Horizon BCBSNJ: OMNIA Platinum-On Exchange

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016 – 12/31/2016
Coverage for: All coverage types| **Plan Type:** EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HorizonBlue.com or by calling 1-800-355-BLUE (2583). If you do not currently have coverage with Horizon and wish to view a sample policy, they are available at http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcforms.html. Starting in January of 2016, once you have enrolled in coverage with Horizon, you may sign into Member Online Services at www.HorizonBlue.com/Member to view your policy. (Please note that document viewing availability is subject to NJDOBI regulatory procedures, enrollment and/or billing activities or other procedures preventing the display.)

Important Questions	Answers	Why this Matters:
What is the overall deductible?	OMNIA Tier 1 providers **$0. $1,000** person/**$2,000** family for Tier 2 providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Common Medical Events chart for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but, see the Common Medical Events chart for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For OMNIA Tier 1 Health/Pharmacy providers **$1,500** person/**$3,000** family. For Tier 2 Health/Pharmacy providers **$2,500**/ **$5,000** family. Tier 1 Out-of-pocket limit accumulates to Tier 2.	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.HorizonBlue.com **or call 1-800-355-BLUE (2583).**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the Common Medical Events chart for how this plan pays different kinds of **providers.**

Do I need a referral to see a specialist?	No. A written referral is not required to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on the Services Your Plan Does Not Cover chart. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an OMNIA Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay/visit.	$15 copay/visit	Not covered.	————————none————————
	Specialist visit	$15 copay/visit.	$35 copay/visit.	Not covered.	————————none————————
	Other practitioner office visit	$5 copay/visit.	$15 copay/visit	Not covered.	Therapeutic Manipulations (chiropractic care) are limited to 30 visits per calendar year. Physical, speech, occupational, and cognitive therapies are limited to 30 visits per therapy per calendar year.

Common Medical Event	Services You May Need	Your Cost If You Use an OMNIA Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Preventive care/screening/ immunization	No charge.	No charge.	Not covered.	One routine physical per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	Office/ Laboratory: No charge. Laboratory: Outpatient Facility: $15 copay/visit. Radiology: Outpatient Facility: $15 copay/visit. Office: Office: $5 copay/PCP or $15 copay/ Specialist.	Office/ Laboratory: No charge. Laboratory: Outpatient Facility: 30% coinsurance after deductible Radiology: Outpatient Facility: 30% coinsurance after deductible. Office: $15 copay / PCP or $35 copay/ Specialist.	Not covered.	————————none————————
	Imaging (CT/PET scans, MRIs)	Office/ Outpatient facility: $15 copay/visit.	Office: $15 copay/visit. Outpatient Facility: 30% coinsurance after deductible	Not covered.	Requires pre-approval.

Common Medical Event	Services You May Need	Your Cost If You Use an OMNIA Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at Prime Therapeutics LLC (Prime) Service Center www.MyPrime.com or 1-800-370-5088. View the formulary at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2016/2016_NJ_3T_HealthInsuranceMarketplaceAdvantage.pdf	Generic drugs	$5 copay/Retail $10 copay/Mail Order.	$5 copay/Retail $10 copay/Mail Order.	Not covered.	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order).
	Preferred brand drugs	10% coinsurance.	10% coinsurance.	Not covered.	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order).
	Non-preferred brand drugs	30% coinsurance.	30% coinsurance.	Not covered.	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order).
	Specialty drugs	30% coinsurance.	30% coinsurance.	Not covered.	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order).

