

Medicare Part D Creditable Coverage Notice

The prescription drug coverage you have under County of Monmouth Health Benefit Plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2026. (This is known as “Creditable Coverage.”) **If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Creditable Coverage Notice sent from Insurance Administrator of America, Inc. for more details.**

USERRA Notice

The Uniformed Services Employment and Reemployment Rights Act (USERRA) was enacted to ensure that members of the uniformed services are entitled to return to their civilian employment upon completion of their service. The following notice is designed to provide you with more information on your entitled rights and benefits under USERRA.

Reconstructive Surgery Following a Mastectomy

If a participant or beneficiary receiving benefits under a medical program in connection with a mastectomy elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

Benefit coverage may be subject to any deductibles, copays and coinsurance limitations applicable to your medical program coverage.

Under federal legislation, group health care plans may not deny participants' eligibility (or continued eligibility) to enroll in or renew coverage under the plan solely to avoid this mandated coverage. Further, plans are also prohibited from providing financial incentives or disincentives to medical providers in order to avoid the mandate.

Maternity and Newborn Infant Coverage

Coverage under the company's medical programs provides that maternity or newborn child coverage may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, health care plans and insurance issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).



Privacy Policy Reminder

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the County of Monmouth Health Benefit Plan to periodically send a reminder to participants about the availability of the plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the plan's legal duties with respect to protected health information (PHI) and how the plan may use and disclose PHI. To obtain a copy of the Privacy Notice or more information on the plan's privacy policies or rights under HIPAA, please contact:

County of Monmouth
One East Main Street
Freehold, NJ 07728
Phone: 732-866-3622
Fax: 732-780-3364

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes in a standard format important information regarding covered benefits such as exclusions, cost-sharing, and continuation of coverage so you may compare across options. You may view your SBC(s) on www.iaatpa.com.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from County of Monmouth, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, please see the attached notice.

Organ and Tissue Donation

Under the Health Care Quality Act, your plan must provide written materials about organ and tissue donation and inform members on how to make an anatomical gift. Donate Life New Jersey is the partnership between the Gift of Life Donor Program (Southern New Jersey) and NJ Sharing Network (Northern and Central New Jersey). If you wish to register to become an organ donor go to <https://registerme.org/>. To learn more about the Gift of Life Donor Program go to <http://www.donors1.org/>. To learn more about NJ Sharing Network go to <https://www.njsharingnetwork.org/>.





YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at <http://www.dol.gov/vets>**. An interactive online USERRA Advisor can be viewed at **<http://www.dol.gov/elaws/userra.htm>**.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: <http://www.dol.gov/vets/programs/userra/poster.htm>. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.



U.S. Department of Labor
1-866-487-2365



U.S. Department of Justice



Office of Special Counsel



1-800-336-4590

Publication Date—October 2008

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki) Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	KANSAS – Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	LOUISIANA – Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPPA program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

OMNIA (with BlueCard) Monmouth County



Benefit	OMNIA Tier 1	Tier 2
Plan Year	Calendar Year	
Deductible		
Individual	\$0	\$1,500
Family	\$0	\$3,000
	Deductible is Plan Year	
Coinsurance	100%	80%
Maximum Out of Pocket		
Individual	\$2,500	\$4,500
Family	\$5,000	\$9,000
Tier 1 Ded/MOOP accumulates to Tier 2 Ded/MOOP but Tier 2 Ded/MOOP does not accumulate to Tier 1 Ded/MOOP. Once Tier 2 Ded/MOOP has been met, Tier 1 will also have been met.		
Split Maximum Out of Pocket is Calendar Year. The deductible, coinsurance, and copayments apply to the Maximum Out of Pocket.		
Benefit Period Maximum	Unlimited	Unlimited
Lifetime Maximum	Unlimited	Unlimited
Primary Care Physician Selection	Not Required	
Doctor's Office Visits		
Primary Care Office Visit	100% after \$5 copay A primary care physician is a family practitioner, internist, pediatrician, or nurse practitioner	100% after \$20 copay
Specialist Office Visit	100% after \$15 copay A referral is not required to visit a specialist.	100% after \$30 copay
Maternity Visits	100% after \$15 copay Copay applies to 1st visit only Dependent children are eligible for maternity/obstetrical benefits.	100% after \$30 copay
Allergy Testing and Treatment	100% in office setting* *Copay only applies to office visit if billed. 100% outpatient facility	80% after deductible outpatient facility
Preventive Care		
Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations	100%	100%
Well Child Exams	100%	100%
Well Child Immunizations and Lead Screening	100%	100%
Diagnostic Procedures		
Laboratory	100% in office or LabCorp 100% in outpatient facility	100% in office or LabCorp 80% after deductible outpatient facility
X-ray/Radiology Services	100% in office 100% in outpatient facility	100% in office 80% after deductible outpatient facility
CT/CTA Scans, Pet Scans, MRIs/MRAs, Nuclear Medicine studies (including Nuclear Cardiology) require prior authorization. The ordering physician should request the prior authorization by calling eviCore at 1-866-496-6200 and providing the necessary clinical information. Once the authorization number is received, the member may call eviCore at 1-866-969-1234 to schedule an appointment.		
<i>Note: Managed Care members can call 1-866-969-1234 to obtain a confirmation number for non-Advanced Imaging diagnostic procedures. Confirmation numbers from eviCore replace the need for a paper referral.</i>		
Hospital Care		
Inpatient Admission	\$150 copay per admission (does not apply to maternity, mental health/substance abuse or hospice)	80% after deductible
Room and Board	100%	80% after deductible
Pre-admission Testing	100%	80% after deductible
Surgery in Hospital	100%	80% after deductible
Inpatient Physician Services	100%	80% after deductible
Outpatient Department Services (Non-Surgical)	100% after \$15 copay	80% after deductible

OMNIA (with BlueCard) Monmouth County



Emergency Care		
	100% after \$100 facility copay (copay waived if admitted)	100% after \$100 facility copay (copay waived if admitted)
Emergency Room	Payment at the in-network level across-the-board applies only to true Medical Emergencies & Accidental Injuries.	
Ambulance	100%	100%
Outpatient Surgery		
Hospital Outpatient Surgery	\$150 copayment	80% after deductible
Surgery in an Ambulatory SurgiCenter	\$150 copayment	80% after deductible
Mental Health Services		
Inpatient	100%	80% after deductible
Outpatient Department	100% after \$15 copay	80% after deductible
Office setting	100% after \$15 copay	100% after \$30 copay
Substance Abuse Services		
Inpatient	100%	80% after deductible
Outpatient Department	100% after \$15 copay	80% after deductible
Office setting	100% after \$15 copay	100% after \$30 copay
Alcohol Abuse Services		
Inpatient	100%	80% after deductible
Outpatient Department	100% after \$15 copay	80% after deductible
Office setting	100% after \$15 copay	100% after \$30 copay
Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Horizon Behavioral Health at 1-800-626-2212.		
Other Services		
Bariatric Surgery	100%	80% after deductible
Diabetic Education	100% after office copayment	100% after office copayment
Diabetic Supplies	100%	80%
Durable Medical Equipment	100%	80% after deductible
Orthotics and Prosthetics	100% after \$5 copay	100% after \$20 copay
Home Health Care	100% after \$5 copay	100% after \$20 copay
Hospice Care	100%	80% after deductible
Infertility	100% after \$15 copay office visit 100% after \$15 copay outpatient facility	100% after \$30 copay office visit 80% after deductible in outpatient facility
Physical Rehabilitation Facility Inpatient Services	\$150 per admission	80% after deductible
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after \$5 copay 100% after \$5 copay in outpatient facility 30 visit maximum per therapy, per benefit period	100% after \$20 copay 80% after deductible in outpatient facility
Private Duty Nursing	100% Limited to 30 visits per benefit period (8-hour shifts)	80% after deductible
Skilled Nursing Facility/Extended Care Center	\$150 per admission Limited to 100 days per benefit period	80% after deductible
Therapeutic Manipulation (Chiropractic Care)	100% after \$15 copay 25 visit maximum per benefit period	100% after \$30 copay
Adult Vision	100% after \$15 copay	100% after \$30 copay
Adult Vision Hardware	Not Covered	
Pediatric Vision and Vision Hardware	Routine Pediatric Vision Covered 1/year and Hardware Services are covered up to \$150	
Telemedicine Services	100% after \$5 copay	
Prescription Drugs	Not Covered	

OMNIA (with BlueCard) Monmouth County



Eligibility	Dependent children, including full-time students are covered until the end of the calendar year in which they reach the age of 26. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to the age of 26. Under certain conditions, coverage may be extended for qualified dependents up to age 31. Please refer to your benefit booklet for further information as this benefit highlight is not an exhaustive list.
Pre-Existing Conditions	Not Applicable
Prior Authorization	Some services/procedures require prior authorization. For a complete list, contact our customer service number at 1-800-355-BLUE (2583) or refer to our website at www.HorizonBlue.com .

The OMNIA plans cover eligible expenses rendered by providers in Horizon's Managed Care network. When you utilize participating providers, you generally only pay your copayment and any applicable in-network coinsurance or deductible. No benefits are available out-of-network, except in emergent situations.

Please note that the benefit highlights are provided for informational purposes. Horizon BCBSNJ makes every effort to provide clear and accurate information pertaining to these benefit highlights. However, because Horizon BCBSNJ generally expects continued guidance from regulators on issues pertaining to Federal health care reform, the information that has been provided is subject to change. Horizon BCBSNJ will provide notice of such changes to members pursuant to State and Federal requirements.

This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract. Please refer to your benefit booklet for more information.

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Three Penn Plaza East, Newark, New Jersey 07105



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 www.HorizonBlue.com/members or by calling 1-800-355-BLUE(2583). If you do not currently have coverage with Horizon BCBSNJ you can view a sample policy here, HorizonBlue.com/sample-benefit-booklets. 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.ccio.cms.gov or call 1-800-355-BLUE(2583) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,500.00 Individual/\$3,000.00 Family per calendar year for Tier 2 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 Health OMNIA Tier 1 providers \$2,500.00 Individual/\$5,000.00 Family. For Health Tier 2 providers \$4,500.00 Individual/\$9,000.00 Family. Aggregate 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. See www.HorizonBlue.com or call 1-800-355-BLUE(2583) for a list of network providers. Benefits provided by in-network providers other than OMNIA Tier 1 providers are at the Tier 2 level of benefits, such as Tier 2 and BlueCard PPO	You pay the least if you use a provider in OMNIA Tier 1. OMNIA Tier 1 applies to both OMNIA and BDTC providers (in select service areas). You pay more if you use a provider in Tier 2. 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.

	<u>providers.</u>	
Do you need a referral to see a specialist ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		OMNIA Tier 1 Provider(You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$5.00 <u>Copayment</u> per visit.	\$20.00 <u>Copayment</u> per visit. \$5.00 <u>Copayment</u> per visit applies only to Horizon CareOnline. <u>Deductible</u> does not apply.	Not Covered.	Horizon CareOnline telemedicine services is an additional telemedicine feature provided through Horizon BCBSNJ's telemedicine vendor.
	<u>Specialist</u> visit	\$15.00 <u>Copayment</u> per visit. \$5.00 <u>Copayment</u> per visit applies only to Horizon CareOnline. <u>Deductible</u> does not apply.	\$30.00 <u>Copayment</u> per visit. \$5.00 <u>Copayment</u> per visit applies only to Horizon CareOnline. <u>Deductible</u> does not apply.	Not Covered.	
	<u>Preventive care/screening</u> /immunization	No Charge.	No Charge. <u>Deductible</u> does not apply.	Not Covered.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge for Office, Independent Laboratory, Outpatient Hospital.	No Charge for Office, Independent Laboratory. <u>Deductible</u> does not apply. 20% <u>Coinsurance</u> for Outpatient Hospital.	Not Covered.	—none—
	Imaging (CT/PET scans, MRIs)	\$15.00 <u>Copayment</u> per visit for Outpatient Hospital.	20% <u>Coinsurance</u> for Outpatient Hospital.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance.

* For more information about limitations and exceptions, see the plan or policy document at **[INSERT GROUP URL HERE WHERE THE SPD IS LOADED]**

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider(You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition	Generic drugs	Not Covered.	Not Covered.	Not Covered.	
	Preferred brand drugs	Not Covered.	Not Covered.	Not Covered.	
	Non-preferred brand drugs	Not Covered.	Not Covered.	Not Covered.	
	Specialty drugs	Not Covered.	Not Covered.	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150.00 <u>Copayment</u> per visit for Outpatient Hospital, Ambulatory Surgical Center.	20% <u>Coinsurance</u> for Outpatient Hospital, Ambulatory Surgical Center.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review.
	Physician/surgeon fees	No Charge for Outpatient Hospital, Ambulatory Surgical Center.	20% <u>Coinsurance</u> for Outpatient Hospital, Ambulatory Surgical Center.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review. No Charge for OMNIA Tier 1 anesthesia in an Outpatient Hospital, Ambulatory Surgical Center. 20% <u>Coinsurance</u> for Tier 2 anesthesia in an Outpatient Hospital, Ambulatory Surgical Center.
If you need immediate medical attention	<u>Emergency room care</u>	\$100.00 <u>Copayment</u> per visit.	\$100.00 <u>Copayment</u> per visit. <u>Deductible</u> does not apply.	\$100.00 <u>Copayment</u> per visit. <u>Deductible</u> does not apply.	<u>Copayment</u> waived if admitted within 24 hours. Out-of-network payment at the OMNIA Tier 1 level of benefits applies only to true emergency room medical emergencies and accidental injuries.
	<u>Emergency medical transportation</u>	No Charge.	No Charge. <u>Deductible</u> does not apply.	Not Covered.	—none—
	<u>Urgent care</u>	\$15.00 <u>Copayment</u> per visit.	\$30.00 <u>Copayment</u> per visit. <u>Deductible</u> does not apply.	Not Covered.	—none—

* For more information about limitations and exceptions, see the plan or policy document at [INSERT GROUP URL HERE WHERE THE SPD IS LOADED]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider (You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150.00 <u>Copayment</u> per admission for Inpatient Hospital.	20% <u>Coinsurance</u> for Inpatient Hospital.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. In-network inpatient separation period is limited to 90 days.
	Physician/surgeon fees	No Charge for Inpatient Hospital.	20% <u>Coinsurance</u> for Inpatient Hospital.	Not Covered.	No Charge for OMNIA Tier 1 anesthesia. 20% <u>Coinsurance</u> for Tier 2 anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15.00 <u>Copayment</u> per visit for Outpatient Hospital.	20% <u>Coinsurance</u> for Outpatient Hospital.	Not Covered.	The Integrated System of Care (ISC) program is available to members with a serious mental illness or substance use disorder. Reimbursement for ISC services requires a contracted ISC <u>provider</u> . Locate a <u>provider</u> at www.Horizonblue.com/member-ISC .
	Inpatient services	No Charge for Inpatient Hospital.	20% <u>Coinsurance</u> for Inpatient Hospital.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance.
If you are pregnant	Office visits	\$5.00 <u>Copayment</u> per visit for Office. \$15.00 <u>Copayment</u> per visit for Specialist.	\$20.00 <u>Copayment</u> per visit for Office. \$30.00 <u>Copayment</u> per visit for Specialist. <u>Deductible</u> does not apply.	Not Covered.	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound.)
	Childbirth/delivery professional services	No Charge for Inpatient Hospital.	20% <u>Coinsurance</u> for Inpatient Hospital.	Not Covered.	—none—
	Childbirth/delivery facility services	No Charge for Inpatient Hospital.	20% <u>Coinsurance</u> for Inpatient Hospital.	Not Covered.	
If you need help recovering or have other special health needs	Home health care	\$5.00 <u>Copayment</u> per visit.	\$20.00 <u>Copayment</u> per visit. <u>Deductible</u> does not apply.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance.
	Rehabilitation services	\$150.00 <u>Copayment</u> per admission for Inpatient Hospital.	20% <u>Coinsurance</u> for Inpatient Hospital.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. In-network OMNIA Tier 1 Tier 2 inpatient separation

* For more information about limitations and exceptions, see the plan or policy document at [\[INSERT GROUP URL HERE WHERE THE SPD IS LOADED\]](#)

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider (You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
	<u>Habilitation services</u>	\$150.00 <u>Copayment</u> per admission for Inpatient Hospital.	20% <u>Coinsurance</u> for Inpatient Hospital.	Not Covered.	period is limited to 90 days.
	<u>Skilled nursing care</u>	\$150.00 <u>Copayment</u> per admission for Inpatient Facility.	20% <u>Coinsurance</u> for Inpatient Facility.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. In-network inpatient skilled nursing facility day limit is 100 days.
	<u>Durable medical equipment</u>	No Charge.	20% <u>Coinsurance</u> .	Not Covered.	Prior authorization required for DME purchases regardless of the amount. 20% penalty applies for non-compliance.
	<u>Hospice services</u>	No Charge for Inpatient Facility.	20% <u>Coinsurance</u> for Inpatient Facility.	Not Covered.	Requires pre-approval. 20% penalty applies for non-compliance.
If your child needs dental or eye care	Children's eye exam	No Charge.	No Charge. <u>Deductible</u> does not apply.	Not Covered.	This benefit is administered by Davis Vision. In-network routine vision exam is limited to 1 visit.
	Children's glasses	Amounts greater than \$150.00 for non-collection frames.	Amounts greater than \$150.00 for non-collection frames. <u>Deductible</u> does not apply.	Not Covered.	This benefit is administered by Davis Vision. Not covered - for adult. In-network lenses and hardware are covered once every 12 months. Limit includes 1 pair of frames from the select Davis Vision collection or \$150.00 allowance for non-collection frames.
	Children's dental check-up	Not Covered.	Not Covered.	Not Covered.	—none—

* For more information about limitations and exceptions, see the plan or policy document at [INSERT GROUP URL HERE WHERE THE SPD IS LOADED]

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
- Routine foot care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture when used as a substitute for other forms of anesthesia
- Bariatric surgery
- Chiropractic care
- Hearing Aids (Only covered for Members age 15 or younger)
- Infertility treatment (Diagnostic Services Only)
- 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.)

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: 1-800-355-BLUE (2583) or visit www.Horizonblue.com. 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 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 <u>plan's</u> overall <u>deductible</u>	\$0.00
■ <u>Specialist Copayment</u>	\$15.00
■ Hospital (facility) <u>Coinsurance</u>	0%
■ Other <u>Coinsurance</u>	0%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$20.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$70.00
The total Peg would pay is	\$90.00

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0.00
■ <u>Specialist Copayment</u>	\$15.00
■ Hospital (facility) <u>Coinsurance</u>	0%
■ Other <u>Coinsurance</u>	0%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$60.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$3,500.00
The total Joe would pay is	\$2,500.00

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0.00
■ <u>Specialist Copayment</u>	\$15.00
■ Hospital (facility) <u>Coinsurance</u>	0%
■ Other <u>Coinsurance</u>	0%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$100.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$40.00
The total Mia would pay is	\$140.00

The plan would be responsible for the other costs of these EXAMPLE covered services.



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 (including limited English proficiency and primary language), age, disability, pregnancy, gender identity, sex, sexual orientation, sex characteristics or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon provides language assistance services and appropriate auxiliary aids and services at no cost 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 1-800-355-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, 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 has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin (including limited English proficiency and primary language), 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

If you are not a Horizon member, you may contact Section 1557 Coordinator by calling 1-866-660-6528 (TTY 711) or by writing to Horizon BCBSNJ's Civil Rights Coordinator at the above-referenced address. 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><https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> opens a dialog window, 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.



Notice of Availability

If you speak English, free language assistance services and auxiliary aids are available to provide information in accessible formats. Call the number on the back of your member ID card for help.

Si habla español, hay servicios gratuitos de asistencia lingüística y ayudas auxiliares disponibles para proporcionar información en formatos accesibles. Llame al número que figura en el reverso de su tarjeta de identificación de miembro para obtener ayuda.

如果您說中文，我們提供免費的語言協助服務和輔助工具，以無障礙格式提供資訊。請撥打您的會員 ID 卡背面的電話號碼尋求協助。

한국어를 사용하시는 경우, 무료 언어 지원 서비스 및 보조 기구를 통해 접근 가능한 형식으로 정보를 제공받을 수 있습니다. 도움이 필요하시면 가입자 ID 카드 뒷면에 있는 번호로 전화하시기 바랍니다.

Se fala português, estão disponíveis serviços de assistência linguística e auxiliares gratuitos para fornecer informações em formatos acessíveis. Telefone para o número no verso do seu cartão de identificação de associado para obter ajuda.

જો તમે ગુજરાતી બોલતા હોવ, તો સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે નિ:શુલ્ક ભાષા સહાયતા સેવાઓ અને પૂરડ સહાયક ઉપલબ્ધ છે. મદદ માટે તમારા સભ્ય આઈડી કાર્ડની પાછળના નંબર પર કોલ કરો.

