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, please see the Evidence of Coverage (EOC) at www.state.nj.us/treasury/pensions/health-benefits.shtml or www.HorizonBlue.com/shbp or by calling 1-609-292-7524. A printed copy of your EOC is available upon request by calling the Member Service number on the back of your member ID card.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100.00** out-of-network deductible applies only to select out-of-network services that are not covered by Medicare but covered by Medicare Advantage NJ DIRECT15.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
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.
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 Medicare eligible in-network and out-of-network services **$5,799.00** a person. For out-of-network services that are not Medicare eligible, **$2,000.00** a person.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Prescription costs under your separate prescription drug program, 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, but you may use both in-network and out-of-network providers as long as the provider accepts Medicare. For a list of in-network providers, see www.HorizonBlue.com/shbp or call 1-800-414-SHBP (7427).	Medicare Advantage NJ DIRECT15 members may access both in-network and out-of-network providers for Medicare eligible services without any difference in copayment, coinsurance, or deductible. However, members need to use a licensed provider that accepts Medicare and the provider must agree to provide 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.

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	$15.00 Copayment per visit.	$15.00 Copayment per visit.	_____none_____
	Specialist visit	$15.00 Copayment per visit; Specialist.	$15.00 Copayment per visit; Specialist.	_____none_____
	Preventive care/screening/immunization	No Charge.	No Charge.	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.	No Charge.	Certain services may require pre-approval.
	Imaging (CT/PET scans, MRIs)	No Charge.	No Charge.	Requires pre-approval.
If you need drugs to treat your illness or condition	Generic drugs	Not covered under Medicare Advantage NJ DIRECT Plan. Please refer to OptumRx SBC available at www.state.nj.us/treasury/pensions/health-benefits.shtml or by calling 1-844-368-8765.		_____none_____
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge.	No Charge.	Certain surgical procedures performed in ambulatory surgical center requires pre-approval.
	Physician/surgeon fees	No Charge.	No Charge.	_____none_____
If you need immediate medical attention	Emergency room care	$75.00 Copayment per visit for Outpatient Hospital.	$75.00 Copayment per visit for Outpatient Hospital.	If admitted within 24 hours, the copayment is waived.
	Emergency medical transportation	10% Coinsurance.	10% Coinsurance.	Payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Urgent care	$15.00 Copayment per visit for Office.	$15.00 Copayment per visit for Office.	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge.	No Charge.	Requires pre-approval. $200 deductible per hospital stay applies for select out-of-network services not covered under Medicare.
	Physician/surgeon fees	No Charge.	No Charge.	Requires pre-approval.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge.	No Charge.	Some specialty outpatient services require pre-approval.
	Inpatient services	No Charge.	No Charge.	Requires pre-approval. $200 deductible per hospital stay applies for select out-of-network services not covered under Medicare.
If you are pregnant	Office visits	$15.00 Copayment per visit for Office.	$15.00 Copayment per visit for Office.	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound.)Copay applies to initial visit only.
	Childbirth/delivery professional services	No Charge.	No Charge.	_____none_____
	Childbirth/delivery facility services	No Charge.	No Charge.	Requires pre-approval. $200 deductible per hospital stay applies for select out-of-network services not covered under Medicare.
If you need help recovering or have other special health needs	Home health care	No Charge.	No Charge.	Requires pre-approval.
	Rehabilitation services	No Charge.	No Charge.	Requires pre-approval. $200 deductible per hospital stay applies for select out-of-network services not covered under Medicare.
	Habilitation services	No Charge.	No Charge.	
	Skilled nursing care	No Charge.	No Charge.	Requires pre-approval. In-network & Out-of-network inpatient skilled nursing facility day limit. Coverage is limited to 120 days per benefit period.

