

Horizon BCBSNJ: OMNIA Silver-Off Exchange

Coverage Period: 01/01/2016-12/31/2016

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

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 plan document, they are available at http://www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html. Starting in January of 2016, once you have enrolled in coverage with Horizon, you may sign into our Member Services portal at www.HorizonBlue.com/Member to view your plan document. (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 <u>deductible</u>?	OMNIA Tier 1 providers \$0. \$2,500 person/ \$5,000 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 <u>deductibles</u> for specific services?	Yes. \$500 for Emergency room services.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For OMNIA Tier 1 Health/Pharmacy providers \$6,600 person/ \$13,200 family. For Tier 2 Health/Pharmacy providers \$6,600/\$13,200 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 <u>out-of-pocket limit</u>?	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 Common Medical Events chart describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	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 .

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Do I need a referral to see a <u>specialist</u>?	No. A written referral is not required to see a specialist.	You can see the <u>specialist</u> 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 <u>excluded services</u> .



- **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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 copay/visit.	50% coinsurance after deductible.	Not covered.	—————none—————
	Specialist visit	\$50 copay/visit.	50% coinsurance after deductible.	Not covered.	—————none—————
	Other practitioner office visit	\$30 copay/visit.	50% coinsurance after deductible.	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.
	Preventive care/screening/immunization	No charge.	No charge.	Not covered.	One routine physical per calendar year.

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If you have a test	Diagnostic test (x-ray, blood work)	Office/ Laboratory: No charge. Laboratory: Outpatient Facility: \$100 copay/visit. Radiology: Outpatient Facility: \$100 copay/visit. Office: \$30 copay/PCP or \$50 copay/Specialist.	Office/ Laboratory: No charge. Laboratory: Outpatient Facility: 50% coinsurance after deductible. Radiology: Outpatient Facility: 50% coinsurance after deductible. Office: 50% coinsurance after deductible.	Not covered.	—————none—————
	Imaging (CT/PET scans, MRIs)	Office/ Outpatient facility: \$100 copay/visit.	Office: \$100 copay/visit. Outpatient Facility: 50% coinsurance after deductible	Not covered.	Requires pre-approval.

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<p>If you need drugs to treat your illness or condition.</p> <p>More information about prescription drug coverage is available at Prime Therapeutics LLC (Prime) Service Center www.MyPrime.com or 1-800-370-5088.</p> <p>View the formulary at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2016/2016_NJ_3T_HealthInsuranceMarketplaceAdvantage.pdf</p>	Generic drugs	\$15 copay Retail \$30 copay Mail Order.	\$15 copay Retail \$30 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	40% coinsurance.	40% 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	50% coinsurance.	50% 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	50% coinsurance.	50% coinsurance.	Not covered.	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order).

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgicenter/ Outpatient hospital: \$250 copay/visit.	Ambulatory Surgicenter/ Outpatient hospital: 50% coinsurance after deductible.	Not covered.	—————none—————
	Physician/surgeon fees	No charge	50% coinsurance after deductible	Not covered.	—————none—————
If you need immediate medical attention	Emergency room services	Deductible after \$100 copay/visit.	50% coinsurance after deductible and \$100 copay/visit.	OMNIA Tier 1: Deductible after \$100 copay/visit. Tier 2: 50% 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: \$30 copay/visit Specialist: \$50 copay/visit.	PCP/Specialist: 50% coinsurance after deductible.	Not covered.	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay per day.	50% coinsurance after deductible	Not covered.	Requires pre-approval. \$2,500 copay maximum per admission.
	Physician/surgeon fee	No charge.	50% coinsurance after deductible.	Not covered.	—————none—————

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Outpatient facility: \$50 copay/visit PCP: \$30 copay/visit. Specialist: \$50 copay/visit.	Outpatient facility 50% coinsurance after deductible. PCP/Specialist: 50% coinsurance after deductible.	Not covered.	—————none—————
	Mental/Behavioral health inpatient services	\$500 copay per day.	50% coinsurance after deductible	Not covered.	Requires pre-approval. \$2,500 copay maximum per admission.
	Substance use disorder outpatient services	Outpatient facility: \$50 copay/visit PCP: \$30 copay/visit. Specialist: \$50 copay/visit.	Outpatient facility 50% coinsurance after deductible. PCP/Specialist: 50% coinsurance after deductible.	Not covered.	—————none—————
	Substance use disorder inpatient services	\$500 copay per day.	50% coinsurance after deductible	Not covered.	Requires pre-approval. \$2,500 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	\$500 copay per day.	50% coinsurance after deductible	Not covered.	\$2,500 copay maximum per admission.

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If you need help recovering or have other special health needs	Home health care	\$50 copay/visit.	\$50 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)	\$500 copay per day.	50% coinsurance after deductible	Not covered.	Requires pre-approval. \$2,500 copay maximum per admission.
	Habilitation services (inpatient)	\$500 copay per day.	50% coinsurance after deductible	Not covered.	Requires pre-approval. \$2,500 copay maximum per admission.
	Skilled nursing care	\$500 copay per day.	50% coinsurance after deductible	Not covered.	Requires pre-approval. \$2,500 copay maximum per admission.
	Durable medical equipment	50% coinsurance	50% coinsurance	Not covered.	Items over 500.00 require pre-approval.
	Hospice service	\$50 copay/visit.	\$50 copay/visit.	Not covered.	Requires pre-approval.
If your child needs dental or eye care	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.
More information					

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about <u>vision coverage</u> 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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Hearing aids (Only covered for Members age 15 or younger) • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.HorizonBlue.com • Long-term care • Private-duty nursing 	<ul style="list-style-type: none"> • 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

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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.)

- 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.**

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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, kwijigo 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.*—————

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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 \$6,820
- Patient pays \$720

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	\$570
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$720

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

- Amount owed to providers: \$5,400
- Plan pays \$3,580
- Patient pays \$1,820

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	\$1,100
Coinsurance	\$640
Limits or exclusions	\$80
Total	\$1,820

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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.

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