Jeśli posługujesz się językiem polski, dostępne są bezpłatne usługi wsparcia językowego i materiały pomocnicze w celu przekazania informacji w przystępnym formacie. Aby uzyskać pomoc, zadzwoń pod numer podany na odwrocie identyfikacyjnej karty członkowskiej.

Se parlate italiano, sono disponibili servizi gratuiti di assistenza linguistica e ausili aggiuntivi per fornire informazioni in formati accessibili. Chiamate il numero sul retro della Vostra tessera identificativa per ricevere assistenza.

إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية المجانية والمساعدات الإضافية لتوفير المعلومات بصيغ يسهل الوصول إليها. اتصل بالرقم الموجود على ظهر بطاقة هوية العضو للحصول على المساعدة.

Kung nagsasalita ka ng Tagalog, handang magamit ang mga libreng tulong na serbisyo sa wika at mga auxiliary na tulong para magbigay ng impormasyon sa mga naa-access na format. Tawagan ang numero sa likod ng iyong kard ng pagkakakilanlan bilang miyembro para sa tulong.

Если вы говорите на Русский язык, мы готовы бесплатно предоставить услуги переводчика и вспомогательные средства для получения информации в доступных форматах. Для получения помощи позвоните по номеру, указанному на обратной стороне вашей карточки участника.

Si w pale Kreyòl Ayisyen, sèvis asistans lang gratis ak èd oksilyè disponib pou bay enfòmasyon nan fòma ki aksesib. Rele nimewo ki sou do kat manm ou a pou èd.

यदि आप हिंदी बोलते हैं, तो सुलभ प्रारूपों में जानकारी प्रदान करने के लिए नि:शुल्क भाषा सहायता सेवाएं और सहायक साधन उपलब्ध हैं। मदद के लिए अपने सदस्य आईडी कार्ड के पीछे दिए गए नंबर पर कॉल करें।

Nếu bạn nói tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí và công cụ hỗ trợ để cung cấp thông tin ở các định dạng có thể truy cập. Hãy gọi số điện thoại ở mặt sau thẻ nhận dạng thành viên của bạn để được trợ giúp.

Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition, ainsi que des outils auxiliaires fournissant des informations dans des formats accessibles. Pour recevoir de l'aide, appelez le numéro indiqué au dos de votre carte de membre.

اگر آپ اردو بولتے ہیں، تو مفت زبان کی مدد کی خدمات اور معاون امداد ایک قابل رسائی شکل میں معلومات کی فراہمی کے لیے دستیاب ہیں۔ مدد کے لیے اپنے ممبر آئی ڈی کارڈ کی پشت پر موجود نمبر پر کال کریں۔

আপনি যদি বাংলায় ভাষায় কথা বলেন, তাহলে সহজলভ্য ফরম্যাটে তথ্য প্রদানের জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা ও সহায়ক উপকরণ উপলব্ধ রয়েছে। সাহায্যের জন্য আপনার সদস্য আইডি কার্ডের পিছনে দেওয়া নম্বরে কল করুন।

ECNA0023235 (0125)

Monmouth County Horizon BCBCNJ Direct Access POS Plan

Benefit	In-Network	Out-of-Network
Plan Year	Calendar Year	
Plan Year Deductible		
Individual	None	\$400
Family	None	\$800
Coinsurance	100%	70%
Maximum Out of Pocket		
Individual	\$5,000	\$5,000
Family	\$10,000	\$10,000
Maximum Out of Pocket is based on the plan year. The deductible plus coinsurance apply to the Maximum Out of Pocket. Balances from non-participating providers over reasonable and customary do not apply towards the Maximum Out of Pocket.		
Benefit Period Maximum	Unlimited	
Lifetime Maximum	Unlimited	
Precertification Penalty	\$200	
Primary Care Physician Selection	Required (A PCP selection is required to direct and manage care)	n/a
Primary and Preventative Care		
Primary Care Office Visits A primary care physician is a general or family practitioner, internist or pediatrician	100% after \$10 copay	70% after deductible
Annual Examinations	100%	Not covered
Annual Child and Well-Baby Care	100%	Not covered
Immunizations	100%	Not covered
Annual Gynecological Exams	100%	Not covered
Annual Mammograms	100%	Not covered
Prostate Screening	100%	Not covered
Routine Eye Exam	100%	Not covered
Eyeglasses/Contact Lenses	\$35 per 24-month period with discount through Davis Vision vendors	Not covered
Routine Hearing Screening	Covered when performed as part of a routing exam by PCP (subject to office visit copay)	Not covered
Hearing Aids	Not covered	Not covered
Specialty and Outpatient Care		
Specialist Office Visits	100% after \$10 copay	70% after deductible
Maternity Visits	100% after \$10 copay Copay only applies to first visit	70% after deductible
Infertility	100% after \$10 copay Limited to 4 egg retrievals per lifetime	70% after deductible (covered limited to diagnosis and treatment of underlying cause of infertility)
Allergy Testing & Treatment	100% after \$10 copay	70% after deductible
Lab Tests	100% in Office or Labcorp 100% in Outpatient facility	70% after deductible
Outpatient X-ray/Radiology Services	100%	70% after deductible
Therapy (speech, occupational, physical)	100% Combined maximum of 60 visits per plan year per condition	70% after deductible
Chiropractic Care	100% after \$10 copay 20 visit maximum per plan year	70% after deductible
Acupuncture	100% after \$10 copay A copay will only apply when an office visit is billed 20 visit maximum per plan year	70% after deductible
		70% after deductible



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.



***Monmouth County
Horizon BCBCNJ***

Home Health Care	100%	(one visit per day, up to 4 hours per visit) 120 visits per plan year
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Monmouth County Horizon BCBCNJ

Hospice Care (outpatient)	100%	70% after deductible
Private Duty Nursing	100%	Unlimited
Diabetic Education	100% after \$10 copay	70% after deductible
Benefit	In-Network	Out of Network
Durable Medical Equipment	100% (requires preapproval)	70% after deductible
Orthotic Devices	Not covered	Not covered
CT/CTA Scans, Pet Scans, MRIs/MRAs, Nuclear Medicine studies (including Nuclear Cardiology) require prior authorization. The ordering physician should request the prior authorization by calling eviCore healthcare at 1-866-496-6200 and providing the necessary clinical information. Once the authorization number is received, the member may call eviCore healthcare at 1-866-969-1234 to schedule an appointment.		
Inpatient Services		
Hospital Room and Board and Other Inpatient Services	100%	70% after deductible
Pre-admission Testing	100%	70% after deductible
Skilled Nursing Facility	100%	70% after deductible Limited to 60 days per plan year
Hospice Facility (inpatient)	100%	70% after deductible
Organ/Bone Marrow Transplant	100%	Not covered
Surgery and Anesthesia		
Inpatient Surgery	100%	70% after deductible
Outpatient Surgery (SurgiCenter)	No Copay-outpatient Facility \$10 copay -specialist's office	70% after deductible
Outpatient Biologically- Based Mental Illness (treated the same as general illnesses)	100% after copayment in office 100% in outpatient facility	70% after deductible
Inpatient Treatment	100%	70% after deductible
Outpatient Treatment	100% after \$10 copay A copay will only apply when an office visit is billed.	70% after deductible
Inpatient Mental Health/Substance Abuse Services must be coordinated through Horizon Behavioral Health at 1-800-626-2212		
Treatment of Alcohol		
Inpatient Detoxification	100%	70% after deductible
Inpatient Rehabilitation	100%	70% after deductible
Outpatient Detoxification	100% after \$10 copay A copay will only apply when an office visit is billed.	70% after deductible
Outpatient Rehabilitation	100% after \$10 copay A copay will only apply when an office visit is billed.	70% after deductible
Emergency Care/ Urgent Care		
Emergency Room	100% after \$100 facility copayment	
Non-Emergency Use of the Emergency Room	Not Covered	
Ambulance	100% if medically necessary	
Additional Information		
Prescription Drugs	Covered under your existing prescription program	
Prior Authorization	Some services/procedures require prior authorization. For a complete list, contact our customer service number at 1-800-355-BLUE (2583) or refer to our website at www.HorizonBlue.com .	
Eligibility	Dependent children, including full-time students are covered until the end of the month in which they reach the age of 26. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to the age of 26.	



Monmouth County
Horizon BCBCNJ



Nurse Line Free 1-888-624-3096	Toll- A health information service that includes a toll free 24 hour health information line staffed by registered nurses. Nurse Line nurses do not diagnose or recommend any treatment. Instead, they provide the member with the necessary health information needed to make informed medical decisions. This helps members determine if their health ailment requires a doctor's visit.

You can save money when you choose to receive care from providers that participate in the Horizon BCBSNJ networks. When you use participating hospitals or other medical facilities or doctors, you generally only pay your copayment and any applicable in-network coinsurance or deductible. Generally, if you have services performed at an out of network facility or by an out of network provider, your out of network benefits will apply. This means that you will be responsible for amounts exceeding Horizon BCBSNJ's allowable reimbursement for that particular service and this may result in significant out of pocket costs. You will be responsible to pay for this amount directly to the non-participating hospital, ambulatory surgery center or provider. By using our Horizon-BCBSNJ network providers, you keep your health care costs down.

This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract. Please refer to your benefit booklet for more information.

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Three Penn Plaza East, Newark, New Jersey 07105



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 www.HorizonBlue.com/members or by calling 1-800-355-BLUE(2583). If you do not currently have coverage with Horizon BCBSNJ you can view a sample policy here, HorizonBlue.com/sample-benefit-booklets. 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.ccio.cms.gov or call 1-800-355-BLUE(2583) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$400.00 Individual/\$800.00 Family per calendar year for out-of-network. Aggregate family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For in-network Health <u>providers</u> \$5,000.00 Individual/\$10,000.00 Family . For out-of-network Health <u>providers</u> \$5,000.00 Individual/\$10,000.00 Family . Aggregate family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.HorizonBlue.com or call 1-800-355-BLUE(2583) for a list of in-network <u>providers</u> . Benefits provided by in- <u>network providers</u> and BlueCard PPO <u>providers</u> are at the in-network level of benefits.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10.00 <u>Copayment</u> per visit.	30% <u>Coinsurance</u> .	———none———
	<u>Specialist</u> visit	\$10.00 <u>Copayment</u> per visit.	30% <u>Coinsurance</u> .	
	<u>Preventive care/screening</u> /immunization	No Charge.	Not Covered.	One per calendar year. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge for Office, Outpatient Hospital, Independent Laboratory.	30% <u>Coinsurance</u> for Office, Outpatient Hospital, Independent Laboratory.	———none———
	Imaging (CT/PET scans, MRIs)	No Charge for Outpatient Hospital.	30% <u>Coinsurance</u> for Outpatient Hospital.	Requires pre-approval; 30% cutback penalty up to \$200 applies for non-compliance.
If you need drugs to treat your illness or condition	Generic drugs	Not Covered.	Not Covered.	———none———
	Preferred brand drugs	Not Covered.	Not Covered.	
	Non-preferred brand drugs	Not Covered.	Not Covered.	
	<u>Specialty drugs</u>	Not Covered.	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge for Outpatient Hospital, Ambulatory Surgical Center.	30% <u>Coinsurance</u> for Outpatient Hospital, Ambulatory Surgical Center.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review. Surgical procedure performed in out-of-network ambulatory surgical center requires pre-approval.

* For more information about limitations and exceptions, see the plan or policy document at [INSERT GROUP URL HERE WHERE THE SPD IS LOADED]

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)	
	Physician/surgeon fees	No Charge for Outpatient Hospital, Ambulatory Surgical Center.	30% <u>Coinsurance</u> for Outpatient Hospital, Ambulatory Surgical Center.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review. 30% <u>Coinsurance</u> for out-of-network anesthesia in an Outpatient Hospital, Ambulatory Surgical Center.
If you need immediate medical attention	<u>Emergency room care</u>	\$100.00 <u>Copayment</u> per visit.	\$100.00 <u>Copayment</u> per visit. <u>Deductible</u> does not apply.	Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	<u>Emergency medical transportation</u>	No Charge.	No Charge. <u>Deductible</u> does not apply.	———none———
	<u>Urgent care</u>	\$10.00 <u>Copayment</u> per visit.	30% <u>Coinsurance</u> per visit.	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge for Inpatient Hospital.	30% <u>Coinsurance</u> for Inpatient Hospital.	Requires pre-approval; 30% cutback penalty up to \$200 applies for non-compliance.
	Physician/surgeon fees	No Charge for Inpatient Hospital.	30% <u>Coinsurance</u> for Inpatient Hospital.	30% <u>Coinsurance</u> for out-of-network anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge for Outpatient Hospital.	30% <u>Coinsurance</u> for Outpatient Hospital.	The Integrated System of Care (ISC) program is available to members with a serious mental illness or substance use disorder. Reimbursement for ISC services requires a contracted ISC <u>provider</u> . Locate a <u>provider</u> at www.Horizonblue.com/member-ISC .

* For more information about limitations and exceptions, see the plan or policy document at [INSERT GROUP URL HERE WHERE THE SPD IS LOADED]

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 are pregnant	Inpatient services	No Charge for Inpatient Hospital.	30% <u>Coinsurance</u> for Inpatient Hospital.	Requires pre-approval; 30% cutback penalty up to \$200 applies for non-compliance.
	Office visits	\$10.00 <u>Copayment</u> per visit for Office.	30% <u>Coinsurance</u> for Office.	<u>Cost sharing</u> 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 for Inpatient Hospital.	30% <u>Coinsurance</u> for Inpatient Hospital.	—————none—————
	Childbirth/delivery facility services	No Charge for Inpatient Hospital.	30% <u>Coinsurance</u> for Inpatient Hospital.	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge.	30% <u>Coinsurance</u> .	Requires pre-approval; 30% cutback penalty up to \$200 applies for non-compliance. In-and-out-of-network home health care visits limit to 120 max.
	<u>Rehabilitation services</u>	No Charge for Inpatient Hospital.	30% <u>Coinsurance</u> for Inpatient Hospital.	Requires pre-approval; 30% cutback penalty up to \$200 applies for non-compliance. Physical rehabilitation day limit is combined in and out-of-network 30 days.
	<u>Habilitation services</u>	No Charge for Inpatient Hospital.	30% <u>Coinsurance</u> for Inpatient Hospital.	
	<u>Skilled nursing care</u>	No Charge for Inpatient Facility.	30% <u>Coinsurance</u> for Inpatient Facility.	Requires pre-approval; 30% cutback penalty up to \$200 applies for non-compliance. Out-of-network inpatient skilled nursing facility day limit is limited to 60 days.

* For more information about limitations and exceptions, see the plan or policy document at [INSERT GROUP URL HERE WHERE THE SPD IS LOADED]

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)	
	<u>Durable medical equipment</u>	No Charge.	30% <u>Coinsurance</u> .	Requires pre-approval; 30% cutback penalty up to \$200 applies for non-compliance.
	<u>Hospice services</u>	No Charge for Inpatient Facility.	30% <u>Coinsurance</u> for Inpatient Facility.	Requires pre-approval; 30% cutback penalty up to \$200 applies for non-compliance.
If your child needs dental or eye care	Children's eye exam	No Charge for Office.	Not Covered.	In-network routine vision exam is limited to 1 visit.
	Children's glasses	No Charge.	Not Covered.	In-network routine vision hardware dollar amount is limited to every 2 years.
	Children's dental check-up	Not Covered.	Not Covered.	———none———

* For more information about limitations and exceptions, see the plan or policy document at [INSERT GROUP URL HERE WHERE THE SPD IS LOADED]

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
- 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, only as described in our Medical Policy (Visit limits apply)
- Bariatric surgery
- Chiropractic care
- Infertility treatment (Diagnostic Services Only)
- Private-duty nursing
- 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: 1-800-355-BLUE (2583) or visit www.Horizonblue.com. 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 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 <u>plan's</u> overall <u>deductible</u>	\$0.00
■ <u>Specialist Copayment</u>	\$10.00
■ Hospital (facility) <u>Coinsurance</u>	0%
■ Other <u>Coinsurance</u>	0%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$30.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$70.00
The total Peg would pay is	\$100.00

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0.00
■ <u>Specialist Copayment</u>	\$10.00
■ Hospital (facility) <u>Coinsurance</u>	0%
■ Other <u>Coinsurance</u>	0%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$80.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$3,500.00
The total Joe would pay is	\$3,580.00

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0.00
■ <u>Specialist Copayment</u>	\$10.00
■ Hospital (facility) <u>Coinsurance</u>	0%
■ Other <u>Coinsurance</u>	0%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$100.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$40.00
The total Mia would pay is	\$140.00

The plan would be responsible for the other costs of these EXAMPLE covered services.



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 (including limited English proficiency and primary language), age, disability, pregnancy, gender identity, sex, sexual orientation, sex characteristics or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon provides language assistance services and appropriate auxiliary aids and services at no cost 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 1-800-355-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, 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 has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin (including limited English proficiency and primary language), 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

If you are not a Horizon member, you may contact Section 1557 Coordinator by calling 1-866-660-6528 (TTY 711) or by writing to Horizon BCBSNJ's Civil Rights Coordinator at the above-referenced address. 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><https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> opens a dialog window, 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.

Notice of Availability

If you speak English, free language assistance services and auxiliary aids are available to provide information in accessible formats. Call the number on the back of your member ID card for help.

Si habla español, hay servicios gratuitos de asistencia lingüística y ayudas auxiliares disponibles para proporcionar información en formatos accesibles. Llame al número que figura en el reverso de su tarjeta de identificación de miembro para obtener ayuda.

如果您說中文，我們提供免費的語言協助服務和輔助工具，以無障礙格式提供資訊。請撥打您的會員 ID 卡背面的電話號碼尋求協助。

한국어를 사용하시는 경우, 무료 언어 지원 서비스 및 보조 기구를 통해 접근 가능한 형식으로 정보를 제공받을 수 있습니다. 도움이 필요하시면 가입자 ID 카드 뒷면에 있는 번호로 전화하시기 바랍니다.

Se fala português, estão disponíveis serviços de assistência linguística e auxiliares gratuitos para fornecer informações em formatos acessíveis. Telefone para o número no verso do seu cartão de identificação de associado para obter ajuda.

જો તમે ગુજરાતી બોલતા હોવ, તો સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે નિ:શુલ્ક ભાષા સહાયતા સેવાઓ અને પૂરડ સહાયક ઉપલબ્ધ છે. મદદ માટે તમારા સભ્ય આઈડી કાર્ડની પાછળના નંબર પર કોલ કરો.

Jeśli posługujesz się językiem polski, dostępne są bezpłatne usługi wsparcia językowego i materiały pomocnicze w celu przekazania informacji w przystępnym formacie. Aby uzyskać pomoc, zadzwoń pod numer podany na odwrocie identyfikacyjnej karty członkowskiej.

Se parlate italiano, sono disponibili servizi gratuiti di assistenza linguistica e ausili aggiuntivi per fornire informazioni in formati accessibili. Chiamate il numero sul retro della Vostra tessera identificativa per ricevere assistenza.

إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية المجانية والمساعدات الإضافية لتوفير المعلومات بصيغ يسهل الوصول إليها. اتصل بالرقم الموجود على ظهر بطاقة هوية العضو للحصول على المساعدة.

Kung nagsasalita ka ng Tagalog, handang magamit ang mga libreng tulong na serbisyo sa wika at mga auxiliary na tulong para magbigay ng impormasyon sa mga naa-access na format. Tawagan ang numero sa likod ng iyong kard ng pagkakakilanlan bilang miyembro para sa tulong.

Если вы говорите на Русский язык, мы готовы бесплатно предоставить услуги переводчика и вспомогательные средства для получения информации в доступных форматах. Для получения помощи позвоните по номеру, указанному на обратной стороне вашей карточки участника.

Si w pale Kreyòl Ayisyen, sèvis asistans lang gratis ak èd oksilyè disponib pou bay enfòmasyon nan fòma ki aksesib. Rele nimewo ki sou do kat manm ou a pou èd.

यदि आप हिंदी बोलते हैं, तो सुलभ प्रारूपों में जानकारी प्रदान करने के लिए नि:शुल्क भाषा सहायता सेवाएं और सहायक साधन उपलब्ध हैं। मदद के लिए अपने सदस्य आईडी कार्ड के पीछे दिए गए नंबर पर कॉल करें।

Nếu bạn nói tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí và công cụ hỗ trợ để cung cấp thông tin ở các định dạng có thể truy cập. Hãy gọi số điện thoại ở mặt sau thẻ nhận dạng thành viên của bạn để được trợ giúp.

Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition, ainsi que des outils auxiliaires fournissant des informations dans des formats accessibles. Pour recevoir de l'aide, appelez le numéro indiqué au dos de votre carte de membre.

