Not Covered.	

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)	
	<u>Skilled nursing care</u>	\$150.00 Copayment per admission for Inpatient Facility.	20% Coinsurance for Inpatient Facility.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. In-network inpatient skilled nursing facility day limit is 100 days. Prior authorization required for DME purchases regardless of the amount. 20% penalty applies for non-compliance Requires pre-approval. 20% penalty applies for non-compliance
	<u>Durable medical equipment</u>	No Charge.	Deductible applies.	Not Covered.	
	<u>Hospice services</u>	\$150.00 Copayment per admission for Inpatient Facility.	\$150.00 Copayment per admission and 20% Coinsurance for Inpatient Facility.	Not Covered.	
If your child needs dental or eye care	Children's eye exam	\$15.00 Copayment for Specialist.	\$30.00 Copayment for Specialist. <u>Deductible</u> does not apply.	Not Covered.	Child. This benefit is administered by Davis Vision. In-network routine vision exam for child is limited to 1 visit. 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 and \$125 allowance for non-collection frames. —————none
	Children's glasses	Amounts greater than \$125.00 for non-collection frames.	Amounts greater than \$125.00 for non-collection frames.	Not Covered.	
	Children's dental check-up	Not Covered.	Not Covered.	Not Covered.	

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. (OMNIA Tier 1 level of benefit)
- Non-emergency care when traveling outside the U.S. (OMNIA Tier 1 level of benefit)
- 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
- Hearing Aids (Only covered for Members age 15 or younger)
- Infertility treatment
- 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)
- Private-duty nursing

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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.

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 <u>plan's</u> overall <u>deductible</u>	\$0.00
<u>Specialist</u> Copayment	\$15.00
Hospital (facility) <u>Coinsurance</u>	0%
Other <u>Coinsurance</u>	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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$0.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$60.00
The total Peg would pay is	\$60.00

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

The <u>plan's</u> overall <u>deductible</u>	\$0.00
<u>Specialist</u> Copayment	\$15.00
Hospital (facility) <u>Coinsurance</u>	0%
Other <u>Coinsurance</u>	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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$50.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$60.00
The total Joe would pay is	\$110.00

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

The <u>plan's</u> overall <u>deductible</u>	\$0.00
<u>Specialist</u> Copayment	\$15.00
Hospital (facility) <u>Coinsurance</u>	0%
Other <u>Coinsurance</u>	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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$60.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$810.00
The total Mia would pay is	\$870.00

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 (Simplified): 如果您需要帮助理解有关新泽西州地平线蓝十字蓝盾保险公司的信息，您有权免费获得您语言方面的帮助。如需与口译员交谈，请在正常营业时间内拨打 1-800-355-BLUE (2583)。

Korean (한국어): Horizon Blue Cross Blue Shield of New Jersey의 서비스를 받으실 때, 귀하의 언어를 무료로 이용하실 수 있습니다. 통역 서비스를 받으시려면, 평일 근무 시간에 1-800-355-BLUE (2583)에 전화하십시오.

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 અહિં આપણી સહાયતાની જરૂર પડે તો, તમે મફત સહાયતા માટે અમારો સંપર્ક કરી શકો છો. અમારો સંપર્ક કરવા માટે કૃપા કરીને 1-800-355-BLUE (2583) નો સંપર્ક 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.

Russian (Русский язык): Ecm1 BaM Heo6xo.D.HMa noMOB B pa3'b CHEHHH 3Toi1 »H<PopMaU.HH, npe.D.OCTaBJieHHOH KOMnaHHeii Horizon Blue Cross Blue Shield of New Jersey, y sac ecTb npaso Ha nOJI"eHHe nOMOL.U11 Ha BameM pO,ll,HOM .ll3bTKe 6eCnJiaTHO. ,(OUI CB.ll311 C nepeBO,ll,"iiKOM 3BOHTe no HOMepy Tene<PoHa 1-800-355-BLUE {2583) s o6brqHbie pa6oql1e 'iaCbi.

Haitian Creole (Kreyol ayisyen): Si ou bezwen ed pou konprann enfomasyon sou Horizon Blue Cross Blue Shield of New Jersey, ou gen dwa pou jwenn ed nan lang natifnatal ou gratis. Pou pale avek yon entepret, tanpri rele nimewo 1-800-355-BLUE {2583) pandan le noma! biznis.

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Vietnamese (Ti ng Vi t): N u đ.n duqc giup dodhiu ro thOng tin nay cua Horizon Blue Cross Blue Shield ofNew Jersey, quyvj c6 quySn duqc giup do b ng ng6n ngrf cua minh min phi. Xin goi s6 1-800-355-BLUE (2583) trong gia lam vic đn6i chuyn v&i ngucri thong dich.

French (Franyais): Si vous avez besoin d'assistance pour comprendre ces informations au sujet de Horizon Blue Cross Blue Shield ofNew Jersey, vous avez le droit d'obtenir de l'aide dans votre langue, sans aucun frais. Pourparler avec un interprete, veuillez appeler le 1-800-355-BLUE {2583) pendant les heures normales de bureau.

Navajo (Dine): *Dii* New Jersey bil hahoodzo Horizon Blue Cross Blue Shield, t'aa ninizaad k'ehji baa hane'ii bik'i diitih bee shika' a 'doowol ninizingo ei bee na'ahoot'i' d66 doo bh ilini da. Ata' halne'e Ia' bich'i' hadeesdzih ninizingo t'aa shQQdi 1-800-355-BLUE (2583)ji' nida'anishgo ookilii bik'ehgo hodiilnih.

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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.

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, 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 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/TDD 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 BCBSNJ has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin, 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 BCBSNJ member, you may contact Horizon BCBSNJ's Civil Rights Coordinator by calling 1-866-660-6528 (TTY/TOO 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>, 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.