

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 01/01/2018 - 12/31/2018**

Horizon BCBSNJ: School Employees' Health Benefits Program- NJ DIRECT10 (PPO)

Coverage for: All Coverage Types

Plan Type: PPO



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?	\$100.00 Individual / \$250.00 Family 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 plan 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, In-network Health providers \$400.00 Individual/ \$1,000.00 Family. Out-of-network providers \$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 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, <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. For a list of in-network <u>providers</u> , see www.HorizonBlue.com/shbp or call 1-800-414-SHBP (7427).	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> 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 referral to see a specialist?	No. You don't need a <u>referral</u> to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without a <u>referral</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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	\$10.00 Copayment per visit.	20% Coinsurance after deductible.	—none—
	Specialist visit	\$10.00 Copayment per visit; Specialist.	20% Coinsurance after deductible.	
	Preventive care/screening/immunization	No Charge.	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.	20% Coinsurance after deductible.	—none—
	Imaging (CT/PET scans, MRIs)	No Charge.	20% Coinsurance after deductible.	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	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)	No Charge.	20% Coinsurance after deductible.	—none—
	Physician/surgeon fees	No Charge.	20% Coinsurance after deductible.	20% <u>Coinsurance</u> after deductible for out-of-network anesthesia.
If you need immediate medical attention	Emergency room care	\$25.00 Copayment per visit for Outpatient Hospital.	\$25.00 Copayment per visit for Outpatient Hospital.	If admitted within 24 hours, the copayment is waived. Payment at the in-network level applies only to true Medical Emergencies & Accidental Injuries.
	Emergency medical transportation	10% Coinsurance.	20% Coinsurance after deductible.	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.
	Urgent care	\$10.00 Copayment per visit.	20% Coinsurance after deductible.	—none—

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge.	20% Coinsurance after deductible.	Requires pre-approval.
	Physician/surgeon fees	No Charge.	20% Coinsurance after deductible.	Requires pre-approval. 20% <u>Coinsurance</u> after deductible for out-of-network anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10.00 Copayment per visit for Mental Health and Behavioral Health. No Charge for Substance Abuse.	20% Coinsurance after deductible.	Some specialty outpatient services require pre-approval.
	Inpatient services	No Charge.	20% Coinsurance after deductible.	Requires pre-approval.
If you are pregnant	Office visits	\$10.00 Copayment per visit for Office.	20% Coinsurance after deductible.	<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.	20% Coinsurance after deductible.	—————none—————
	Childbirth/delivery facility services	No Charge.	20% Coinsurance after deductible.	Requires pre-approval.
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge.	20% Coinsurance after deductible.	Requires pre-approval.
	<u>Rehabilitation services</u>	\$10.00 Copayment per visit for Office. No Charge for Inpatient and Outpatient Facility.	20% Coinsurance after deductible.	Requires pre-approval.
	<u>Habilitation services</u>	\$10.00 Copayment per visit for Office. No Charge for Inpatient and Outpatient Facility.	20% Coinsurance after deductible.	
	<u>Skilled nursing care</u>	No Charge.	20% Coinsurance after deductible.	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Durable medical equipment</u>	10% Coinsurance.	20% Coinsurance after deductible.	Requires pre-approval for all rentals and some purchases.
	<u>Hospice services</u>	No Charge.	20% Coinsurance after deductible.	Requires pre-approval.
If your child needs dental or eye care	Children's eye exam	\$10.00 Copayment 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—

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

Long Term Care

Routine foot care

Dental care (Adult)

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 (Only covered for members age 15 or younger)

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

Bariatric surgery (requires pre-approval)

Infertility treatment (requires pre-approval)

Routine eye care (Adult)

Chiropractic care (limited to 30 visits/year)

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

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)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
--	---	--

The plan's overall deductible	\$0.00	The plan's overall deductible	\$0.00	The plan's overall deductible	\$0.00
Specialist Copayment	\$10.00	Specialist Copayment	\$10.00	Specialist Copayment	\$10.00
Hospital (facility) Coinsurance	0%	Hospital (facility) Coinsurance	0%	Hospital (facility) Coinsurance	0%
Other Coinsurance	10%	Other Coinsurance	10%	Other Coinsurance	10%