اگر آپ اردو بولتے ہیں، تو مفت زبان کی مدد کی خدمات اور معاون امداد ایک قابل رسائی شکل میں معلومات کی فراہمی کے لیے دستیاب ہیں۔ مدد کے لیے اپنے ممبر آئی ڈی کارڈ کی پشت پر موجود نمبر پر کال کریں۔

আপনি যদি বাংলায় ভাষায় কথা বলেন, তাহলে সহজলভ্য ফরম্যাটে তথ্য প্রদানের জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা ও সহায়ক উপকরণ উপলব্ধ রয়েছে। সাহায্যের জন্য আপনার সদস্য আইডি কার্ডের পিছনে দেওয়া নম্বরে কল করুন।

ECNA0023235 (0125)

Advantage EPO Design 1 Monmouth County



Benefit	In-Network Benefits Only (Includes Bluecard network)
Benefit Period	Calendar Year
Deductible	
Individual	None
Family	None
Coinsurance	100%
Maximum Out of Pocket	
Individual	\$2,500
Family	\$5,000
Maximum Out of Pocket is based on the plan year. The deductible plus coinsurance and copays apply to the Maximum Out of Pocket. Charges from non-participating providers do not apply towards the Maximum Out of Pocket.	
Benefit Period Maximum	Unlimited
Lifetime Maximum	Unlimited
Precertification Penalty	None
Primary Care Physician Selection	Not Required
Doctor's Office Visits	
Primary Care Office Visit A primary care physician is a general or family practitioner, internist or pediatrician	100% after \$20 copay
Specialist Office Visit	100% after \$40 copay A referral is not required to visit a specialist.
Maternity Visits	100% after \$40 copay Copay applies to 1st visit only Dependent children are ineligible for Maternity/Obstetrical Benefits.
Allergy Testing and Treatment	100% Note: A copay will only apply when an office visit is billed.
Preventive Care	
Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostate Cancer Screening, Colorectal Screening, Immunizations	100%
Well Child Exams	100%
Well Child Immunizations and Lead Screening	100%
Diagnostic Procedures	
Laboratory	100% in office setting or Labcorp 100% in outpatient facility
Outpatient X-ray/Radiology Services	100% in office setting 100% in outpatient facility
CT/CTA Scans, Pet Scans, MRIs/MRAs, Nuclear Medicine studies (including Nuclear Cardiology) require prior authorization. The ordering physician should request the prior authorization by calling eviCore healthcare at 1-866-496-6200 and providing the necessary clinical information. Once the authorization number is received, the member may call eviCore healthcare at 1-866-969-1234 to schedule an appointment.	
<i>Note: Managed Care members can call 1-866-969-1234 to obtain a confirmation number for non-Advanced Imaging diagnostic procedures. Confirmation numbers from eviCore healthcare replace the need for a paper referral.</i>	
Hospital Care	
Inpatient Admission (including maternity)	100% after \$100 copay per day (up to 5 days)
Room and Board	100%
Pre-admission Testing	100%
Surgery in Hospital	100%
Inpatient Physician Services	100%
Outpatient Dept. Services	100%
Emergency Care	



Emergency Room	100% after \$100 facility copay (waived if admitted) Emergent Use Only. Non-Emergent use is not covered.
Ambulance	100% (When Medically Necessary)

Advantage EPO Design 1 Monmouth County



Outpatient Surgery	
Hospital Outpatient Surgery	100% after \$100 copay
Surgery in an Ambulatory SurgiCenter	100% after \$100 copay
Mental Health Services	
Inpatient	100% after \$100 copay per day (up to 5 days)
Outpatient department	100%
Office setting	100% after \$40 copay
Substance Abuse Services	
Inpatient	100% after \$100 copay per day (up to 5 days)
Outpatient department	100%
Office setting	100% after \$40 copay
Alcohol Abuse Services	
Inpatient	100% after \$100 copay per day (up to 5 days)
Outpatient department	100%
Office setting	100% after \$40 copay
	Inpatient and Outpatient Mental Health/Substance Abuse/Alcoholism Services must be coordinated through Horizon Behavioral Health at 1-800-626-2212.
Other Services	
Acupuncture	Not covered
Diabetic Education	100% after \$20 or \$40 copay
Diabetic Supplies	100%
Durable Medical Equipment	100%
Orthotics and Prosthetics (Per NJ mandate)	100%
Home Health Care	100%
Hospice Care	100%
	100% after copayment in office setting 100% in outpatient facility Limited to 4 egg retrievals per lifetime
Infertility (including in-vitro fertilization)	
Physical Rehabilitation Facility Inpatient Services	100% Limited to 60 days per benefit period
	100%
Private Duty Nursing	Limited to 30 visits per benefit period (8-hour shifts)
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after office copayment 30 visit maximum per therapy, per benefit period
Skilled Nursing Facility/Extended Care Center	100% Limited to 100 days per benefit period
Therapeutic Manipulation (Chiropractic Care)	100% after \$40 copay 25 visit maximum per benefit period
Vision - Routine Eye Exam	100% after \$40 copay
Vision Hardware	\$50 every 2 years with discount through Davis Vision vendors
Prescription Drugs	Covered under a freestanding prescription program
Eligibility	Dependent children, including full-time students, are covered until the end of the Month in which they reach the age of 26. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to the age of 26.

Advantage EPO Design 1

Monmouth County



Prior Authorization	Some services/procedures require prior authorization. For a complete list, contact our customer service number at 1-800-355-BLUE (2583) or refer to our website at www.HorizonBlue.com .
24/7 Nurse Line	24/7 Nurse Line is a health information service that includes a toll free 24 hour health information line staffed by registered nurses. 24/7 Nurse Line nurses do not diagnose or recommend any treatment. Instead, they provide the member with the necessary health information needed to make informed medical decisions. This helps members determine if their health ailment requires a doctor's visit.

The Advantage EPO plans cover eligible expenses rendered by providers in Horizon's Managed Care network. When you utilize participating providers, you generally only pay your copayment and any applicable in-network coinsurance or deductible. No benefits are available out-of-network, except in emergency situations.

This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract. Please refer to your benefit booklet for more information.

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Three Penn Plaza East, Newark, New Jersey 07105



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 www.HorizonBlue.com/members or by calling 1-800-355-BLUE(2583). If you do not currently have coverage with Horizon BCBSNJ you can view a sample policy here, HorizonBlue.com/sample-benefit-booklets. 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.ccio.cms.gov or call 1-800-355-BLUE(2583) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For in-network Health <u>providers</u> \$2,500.00 Individual/\$5,000.00 Family. Aggregate Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	This plan does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.HorizonBlue.com or call 1-800-355-BLUE(2583) for a list of network <u>providers</u> . Benefits provided by in- <u>network providers</u> and BlueCard PPO <u>providers</u> are at the in-network level of benefits.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20.00 <u>Copayment</u> per visit.	Not Covered.	—none—
	<u>Specialist</u> visit	\$40.00 <u>Copayment</u> per visit.	Not Covered.	
	<u>Preventive care/screening</u> /immunization	No Charge.	Not Covered.	One per calendar year. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge for Outpatient Hospital, Independent Laboratory, Office.	Not Covered.	—none—
	Imaging (CT/PET scans, MRIs)	No Charge for Outpatient Hospital.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance.
If you need drugs to treat your illness or condition	Generic drugs	Not Covered.	Not Covered.	—none—
	Preferred brand drugs	Not Covered.	Not Covered.	
	Non-preferred brand drugs	Not Covered.	Not Covered.	
	<u>Specialty drugs</u>	Not Covered.	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200.00 <u>Copayment</u> per visit for Outpatient Hospital. \$100.00 <u>Copayment</u> per visit for Ambulatory Surgical Center.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review.
	Physician/surgeon fees	No Charge for Outpatient Hospital, Ambulatory Surgical Center.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review.

*For more information about limitations and exceptions, see the plan or policy document at [\[INSERT GROUP URL HERE WHERE THE SPD IS LOADED\]](#).

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 immediate medical attention	<u>Emergency room care</u>	\$100.00 <u>Copayment</u> per visit.		The listed benefits apply only to true medical emergencies and accidental injuries rendered in the emergency room only.
	<u>Emergency medical transportation</u>	No Charge.	Not Covered.	——none——
	<u>Urgent care</u>	\$40.00 <u>Copayment</u> per visit.	Not Covered.	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100.00 <u>Copayment</u> per day for Inpatient Hospital.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. <u>Copayment</u> per day applies for 5 days per admission. In-network inpatient separation period is limited to 90 days.
	Physician/surgeon fees	No Charge for Inpatient Hospital.	Not Covered.	——none——
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge for Outpatient Hospital.	Not Covered.	The Integrated System of Care (ISC) program is available to members with a serious mental illness or substance use disorder. Reimbursement for ISC services requires a contracted ISC <u>provider</u> . Locate a <u>provider</u> at www.Horizonblue.com/member-ISC .
	Inpatient services	\$100.00 <u>Copayment</u> per day for Inpatient Hospital.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. <u>Copayment</u> per day applies for 5 days per admission. In-network inpatient separation period is limited to 90 days.

*For more information about limitations and exceptions, see the plan or policy document at [\[INSERT GROUP URL HERE WHERE THE SPD IS LOADED\]](#).

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 are pregnant	Office visits	\$20.00 <u>Copayment</u> per visit for Office. \$40.00 <u>Copayment</u> per visit for Specialist.	Not Covered.	Not covered - for child. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound).
	Childbirth/delivery professional services	No Charge for Inpatient Hospital.	Not Covered.	Not covered - for child.
	Childbirth/delivery facility services	\$100.00 <u>Copayment</u> per day for Inpatient Hospital.	Not Covered.	Not covered - for child. <u>Copayment</u> per day applies for 5 days per admission In-network inpatient separation period is limited to 90 days.
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance.
	<u>Rehabilitation services</u>	No Charge for Inpatient Hospital.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. In-network days are limited to 60 days.
	<u>Habilitation services</u>	No Charge for Inpatient Hospital.	Not Covered.	
	<u>Skilled nursing care</u>	No Charge for Inpatient Facility.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. In-network inpatient skilled nursing facility days are limited to 100 days.
	<u>Durable medical equipment</u>	No Charge.	Not Covered.	Prior authorization required for DME purchases over \$500. 20% penalty applies for non-compliance.
	<u>Hospice services</u>	No Charge for Inpatient Facility.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance.

*For more information about limitations and exceptions, see the plan or policy document at [\[INSERT GROUP URL HERE WHERE THE SPD IS LOADED\]](#).

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 your child needs dental or eye care	Children's eye exam	\$40.00 Copayment for Specialist.	Not Covered.	In-network routine vision exam for a child is limited to 1 visit.
	Children's glasses	\$50.00 Reimbursement.	Not Covered.	In-network routine vision hardware dollar amount is every 2 years.
	Children's dental check-up	Not Covered.	Not Covered.	—————none—————

*For more information about limitations and exceptions, see the plan or policy document at [\[INSERT GROUP URL HERE WHERE THE SPD IS LOADED\]](#).

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.)

- Acupuncture
- Long Term Care
- Routine foot care
- Cosmetic Surgery
- Most coverage provided outside the United States
- Weight Loss Programs
- Dental care
- Non-emergency care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Hearing Aids (Only covered for Members age 15 or younger)
- Private-duty nursing
- Chiropractic care
- Infertility treatment (Diagnostic Services Only)
- Routine eye care (Adult)

*For more information about limitations and exceptions, see the plan or policy document at [\[INSERT GROUP URL HERE WHERE THE SPD IS LOADED\]](#).

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: 1-800-355-BLUE (2583) or visit www.Horizonblue.com. 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 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.

*For more information about limitations and exceptions, see the plan or policy document at [\[INSERT GROUP URL HERE WHERE THE SPD IS LOADED\]](#).

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 <u>plan's</u> overall <u>deductible</u>	\$0.00
■ <u>Specialist Copayment</u>	\$40.00
■ Hospital (facility) <u>Coinsurance</u>	0%
■ Other <u>Coinsurance</u>	0%

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:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$200.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$70.00
The total Peg would pay is	\$270.00

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0.00
■ <u>Specialist Copayment</u>	\$40.00
■ Hospital (facility) <u>Coinsurance</u>	0%
■ Other <u>Coinsurance</u>	0%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$200.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$3,500.00
The total Joe would pay is	\$2,500.00

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0.00
■ <u>Specialist Copayment</u>	\$40.00
■ Hospital (facility) <u>Coinsurance</u>	0%
■ Other <u>Coinsurance</u>	0%

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:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$200.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$40.00
The total Mia would pay is	\$240.00

The plan would be responsible for the other costs of these EXAMPLE covered services.



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 (including limited English proficiency and primary language), age, disability, pregnancy, gender identity, sex, sexual orientation, sex characteristics or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon provides language assistance services and appropriate auxiliary aids and services at no cost 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 1-800-355-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, 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 has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin (including limited English proficiency and primary language), 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

If you are not a Horizon member, you may contact Section 1557 Coordinator by calling 1-866-660-6528 (TTY 711) or by writing to Horizon BCBSNJ's Civil Rights Coordinator at the above-referenced address. 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> <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> opens a dialog window, 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.



Notice of Availability

If you speak English, free language assistance services and auxiliary aids are available to provide information in accessible formats. Call the number on the back of your member ID card for help.

Si habla español, hay servicios gratuitos de asistencia lingüística y ayudas auxiliares disponibles para proporcionar información en formatos accesibles. Llame al número que figura en el reverso de su tarjeta de identificación de miembro para obtener ayuda.

如果您說中文，我們提供免費的語言協助服務和輔助工具，以無障礙格式提供資訊。請撥打您的會員 ID 卡背面的電話號碼尋求協助。

한국어를 사용하시는 경우, 무료 언어 지원 서비스 및 보조 기구를 통해 접근 가능한 형식으로 정보를 제공받을 수 있습니다. 도움이 필요하시면 가입자 ID 카드 뒷면에 있는 번호로 전화하시기 바랍니다.

Se fala português, estão disponíveis serviços de assistência linguística e auxiliares gratuitos para fornecer informações em formatos acessíveis. Telefone para o número no verso do seu cartão de identificação de associado para obter ajuda.

જો તમે ગુજરાતી બોલતા હોવ, તો સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે નિ:શુલ્ક ભાષા સહાય સેવાઓ અને પૂરઠા સહાયો ઉપલબ્ધ છે. મદદ માટે તમારા સભ્ય આઈડી કાર્ડની પાછળના નંબર પર કોલ કરો.

Jeśli posługujesz się językiem polski, dostępne są bezpłatne usługi wsparcia językowego i materiały pomocnicze w celu przekazania informacji w przystępnym formacie. Aby uzyskać pomoc, zadzwoń pod numer podany na odwrocie identyfikacyjnej karty członkowskiej.

Se parlate italiano, sono disponibili servizi gratuiti di assistenza linguistica e ausili aggiuntivi per fornire informazioni in formati accessibili. Chiamate il numero sul retro della Vostra tessera identificativa per ricevere assistenza.

إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية المجانية والمساعدات الإضافية لتوفير المعلومات بصيغ يسهل الوصول إليها. اتصل بالرقم الموجود على ظهر بطاقة هوية العضو للحصول على المساعدة.

Kung nagsasalita ka ng Tagalog, handang magamit ang mga libreng tulong na serbisyo sa wika at mga auxiliary na tulong para magbigay ng impormasyon sa mga naa-access na format. Tawagan ang numero sa likod ng iyong kard ng pagkakakilanlan bilang miyembro para sa tulong.

Если вы говорите на Русский язык, мы готовы бесплатно предоставить услуги переводчика и вспомогательные средства для получения информации в доступных форматах. Для получения помощи позвоните по номеру, указанному на обратной стороне вашей карточки участника.

Si w pale Kreyòl Ayisyen, sèvis asistans lang gratis ak èd oksilyè disponib pou bay enfòmasyon nan fòma ki aksesib. Rele nimewo ki sou do kat manm ou a pou èd.

यदि आप हिंदी बोलते हैं, तो सुलभ प्रारूपों में जानकारी प्रदान करने के लिए नि:शुल्क भाषा सहायता सेवाएं और सहायक साधन उपलब्ध हैं। मदद के लिए अपने सदस्य आईडी कार्ड के पीछे दिए गए नंबर पर कॉल करें।

Nếu bạn nói tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí và công cụ hỗ trợ để cung cấp thông tin ở các định dạng có thể truy cập. Hãy gọi số điện thoại ở mặt sau thẻ nhận dạng thành viên của bạn để được trợ giúp.

Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition, ainsi que des outils auxiliaires fournissant des informations dans des formats accessibles. Pour recevoir de l'aide, appelez le numéro indiqué au dos de votre carte de membre.

اگر آپ اردو بولتے ہیں، تو مفت زبان کی مدد کی خدمات اور معاون امداد ایک قابل رسائی شکل میں معلومات کی فراہمی کے لیے دستیاب ہیں۔ مدد کے لیے اپنے میمبر آئی ڈی کارڈ کی پشت پر موجود نمبر پر کال کریں۔

আপনি যদি বাংলায় ভাষায় কথা বলেন, তাহলে সহজলভ্য ফরম্যাটে তথ্য প্রদানের জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা ও সহায়ক উপকরণ উপলব্ধ রয়েছে। সাহায্যের জন্য আপনার সদস্য আইডি কার্ডের পিছনে দেওয়া নম্বরে কল করুন।

ECNA0023235 (0125)

Monmouth County Benefit Plan Comparison

PRODUCT DESIGN	DIRECT ACCESS		EPO	OMNIA	
	In-Network	Out-of-Network		Tier 1	Tier 2
Deductible	\$0 in-network	\$400/\$800	\$0	\$0	\$1,500/\$3,000
Coinsurance	100%	70%	100%	100%	80%
MOOP (Max Out of Pocket)	\$5,000 individual/ \$10,000 family	\$5,000 individual/ \$10,000 family	\$2,500 individual/ \$5,000 family	\$2,500/\$5000	\$4,500/\$9000
PCP copay	\$10	70% after deductible	\$20	\$5	\$20
Specialist copay	\$10	70% after deductible	\$40	\$15	\$30
ER copay	\$100	\$100	\$100	\$100	\$100
Inpatient Hospital (per day)	100%	70% after Deductible	\$100 Copay (Max 5 Days)	\$150 Copay	Deductible / Coinsurance
Outpatient Hospital or Ambulatory Center Surgery	100%	70% after Deductible	100% after \$100 Copay	\$150 Copay	Deductible / Coinsurance
Out-of-Network Care	Yes	Yes	No Out of Network	No Out of Network	No Out of Network
Pharmacy Copays (Retail) 30 Day	\$5 Generic (no out of network) \$20 Brand (no out of network)		\$5 Retail (Generic) \$20 Retail (Preferred Brand) \$35 Retail Non-preferred Brand	\$5 Generic \$20 Brand	
Pharmacy Copays (Mail) 90 Day	\$0 Generic (no out of network) \$15 Brand (no out of network)		\$15 Mail Generic \$50 Mail Preferred Brand \$87.50 Non-Preferred Brand	\$0 Generic \$15 Brand	
Pharmacy MOOP	\$2000 Individual / \$4000 Family		\$2000 Individual / \$4000 Family	\$2000 Individual / \$4000 Family	

Monmouth County Health Plan Comparison			
Scenario	Omnia	Direct Access	EPO
Mary Monmouth has a sore throat and goes to her primary care physician (PCP). She is given a throat culture and diagnosed with strep. She is prescribed antibiotics.	If Mary's PCP is an Omnia Tier 1 provider, Mary will be responsible for her co-payment of \$5. If Mary's PCP is an Omnia Tier 2 provider, she will be responsible for a co-pay of \$20. If the prescribed antibiotics are generic, Mary will have a \$5 copay for her medication. Total out of pocket cost of care: Tier 1: \$10 and Tier 2: \$25	If Mary's PCP is an in-network provider, she will be responsible for a \$10 copay. If the prescribed antibiotics are generic, Mary will have a \$5 copay for her medication. Total out of pocket cost of care: \$15	If Mary's PCP is an in-network provider, she will be responsible for a \$20 copay. If the prescribed antibiotics are generic, Mary will have a \$5 copay for her medication. Total out of pocket cost of care: \$25
James Doe visited an orthopedic specialist office after injuring his wrist over a weekend. He received x-rays and received a soft removable splint.	If the specialist is a Tier 1 provider, James will be responsible for a copay of \$15. If the specialist is a Tier 2 provider, James will be responsible for a \$30 copay. In-office x-rays are covered 100% for both Tier 1 and 2. The removable soft splint is not covered under durable medical equipment. However, if James has FSA, he can use those funds to purchase the splint.	If the specialist is an in-network provider, James will be responsible for a copay of \$10. In-office x-rays are covered 100%. The removable soft splint is not covered under durable medical equipment. However, if James has FSA, he can use those funds to purchase the splint.	If the specialist is an in-network provider, James will be responsible for a copay of \$40. In-office x-rays are covered 100%. The removable soft splint is not covered under durable medical equipment. However, if James has FSA, he can use those funds to purchase the splint.
Jane Smith was on vacation out of state and went to an urgent care center for a stomach virus.	Since Jane is out of state, the participating urgent care facility is considered a Tier 2 provider. Jane will be responsible for a \$30 copay.	If Jane goes to a participating facility which accepts a PPO plan, it is considered an in-network provider. Jane would be responsible for a \$10 copay.	If Jane goes to a participating facility which accepts a EPO plan, it is considered an in-network provider. Jane would be responsible for a \$40 copay.
Amy March fell while visiting family and went to an emergency room.	If Amy went to a Tier 1 or 2 hospital and was not admitted, her copay for the emergency room is \$100.	If Amy went to an in-network or out-of-network hospital but was not admitted, she would be responsible for a \$100 copay to the emergency room.	If Amy went to an in-network hospital and was not admitted, she would be responsible for a \$100 copay to the emergency room.
Ethan Hunt needed emergency care while out of state. He was admitted to the hospital and stayed for three days.	Ethan used the Horizon Doctor Finder to find a hospital which accepts a PPO plan as a Tier 2 provider. Since Ethan was admitted, the emergency room copay was waived. However, Ethan was responsible for 20% of the total bill after meeting his deductible. The cost of the hospital stay exceeded his maximum out of pocket of \$9,000. His plan covered the remaining balance.	Ethan was unable to locate an in-network facility. The emergency room services were covered at 100%. Since Ethan was admitted, the emergency room copay was waived. Ethan was responsible for 30% of the total bill as an in-patient after meeting his deductible. The cost of the hospital stay exceeded his maximum out of pocket of \$10,000. His plan covered the remaining balance.	Ethan found a facility which accepts EPO coverage. Since Ethan was admitted, the emergency room copay was waived. Ethan owed a \$100 copay to the hospital for each day of his stay.

