



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.state.nj.us/treasury/pensions/health-benefits.shtml or by calling 1-609-292-7524.


Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$4000 Single / \$8000 Member & Spouse/Partner, Parent & Child(ren) or Family. Does not apply to preventive care.	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 chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For in-network providers \$1000 Single / \$2,000 Member & Spouse/Partner, Parent & Child(ren) or Family. For out-of-network providers \$2,000 Single / \$4,000 Member & Spouse/Partner, Parent & Child(ren) or Family.	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, deductible, balance-billed 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 .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 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 on in-network providers, see www.HorizonBlue.com/shbp or call 1-800-414-SHBP (7427).	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 chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a written referral to see a specialist.	You can see the in-network specialist you choose without permission from this plan.

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Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services .
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- **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 In-network 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	20% coinsurance after deductible	40% coinsurance after deductible	—————none—————
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	—————none—————
	Other practitioner office visit	20% coinsurance after deductible	40% coinsurance after deductible	Chiropractic care is limited to 30 visits combined per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	One routine physical per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	—————none—————
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition. Prescription drugs are provided by Express Scripts.</p> <p>More information about <u>prescription drug coverage</u> is available at www.state.nj.us/treasury/pensions/health-benefits.shtml.</p>	Generic drugs	20% coinsurance after deductible	40% coinsurance after deductible	Utilization Management Programs may apply.
	Preferred brand drugs	20% coinsurance after deductible	40% coinsurance after deductible	Utilization Management Programs may apply.
	Non-preferred brand drugs	20% coinsurance after deductible	40% coinsurance after deductible	Utilization Management Programs may apply.
	Specialty drugs	20% coinsurance after deductible	40% coinsurance after deductible	Utilization Management Programs may apply.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	—————none—————
	Physician/ surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	—————none—————
<p>If you need immediate medical attention</p>	Emergency room services	20% coinsurance after deductible	20% coinsurance after deductible	Payment at the in-network level applies only to true Medical Emergencies & Accidental Injuries.
	Emergency medical transportation	20% coinsurance after deductible	40% coinsurance after deductible	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.

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	Urgent care	20% coinsurance after deductible	40% coinsurance after deductible	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval.
	Physician/ surgeon fee	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Pre-approval required for some specialty outpatient services.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval.
	Substance use disorder outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Pre-approval required for some specialty outpatient services.
	Substance use disorder inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval.
If you are pregnant	Prenatal and postnatal care	20% coinsurance after deductible	40% coinsurance after deductible	—————none—————
	Delivery and all inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network 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	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval.
	Skilled nursing care	20% coinsurance after deductible	40% 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.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval for all rentals and some purchases.
	Hospice service	20% coinsurance after deductible	40% coinsurance after deductible	Requires pre-approval. Respite days limited to 10 days.
If your child needs dental or eye care	Eye exam	20% coinsurance after deductible	Not Covered	Limited to one exam every 12 months.
	Glasses	Not Covered	Not Covered	—————none—————
	Dental check-up	Not Covered	Not Covered	—————none—————

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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)
- Long-term care
- Private-duty nursing (inpatient)
- 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.)

- Acupuncture (for pain management only)
- Bariatric surgery (requires pre-approval)
- Chiropractic care (limited to 30 visits/year)
- Hearing aids
- Infertility treatment (requires pre-approval)
- 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:

“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 BCBSNJ Member Services at 1-800-255-2583. 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-609-292-7524.

—————*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 \$2,730
- Patient pays \$4,810

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	\$4,000
Copays	\$0
Coinsurance	\$660
Limits or exclusions	\$150
Total	\$4,810

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

- Amount owed to providers: \$5,400
- Plan pays \$1,070
- Patient pays \$4,330

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	\$4,000
Copays	\$0
Coinsurance	\$250
Limits or exclusions	\$80
Total	\$4,330

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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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