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)	
	Durable medical equipment	10% Coinsurance.	10% Coinsurance.	Requires pre-approval.
	Hospice services	Not Covered.	Not Covered.	Covered by Medicare.
If your child needs dental or eye care	Children's eye exam	Not Covered.	Not Covered.	_____none_____
	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
- Dental care (Adult)
- Hearing Aids
- Long Term Care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- 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
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Private-duty nursing)
- 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 may require you to pay an additional premium or make additional contributions. These 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) or review the plan document at www.state.nj.us/treasury/pensions/health-benefits.shtml or www.HorizonBlue.com/shbp.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. 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) or review the plan document at www.state.nj.us/treasury/pensions/health-benefits.shtml or www.HorizonBlue.com/shbp.

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.

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**
■ **Specialist *Copayment***	**$15.00**	■ **Specialist *Copayment***	**$15.00**
■ **Hospital (facility) *Coinsurance***	**0%**	■ **Hospital (facility) *Coinsurance***	**0%**
■ **Other *Coinsurance***	**10%**	■ **Other *Coinsurance***	**10%**
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	$7,400.00	**Total Example Cost**	$1,900.00
In this example, Joe would pay:		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*	
Deductibles	$0.00	Deductibles	$0.00
Copayments	$150.00	Copayments	$100.00
Coinsurance	$170.00	Coinsurance	$20.00
What isn't covered		*What isn't covered*	
Limits or exclusions	$4,310.00	Limits or exclusions	$810.00
The total Joe would pay is	**$4,630.00**	**The total Mia would pay is**	**$930.00**

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

Multi-Language Insert
Multi-language Interpreter Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-414-7427** (TTY/TDD **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al **1-800-414-7427**, (TTY/TDD **711**).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-414-7427** (TTY/TDD **711**).

ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le **1-800-414-7427** (le **711** pour service TTY/TDD).

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવાઓ તમને વિના મૂલ્યે ઉપલબ્ધ છે. કૉલ કરો **1-800-414-7427** (TTY/TDD **711**).

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आप के लिए भाषा सहायता सेवाएँ नि:शुल्क उपलब्ध हैं। फोन करें **1-800-414-7427** (TTY/TDD **711**).

ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il numero **1-800-414-7427** (TTY/TDD **711**).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-414-7427**(TTY/TDD **711**)로 전화하십시오.

Horizon Blue Cross Blue Shield of New Jersey

BAA ÁKOHWIINDZIN DOOÍGÍ: Díí Diné, k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo bee náhaz'ą. Kojį éí béésh bee hodíílnih **1-800-414-7427** (TTY/TDD **711**) biniiyégo éí 711jį' béésh bee hodíílnih.

UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Zadzwoń pod numer **1-800-414-7427** (TTY/TDD **711**).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Ligue **1-800-414-7427** (TTY/TDD **711**).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами переводчика. Звоните по телефону **1-800-414-7427** (телетайп/текстовый телефон **711**).

PAUNAWA: Kung nagsasalita kayo ng wikang Tagalog, mayroon kayong makukuhang mga libreng serbisyo para sa tulong sa wika. Tumawag sa **1-800-414-7427** (TTY/TDD **711**).

LƯU Ý: Nếu quý vị nói Tiếng Việt, luôn có các dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị. Gọi số **1-800-414-7427** (TTY/TDD **711**).

توجہ دیں: اگر آپ اردو زبان بولتے ہیں، تو آپ کو زبان سے متعلق اعانت کی خدمات مفت دستیاب ہیں۔ **1-800-414-7427** (ٹی ٹی وائی/ٹی ڈی ڈی **711**) پر کال کریں۔

انتباه: إذا كنت تتحدث *اللغة العربية*، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل على الرقم **1-800-414-7427** (TTY/TDD **711**).

注意：如果您說中文，我們可以為您提供免費的語言協助服務。請致電 **1-800-414-7427** (TTY/TDD **711**)。

Horizon BCBSNJ

Three Penn Plaza East
Newark, NJ 07105-2200
HorizonBlue.com

Horizon Blue Cross Blue Shield of New Jersey

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 **1-800-414-7427** (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

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**.

Para ayuda en español, llame a **1-800-414-7427** (TTY/TDD **711**).