Monmouth County Health Plan Comparison			
Scenario	Omnia	Direct Access	EPO
Jay Gatsby needs orthotics.	Orthotics are covered Tier 1 at 100% after a \$5 copay. Tier 2 is covered 100% after \$20 copay.	Orthotics are not covered.	Orthotics are covered at 100% after a \$20 copay.
Marcia Brady, dependent of employee Carol Brady, attends college out of state. Marcia feels ill and visits a general practitioner.	Since Marcia is out of state, if the practitioner is in-network, it will be considered a Tier 2 provider. Marcia will be responsible for a \$20 copay. Carol will later receive an explanation of benefits for the services Marcia received.	If Marcia goes to a participating provider which accepts a PPO plan, it is considered in-network. Marcia will be responsible for a \$10 copay. If Marcia goes to an out-of-network provider, she will be responsible for 30% of the whole bill after meeting the deductible. The amount billed will go towards meeting the Maximum out of Pocket for the plan year. In either case, Carol will later receive an explanation of benefits for the services Marcia received.	If Marcia goes to a participating provider which accepts the EPO plan, she will be responsible for a \$20 copay. Carol will later receive an explanation of benefits for the services Marcia received.
Bruce Banner receives mental health services in an office setting.	If Bruce uses a Tier 1 provider, he will be responsible for a \$15 copay. If Bruce uses a Tier 2 provider, he will be responsible for a \$30 copay.	If Bruce uses an in-network provider, he will be responsible for a \$10 copay. If Bruce uses an out-of-network provider, he will be responsible for 30% of the total bill once he has met his deductible. If he has single coverage, his out-of-network deductible is \$400 per plan year.	If Bruce uses an in-network provider, the services will be covered at 100%, and he will be responsible for a \$40 copay.
Peter Parker needs physical therapy.	If Peter uses a Tier 1 facility, he will be responsible for a \$5 copay per session. If Peter uses a Tier 2 facility, he will be responsible for a \$20 copay per session. Both Tier 1 and 2 have a maximum of 30 visits per plan year.	If Peter uses an in-network facility, the services are covered at 100%. If Peter uses an out-of-network facility, he will be responsible for 30% of the total bill once he has met his deductible. If he has single coverage, his out-of-network deductible is \$400 per plan year. Therapy visits are limited to 60 visits per plan year for both in and out of network facilities combined.	If Peter uses an in-network provider, the services are covered at 100% after the office copayment. Therapy visits are limited to 30 visits per plan year.
Lois Lane needs chiropractic care.	If Lois uses a Tier 1 provider, she will be responsible for a \$15 copay per visit. If she uses a Tier 2 provider, she will be responsible for a \$20 copay per visit. There is a limit of 30 visits per plan year.	If Lois uses an in-network provider, she will be responsible for a \$10 copay. If she uses an out-of-network provider, she will be responsible for 30% of the total bill once she has met his deductible. If she has single coverage, her out-of-network deductible is \$400 per plan year. There is a limit of 20 visits per plan year.	If Lois uses an in-network provider, the services are covered at 100% after \$40 copay per visit. There is a limit of 25 visits per plan year.



County of Monmouth

Your prescription copayments at a glance

Show this to your doctor and discuss ways to pay less for your medications.

If you need a long-term medication, you may pay less over time by using Express Scripts Pharmacy®. We'll deliver up to a 90-day supply right to you and **standard shipping is free**. To learn more about your benefit, log in at express-scripts.com and select Benefits Overview from the drop-down menu under Benefits. First-time visitors, please take a moment to register before using this service.

County of Monmouth

Retail	Retail
\$5 Generic	\$20 Brand
Mail	Mail
\$0 Generic	\$15 Brand
Specialty	Specialty
Same as mail	Same as mail

County of Monmouth - Advantage EPO

Retail	Retail
\$5 Generic	\$20 Brand/\$35 Non-Preferred Brand
Mail	Mail
\$15 Generic	\$50 Brand/\$87.50 Non-Preferred Brand
Specialty	Specialty
Same as mail	Same as mail

KEEP THIS INFORMATION

**For more information about your benefit,
log in at express-scripts.com**

or call Member Services toll free at (800) 711-0917

Note: If you request a brand-name medication when a generic equivalent is available, you will pay the applicable copayment, plus the difference in cost between the brand and the generic.

For short-term prescriptions, such as antibiotics, use a participating retail pharmacy

As a member, you can go to any of nearly 60,000 retail pharmacies, including most major drugstores. Just ask your retail pharmacy if it's in our network. You can also log in at express-scripts.com and select **Find a Pharmacy** from the menu under **Prescriptions**.

Use generics and preferred medications

If you are taking a medication that's not on the preferred list, ask your doctor to consider prescribing a lower-cost generic or preferred brand-name drug. To find out which drugs are preferred, log in at express-scripts.com and select **Price a Medication** from the **Prescriptions** menu. Enter your drug's name and view cost and coverage information on the results page.

Prior authorization: When is a coverage review necessary?

Some medications are covered only after you first receive approval through a coverage review (prior authorization). This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective.

During this review, Express Scripts asks your doctor for more information than what is on the prescription before the medication may be covered under your plan. To find out whether a medication requires a coverage review, log in at express-scripts.com anytime, select **Price a Medication** under **Prescriptions**, and search for your medication. On the pricing results page, select "View coverage notes" to see coverage details.

Drug Quantity Management: The right medication in the right amount

When you are prescribed certain medications that are a part of a drug quantity management (DQM) program, Express Scripts will make sure you get it in the amount – or quantity – considered safe and effective by the U.S. Food & Drug Administration (FDA)

You get the right amounts for good health and the health of your family. There is nothing that you need to do differently when you submit a prescription for a medication in a DQM program – you'll get the recommended amount, which should last until it's time for a refill.

Step Therapy: Step therapy is in place to make sure you get safe and proven-effective medication for your condition – at the lowest possible cost to you and your plan sponsor

Here's how step therapy works:

A panel of independent licensed physicians, pharmacists and other medical experts work with Express Scripts to recommend medications for the step therapy program.

First-step medicines – Generic and lower-cost brand-name medications. They are proven to be safe and effective, as well as affordable. Step therapy suggests that you should try these medications first because in most cases they provide the same health benefit as more expensive drugs, but at a lower cost.

Second-step medicines – Typically brand-name medications. They are best suited for patients who do not respond to first-line medicines.

The first time you try to fill a prescription that isn't for a first-step medicine, your pharmacist should explain that step therapy asks you to try a first-step medicine before a second-step drug. Only your doctor can change your current prescription to a first-step medicine covered by your program.

To get a first-step medicine that your plan covers, ask your pharmacist to call your doctor and ask for a new prescription. If it's easier, you could call your doctor to ask for a new prescription.

Livongo: Diabetes Remote Monitoring

Under this program, participating members receive a welcome kit, which includes Livongo's connected glucose meter, a lancing device, 300 test strips, 300 lancets, and a carrying case. Members also receive:

- Unlimited test strips and lancets shipped to their front door
- Coaching by phone, by text message, and through the Livongo Certified Diabetes Educators
- Online access to blood glucose readings, along with graphs and insights

Specialty medications: Get individualized service through Accredo

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Accredo, an Express Scripts specialty pharmacy, is composed of therapy-specific teams that provide an enhanced level of individual service to patients with special therapy needs.

Whether they're administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service. By ordering your specialty medications through Accredo, you can receive:

- Toll-free access to specialty-trained pharmacists and nurses 24 hours a day, 7 days a week
- Delivery of your medications within the United States, on a scheduled day, Monday through Friday, at no additional charge
- Most supplies, such as needles and syringes, provided with your medications
- Safety checks to help prevent potential drug interactions
- Refill reminders
- Up to a **90-day supply** of your specialty medication for just one copayment

SaveonSP: Specialty copay assistance program

SaveonSP is a copay assistance program for a selection of specialty medications where member copays will be reduced to \$0. Express Script's leverages existing Manufacturers' Copay Assistance programs to maximize savings and reduce overall plan and member costs. Please refer to the County's Benefits Intranet Page to view the list of medications.

Automatic refills: A convenient program for your long-term medications

When you refill certain home delivery prescriptions, you'll be asked whether you want to enroll. Once you enroll and are ready for a refill or renewal, your medications will automatically ship to you. Find out more about how automatic refills works by logging in at express-scripts.com.

Stretch your home delivery payments with the Extended Payment Program

Instead of paying in full up front, you'll be billed for the cost of your medications over three installments. You can enroll online.

We are here to help:

- For any questions or more information about your prescription plan ...
 - Log in at express-scripts.com or get the Express Scripts® mobile app at express-scripts.com/mobileapp
 - Call the Member Services number on the back of your card
- To speak to a pharmacist about your prescriptions ...
 - Call the Member Services number on the back of your card
- To register to receive your prescriptions by home delivery ...
 - Log in at express-scripts.com or use the mobile app
 - (Register using your member ID number.)

Express Scripts manages your prescription plan for your employer.

CRP2008_004251.1 LT2008_004251

Single Plan Contributions - January 2026 (per 24 pay periods)

Salary Range		C-78%	1.5%	Plan	Cost Per Pay	Annual EE Cost
Less than \$20,000.00		4.50%	\$12.50	H-Value	\$14.67	\$352.09
				Horizon DA	\$29.03	\$696.67
				IAA	\$45.16	\$1,083.75
				OMNIA	\$16.29	\$391.06
\$20,000.00 - \$24,999.99		5.50%	\$15.62	H-Value	\$17.93	\$430.33
				Horizon DA	\$35.48	\$851.49
				IAA	\$55.19	\$1,324.59
				OMNIA	\$19.91	\$477.96
\$25,000.00 - \$29,999.99		7.50%	\$18.75	H-Value	\$24.45	\$586.82
				Horizon DA	\$48.38	\$1,161.12
				IAA	\$75.26	\$1,806.26
				OMNIA	\$27.16	\$651.76
\$30,000.00 - \$34,999.99		10.00%	\$21.87	H-Value	\$32.60	\$782.42
				Horizon DA	\$64.51	\$1,548.16
				IAA	\$100.35	\$2,408.34
				OMNIA	\$36.21	\$869.02
\$35,000.00 - \$39,999.99		11.00%	\$25.00	H-Value	\$35.86	\$860.67
				Horizon DA	\$70.96	\$1,702.97
				IAA	\$110.38	\$2,649.17
				OMNIA	\$39.83	\$955.92
\$40,000.00 - \$44,999.99		12.00%	\$28.12	H-Value	\$39.12	\$938.91
				Horizon DA	\$77.41	\$1,857.79
				IAA	\$120.42	\$2,890.01
				OMNIA	\$43.45	\$1,042.82
\$45,000.00 - \$49,999.99		14.00%	\$31.25	H-Value	\$45.64	\$1,095.39
				Horizon DA	\$90.31	\$2,167.42
				IAA	\$140.49	\$3,371.68
				OMNIA	\$50.69	\$1,216.62
\$50,000.00 - \$54,999.99		20.00%	\$34.37	H-Value	\$65.20	\$1,564.85
				Horizon DA	\$129.01	\$3,096.31
				IAA	\$200.70	\$4,816.68
				OMNIA	\$72.42	\$1,738.03
\$55,000.00 - \$59,999.99		23.00%	\$37.50	H-Value	\$74.98	\$1,799.58
				Horizon DA	\$148.36	\$3,560.76
				IAA	\$230.80	\$5,539.18
				OMNIA	\$83.28	\$1,998.74
\$60,000.00 - \$64,999.99		27.00%	\$40.62	H-Value	\$88.02	\$2,112.54
				Horizon DA	\$174.17	\$4,180.02
				IAA	\$270.94	\$6,502.52
				OMNIA	\$97.76	\$2,346.34
\$65,000.00 - \$69,999.99		29.00%	\$43.75	H-Value	\$94.54	\$2,269.03
				Horizon DA	\$187.07	\$4,489.65
				IAA	\$291.01	\$6,984.19
				OMNIA	\$105.01	\$2,520.15
\$70,000.00 - \$74,999.99		32.00%	\$46.87	H-Value	\$104.32	\$2,503.76
				Horizon DA	\$206.42	\$4,954.10
				IAA	\$321.11	\$7,706.69
				OMNIA	\$115.87	\$2,780.85
\$75,000.00 - \$79,999.99		33.00%	\$50.00	H-Value	\$107.58	\$2,582.00
				Horizon DA	\$212.87	\$5,108.91
				IAA	\$331.15	\$7,947.52
				OMNIA	\$119.49	\$2,867.75
\$80,000.00 - \$94,999.99		34.00%	\$59.37	H-Value	\$110.84	\$2,660.24
				Horizon DA	\$219.32	\$5,263.73
				IAA	\$341.18	\$8,188.36
				OMNIA	\$123.11	\$2,954.65
\$95,000.00 and over		35.00%	\$59.38	H-Value	\$114.10	\$2,738.48
				Horizon DA	\$225.77	\$5,418.55
				IAA	\$351.22	\$8,429.19
				OMNIA	\$126.73	\$3,041.56

**If cost per pay is lower than the 1.5% rate, the 1.5% rate applies*

Employee Plus Plan Contributions - January 2026 (per 24 pay periods)

Salary Range		C-78%	1.5%	Plan	Cost Per Pay	Annual EE Cost
\$0.00	\$24,999.00	3.50%	\$15.62	H-Value	\$25.61	\$614.75
				Horizon DA	\$50.58	\$1,214.01
				IAA	\$76.35	\$1,832.43
				OMNIA	\$28.52	\$684.41
\$25,000.00	\$29,999.00	4.50%	\$18.75	H-Value	\$32.93	\$790.39
				Horizon DA	\$65.04	\$1,560.87
				IAA	\$98.17	\$2,355.98
				OMNIA	\$36.66	\$879.95
\$30,000.00	\$34,999.00	6.00%	\$21.87	H-Value	\$43.91	\$1,053.85
				Horizon DA	\$86.72	\$2,081.16
				IAA	\$130.89	\$3,141.30
				OMNIA	\$48.89	\$1,173.27
\$35,000.00	\$39,999.00	7.00%	\$25.00	H-Value	\$51.23	\$1,229.49
				Horizon DA	\$101.17	\$2,428.02
				IAA	\$152.70	\$3,664.85
				OMNIA	\$57.03	\$1,368.81
\$40,000.00	\$44,999.00	8.00%	\$28.12	H-Value	\$58.55	\$1,405.13
				Horizon DA	\$115.62	\$2,774.88
				IAA	\$174.52	\$4,188.40
				OMNIA	\$65.18	\$1,564.36
\$45,000.00	\$49,999.00	10.00%	\$31.25	H-Value	\$73.18	\$1,756.42
				Horizon DA	\$144.53	\$3,468.60
				IAA	\$218.15	\$5,235.50
				OMNIA	\$81.48	\$1,955.45
\$50,000.00	\$54,999.00	15.00%	\$34.37	H-Value	\$109.78	\$2,634.62
				Horizon DA	\$216.79	\$5,202.90
				IAA	\$327.22	\$7,853.26
				OMNIA	\$122.22	\$2,933.17
\$55,000.00	\$59,999.00	17.00%	\$37.50	H-Value	\$124.41	\$2,985.91
				Horizon DA	\$245.69	\$5,896.62
				IAA	\$370.85	\$8,900.36
				OMNIA	\$138.51	\$3,324.26
\$60,000.00	\$64,999.00	21.00%	\$40.62	H-Value	\$153.69	\$3,688.47
				Horizon DA	\$303.50	\$7,284.06
				IAA	\$458.11	\$10,994.56
				OMNIA	\$171.10	\$4,106.44
\$65,000.00	\$69,999.00	23.00%	\$43.75	H-Value	\$168.32	\$4,039.76
				Horizon DA	\$332.41	\$7,977.78
				IAA	\$501.74	\$12,041.66
				OMNIA	\$187.40	\$4,497.53
\$70,000.00	\$74,999.00	26.00%	\$46.87	H-Value	\$190.28	\$4,566.68
				Horizon DA	\$375.77	\$9,018.36
				IAA	\$567.18	\$13,612.31
				OMNIA	\$211.84	\$5,084.16
\$75,000.00	\$79,999.00	27.00%	\$50.00	H-Value	\$197.60	\$4,742.32
				Horizon DA	\$390.22	\$9,365.22
				IAA	\$588.99	\$14,135.86
				OMNIA	\$219.99	\$5,279.71
\$80,000.00	\$84,999.00	28.00%	\$53.12	H-Value	\$204.92	\$4,917.96
				Horizon DA	\$404.67	\$9,712.08
				IAA	\$610.81	\$14,659.41
				OMNIA	\$228.14	\$5,475.25
\$85,000.00	\$99,999.00	30.00%	\$62.50	H-Value	\$219.55	\$5,269.25
				Horizon DA	\$433.58	\$10,405.80
				IAA	\$654.44	\$15,706.51
				OMNIA	\$244.43	\$5,866.34
\$100,000.00	and over	35.00%	\$62.50	H-Value	\$256.14	\$6,147.46
				Horizon DA	\$505.84	\$12,140.10
				IAA	\$763.51	\$18,324.26
				OMNIA	\$285.17	\$6,844.07

Family Plan Contributions - Janauary 2026 (per 24 pay periods)

Salary Range		C-78%	1.5%	Plan	Cost Per Pay	Annual EE Cost
\$0.00	\$24,999.00	3.00%	\$15.62	H-Value	\$27.83	\$667.90
				Horizon DA	\$56.03	\$1,344.83
				IAA	\$74.97	\$1,799.24
				OMNIA	\$29.96	\$718.95
\$25,000.00	\$29,999.00	4.00%	\$18.75	H-Value	\$37.11	\$890.54
				Horizon DA	\$74.71	\$1,793.11
				IAA	\$99.96	\$2,398.99
				OMNIA	\$39.94	\$958.59
\$30,000.00	\$34,999.00	5.00%	\$21.87	H-Value	\$46.38	\$1,113.17
				Horizon DA	\$93.39	\$2,241.39
				IAA	\$124.95	\$2,998.74
				OMNIA	\$49.93	\$1,198.24
\$35,000.00	\$39,999.00	6.00%	\$25.00	H-Value	\$55.66	\$1,335.81
				Horizon DA	\$112.07	\$2,689.67
				IAA	\$149.94	\$3,598.49
				OMNIA	\$59.91	\$1,437.89
\$40,000.00	\$44,999.00	7.00%	\$28.12	H-Value	\$64.94	\$1,558.44
				Horizon DA	\$130.75	\$3,137.95
				IAA	\$174.93	\$4,198.24
				OMNIA	\$69.90	\$1,677.54
\$45,000.00	\$49,999.00	9.00%	\$31.25	H-Value	\$83.49	\$2,003.71
				Horizon DA	\$168.10	\$4,034.50
				IAA	\$224.91	\$5,397.73
				OMNIA	\$89.87	\$2,156.84
\$50,000.00	\$54,999.00	12.00%	\$34.37	H-Value	\$111.32	\$2,671.62
				Horizon DA	\$224.14	\$5,379.34
				IAA	\$299.87	\$7,196.98
				OMNIA	\$119.82	\$2,875.78
\$55,000.00	\$59,999.00	14.00%	\$37.50	H-Value	\$129.87	\$3,116.89
				Horizon DA	\$261.50	\$6,275.89
				IAA	\$349.85	\$8,396.47
				OMNIA	\$139.79	\$3,355.08
\$60,000.00	\$64,999.00	17.00%	\$40.62	H-Value	\$157.70	\$3,784.79
				Horizon DA	\$317.53	\$7,620.73
				IAA	\$424.82	\$10,195.72
				OMNIA	\$169.75	\$4,074.02
\$65,000.00	\$69,999.00	19.00%	\$43.75	H-Value	\$176.25	\$4,230.06
				Horizon DA	\$354.89	\$8,517.28
				IAA	\$474.80	\$11,395.21
				OMNIA	\$189.72	\$4,553.32
\$70,000.00	\$74,999.00	22.00%	\$46.87	H-Value	\$204.08	\$4,897.97
				Horizon DA	\$410.92	\$9,862.12
				IAA	\$549.77	\$13,194.46
				OMNIA	\$219.68	\$5,272.26
\$75,000.00	\$79,999.00	23.00%	\$50.00	H-Value	\$213.36	\$5,120.60
				Horizon DA	\$429.60	\$10,310.39
				IAA	\$574.76	\$13,794.20
				OMNIA	\$229.66	\$5,511.91
\$80,000.00	\$84,999.00	24.00%	\$53.12	H-Value	\$222.63	\$5,343.24
				Horizon DA	\$448.28	\$10,758.67
				IAA	\$599.75	\$14,393.95
				OMNIA	\$239.65	\$5,751.56
\$85,000.00	\$89,999.00	26.00%	\$56.25	H-Value	\$241.19	\$5,788.50
				Horizon DA	\$485.63	\$11,655.23
				IAA	\$649.73	\$15,593.45
				OMNIA	\$259.62	\$6,230.86
\$90,000.00	\$94,999.00	28.00%	\$59.37	H-Value	\$259.74	\$6,233.77
				Horizon DA	\$522.99	\$12,551.78
				IAA	\$699.71	\$16,792.94
				OMNIA	\$279.59	\$6,710.16
\$95,000.00	\$99,999.00	29.00%	\$62.50	H-Value	\$269.02	\$6,456.41
				Horizon DA	\$541.67	\$13,000.06
				IAA	\$724.70	\$17,392.69
				OMNIA	\$289.58	\$6,949.80
\$100,000.00	\$109,999.00	32.00%	\$68.75	H-Value	\$296.85	\$7,124.31
				Horizon DA	\$597.70	\$14,344.90
				IAA	\$799.66	\$19,191.94
				OMNIA	\$319.53	\$7,668.75
\$110,000.00	and over	35.00%	\$68.75	H-Value	\$324.68	\$7,792.22
				Horizon DA	\$653.74	\$15,689.73
				IAA	\$874.63	\$20,991.18
				OMNIA	\$349.49	\$8,387.69



Attention Monmouth County Employees!