This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)	This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)	This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)
--	--	--

Total Example Cost	\$12,800.00	Total Example Cost	\$7,400.00	Total Example Cost	\$1,900.00
---------------------------	--------------------	---------------------------	-------------------	---------------------------	-------------------

In this example, Peg would pay:	In this example, Joe would pay:	In this example, Mia would pay:
<i>Cost Sharing</i>	<i>Cost Sharing</i>	<i>Cost Sharing</i>
Deductibles	Deductibles	Deductibles
\$0.00	\$0.00	\$0.00
Copayments	Copayments	Copayments
\$10.00	\$100.00	\$70.00
Coinsurance	Coinsurance	Coinsurance
\$0.00	\$0.00	\$80.00
<i>What isn't covered</i>	<i>What isn't covered</i>	<i>What isn't covered</i>
Limits or exclusions	Limits or exclusions	Limits or exclusions
\$100.00	\$6,040.00	\$0.00
The total Peg would pay is	The total Joe would pay is	The total Mia would pay is
\$110.00	\$6,140.00	\$150.00

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 ક્લાકો 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.

Russian (Русский язык): Если вам необходима помощь в разъяснении этой информации, предоставленной компанией Horizon Blue Cross Blue Shield of New Jersey, у вас есть право на получение помощи на вашем родном языке бесплатно. Для связи с переводчиком звоните по номеру телефона **1-800-355-BLUE (2583)** в обычные рабочие часы.

Haitian Creole (Kreyòl ayisyen): Si ou bezwen èd pou konprann enfòmasyon sou Horizon Blue Cross Blue Shield of New Jersey, ou gen dwa pou jwenn èd nan lang natifnatal ou gratis. Pou pale avèk yon entèprèt, tanpri rele nimewo **1-800-355-BLUE (2583)** pandan lè nòmal biznis.

Hindi (हिंदी): यदि आपको न्यू जर्सी की इस होराइजन ब्लू क्रॉस ब्लू शील्ड सूचना को समझने में सहायता की ज़रूरत है, तो आपके पास मुफ्त में अपनी भाषा में सहायता पाने का अधिकार है। किसी दुभाषिए से बात करने के लिए, कृपया सामान्य कार्य समय के दौरान **1-800-355-BLUE (2583)** पर कॉल करें।

Vietnamese (Tiếng Việt): Nếu cần được giúp đỡ để hiểu rõ thông tin này của Horizon Blue Cross Blue Shield of New Jersey, quý vị có quyền được giúp đỡ bằng ngôn ngữ của mình miễn phí. Xin gọi số **1-800-355-BLUE (2583)** trong giờ làm việc để nói chuyện với người thông dịch.

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

Navajo (Diné): Díí New Jersey bíł hahoodzo Horizon Blue Cross Blue Shield, t'áá ninizaad k'ehjí baa hane'íí bik'i diitjìh bee shiká' a'doowoł nínízingo éí bee ná'ahoot'i' dóó doo b'ááh ílíní da. Ata' halne'é ła' bich'í' hadeesdzih nínízingo t'áá shqódí **1-800-355-BLUE (2583)**jjí' nida'anishgo oolkiíí bik'ehgo hodíílnih.

Arabic (عربي): إذا كنت بحاجة إلى المساعدة في فهم معلومات Horizon Blue Cross Blue Shield of New Jersey لديك الحق في الحصول على المساعدة بلغتك دون تحميلك أية تكلفة. للتكلم مع مترجم، يرجى الاتصال خلال ساعات العمل العادية بالرقم **1-800-355-BLUE (2583)**.

Urdu (اردو): اگر آپ کو نیوجرسی انفارمیشن کے اس آسمانی نیلے رنگ والے تیز نیلے رنگ والے شیلڈ کو سمجھنے میں مدد کی ضرورت ہے تو، آپ کو اپنی زبان میں بغیر کسی خرچ کے مدد حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، براہ کرم، معمول کے کاروباری اوقات میں **1-800-355-BLUE (2583)** پر کال کریں۔

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.



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.