Common Medical Event	Services You May Need	Your Cost If You Use an OMNIA Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgicenter/ Outpatient hospital: $150 copay/visit.	Ambulatory Surgicenter/ Outpatient hospital: 30% coinsurance after deductible.	Not covered.	————————none————————
	Physician/surgeon fees	No charge	30% coinsurance after deductible	Not covered.	————————none————————
If you need immediate medical attention	Emergency room services	$100 copay/visit.	30% coinsurance after deductible and $100 copay/visit	OMNIA Tier 1: $100 copay/visit Tier 2: 30% coinsurance after deductible and $100 copay/visit	Copayment waived if admitted within 24 hours. Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Emergency medical transportation	No charge.	No charge.	No charge.	Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Urgent care	PCP: $5 copay/visit Specialist: $15 copay/visit.	PCP: $15 copay/visit. Specialist: $35 copay/visit	Not covered.	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay per day.	30% coinsurance after deductible	Not covered.	Requires pre-approval. $1,500 copay maximum per admission.
	Physician/surgeon fee	No charge.	30% coinsurance after deductible.	Not covered.	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use an OMNIA Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Outpatient facility: $15 copay/visit. PCP: $5 copay/visit. Specialist: $15 copay/visit.	Outpatient facility 30% coinsurance after deductible. PCP: $15 copay/visit. Specialist: $35 copay/visit.	Not covered.	————————none————————
	Mental/Behavioral health inpatient services	$300 copay per day.	30% coinsurance after deductible.	Not covered.	Requires pre-approval. $1,500 copay maximum per admission.
	Substance use disorder outpatient services	Outpatient facility: $15 copay. PCP: $5 copay/visit. Specialist: $15 copay/visit.	Outpatient facility 30% coinsurance after deductible. PCP: $15 copay/visit. Specialist: $35 copay/visit.	Not covered.	————————none————————
	Substance use disorder inpatient services	$300 copay per day.	30% coinsurance after deductible.	Not covered.	Requires pre-approval. $1,500 copay maximum per admission.
If you are pregnant	Prenatal and postnatal care	No charge.	No charge.	Not covered.	Copayment applies to initial visit only.
	Delivery and all inpatient services	$300 copay per day.	30% coinsurance after deductible.	Not covered.	$1,500 copay maximum per admission.

Common Medical Event	Services You May Need	Your Cost If You Use an OMNIA Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$15 copay/visit.	$15 copay/visit.	Not covered.	Requires pre-approval. Private-duty nursing is only covered under the Home health care benefit when required by a Home health care plan. Coverage is limited to 60 visits per calendar year.
	Rehabilitation services (inpatient)	$300 copay per day.	30% coinsurance after deductible	Not covered.	Requires pre-approval. $1,500 copay maximum per admission.
	Habilitation services (inpatient)	$300 copay per day.	30% coinsurance after deductible.	Not covered.	Requires pre-approval. $1,500 copay maximum per admission.
	Skilled nursing care	$300 copay per day.	30% coinsurance after deductible.	Not covered.	Requires pre-approval. $1,500 copay maximum per admission.
	Durable medical equipment	No Charge.	No Charge.	Not covered.	Items over 500.00 require pre-approval.
	Hospice service	$15 copay/visit.	$15 copay/visit.	Not covered.	Requires pre-approval.
If your child needs dental or eye care More information	Eye exam	No Charge.	No charge.	Not covered.	Limited to one exam per 12 months.
	Glasses	No charge.	No charge.	Not covered.	Lenses are covered Once every 12 months. Vision hardware is reimbursed every 24 months, Fashion level only.

Common Medical Event	Services You May Need	Your Cost If You Use an OMNIA Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
about **vision coverage** is available at www.HorizonBlue.com or 1-800-278-7753.	Dental check-up	Not Covered	Not Covered	Not Covered.	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids (Only covered for Members age 15 or younger)
- Non-emergency care when traveling outside the U.S. See www.HorizonBlue.com
- Most coverage provided outside the United States. See www.HorizonBlue.com
- Long-term care
- Private-duty nursing
- 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Abortion Services
- Acupuncture when used as a substitute for other forms of anesthesia
- Bariatric surgery
- Chiropractic care
- Infertility treatment (Requires pre-approval)

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 will require you to pay a **premium,** which 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 1-800-355-BLUE (2583). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

For questions about your rights, this notice, or assistance, you can contact: Horizon Blue Cross Blue Shield of New Jersey Member Services at 1-800-355-BLUE (2583). 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-355-BLUE (2583).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-355-BLUE (2583).

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-355-BLUE (2583).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-355-BLUE (2583).

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,060
- **Patient pays** $480

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$330
Coinsurance	$0
Limits or exclusions	$150
Total	**$480**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,070
- **Patient pays** $330

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$250
Coinsurance	$0
Limits or exclusions	$80
Total	**$330**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.