Are you adding a dependent to your benefits?

Here's the documentation you need to provide in addition to your enrollment form:

Type of Dependent	Documentation needed
Spouse/Civil Union Partner	-Copy of marriage certificate/civil union certificate -Copy of Social Security cards for new spouse/partner -Document showing shared assets, i.e. bank statement, utility bill, tax forms; all personal information can be blacked out/redacted
Biological Child /Adopted Child	-Birth Certificate / Adoption documents for Court -Social Security card for child
Legal Guardianship	-Guardianship documents from Court -Social Security card for child

Please be sure to email all enrollment forms and supporting documents to enrollments@co.monmouth.nj.us



County of Monmouth Medical Enrollment/Change Form

[Print Form](#)
[Clear Form](#)

A. Employee Information Please read and complete the entire form. If you are making changes, please check box in part **B**. Even if you have no changes, read, complete and sign the form.

Last Name	First Name and Middle Initial	Social Security #	Date of Birth	Marital Status (select one) Single ☐ Married ☐ Civil Union ☐ Divorced/Separated ☐			
Street Address		Apt #	City	State	ZIP Code	Email address (if available)	Union Name (if applicable)
Home Telephone ()	Work Telephone ()	Full-Time Hire Date	Hrs Worked Per Week	Effective Date	B. Coverage or Enrollment Change-Important! ☐ Check this box if you are making any enrollment or plan changes since your last enrollment.		

C. Individuals Covered - List individuals for whom you are requesting coverage. Attach a sheet to list additional children.

Last Name, First Name, M.I.	Relationship to employee	(A)dd (C)hange (R)emove (K)eep	Date of Birth (MM/DD/YY)	Social Security Number	Gender M F	Other Health Coverage (✓ if Yes)
	Employee				☐ ☐	☐
	Spouse/Civil Union Partner				☐ ☐	☐
	Child				☐ ☐	☐
	Child				☐ ☐	☐
	Child				☐ ☐	☐
	Child				☐ ☐	☐

*For Horizon BCBS PCP information, visit www.Horizonblue.com, quick physician search; choose the Direct Access network for NJ Providers.

D. Plan Option & Coverage Level Selection

Carrier and Plan Selection	Check Box (select one)	Coverage Level Selection	
		From	To
Horizon Direct Access PPO	☐	Employee Only	☐ Employee Only
Horizon Value Plan	☐	Employee + 1 (Spouse or CU Partner)	☐ Employee + 1 (spouse or CU Partner)
Horizon OMNIA	☐	Employee and Child(ren)	☐ Employee and Child(ren)
Waive Benefits	☐	Family	☐ Family

E. Other Insurance

F. Dependent Information

1. Is your Spouse/Civil Union Partner Employed? ☐ Yes ☐ No If Yes, provide name & address of his or her employer. 2. If "Yes" to Other Health Coverage (Section C), provide name & policy number of insurance carrier, HMO, or other source. Explain the circumstances. 3. If anyone listed on this enrollment form are enrolled in Medicare Parts A, B and/or D identify the coverage and provide the Medicare ID#.	1. Does any dependent listed in Section C live at a different address than the employee? ☐ Yes ☐ No If "Yes," who and what address? Explain the circumstances. 2. If any dependent's last name differs from yours, explain the circumstances.
G. Employee Signature I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions on the reverse side/page 2 of this enrollment form.	Employee Signature – Required X Date: / /
Employer Verification X Date: / /	Horizon Enrollments Only Group Number-86260 Sub-Group number _____

Employee - Complete Sections A - G Section A - Employee Information: Complete all information to order for your application to be processed. Section B - Plan or Demographic Change Indicator: Check this box if you are making any plan or enrollment changes since your last enrollment. Section C - Individuals Covered: - Print name(s) of your dependent(s), if applicable under the appropriate relationship. Circle whether spouse or civil union partner. - Add/Change/Remove/Keep - Use "A", "C", "R" or "K" to indicate whether you are adding, changing, removing, or keeping coverage for an individual. - Indicate Gender, Date of Birth, and Social Security Number for each individual listed. - Complete PCP information for all members including the employee. - If you or your dependent(s) have other Health or Rx drug coverage check off the "Yes" box(es) and complete Section E - Other Insurance at the bottom of the form. Note: If a dependent is disabled and being continued beyond the limiting age of 26, attach proof of disability. - From the appropriate provider directory or on-line, locate the PCP office ID number for the primary care physician. Indicate office ID selection(s) on the form and list PCP's name and location. - If you are a current patient, please check "Current patient" box. Section D - Plan Option and Coverage Level Selection: - Select Carrier and Plan Option. - Indicate coverage level prior to 10/1/09 and after 10/1/09. This answer may or may not be the same depending upon if you have enrollment changes or not. Section E - Other Insurance: - If you are including coverage for your spouse or civil union partner, answer question 1 regarding his or her employment status. - Answer questions 2 and/or 3 if you have indicated other health or rx coverage in section C. Section F - Dependent Information: - Answer question 1 regarding dependents listed in Section C. - Answer question 2 if dependents have different last names than your own. Section G - Employee Signature: - Read the acknowledgment and agreements section on the right side of this page. - Employee must sign and date in order for the form to be processed. - Signature indicates agreement to terms and attests to complete, accurate, and true information.	Employee Acknowledgement and Agreements On behalf of myself and the dependents listed on the reverse side/page(s), I agree to or with the following: a) I authorize the sources stated below to give Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc. LAA or any consumer reporting agency acting on its behalf, information about me and any minor children, if applying for coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital clinic or other medical care institution; any carrier; any consumer reporting agency; any employer. b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which LAA, Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier. c) I know that I have a right to receive a copy of this authorization if I request one. d) I agree that a photocopy of this authorization is as valid as the original. - I acknowledge by enrolling in LAA, Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) or Horizon Healthcare of New Jersey, Inc. plan coverage is provided by in accordance with the contract. - Enrollment of myself and of the listed dependents into the plan is effective on acceptance by LAA, Horizon BCBSNJ or Horizon Healthcare of New Jersey, Inc. - I understand that my employer may request proof of dependent eligibility from time to time and I agree to provide appropriate documentation as requested. - I agree to inform my employer of any changes of dependent eligibility status within 30 days of a status change. Misrepresentation Any person who includes any false or misleading information on an Enrollment Form for a health benefits plan is subject to criminal and civil penalties. Employee healthcare deductions are automatically taken on a pretax, Section 125 plan basis to enable employees to take advantage of the obvious tax advantages. If for some reason, you would prefer not to have the deduction taken on a pretax basis, please call the Monmouth County Benefits Department at 732-866-3622 ext 7655, or 732-866-3622 ext 6671.
Waiver of Insurance Coverage Notice of Special Enrollment Period If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health insurance coverage, or if you lose coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or during open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage birth, adoption, or placement for adoption. If you decline coverage for yourself and/or your eligible dependent(s) because of other health/ dental coverage and you fail to fill out the floor of this form concerning your (and/or your eligible dependent's) other coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental coverage.	



Horizon Dental Choice (HDC) Plan A—COINSURANCE PLAN

50% Coinsurance, \$0 Deductible, No Annual Max

Coverage Type	In Network
EXAMS AND PREVENTIVE SERVICES	
Oral exams	100%
Fluoride treatment (up to age 19)	100%
Prophylaxis	100%
Sealant application (up to age 14)	100%
X-RAYS	
Full-mouth	100%
Panoramic	100%
ENDODONTICS	
Pulp cap	100%
Pulpotomy	100%
Root canal therapy — anterior and premolar	100%
Root canal therapy — molar	50% out-of-pocket coinsurance
ORAL SURGERY	
Incision and drainage of abscess	100%
Routine extractions	100%
Soft tissue surgical extractions	100%
Surgical extractions — impacted	50% out-of-pocket coinsurance
PERIODONTICS	
Gingivectomy	100%
Periodontal maintenance	100%
Scaling and root planing	100%
Soft tissue grafts	100%
Osseous surgery	50% out-of-pocket coinsurance

DENTAL PLANS



Coverage Type	In Network
RESTORATIONS AND REPAIRS	
Amalgam restorations	100%
Composite restorations (other than for molars)	100%
Crowns	50% out-of-pocket coinsurance
DENTURES	
Complete and partial dentures	50% out-of-pocket coinsurance
Denture adjustments and repairs	50% out-of-pocket coinsurance
FIXED BRIDGES	
Retainers and pontics	50% out-of-pocket coinsurance
SPACE MAINTAINERS (up to age 19)	
Fixed unilateral bilateral	50% out-of-pocket coinsurance
Removable unilateral bilateral	50% out-of-pocket coinsurance
Benefit waiting period	None
FAQs	

Can I go to any dentist?

No. You must go to your Primary Care Dentist (PCD) from the HDC Network and receive care, or be referred for care, from that PCD.

How does my plan work?

The HDC plan covers 100 percent of all eligible preventive and basic services with no maximums or deductibles. The HDC plan also covers a significant amount of charges for all eligible major and specialty dental services. Care must be coordinated through the participating HDC dentist known as your PCD. There is no out-of-network benefit for the HDC plan.

Do I need to choose a PCD?

A PCD will be auto-assigned for you based on your home address. It will be the closest participating office to you and can be changed when you receive your ID card.

Can my family members choose different dentists?

Yes. Your eligible dependents may have a different PCD from the HDC Network.

Can I change my primary care dentist?

Yes. The auto-assigned PCD may be changed effective the first day of any month by giving Horizon BCBSNJ 15 days' notice. This can be done by calling the customer service phone number on your ID card.

How do I find a participating dentist?

To locate a participating provider, please utilize the doctor finder at horizonblue.com/doctorfinder or by calling **1-800-4-Dental**. Simply log in or continue as a guest, select dental, select the Horizon Dental Choice plan, input any location in NJ, select the dentist, specialty or group practice and the results will automatically generate based on the network(s) your plan belongs to.

EXCLUSIONS

Please review contract for full list of exclusions.

Services relating to TMJ | Orthodontics | Implants | Missing Teeth Coverage

This document is for informational purposes only and does not constitute a binding agreement. Please note that rates are subject to change. Contact Horizon for the most current rates. The information provided by this document is not intended to replace or modify the terms, conditions, limitations and exclusions contained within health, dental or vision benefit plans issued or administered by Horizon. In the event of a conflict between the information contained in this document and your plan documents, your plan documents shall control.

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ECNA006069



Monmouth County DOP PLAN

Benefit	
Benefit Period	Benefit Year
DEDUCTIBLE	
Individual	\$25
Family	\$75
Deductible Applies To	Preventive & Diagnostic, Treatment & Therapy, Endodontics, Periodontics, Oral Surgery, Prosthodontics, Crowns and Onlays
BENEFIT PERIOD MAXIMUM	\$2,000 (per person)
Benefit Period Maximum Applies To	Preventive & Diagnostic, Treatment & Therapy, Endodontics, Periodontics, Oral Surgery, Prosthodontics, Crowns and Onlays
COINSURANCE	
Preventive Diagnostic	
Strong Smile Rider	Excluded
Exam and Preventive Services Exams	100%
Fluoride Treatment	100%
Sealants Application	100%
Adult Prophylaxis	100%
X-rays (Bitewing & Full Mouth)	100%
Treatment and Therapy	
Space Maintainers	80%
Amalgam Restorations	80%
Composite Restorations - Anterior & Bicuspid	80%
Denture Adjustments	80%
Denture Repairs	80%
Simple Extractions	80%
Endodontics	
Root Canal Therapy - Anterior & Bicuspid	80%
Root Canal Therapy - Molar	80%
Periodontics	
Scaling & Root Planing	80%
Gingivectomy	80%
Periodontal Maintenance	80%
Osseous Surgery	80%
Oral Surgery	
Surgical Extractions	80%
Partial Bony Extractions	80%
Complete Bony Extractions	80%
Prosthodontics	
Bridgework	50%
Partial Dentures	50%
Crowns and Onlays	
Crown – porcelain fused to high noble metal	50%
Orthodontics	NOT COVERED
Eligibility	Dependent Children of enrolled employees are covered to the end of the month age 26, full-time students are covered to end of the month age 26.
Services are for illustrative purposes only. For complete listing of covered services, plan limitations, deductibles and maximums, consult your benefit booklet.	
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Horizon Monthly Dental Plan Rates January 1, 2026 - December 31, 2026

Horizon Dental Choice

Single: \$16.60

Employee + Spouse: \$32.11

Employee + Child: \$31.56

Employee + Family: \$47.02

Horizon Dental Option

Single: \$42.27

Employee + Spouse: \$76.52

Employee + Child: \$87.88

Employee + Family: \$122.56

Dependent children are covered to end of the month in which they turn 26.

Please note:

1. If your dependent child has aged out of dental coverage, but has not yet reached the age of 26, it is possible to re-enroll them during Open Enrollment. Please fill out an enrollment form and send to HR Benefits.
2. In case of divorce, legal separation, or other dependent status changes, it is your responsibility to notify the County's Benefits Department within 30 days of the event to ensure the applicable changes are made timely and your payroll deduction is adjusted accordingly.



Dental Services Organization, LLC

PREPAID GROUP DENTAL PLAN A



1030 St. Georges Avenue • Suite 401
Avenel, NJ 07001 • (732) 634-4810
www.dentalservicesorganization.com

PROCEDURE

Patient Cost with DSO option

DIAGNOSTIC

Charting history, oral examination, periodic recall examination (every six months), emergency treatment	No Charge
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RADIOGRAPHIC

Complete intraoral series, periapical and bitewing films	No Charge
Intraoral periapical.....	No Charge
Each additional single film (periapical or bitewing)	No Charge
Occlusal view x-ray	No Charge
Lateral jaw x-ray, each	No Charge
Four bitewing x-ray films	No Charge
Antero-posterior x-ray of head and jaw	No Charge
Cephalometric radiograph.....	No Charge
Panoramic (panorgraphy) including bitewings	No Charge

PREVENTIVE

Oral prophylaxis (every six months)	No Charge
Topical fluoride treatment following prophylaxis (to age 19)	No Charge
Space maintainers – unilateral	\$ 5.00
Space maintainers – bilateral	\$ 10.00

OPERATIVE (RESTORATIVE) SERVICES

Primary Silver amalgam – 1 surface	No Charge
Primary Silver amalgam – 2 surfaces	No Charge
Primary Silver amalgam – 3 surfaces or more	No Charge
Permanent Silver amalgam – 1 surface	No Charge
Permanent Silver amalgam – 2 surfaces	No Charge
Permanent Silver amalgam – 3 surfaces or more	No Charge
Silver amalgam reinforcement pins – 1st	No Charge
Each additional pin	No Charge
Composite filling (for front teeth)	No Charge
Composite Class III	No Charge
Composite Class IV	No Charge
Core build-up (including any pins)	\$ 15.00

PERIODONTIA

Root scaling and root planing (per quadrant)	\$ 50.00
Prophylaxis, medication and minor bite correction	\$ 20.00
Gingivectomy, Gingivoplasty (per quadrant).....	\$ 120.00
Occlusal adjustment (and/or equilibration)	\$ 10.00
Bite guard	\$ 25.00
Osseous surgery (per quadrant).....	\$ 140.00

ENDODONTICS (INCLUDING RADIOGRAPHS)

Single root canal, filling.....	\$ 50.00
Double root canal, filling	\$ 85.00
Triple or more root canal, filling	\$ 125.00
Apicoectomy (per root)	\$ 55.00

SIMPLE EXTRACTIONS (INCLUDING LOCAL ANESTHESIA)

Single tooth.....	\$ 10.00
Each additional tooth	\$ 10.00

PROCEDURE

Patient Cost with DSO option

ORAL SURGERY EXTRACTIONS (INCLUDING LOCAL ANESTHESIA)

Surgical extraction	\$ 20.00
Extraction of tooth (soft tissue impaction).....	\$ 50.00
Extraction of tooth (partial bony impaction)	\$ 75.00
Extraction of tooth (complete bony impaction)	\$ 90.00
Alveoplasty/Alveolectomy (per jaw maximum) per quadrant in conjunction with extraction.....	\$ 55.00
Alveoplasty, including ridge extension, arch	No Charge
Excision of benign tumor, lesion diameter up to 2.5 cm	\$ 15.00
Removal of cyst up to 2.5 cm diameter	\$ 50.00

PROSTHETICS (INCLUDING ADJUSTMENTS AND RELINES FOR 6 MONTHS FOLLOWING INSTALLATION) REMOVABLE

Full upper denture	\$ 175.00
Full lower denture	\$ 175.00
Partial upper or lower denture without clasps, acrylic base.....	\$ 150.00
Partial upper or lower denture with two chrome clasps with rests, acrylic base	\$ 175.00
Partial upper or lower with chrome lingual or palatal bar with two clasps and rests, acrylic base	\$ 175.00
Repair broken full or partial denture, no teeth damaged	No Charge
Repair broken full or partial denture, replace broken tooth	\$ 10.00
Each additional tooth	\$ 10.00
Replace broken tooth on denture, no other repairs	\$ 10.00
Each additional tooth	\$ 10.00
Adding tooth to partial denture to replace extracted tooth.....	\$ 20.00
Each additional tooth	\$ 20.00
Reattaching clasp on denture, clasp intact.....	\$ 35.00
Replacing broken clasp with new clasp on denture.....	\$ 55.00
Relining upper or lower full or partial denture (office) once every 3 years.....	\$ 20.00
Relining upper or lower full or partial denture (lab) once every 3 years.....	\$ 35.00
Jump case, complete denture (duplicate of denture) once every 3 years.....	\$ 90.00

CROWNS

Two surface gold inlay	\$ 175.00
Three or more surfaces gold inlay	\$ 175.00
Acrylic jacket	No Charge
Acrylic with metal (semi-precious)	\$ 150.00
Porcelain jacket	\$ 175.00
Porcelain fused to metal (semi-precious)	\$ 175.00
¾ cast	\$ 150.00
Full cast	\$ 150.00

BRIDGES – PONTICS & ABUTMENTS (FIXED)*

Cast	\$ 150.00 each
Maryland bridge	\$ 175.00 each
Porcelain fused to metal (semi-precious)	\$ 175.00 each
Plastic processed to metal (semi-precious)	\$ 175.00 each

*Refer to exclusion #22

ORTHODONTIC

Maximum, 24 months (to age 19)	\$ 1,300.00
Adult (19 years or older)	\$ 2,500.00

LIMITATIONS AND EXCLUSIONS

BENEFITS shall not be provided for any of the following:

