Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 01/01/2025 - 12/31/2025**

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. 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 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 per calendar year for out-of-network providers. Aggregate family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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 Active employee in-network Health providers **$400.00** Individual/ **$1,000.00** Family. Out-of-network providers **$2,000.00** Individual/ **$5,000.00** Family.	The out-of-pocket limit 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, 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. For a list of in-network **providers,** see **www.HorizonBlue.com/shbp** or call **1-800-414-SHBP (7427).** Benefits provided by in-network providers and BlueCard PPO providers are at the in-network level of benefits.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		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.	Out-of-network allowances for Chiropractic, Acupuncture and Physical Therapy services are limited to no more than $35.00 per visit for Chiropractic, $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.
	Specialist visit	$10.00 Copayment per visit.	20% Coinsurance.	
	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.	———none———
	Imaging (CT/PET scans, MRIs)	No Charge.	20% Coinsurance.	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.	———none———
	Physician/surgeon fees	No Charge.	20% Coinsurance.	20% Coinsurance 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. Deductible does not apply.	If admitted within 24 hours, the copayment is waived. Payment at the in-network level applies only to true Medical Emergencies & Accidental Injuries.

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)	
	Emergency medical transportation	10% Coinsurance.	20% Coinsurance.	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.
	Urgent care	$10.00 Copayment per visit for Specialist.	20% Coinsurance for Specialist.	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital.	Requires pre-approval.
	Physician/surgeon fees	No Charge for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital.	Requires pre-approval. 20% Coinsurance for out-of-network anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge for Outpatient Hospital. $10.00 Copayment per Office visit for Mental Health and Behavioral Health. No Charge for Substance Abuse Office visit.	20% Coinsurance for Outpatient Hospital.	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 for Inpatient Hospital.	20% Coinsurance for Inpatient Hospital.	Requires pre-approval.
If you are pregnant	Office visits	$10.00 Copayment per visit for Office.	20% Coinsurance.	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.	20% Coinsurance.	————none————
	Childbirth/delivery facility services	No Charge.	20% Coinsurance.	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 help recovering or have other special health needs	Home health care	No Charge.	20% Coinsurance.	Requires pre-approval.
	Rehabilitation services	No Charge for Inpatient and Outpatient Facility. $10.00 Copayment per visit for Office.	20% Coinsurance.	Requires pre-approval. Out-of-network allowance for Physical Therapy services is limited to $52.00 per visit or 75% of the in network cost per visit, whichever is less.
	Habilitation services	No Charge for Inpatient and Outpatient Facility. $10.00 Copayment per visit for Office.	20% Coinsurance.	
	Skilled nursing care	No Charge.	20% Coinsurance.	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.
	Durable medical equipment	10% Coinsurance.	20% Coinsurance.	Requires pre-approval for all rentals and some purchases.
	Hospice services	No Charge.	20% Coinsurance.	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
- Dental care
- Long Term Care
- Private-duty nursing
- 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 (for pain management only)
- Bariatric surgery (requires pre-approval)
- Chiropractic care (limited to 30 visits/year)
- Hearing Aids
- Infertility treatment (requires pre-approval)
- Most coverage provided outside the United States. (Subject to deductible/coinsurance and balance billing.)
- Non-emergency care when traveling outside the U.S. (Subject to deductible/coinsurance and balance billing.)
- Routine eye care (Adult)

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 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

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 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 plan's overall deductible**	**$0.00**
■ **Specialist *Copayment***	**$10.00**
■ **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)*

Total Example Cost	$12,700.00

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$10.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$70.00
The total Peg would pay is	**$80.00**

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

■ **The plan's overall deductible**	**$0.00**
■ **Specialist *Copayment***	**$10.00**
■ **Hospital (facility) *Coinsurance***	**0%**
■ **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)*

Total Example Cost	$5,600.00

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$100.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$4,300.00
The total Joe would pay is	**$4,400.00**

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

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

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	$2,800.00

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$100.00
Coinsurance	$100.00
What isn't covered	
Limits or exclusions	$10.00
The total Mia would pay is	**$210.00**

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.

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 (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. 20201**or 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 અંગ્રેજી સિવાયની ભાષા બોલતા હોવ, તો મફતમાં 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'identificazione.
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 الموجود 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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