1. *Any dental services which were not rendered, prescribed, arranged, or approved by a Participating Dentist.*
2. *Bedside calls, either at home or in a hospital.*
3. *Any Hospital, outpatient or emergency facility administered anesthesia or any form of general anesthesia wherever administered, hospital charges, prescription drugs and/or laboratory tests.*
4. *Consultation by Non-Participating Dentist(s) unless specifically directed by DSO.*
5. *Any service or appliance for which the Covered Person incurs no charge.*
6. *Any service or appliance not required in accordance with accepted standards of dental practice in the geographic area and/or location in which the service is provided.*
7. *Any service or appliance received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or other similar person or group.*
8. *Services provided under any governmental program (excluding the Medicaid Act), any state or federal worker's compensation, employer's liability or occupational disease law or similar law for loss covered by such benefits; and services performed by a member of a Member's immediate family.*
9. *Anything other than services enumerated in this Contract.*
10. *Services rendered or items furnished for any conditions, disease, ailment or injury occurring while the Covered Person is on active duty during military service, or for services or items provided under the laws of the United States of America or of any State of the United States or of any Foreign country or of any political subdivision of any of the foregoing.*
11. *Dental services rendered prior to the date the Enrollee or Covered Person became eligible for such services under this Contract.*
12. *Any service(s) or item(s) which are determined by DSO's Dental Director, prior to being provided, not to be a necessary service or item incidental to the condition, disease or injury for which the Covered Person is being treated.*
13. *Broken appointments. An Enrollee may be liable for charges for broken appointments consistent with and if that is the policy of the provider office.*
14. *Any dependent(s) below age ten (10) where such dependent is so unruly as to make the rendering of services impractical under the circumstances in the opinion of the Participating Dentist.*
15. *Treatment of unmanageable patients. An attempt will be made to treat all patients; however, if a Covered Person is untreatable by virtue of fear or phobia, it is the Enrollee's responsibility to contact DSO and discuss possible referral to another office for treatment at the Enrollee's expense.*
16. *Treatment of a Covered Person with a communicable disease without medical clearance from such person's physician.*
17. *Services/supplies partially or wholly cosmetic in nature, including bleaching, bonding procedures and orthodontic services and appliances.*
18. *Replacement of any lost, stolen or existing prosthesis made within five (5) years.*
19. *Prosthetic devices, including but not limited to bridges, crowns, inlays, complete and partial removable dentures for which the final impressions were taken while the Covered Person was not Covered under this Plan; or where final impressions were taken while such Covered Person was covered under this Plan, but not finally installed or delivered to such Covered Person within sixty (60) days after termination of coverage.*
20. *Replacement of an orthodontic appliance including retainers, bite plates, functional appliances, lingual arches and tongue cribs or repair due to patient negligence.*
21. *Dental procedure(s) required because of insurrection, invasion, bombardment, rebellion, revolution, military or usurped power or riot or resulting from any type of accidental injury, whether or not due to or caused by negligence, act of God, deliberate conduct of any kind or caused by anything other than natural biological factors, improper, poorly performed or nonexistent dental hygiene or by reason of dental (including periodontal) disease.*
22. *Replacement of teeth by fixed bridgework where teeth are missing on both sides of the same arch or jaw. Where teeth are missing on both sides of the same arch, replacement will be accomplished by removable prosthesis.*
23. *Expenses for duplication, maintenance or repair of any appliance to be used as a spare.*
24. *Expenses for all periodontal regenerative therapy and appliances or restorations necessary to accomplish periodontal splinting, increase vertical dimensions or restore occlusion.*
25. *Expenses for occlusal equilibration except to the extent necessary to treat periodontal disease.*
26. *Expenses for implantology, sealants or mouthguards.*
27. *Treatment of major congenital defects, such as cleft palates, and associated deformities and temporomandibular joint dysfunction.*
28. *Repairs to a removable denture which is (i) at least five (5) years old; (ii) to be replaced; (iii) beyond repair; and (iv) no longer serviceable.*



Dental Services Organization, LLC

PROVIDER OFFICES

1. Eastern Dental® of Burlington
2. Eastern Dental® of Eatontown
3. Eastern Dental® of Ewing
4. Eastern Dental® of Flemington
5. Eastern Dental® of Hamilton
6. Eastern Dental® of Howell
7. Eastern Dental® of Lacey
8. Eastern Dental® of Laurel Springs
9. Eastern Dental® of Lawrenceville
10. Eastern Dental® of Manahawkin
11. Eastern Dental® of Marlton
12. Eastern Dental® of Northfield
13. Eastern Dental® of Ocean/Monmouth
14. Eastern Dental® of Old Bridge
15. Eastern Dental® of Parsippany
16. Eastern Dental® of Passaic/Essex
17. Eastern Dental® of Toms River
18. Eastern Dental® of Union
19. Eastern Dental® of Vineland
20. Eastern Dental® of Woodbridge
21. Eastern Dental® of Woodbury Heights



*Offering
managed care
dental plans
throughout New Jersey
for almost 30 years.*



PROVIDER OFFICES

**Eastern Dental®
of Burlington**
(856) 303-0600

Pep Boys Plaza
202 Route 130 North
Cinnaminson, NJ 08077-3304

**Eastern Dental®
of Eatontown**
(732) 660-0500

1802 Route 35 South
Oakhurst, NJ 07755-2912

**Eastern Dental®
of Ewing**
(609) 883-0801

1330 Parkway Avenue
Ewing, NJ 08628-3091

**Eastern Dental®
of Flemington**
(908) 237-2100

433 US Highway 202
Flemington, NJ 08822-6041

**Eastern Dental®
of Hamilton**
(609) 587-0600

2103 Whitehorse-Mercerville Road
Hamilton, NJ 08619-2694

**Eastern Dental®
of Howell**
(732) 683-1130

2346 Route 9 South
Howell, NJ 07731-4017

**Eastern Dental®
of Lacey**
(609) 693-6066

131 South Main Street (Route 9)
Forked River, NJ 08731-3635

**Eastern Dental®
of Laurel Springs**
(856) 784-5100

3 Kelly Drivers Road
Laurel Springs, NJ 08021-4823

**Eastern Dental®
of Lawrenceville**
(609) 587-6300

520 Lawrence Square Boulevard South
Lawrenceville, NJ 08648-2674

**Eastern Dental®
of Manahawkin**
(609) 489-0030

733 Route 72 East
Manahawkin, NJ 08050-2864

Eastern Dental® of Marlton
(856) 983-5400

951 Route 73 North, Suite A
Marlton, NJ 08053-3211

Eastern Dental® of Northfield
(609) 677-1589

1634 New Road (Route 9)
Northfield, NJ 08225-1108

**Eastern Dental®
of Ocean/Monmouth**
(732) 477-9200

Kennedy Plaza
2770 Hooper Avenue, Unit 4
Brick, NJ 08723-4108

Eastern Dental® of Old Bridge
(732) 727-3399

Sayrebrook Towne Center
2909 Washington Road, Suite 135
Parlin, NJ 08859-1513

**Eastern Dental®
of Parsippany**
(973) 292-2550

Powder Mill Plaza West
2936 Route 10 West
Morris Plains, NJ 07950-1244

**Eastern Dental®
of Passaic/Essex**
(973) 478-9300

600 Getty Avenue
Clifton, NJ 07011-1915

Eastern Dental® of Toms River
(732) 286-7020

1228 Route 37 West
Toms River, NJ 08755-4922

Eastern Dental® of Union
(908) 964-5406

2115 Route 22 West
Union, NJ 07083-8403

Eastern Dental® of Vineland
(856) 692-5400

1145 East Chestnut Avenue
Vineland, NJ 08360-5001

**Eastern Dental®
of Woodbridge**
(732) 750-3600

1030 St. Georges Avenue
Avenel, NJ 07001-1327

**Eastern Dental®
of Woodbury Heights**
(856) 845-7775

1006B Mantua Pike, Suite 1
Woodbury Heights, NJ 08097-1228



Dental Services Organization, LLC

1030 St. Georges Avenue • Suite 304
Avenel, NJ 07001 • 1(800) 982-5529





DENTAL PLAN OPTION FOR MONMOUTH COUNTY EMPLOYEES AND FAMILIES

FEATURES -----

NO DEDUCTIBLES
NO ANNUAL MAXIMUMS
NO CLAIM FORMS
MINIMAL COPAYS *

COVERS -----

PREVENTIVE CARE
RESTORATIVE CARE *
ORTHODONTIC CARE *
PERIODONTIC CARE *
and much more.

All services are available at Eastern Dental®, a provider of dental care for Dental Services Organization, LLC, a licensed Dental Provider Organization in the State of New Jersey.

Compare this Option with the examples of typical fees for dental services on the reverse side. Also, check our office locations for the one closest to you. Complete the enrollment form once you decide and return as instructed.

DSO has partnered with Eastern Dental® offering benefits to members and their families at locations throughout New Jersey.

If you need any additional information about the DSO dental option call 1-800-982-5529 between 9:00 am and 4:30 pm and ask for the Monmouth County benefit representative.

* Some payments will be required for these services.



MONMOUTH COUNTY

Partial List of Services	Typical Fees	Cost With DSO Option
Periodic Exam	\$ 77.00	NONE
Cleaning (Adult)	\$ 134.00	NONE
Cleaning (Child)	\$ 101.00	NONE
Fluoride Treatment (to age 19)	\$ 43.00	NONE
<u>Silver Fillings</u>		
1 Surface	\$ 208.00	NONE
2 Surfaces	\$ 262.00	NONE
<u>Root Canals</u>		
1 Root	\$1,066.00	\$ 50.00
2 Roots	\$1,213.00	\$ 85.00
<u>Gum Surgery</u>		
Osseous Surgery Per quadrant	\$1,594.00	\$ 140.00
<u>Crown - Individual</u>		
Pontic	\$1,543.00	\$ 175.00
<u>Dentures - Complete</u>		
Upper or Lower	\$2,513.00	\$ 175.00
<u>Dentures - Partial</u>		
Upper or Lower	\$2,616.00	\$ 175.00
<u>Orthodontic - Braces</u>		
Stainless Steel (Child)	\$5,740.00	\$1,300.00
Adult	\$5,740.00	\$2,500.00



Dental Plan Comparison

Feature	Dental Choice	Dental Option	DSO
Deductible	None	\$25/person \$75/family	None
Choice of Dentists	Their Network	Any Dentist	Eastern Dental
Annual Benefit Maximum	Unlimited	\$2,000	Unlimited
Coverage			
Preventive	100%	100% of Maximum Allowable Charge (MAC)	No Cost
Basic	100%	80% of MAC	No Cost
Major	50%	50% of MAC	\$175.00*
Orthodontic	None	None	\$1300 stainless steel (child)/\$2500 adult



ENROLLMENT/CHANGE REQUEST

Horizon BCBSNJ Dental Programs

P.O. Box 1938
Newark, NJ 07101-1938
www.HorizonBlue.com/dental
1-800-4DENTAL

Horizon Blue Cross Blue Shield of New Jersey

Group Information - To Be Completed by Employer

Group Name	Group Number	Subgroup Number
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A. Type of Activity - To Be Completed by Employer Refer to instructions on back before completing this form. Print clearly.

1. Enrollment ☐ New Subscriber Effective Date ____/____/____ Date of Hire ____/____/____	2. Change - Check all that apply. ☐ Add Spouse ☐ Domestic Partner ☐ Civil Union Partner ☐ Add Dependent Child ☐ Name Change ☐ Change Plan ☐ Other ☐ Add/Change Dentist Office ID Date of Event ____/____/____ Reason _____	3. Remove or Terminate - Check all that apply. ☐ Remove Spouse/Domestic Partner/ Civil Union Partner* ☐ Remove Dependent Child* ☐ Employee Withdrawal/Termination Note: Employee must be enrolled for spouse/domestic partner/civil union partner/ dependent(s) to have coverage. *Please complete Add/Change/Remove and Name columns in Section D. Effective Date ____/____/____ Reason _____	4. Continuation of Coverage, i.e., COBRA, State, Total Disability Not all options are available. Contact Employer for available options. Coverage For: ☐ Employee ☐ Dependents Length of Continuation: ☐ 18 mos ☐ 29 mos* ☐ 36 mos ☐ Total Disability Date of Loss of Coverage: ____/____/____ Date of Qualifying Event: ____/____/____ *Attach proof of disability
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B. Employee Information - Complete Sections B - G

Social Security Number	Last Name, First Name, M.I.		Home Telephone ()	
Home Address	Apt. No.	City, State	ZIP Code	
Employer Name The County of Monmouth			Work Telephone ()	
Work Address 1 East Main Street	City, State Freehold, NJ	ZIP Code 07728		
Date of Employment	Hours Worked			

C. Plan Option - Your selection must be offered by your employer.

Horizon BCBSNJ ☐ Horizon Dental Option	Horizon Healthcare Dental ☐ *Horizon Dental Choice	Contract Type ☐ S - Single ☐ F - Family ☐ 2 Adults ☐ P/C - Parent & Child
*Please select Dentist Office ID Number-Section D		

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student. Attach proof of disability.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Dental Coverage Check if Yes	Dentist Office ID Number (if applicable)	NPI Number	Current Patient Check if Yes	Previous Coverage Check if Yes
Employee			☐ ☐	/ /		☐			☐	☐
Spouse			☐ ☐	/ /		☐			☐	☐
Domestic Partner			☐ ☐	/ /		☐			☐	☐
Civil Union Partner			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐

E. Other/Previous Insurance

Is your Spouse/Domestic Partner/Civil Union Partner Employed? ☐ Yes ☐ No If Yes, give name & address of spouse s/ Domestic Partner s/Civil Union Partner s employer.
If Yes to Other Dental Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.
If "Yes" to previous coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number and submit a copy of the Certificate of Credible Coverage issued by the previous carrier, if available.

F. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? ☐ Yes ☐ No If Yes, who and at what address?
Explain the circumstances.
If any dependent s last name differs from yours, explain the circumstances.

G. Employee Signature If you have any questions concerning the benefits and services provided by or excluded under this contract, contact a benefits representative at your company before signing this form.

I represent that all the information supplied in this enrollment/change request form is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/ change request. I authorize deductions from my earnings for any required contribution.	Employee Signature - Required	
	X Date ____/____/____	E-Mail Address _____

H. Employer Verification - To Be Completed by Employer

Employer Signature - Required	
X Title _____	Date ____/____/____

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Horizon BCBSNJ Dental Programs prior to visiting a specialist or admission to a hospital.

Services and products may be provided by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare Dental, Inc., each of which is an independent licensee of the Blue Cross and Blue Shield Association. Horizon Healthcare Dental Inc., is a subsidiary of Horizon Blue Cross Blue Shield of New Jersey.

Instructions

Employer

Complete the **Employer Group Information** in the upper right corner of the form.

Section A - Type of Activity: Check box(es) indicating reason(s) for submitting The Enrollment Change Request Form.

If reason is other then indicated check **other** in box 2 and provide reason (i.e., rehire, open enrollment, newly eligible or previously refused/waived coverage).

Complete **Section H - Employer Verification** in the lower right corner of the form.

Employer must complete this section for all new enrollments, coverage changes and terminations.

Employer must sign and date The Enrollment/Change Request Form in order for it to be processed.

Employee - Complete Sections B - G

Section B - Employee Information:

Complete **all** information in order for your application to be processed.

Section C - Plan Option:

Check one Plan Option box, indicate Plan Option Name (where applicable).

Select only an option offered by your employer.

Select Contract Type: **S**-Single, **F**-Family, **2**-Adults (Husband/Wife, Domestic Partner or Civil Union Partner), **P/C**-Parent & Child

Section D - Individuals Covered:

Add/Change/Remove - Use **A** , **C** , or **R** to indicate whether you are adding, changing or removing coverage for an individual.

Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.

If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits). If dependent is disabled and being continued beyond the limiting age, attach proof of disability.

If you or your dependent(s) have other dental coverage, check off the

Yes box(es) and complete Section E - Other/Previous Insurance.

If the Plan Option selected is Horizon Dental Choice or Horizon TotalCare Dental-from the appropriate Provider directory, locate the alphanumeric office ID code for the dentist. Indicate office ID number selection(s) and NPI Number on the form. Only one provider selection allowed under the Horizon TotalCare Dental Option per family

If you are a current patient, please check the Current Patient box. (only applicable if the Plan Option selected is Horizon Dental Choice or Horizon TotalCare Dental).

Section E - Other/Previous Insurance:

Complete this section for all new enrollments or coverage changes. Coverage includes group, governmental and Medicare coverages and church plans.

Section F - Dependent Information:

Complete this section for all new enrollments or coverage changes. Coverage includes group, governmental and Medicare coverages and church plans.

Section G - Employee Signature:

Complete this section for all new enrollments, coverage changes and terminations.

Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section H - Employer Verification:

Employer must complete this section for all new enrollments, coverage changes and terminations.

Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment

Employee Acknowledgements and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

- a) I authorize the sources stated below to give to Horizon BCBSNJ, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Horizon BCBSNJ has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
c) I know that I have a right to receive a copy of this authorization if I request one.
d) I agree that a photocopy of this authorization is as valid as the original.
- I acknowledge by enrolling in a Horizon BCBSNJ dental program, coverage is provided by Horizon BCBSNJ in accordance with the contract.
- Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Horizon BCBSNJ.
- Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

- Any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.

DENTAL SERVICES ORGANIZATION, LLC

COUNTY OF MONMOUTH EMPLOYEE-FUNDED (VOLUNTARY) DENTAL COVERAGE

MONTHLY PREMIUMS:

	<u>SINGLE</u>	<u>TWO PARTY</u>	<u>FAMILY</u>
PLAN A	\$25.70	\$49.25	\$73.43

CURRENT ENROLLMENT:

<u>SINGLE</u>	<u>TWO PARTY</u>	<u>FAMILY</u>
68	44	75

DEPENDENT COVERAGE:

Dependent Children Covered	to age 26
Full-time students Covered	to age 26

The proposed rates outlined above are subject to approval by New Jersey Department of Banking and Insurance and will expire six months from date of issue. Upon acceptance the rates will be guaranteed for a period of two (2) years from the effective date of the program. All rates are net of commissions.

Date of Issue: October 9, 2025

DSO Dental Plan Enrollment/Change Form

Monmouth County

Employee Name: Last,		MI	Employee First Name:	
Birth Date:			Social Security Number	
Mailing Address:			City:	State: Zip:
Phone Number:	Sex: Female ☐ Male ☐		Marital Status: ☐ Single ☐ Married ☐ Divorced	

Complete the following information & sign form:
Dependents children are covered to age 26.

DEPENDENTS:	Last Name, First	Date of Birth			
		Month	Day	Year	
☐ Husband					☐ Male
☐ Wife					☐ Female
☐ Child					☐ Male
☐ Stepchild					☐ Female
☐ Child					☐ Male
☐ Stepchild					☐ Female
☐ Child					☐ Male
☐ Stepchild					☐ Female
☐ Child					☐ Male
☐ Stepchild					☐ Female

I select Eastern Dental® of _____ as my primary care dentist.

Signature: _____ Date: _____

Horizon Panorama III Alt B

Welcome to Horizon Blue Cross Blue Shield of New Jersey!

We are pleased to provide you with information on your vision benefit to help you care for your vision and eye health – a key part of overall health and wellness!

If you are not currently enrolled, please visit our member site at davisvision.com or call 1.800.278.7753 and enter client code 3159 to locate providers or for additional information.

DAVIS VISION
EYECARE REFRAMEDSM

Using your benefits is easy! Just log on to our Member site at davisvision.com and click *Find a Provider*, or call us at **1.800.278.7753**.

Make an appointment. Tell your provider you have vision coverage through Horizon Blue Cross Blue Shield of New Jersey. Provide your member ID number, name and date of birth, and do the same for your covered dependents seeking vision services. Your provider will take care of the rest!

Your Horizon Panorama III Alt B Plan Benefits

100% OF YOUR CALLS & CLAIMS ARE PROUDLY ADMINISTERED IN THE USA 

Benefit	Frequency Based on 1/1 -12/31	In-network Copayment	In-network Coverage
Eye Examination	January 1	\$0	Covered in full. <i>Includes dilation when professionally indicated.</i>
Spectacle Lenses	January 1	\$10	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings.)
Frame	every other January 1	\$0	Covered in Full Frames: Any Fashion or Designer level frame from Davis Vision's Collection ² (retail value, up to \$160). OR, Frame Allowance: \$130 toward any frame from provider plus 20% off any balance. ¹ No Copayment required. OR, Visionworks Frame Allowance: \$180 allowance plus 20% off any balance toward any frame from a Visionworks retail store. ⁶ No Copayment required.
Contact Lens Evaluation, Fitting & Follow Up Care	January 1	\$0	Davis Vision Collection Contacts: Covered in full. Non Collection Standard Contacts: 15% discount ¹ Non Collection Specialty Contacts: ³ 15% discount ¹
Contact Lenses (in lieu of eyeglasses)	January 1	\$0	Covered in Full Contacts: From Davis Vision's Collection ² , up to: Planned Replacement Two boxes/multi-packs* Disposable Four boxes/multi-packs* OR, Contact Lens Allowance: \$130 allowance toward any contacts from provider's supply plus 15% off balance. ¹ No Copayment required. OR, Medically Necessary Contacts: Covered in full with prior approval. *Number of contact lens boxes may vary based on manufacturer's packaging.

Significant savings on optional frames, lens types and coatings!

Member Price

Davis Vision Collection Frames: Fashion Designer Premier	\$0 \$0 \$25
Tinting of Plastic Lenses	\$0
Oversize Lenses.....	\$0
Scratch-Resistant Coating.....	\$0
Ultraviolet Coating	\$12
Anti-Reflective Coating: Standard Premium Ultra	\$35 \$48 \$60
Polycarbonate Lenses	\$0 ⁴ -\$30
High-Index Lenses	\$55
Progressive Lenses: Standard Premium Ultra	\$50 \$90 \$140
Polarized Lenses	\$75
Photochromic Lenses (i.e. Transitions®, etc.) ⁵	\$65
Intermediate-Vision Lenses	\$30
Scratch Protection Plan: Single Vision Multifocal Lenses	\$20 \$40

¹ Additional discounts not applicable at Walmart, Sam's Club or Costco locations
² The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.

³ Including, but not limited to toric, multifocal and gas permeable contact lenses.

⁴ For dependent children, monocular patients and patients with prescriptions of +/- 6.00 diopters or greater.

⁵ Transitions® is a registered trademark of Transitions Optical Inc.

⁶ Enhanced Allowance is available at Visionworks store locations nationwide.

Please note: Your provider reserves the right to not dispense materials until all applicable member costs, fees and copayments have been collected. Contact lenses: Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees above the evaluation and fitting allowance are the responsibility of the member. If contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable. May not be combined with other discounts or offers. Please be advised these lens options and copayments apply to in-network benefits.

Frequently Asked Questions

How can I contact Member Services?

Call **1.800.278.7753** for automated help 24/7. Live help is also available seven days a week: Monday-Friday, 8 a.m.-11 p.m. | Saturday, 9 a.m.-4 p.m. | Sunday, 12 p.m.-4 p.m. (Eastern Time). (TTY services: 1.800.523.2847.)

Which frames are in Davis Vision's Collection?

Our Collection offers a great selection of fashionable and designer frames, most of which are covered in full. No wonder 8 out of 10 members select a Collection frame. Log on to our Member Site at **davisvision.com** and take a look!

When will I receive my eyewear?

Your eyewear will be delivered to your network provider generally within five business days of order receipt. Special prescriptions, lens coatings, provider frames or out-of-stock frames may delay the standard turnaround time.

Do I need a claim form?

Claim forms are only required if you visit an out-of-network provider. Claim forms are available on our Member Site at **davisvision.com**.

Can I split my benefits?

You may split your benefits by receiving your eye examination and eyeglasses or contact lenses on different dates or through different provider locations. To maximize your benefit value, we recommend that all services be obtained from a network provider.

Can I use an out-of-network provider?

Yes; however, you receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement, up to the following amounts: eye exam - \$40 | single vision lenses - \$40 | bifocal - \$60 | trifocal - \$80 | lenticular - \$100 | frame - \$50 | elective contacts - \$105 | medically necessary contacts - \$225.

Are there any exclusions to the vision benefits?

Your vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

DAVIS VISION EXTRAS!

One Year Breakage Warranty Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a network retail location where the Collection is not displayed.

Greater Benefits Access a higher frame allowance by visiting a Visionworks retail store⁷.

Additional Savings At most participating network locations, members receive up to 20% off additional eyeglasses, sunglasses and items not covered by the benefit and 10% off disposable contact lenses.⁸

Mail Order Contact Lenses Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.

Laser Vision Correction Up to 25% discount off participating provider's U&C or 5% off advertised special (whichever is lower). Log on to our Member Site at **davisvision.com** for details and to locate a provider.

Low Vision Services Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

Eye Health & Wellness Log on to and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

For more details... about your vision benefits, patient rights and responsibilities about Davis Vision or to obtain a copy of Davis Vision's Privacy Practices Notices, please log on to our Member Site at **davisvision.com** or call us at **1.800.278.7753**.

Davis Vision has made every effort to correctly summarize your vision plan features herein. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract will prevail.

Products and policies provided by Horizon Insurance Company and services provided by Horizon Blue Cross Blue Shield of New Jersey, each an independent licensee of the Blue Cross and Blue Shield Association. Communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies. Davis Vision supports Horizon Blue Cross Blue Shield of New Jersey in the administration of vision benefits. Davis Vision is independent from and not affiliated with Horizon Blue Cross Blue Shield of New Jersey or the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® names and symbols are registered marks of the Blue Cross and Blue Shield Association. The Horizon® name and symbols are registered marks of Horizon Blue Cross Blue Shield of New Jersey. © 2017 Horizon Blue Cross Blue Shield of New Jersey. Three Penn Plaza East, Newark, New Jersey 07105.

⁷ Enhanced Allowance is available at Visionworks store locations nationwide.

⁸ Additional discounts not applicable at Walmart or Sam's Club locations.

Fully insured product administered by Davis Vision, which may operate as Davis Vision Insurance Administrators in California.

Horizon Panorama IIIB (Horizon/Davis Vision View Network)



Horizon Panorama IIIB			
Frequency — Once Every:			
Eye examination including dilation (when professionally indicated)		12 months	
Spectacle lenses		12 months	
Frame		24 months	
Contact lens evaluation, fitting and follow-up care		12 months	
Contact lenses (in lieu of eyeglasses)		12 months	
Copayments			
Eye examination / Spectacle lenses / Contact lens evaluation, fitting and follow-up care		\$0 / \$10 / \$0 ¹	
Eyeglass Benefit — Frame		Member Charges	
Non-collection frame allowance (retail)		Up to \$130 or \$180 ² plus a 20% discount ³ on any overage	
Davis Vision Frame Collection ⁴ (in lieu of allowance):			
– Fashion level		Included	
– Designer level		Included	
– Premier level		\$25	
Eyeglass Benefit — Spectacle Lenses			
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)		Included	
Oversize lenses / Tinting of plastic lenses / Scratch-resistant coating		Included	
Polycarbonate lenses ⁵		\$0 or \$30	
Ultraviolet coating		\$12	
Anti-reflective (AR) coating (standard / premium / ultra)		\$35 / \$48 / \$60	
Progressive lenses (standard / premium / ultra)		\$50 / \$90 / \$140	
High-index lenses / Intermediate-vision lenses / Polarized lenses		\$55 / \$30 / \$75	
Plastic photochromic lenses		\$65	
Scratch Protection Plan: Single vision / Multifocal lenses		\$20 / \$40	
Contact Lens Benefit (in lieu of eyeglasses):			
Non-collection contact lenses: Materials allowance		Up to \$130 plus a 15% discount ³ on any overage	
Evaluation, fitting and follow-up care — standard and specialty lens types		15% discount	
Collection Contact Lenses ⁴ (in lieu of allowance):			
– Disposable		4 boxes/multipacks	
– Planned replacement		2 boxes/multipacks	
Evaluation, fitting and follow-up care		Included	
Visually required contact lenses (with prior approval) Materials, evaluation, fitting and follow-up care		Included	
Out-of-Network Reimbursement Schedule — Up to:			
Eye examination: \$40	Single-vision lenses: \$40	Trifocal lenses: \$80	Elective contact lenses: \$105
Frame: \$50	Bifocal/progressive lenses: \$60	Lenticular lenses: \$100	Visually required contact lenses: \$225

¹ Copayment applies to Collection Contact Lenses only.

² Members receive an additional \$50 allowance at Visionworks retail locations.

³ Additional discounts not applicable at Walmart, Sam's Club or Costco locations.

⁴ Davis Vision Collection is available at most participating independent provider offices. Frame collection is subject to change.

⁵ Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

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Horizon Blue Cross Blue Shield of New Jersey

HorizonBlue.com



Voluntary Vision Program

Horizon BCBSNJ

Plan Name—Horizon Panorama III –Alt B

Monthly Premium

January 1, 2026 to December 31, 2026

Category	Premium
Single	\$7.28
Family	\$26.36
Parent & Child	\$19.64

ENROLLMENT/CHANGE REQUEST

Horizon BCBSNJ Vision Plan

www.horizonblue.com

www.davisvision.com

Group Information - To Be Completed by Employ

A. Type of Activity - To Be Completed by Employer Refer to instructions on back before completing this form. Print clearly.

1. Enrollment ☐ New Subscriber Effective Date: ____/____/____ Date of Hire: ____/____/____		2. Change - Check all that apply. Date of Event: ____/____/____ Reason: ____ ☐ Add Spouse ☐ Domestic Partner ☐ Civil Union Partner ☐ Add Dependent Child ☐ Name Change ☐ Change Plan ☐ Other		3. Remove or Terminate - Check all that apply. Effective Date: ____/____/____ Reason: ____ ☐ Remove Spouse/Domestic Partner/ Civil Union Partner* ☐ Remove Dependent Child* ☐ Employee Withdrawal/Termination Note: Employee must be enrolled for spouse/domestic partner/civil union partner/ dependent(s) to have coverage. *Please complete Add/Change/Remove and Name columns in Section D.		4. Continuation of Coverage, i.e., COBRA, State, Total Disability Not all options are available. Contact Employer for available options. Coverage For: ☐ Employee ☐ Dependents Length of Continuation: ☐ 18 mos ☐ 29 mos* ☐ 36 mos ☐ Total Disability Date of Loss of Coverage: ____/____/____ Date of Qualifying Event: ____/____/____ *Attach proof of disability	
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B. Employee Information - Complete Sections B – G

C. Plan Option - Your selection must be offered by your employer.

Social Security Number	Last Name, First Name, M.I.		Home Telephone ()	
Home Address	Apt. No.	City, State	ZIP Code	
Employer Name			Work Telephone ()	
Work Address	City, State		ZIP Code	
Date of Employment	Hours Worked			

Horizon Panorama III III Alt B Contract Type ☐ S - Single ☐ F - Family ☐ 2 Adults ☐ P/C - Parent & Child
--

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children.

	A)dd C)hange R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number						
Employee			☐ ☐	/ /							
Spouse			☐ ☐	/ /							
Domestic Partner			☐ ☐	/ /							
Civil Union Partner			☐ ☐	/ /							
Child			☐ ☐	/ /							
Child			☐ ☐	/ /							
Child			☐ ☐	/ /							

E. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? ☐ Yes ☐ No If "Yes," who and at what address? If any dependent's last name differs from yours, explain the circumstances.	Explain the circumstances.
--	----------------------------

F. Employee Signature _____ Date _____

If you have any questions concerning the benefits and services provided by or excluded under this contract, contact a benefits representative at your company before signing this form.

G. Employer Verification - To Be Completed by Employer

I represent that all the information supplied in this enrollment/change request form is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/change request. I authorize deductions from my earnings for any required contribution.	Employee Signature - Required ☒		Employer Signature - Required ☒	
	Date: ____/____/____	E-Mail Address: _____	Title: _____	Date: ____/____/____



Plan Year 1/1/2026 to 12/31/2026

Flexible Spending Account

Group Name

Group #

What is a Flexible Spending Account (FSA)?

A Flexible Spending Account allows you to pay for eligible medical and dependent care expenses with pre-tax dollars. These valuable benefits, chosen by your employer as part of your benefits package, can help increase your take-home pay. We encourage you to take a moment to review the attached materials for more information.

Enrollment/Waiver

Please see the attached information to help you determine your election. The attached Enrollment Form must be completed, even if you are choosing to waive coverage.

2026 FSA Maximum Amounts

Medical FSA: **\$3,300 per year**

Dependent Care: **\$5,000 per year**



Run-Out Period

Claims for the **2026** plan year must be submitted by **March 31, 2027**.

Medical FSA Carryover – \$660

Any remaining medical FSA funds from the 2026 plan year, **up to \$660**, will be carried over into the 2027 plan year. During the run-out period, these funds are held in a separate “Rollover” account and can be used for eligible claims incurred in both the 2026 and 2027 plan years.

Termination of Employment

If your employment ends for any reason, you have **90 days** from your termination date to submit claims for expenses incurred before your termination date. Claims for expenses incurred after your termination date are not eligible.

Transportation Management Accounts (TMA)

TMAs allow employees to contribute up to \$325 per month for Transit and \$325 per month for Parking with pre-tax dollars. Unused funds can be carried over into the next plan year.

Point-C Flex

Important Contact Information



Hours of Operation:

Monday to Thursday 8:30 AM to 6:00 PM EST
Friday 8:30 AM to 4:30 PM EST

Claim Submission:

Email: flex@pointhealth.com

Fax: 856-888-2855

Contact your Point-C Claim Team: 1-855-408-6507

Mail: PO Box 2527 Overland Park, KS 66225

Refer to the web portal instructions for 24/7 account access to your Account Balance, Electronic



Flexible Spending Account (FSA)

What is a Flexible Spending Account (FSA)?

A Flexible Spending Account (FSA) allows you to set aside pre-tax dollars to pay for qualified expenses that you would normally cover out of pocket with after-tax dollars. By contributing to an FSA, you do not pay Federal or Social Security taxes on the money you deposit, which can lower your taxable income and potentially reduce your overall tax liability.

In this packet, you will find a worksheet to help you estimate your FSA election.

You may choose to participate in a Health Care Flexible Spending Account (FSA).

- FSA funds can be used for eligible expenses for you and anyone you claim as a dependent on your income tax return.

How to Set Up an FSA

- During your FSA Open Enrollment Period, it is a good idea to review your current year's health care expenses and estimate the amount you expect to spend out of pocket for the upcoming year.
- Through your employer, the amount you elect is available to you on your FSA plan effective date.
- The amount you elect is deducted from your paycheck tax-free, in equal installments throughout the year.
- By participating, your taxable income is reduced by the amount you contribute to your FSA.

Health Care FSA Eligible Expenses

FSA funds can be used for a wide range of qualified health care expenses, including but not limited to:

- Medical, prescription, dental, and vision expenses, including costs not covered by your health plan.
- Deductibles, coinsurance, and copayments
- Over-the-counter drugs and feminine hygiene care products (effective January 1, 2020)
- Hearing exams and hearing aids

Expenses are incurred when the service is provided, not when the participant is formally billed or pays for the service.

IRS Rules

In exchange for tax advantages of FSAs, the IRS imposes the following restrictions:

- **Use it or lose it** - amounts left in your account at the end of the year are forfeited. They cannot be returned to you or carried over to the next year unless your plan has adopted the 2 and a 1/2-month grace period OR the \$660 carry over option. See page 1 to find out which option applies.
- **No transfers** - you cannot use money from your health care FSA for other accounts, i.e., dependent care, transit, or vice versa.
- **No changes** - once you enroll you may not stop or change your contributions during the year unless you have a change in status.

It is important to plan carefully when deciding how much to contribute.

Please follow the instructions enclosed to register on our website and track your FSA expenses. If you have any questions, please contact the Point-C Flex Department at flex@pointhealth.com.

For a more complete list of health care and dependent care expenses that can be reimbursed through your FSA, you may contact the IRS at <https://www.irs.gov/forms-instructions-and-publications> for publications 502 and 503.

Note: Reimbursement under a health care FSA must be for medical care as defined in Code 213(d). Most, but not all, of the Code 213(d) rules are incorporated by reference into the rules governing health FSAs. There are two important differences. First, under a health care FSA, expenses can only be reimbursed in the year in which they are incurred, while an expense is deductible by a taxpayer for the year in which the expense was paid. Second, insurance premiums are not reimbursable under a health care FSA.

Qualified Health Care Expense Worksheet	
Medical/RX Insurance Out of Pocket Expenses (Deductible, Copayments, Coinsurance)	\$
Dental Expenses	\$
Vision Expenses	\$
Hearing Expenses	\$
Over The Counter Drugs	\$
Other Medically Necessary Out of Pocket Expenses	\$
Total Anticipated Health Care Expenses for the Plan Year	\$
Divided By the Number of Pay Periods	\$
Deduction Amount Per Pay Period	\$

Income Tax Filing: Married Filing Jointly with 4 Exemptions

FSA Savings Example Married Employee with Children

David and his wife, Vicki, both work outside the home and have a combined annual income of \$65,000 and two small children who are both in day care.

They decided to deposit \$1,200 in their Health Care Account to pay deductibles and copayments.

They also decide to deposit \$4,800 in their Dependent Care Account to help pay the children's day care expenses.

Expenses	With FSA	Without FSA
Gross Annual Pay	\$65,000	\$65,000
FSA Election for Health Care Expenses	\$1,200	\$0
DCA Election for Day Care Expenses	\$4,800	\$0
Adjusted Gross Taxable Income	\$59,000	\$65,000
Federal Income Tax	\$6,124	\$7,515
Social Security Tax	\$4,514	\$4,973
After Tax Health Care Expenses	\$0	\$1,200
After-Tax Day-Care Expenses	\$0	\$4,800
Net Annual Income	\$48,362	\$46,512
FSA Saved David & Vicki	\$1,850	

Expenses	With FSA	Without FSA
Gross Annual Pay	\$25,000	\$25,000
FSA Election for Health Care Expenses	\$500	\$0
Adjusted Gross Taxable Income	\$24,500	\$25,000
Federal Income Tax	\$2,621	\$2,696
Social Security Tax	\$1,875	\$1,913
After Tax Health Care Expenses	\$0	\$500
Net Annual Income	\$20,004	\$18,891
FSA Saved Tony	\$113	

Income Tax Filing: Single with Standard Deductions

FSA Savings Example Single Employee

Tony, recently out of college, is healthy earns \$25,000 a year. He decided to deposit \$500 into a Health Care FSA to pay for a new pair of eyeglasses.

FREQUENTLY ASKED QUESTIONS REGARDING FLEXIBLE SPENDING ACCOUNTS

- **What is an FSA plan?**

A flexible spending account is an employer-sponsored benefit that allows you to set aside pre-tax dollars to pay for eligible out of pocket medical, dental, vision & RX expenses and/or dependent daycare expenses.

- **Who owns the FSA?**

The money is the account holders to use during the plan year. Your employer owns the account and any unused balance, after the end of the plan year or any run-out period, is forfeited back to your employer.

- **Does the money in my FSA earn interest?**

No. The money is simply set aside tax-free to be used for qualified expenses.

- **How does the FSA work?**

You estimate your eligible expenses for health care and/or dependent care based on your needs for the upcoming year. You may take under consideration any regular maintenance medications you are on, any planned procedures (non-cosmetic), co-pays for office visits, co-insurance for medical equipment or dental work, prescription eyewear etc. Try the on-line FSA estimation calculator tool included in your member packet.

NOTE: This is a “use it or lose it” benefit so make your election wisely! Err on the side of conservative! Once you determine how much you want to have set aside from your pay you will be required complete an election form. The money you elect for your FSA will be automatically deducted from your paycheck over the course of a year on a pre-tax basis. When you have an eligible expense, you can either swipe your card at the point of service or manually submit a claim form along with supporting documentation to be reimbursed from your FSA. For health care FSA claims, you have access to your full election DAY.

1. For dependent care claims, you may only be reimbursed your accrued balance.

- **What does pre-tax dollars mean and why is this important?**

With an FSA, the money you set aside to pay for health care and/or dependent care expenses come out of your salary before taxes are withheld. This reduces your taxable income, and consequently, your tax liability. You pay for your eligible expenses with tax-free money from your FSA.

- **What is the difference between the health care FSA and the dependent care FSA?**

These are two separate accounts with separate purposes. Health care and dependent care elections and balances cannot be co-mingled. Health care elections are used for expenses such as doctor office co-pays, RX co-pays, prescription eyeglasses, and dental co-insurance. Dependent care elections are used for child day care and after school program fees.

- **Can I change my annual election amount?**

You can change your elected amount during the plan year only if you have a “Qualified Life Event.” Such as a change in employment status or family status (e.g., marriage, divorce, or the birth of a child). Contact your employer if any employment or family status changes occur to determine if your status change would allow you to modify your election amount. Election changes must be made within 30 days of the event.

- **Are there contribution limits?**

For health care FSAs, your employer determines the minimum and maximum amounts you can set aside in your FSA. However, because of Health Care Reform beginning January 1, 2025 the maximum contribution amount for the health care FSA will be \$3,300. For dependent care FSAs, the annual maximum you can contribute is \$5,000, including any amount set aside by a spouse into their dependent care FSA.

- **What happens to the money in the FSA if I do not use it all in one year?**

The IRS has a “use or lose” rule for FSAs. This rule states that you will lose any unused money still in your account at the end of the plan year. Your employer, however, may have a “run out” period after the plan year’s ends that allows you to submit claims for eligible expenses that were incurred during the plan year. This run-out period may or may not include a grace period that allows you to incur claims for up to 2.5 months after the end of the plan year and submit them against the prior year’s balance for reimbursement. Your employer may have a rollover option that allows a maximum dollar amount to roll over into the next year. Check with your employer or plan document to determine if your plan has a run- out period, rollover, or a grace period.

- **What are eligible medical expenses?**

Your health care FSA can be used to pay for a variety of health care expenses incurred by you, your spouse and your dependents. Doctor visits, chiropractor fees, prescription drug copayments, dental care and vision care not otherwise covered by a health plan are all eligible health care expenses. You may also use your FSA funds to reimburse eligible expenses under a spouse’s health plan. For a complete list of eligible expenses, see your administrator.

- **What are eligible dependent care expenses?**

Eligible dependent care expenses include in-home childcare, payments to licensed day care facilities, before or after school programs, and elder care. You may be reimbursed for dependent care expenses incurred for any individual in your family who is under age 13 and can be claimed as a dependent on your federal income tax return, or for a spouse or dependent who is not able to care for him or herself. These expenses must be incurred, regardless of when billed or paid, while you are working or looking for work.

Unlike a health care FSA, you are only able to receive a reimbursement from a dependent care FSA if sufficient funds have accumulated in your account from payroll deductions.

- **If my child turns 13 this year, can I use the dependent care account for the entire year?**

No. You may only submit claims for reimbursement for expenses incurred before your child reaches the age of 13.

- **I am enrolled in a Health Savings Account (HSA). Can I still enroll in an FSA?**

If you contribute to an HSA, you may only participate in a limited-use FSA and dependent care FSA. A limited-use FSA allows reimbursement of dental, vision, and preventive care services only.

- **How am I reimbursed from my FSA?**

You may use your Point C debit card at the point of service. This transaction will automatically be withdrawn from your election amount. You may also use your card to pay balance due for any eligible expenses. Please NOTE: in some cases, substantiation may be required. If you have an eligible expense, you can complete an FSA claim form and send it along with required supporting documentation by online portal, mobile app, mail, email, or fax. Claims forms can be found in your member packet, or contacting the Flex Team at Point C.

- **Where can I use my prepaid Point C card?**

IRS regulations allow you to use your Prepaid Benefits Cards in participating pharmacies, mail-order pharmacies, discount stores, department stores, and supermarkets that can identify FSA/HRA-eligible items at checkout and accept Mastercard® prepaid FSA cards. Eligible expenses are deducted from the account balance at the point of sale. Transactions are fully substantiated, and in most cases, no paper follow-up is needed. You may also use the Card to pay a hospital, doctor, dentist, or vision provider that accepts Mastercard®. In this case, there is auto-substantiation technology that electronically verifies the transaction’s eligibility according to IRS rules. If the transaction cannot be auto substantiated, a paper follow-up will be required.

- **How will I receive the FSA reimbursement for paper claims I submit?**

After your claim is approved, you will receive a check in the mail or direct deposit if you are allowed and opt in.

- **How often are claims for reimbursement paid?**

Claims are processed and paid on a weekly basis. After claims are approved, members are typically reimbursed from their FSA right away.

- **What is acceptable documentation for FSA claims?**

When you send a manual FSA claim, please include documentation, such as:

- * An explanation of benefits (EOB) that you received for the medical service for which you are filing a claim.
- * Receipts containing the type of service or product provided, date the expense was incurred, name of employee or dependent for whom the service or product was provided, person or organization providing the service or product, and the amount of the expense.
- * Payment plan for regular expenses such as orthodontia payment plans.
- * For dependent care expenses, a copy of the bill or signed receipt is acceptable. Also, have your provider complete the Dependent Care section of the claim form.
- * **IMPORTANT: WE MUST BE ABLE TO AUTHENTICATE WHO IS SUBMITTING A CLAIM.** You may include any of the following three points to be identified OR the last 4 Digits of your card number is acceptable by itself.

(Member full name, member email address, member full address, employer name, phone number, date of birth, last four of social.)

- **What about recurring claims, such as orthodontia payments?**

You can submit a health care FSA claim form with supporting payment plan documentation from the service provider. This eliminates the need to send in a claim form for each payment. You will automatically receive monthly allocation reimbursements up to your annual elected amount. You will need to submit a new orthodontia claim each year.

- **How do I keep track of my FSA balance?**

You should always know your account balance before you make a purchase with your Card. You can visit your Account Summary page at www.pointc.wealthcareportal.com thru the member portal and view your account activity and current balance. You will need to register to view your account – simply follow the online instructions. Access your account with the mobile app! It's free, secure and easy!

- **Can I elect the FSA plan even if I am not enrolled in my company's health plan?**

Yes, provided you meet the FSA plan's eligibility requirements.

- **What happens to the money in the FSA if I leave my employer?**

If you leave your place of employment during the plan year, you may have a period after termination to submit claims for reimbursement. Services and health care expenses must be incurred before your termination date unless you continue to contribute to your health care FSA account through COBRA. Check with your employer for more information.

- **My spouse and I are each offered an FSA through our employers, can we both elect?**

Yes. You cannot however, use both FSAs to pay for the same expense. As a bonus, if you both have a health care FSA, you may each be eligible to elect up to the maximum contribution of \$3,300, for a combined household contribution of \$6,600.

- **How does participation in my employer's dependent care FSA affect my ability to claim the dependent care tax credit on my federal income tax returns?**

You cannot claim a dependent care tax credit for amounts received under an employer's FSA plan. You may wish to consult with a tax advisor to determine whether the FSA plan or the dependent care tax credit is more beneficial in your individual case. Generally, the higher your income, the more beneficial it is to participate in the dependent care FSA.

- **Can I continue to use an FSA after I retire?**

No. Only active employees are eligible to participate in an FSA. Retirees are not eligible to have an FSA.

- **My domestic partner is covered on my insurance plan. Can I use my FSA for my domestic partner's medical expenses?**

If your domestic partner meets the IRS qualifications of a tax dependent, you can legally use your FSA funds for his or her medical expenses. If your partner does not meet the qualifications, you cannot use your FSA for any of their expenses.

- **Can I use my FSA to pay for voluntary cosmetic surgery?**

No. The FSA can however, be used for cosmetic surgery *only* if prescribed by a physician and deemed medically necessary.



Dependent Care Account (DCA)

You may also choose to participate in a Dependent Care FSA, which allows you to set aside pre-tax dollars to help pay for dependent care expenses while you are working.

- * Funds can be used for the care of an eligible dependent while you (and your spouse, if applicable) are working
- * The IRS annual contribution limit is \$5,000 if filing Married Jointly or Head of Household.
- * The IRS annual contribution limit is \$2,500 if filing Married Separately.

How to Set Up a Dependent Care FSA

Setting up a Dependent Care FSA is simple and can help you save money on qualified dependent care expenses.

- * Review your current dependent care expenses and estimate how much you expect to spend next year.
- * The amount you elect will be deducted from your paycheck tax-free throughout the year.
- * Unlike a Health Care FSA, funds are not available in advance; they become available as contributions are made.
- * By participating, your taxable income is reduced by the amount you contribute to your Dependent Care FSA.

Dependent Care Account Eligible Expenses

Eligible expenses are those incurred for the care of an eligible dependent and must be necessary so that you — and your spouse, if married — can work. Examples of eligible expenses include:

Babysitters and in-home caregivers	Licensed day care centers
Preschool or nursery school programs	Summer day camps (not overnight camps)

Eligible Dependents

A child under 13 or any dependent, including a spouse or parent, who lives with you and is physically or mentally incapable of self-care.

How to Claim Reimbursement from Your FSAs

You must submit a Reimbursement Claim Request form and a receipt for your dependent care expense for reimbursement.

The receipt must include:

- * Name of person receiving care.
- * Name of the Care Provider with their Tax Identification number or Social Security Number.
- * Date(s) care was rendered with the corresponding cost.

Reimbursement

- * You will receive the full amount of your claim provided you have enough funds in your account.
- * If you do not have enough money in your account, you will receive partial payment, and the balance will be sent once you have the funds in your account.

IRS Rules

In exchange for tax advantages of FSAs, the IRS imposes the following restrictions:

No Grace Period, No Carry Over Provision

You cannot Transfer money from your Dependent Care to your Medical FSA and vice versa.

You can only make changes during open enrollment or if you have a life event.

Qualified Dependent Care Worksheet

Childcare Service	\$
Pre-School	\$
After School Care	\$
Other Dependent Care Expense	\$
Total Anticipated Health Care Expenses for the Plan Year	\$
Divided By the Number of Pay Periods	\$
Deduction Amount Per Pay Period	\$

What is a Transportation Management Account?

A Transportation Management Account, also called a "TMA," allows employees to contribute pre-tax dollars for commuting expenses. Within a TMA, there are two "sub" categories: a Mass Transit Account and a Parking Account. Allowing you to save money on expenses you already incur.

- * **Mass Transit** - Qualified transit or bus expenses to and from work
- * **Parking** - Qualified parking at or near a transit stop or station, paid parking at your work location

How is a TMA funded?

You contribute to a TMA through payroll deductions. Your deductions can be made on a pre-tax basis, which means before taxes, FICA, and Medicare are taken out of your paycheck.

How much money can I set aside in my account on a pre-tax basis?

Effective 1/1/2025, if you have qualified expenses, you may contribute on a pretax basis up to \$325 a month into the **Mass Transit Account** if you have qualified mass transit expenses, and \$325 a month into the **Parking Account** if you have qualified parking expenses.

These limits are set by the IRS, our benefit packet will be updated as the limits change. Should your monthly expenses for transit or parking be higher than these amounts, your employer may allow you to contribute additional funds on a post-tax basis – be sure to check your employer's benefit plan design.

IRS Requirements

- * The IRS requires the use of your Point-C Benefit Debit Card for all **transit** expenses.
- * Pre-tax **transit & parking** funds can only be used at authorized vendors.
- * You can make changes to your **transit & parking** contribution throughout the year as long as you do not exceed the annual limit, check with your employer regarding change restrictions
- * Retroactive changes are not allowed
- * Funds for **transit & parking** rollover month to month, ONLY **parking** has a run-out period, unused **transit** funds are forfeited when employment ends
- * Pre-tax **transit & parking** expenses are not tax deductible, however Post-tax **transit & parking** expenses are tax deductible
- * Your Point-C Benefit Debit Card is optional for **parking** expenses, If another form of payment is used for **parking**, you will need to submit your receipt and claim form for reimbursement
- * Money from the **parking** account cannot be used for mass **transit** expenses, and vice versa.

Examples of qualified Transportation and Parking expenses

- * Transit Passes, Tokens, Fare Cards, and Vouchers
- * Parking in order to use mass transit and Parking at your work location
- * Commuter highway vehicles seating at least 6 adults, not including the driver, at least 80% of the vehicle's mileage must be for transportation between home and work and employees must occupy at least half of the seating space

Examples of Non-qualified expenses

- * Carpooling, Tolls, Mileage, Gas
- * Transportation and/or Parking expenses to attend work meetings or leisure events
- * Expenses incurred by your spouse and/or dependents in connection with their commutes

Please go to the IRS web site for more information regarding Internal Revenue Code Section 132, and be sure to check your employer's benefit plan material, too.

Questions or Concerns? Please call Point-C at 855-408-6507 or e-mail flex@pointchealth.com

PO Box 25247 Overland Park, KS 66225

Transit Benefits – Terminal Restrictions

The IRS requires debit card use for the pre-tax transportation benefit, manual claim reimbursement is not allowed. Your Point C Debit Card will work at the transit vendor terminals that sell only transit media fares. If the cost of your pass exceeds your current Transit Account balance, you will need to split the payment at the ticket counter and use another form of payment for the difference.

Please note: The separate Parking Benefit does allow the option of manual claim reimbursement or the use of your Point C Debit Card.

It is recommended that you purchase your transit passes at terminals similar to the ones shown or on the transit vendors web site.

If a ticket counter sells other items such as newspapers, food items, etc, your card will be declined.

If you are unsure of whether or not the transit vendor that you use will be compliant with the terminal restrictions, please contact Point C at 855-408-6507, and we will be happy to assist you.

Introducing uberPOOL, Lyft, and Via!

Point C is excited to announce a new feature that enables your Point C Benefits Debit Card to pay for eligible uberPool, Lyft, and Via rides using your Transit Benefits.

Within select cities, these companies offer van pool-compliant vehicles for you to commute to/from your workplace. These compliant vehicles hold a minimum of 6 passengers, as you will be sharing this ride with other commuters (in the true spirit of commuter programs).

Using your Point C Benefits Debit Card to pay for these services is easy!

1. Sign up for the eligible provider in your area using their mobile app.
2. Add your Point C Benefits Debit Card to the wallet to your provider's account.
3. When you request a ride, choose your IAA Benefits Debit Card as the payment method.
4. When the ride is requested, the service provider will automatically send you a compliant vehicle.

These ridesharing companies are available for use in the following cities:

UberPool

Atlanta, GA
Boston, MA
Chicago, IL
Denver, CO
Las Vegas, NV
Los Angeles, CA

Miami, FL
New York, NY
Philadelphia, PA
San Diego, CA
San Francisco, CA
Seattle, WA
New Jersey
Washington DC

Lyft Line

Atlanta, GA
Austin, TX
Boston, MA
Chicago, IL
Denver, CO
Las Vegas, NV
Los Angeles, CA

Miami, FL
Nashville, TN
New Jersey
New York, NY
Philadelphia, PA
Portland, OR
San Diego, CA
Seattle, WA

Silicon Valley
Washington DC

Via

Chicago, IL
New York, NY
Washington DC



Questions or Concerns? Please call Point-C at 855-408-6507 or e-mail flex@pointchealth.com



WealthCare Portal Online Enrollment

It's time to enroll in your employer offered Tax Advantage accounts! Online enrollment for these benefits is available at <https://pointc.wealthcareportal.com>.

If you currently have an account.

You will receive an email with a link and instructions on how to enroll in the new plan year.

If you are new or have never enrolled.

You will need to register before making your elections. You can do this by selecting "Register" at the bottom of the home page, then fill out the appropriate information.

Your employee ID is your SSN with no dashes, and the registration ID is the name of your employer.

Enrollment Steps.

1. Visit the "My Accounts" tab and select "Online Enrollment".
2. On this screen, you will see all the plans that are available for enrollment.
3. You must select either "Enroll" or "Waive" for each plan offered.
4. Read the instructions at the top of the enrollment form, and fill out all of the required fields. If you do not have time to complete all of the information, you can click the "Save for Later" button and come back to it any time during the Open Enrollment Period.
5. On the next page, you will choose your annual election. The system will calculate the annual amount based on your per pay election. Check the box to agree to the terms of enrollment and hit "next".
6. The last page will confirm all of the options for the plan chosen. You can make changes by hitting the "Edit Info" button. If there are no changes, hit "next".
7. You are now enrolled in this plan. You have until midnight May 19th to make any changes.
8. Please continue this process for all of the available plans, even if you are choosing to waive enrollment.

If you have any concerns or questions during the online enrollment process, please contact Point C directly at 1-855-408-6507 option 1 for Flex department or flex@pointchealth.com.

Thank you for using our online enrollment system!
Flexible Spending Department

Mobile Convenience

For ultimate convenience, get 24/7 access, direct from your tablet or mobile device.

Getting started

- * Install "Point C Benefits Mobile" from the App Store or Google Play .
- * If you previously registered online, enter your User Name and Password to access your account.

To Register:

- * Enter your first and last name, and zip code.
- * If prompted, enter Employer Name and Employee ID (SSN without dashes)
- * The portal will then prompt you to send a one-time passcode to verify your identity. Enter the code to continue.
- * Create a username and set up your security questions.
- * If no e-mail or mobile phone is in our records, please contact us to update and set up account 855-408-6507.
- * Once completed, you'll be able to access your account!



Check out these convenient mobile features, which help make managing your healthcare easier than ever.

Access accounts: Check balances, view transaction

Manage claims: Submit new claims, upload receipts and check claims status.

Track and pay expenses: Track medical claims and other expenses.

Access cards: Manage card details, access your PIN, and more.

Receive alerts: View important account messages.

Update your profile: Update personal information, including your email and mobile phone.

Calculate your tax savings:

<https://pointc.wealthcareportal.com/Page/TaxSavings>

Online Control

The member website provides powerful self-service account access, plus education and decision-support resources to help put you in the driver's seat.

Getting started

- * Register at <https://pointc.wealthcareportal.com>.
- * Enter your first and last name, and zip code.
- * If prompted, enter Employer Name and Employee ID (SSN without dashes)
- * The portal will then prompt you to send a one-time passcode to verify your identity. Enter the code to continue.
- * Create a username and set up your security questions.
- * If no e-mail or mobile phone is in our records, please contact us to update and set up account 855-408-6507.
- * Once completed, you'll be able to access your account!



Enjoy a full suite of capabilities that help you maximize your healthcare experience.

Full account details: View plan details and account history.

Multimedia education: Learn more about account features, benefits, and how to optimize your experience.

Interactive tools: Access tools and calculators to help you plan and make critical spend/save decisions.

Communications: View a complete history of account communications and manage your personal preferences.

Self-service: Take advantage of expanded account servicing options to manage your account and answers to your questions.

10 Tips to optimize your account experience.



Use your debit card whenever possible to avoid the hassle of filing claims.



Submit claims via mobile app or our member website for quicker reimbursement.



Check your balance 24/7 via mobile app, text, or our member website.



Upload and store your receipts for quick reference and safekeeping.



Register to receive mobile alerts to stay engaged with your account.



Register your bank account to enable direct deposit and avoid reimbursement delays.



Use our convenient eligibility checker to verify that an expense is eligible.



Use online bill pay to pay providers for qualified expenses.



Snap a picture and upload receipts instantly - right from your mobile device.



Track all of your healthcare spending with our online expense tracker.



SUBSTANTIATION DETAILS & INFORMATION REGARDING YOUR POINT C CARD

- The Point C card is a limited merchant category Mastercard® Card which provides instant access to your plan's funds, reducing out-of-pocket expenditures for which you must file a claim and await reimbursement.
- By using the Point C Card, there is less paperwork to submit. It is designed to work at merchants with a health-care merchant category code, such as a doctor's office, hospital, dentist or optometrist. The IRS allows the following tools to reduce paperwork submitted to Point C.
 - The IRS allows the plan to automatically substantiate any card transaction that is up to 5X the health plan's copay and is an even number. (ie: if the health plan copay is \$50, the plan can automatically substantiate up to \$250) Therefore, you will not need to submit documentation.
 - The Point C Card will also work at retail merchants which have an Inventory Information Approval System (IIAS) in place. The IIAS will provide automatic substantiation at the point of sale for FSA-eligible items. This means you can only purchase eligible items with your card at these locations, and you will not need to submit documentation. (ie: typically CVS, Walgreens, Target, Walmart, and more)
 - A recurring transaction for which documentation for the first purchase in a plan year was provided to Point C will also automatically substantiate. Recurring transactions must match exactly to automatically substantiate.
- Documentation will need to be submitted for debit card purchases that do not meet the above auto-substantiation criteria. You will receive a statement from Point C via email or paper form if there are transactions for which documentation is required per IRS rules.
- The documentation must contain the following information: Provider, Date of Service, Details of the Service/ Purchase and the Patient Responsibility. An Explanation of Benefits from the insurance plan or a detailed bill from the provider works best.
- You will receive one card that will be mailed to the address on file with Point C's FSA department. If you need additional cards for your spouse or dependents, you can order them through the online portal or by calling Point C Flex Department. Keep your card even if you have used all available funds from your account.

**The card will not expire for 5 years. Your new election in subsequent years will be loaded to this card.
Additional cards or replacement cards are at cost.**

Note: According to IRS requirements, save your receipts Even if you are not required to provide documentation for substantiation of the charges, you should keep your receipts in case of a tax audit.

If you have any questions regarding substantiation, how to use your Point C card, eligible items, or need more information about your FSA/HRA/HSA plan(s):

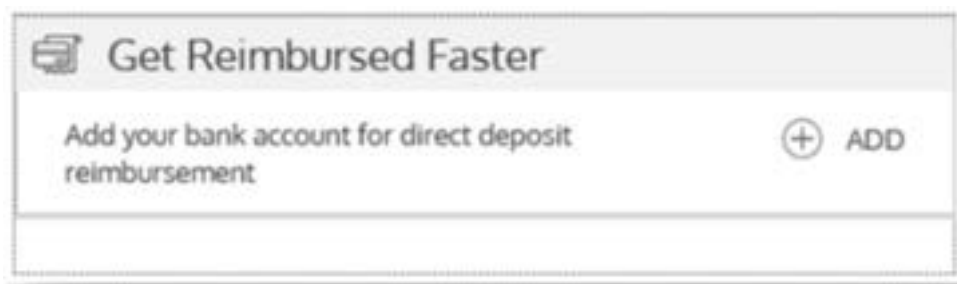
Questions or Concerns? Please call Point-C at 855-408-6507 or e-mail flex@pointchealth.com

PO Box 25247 Overland Park, KS 66225

Direct Deposit—Micro Validation

To eliminate hassles and delays caused by invalid participant direct deposit accounts, Point-C has implemented a bank account validation process for new direct deposit accounts. As a participant, you will obtain *micro-transaction* amounts from your bank account and enter them into the WealthCare Portal or Mobile application.

Once you are logged into the portal, you will see the below widget on your home page:

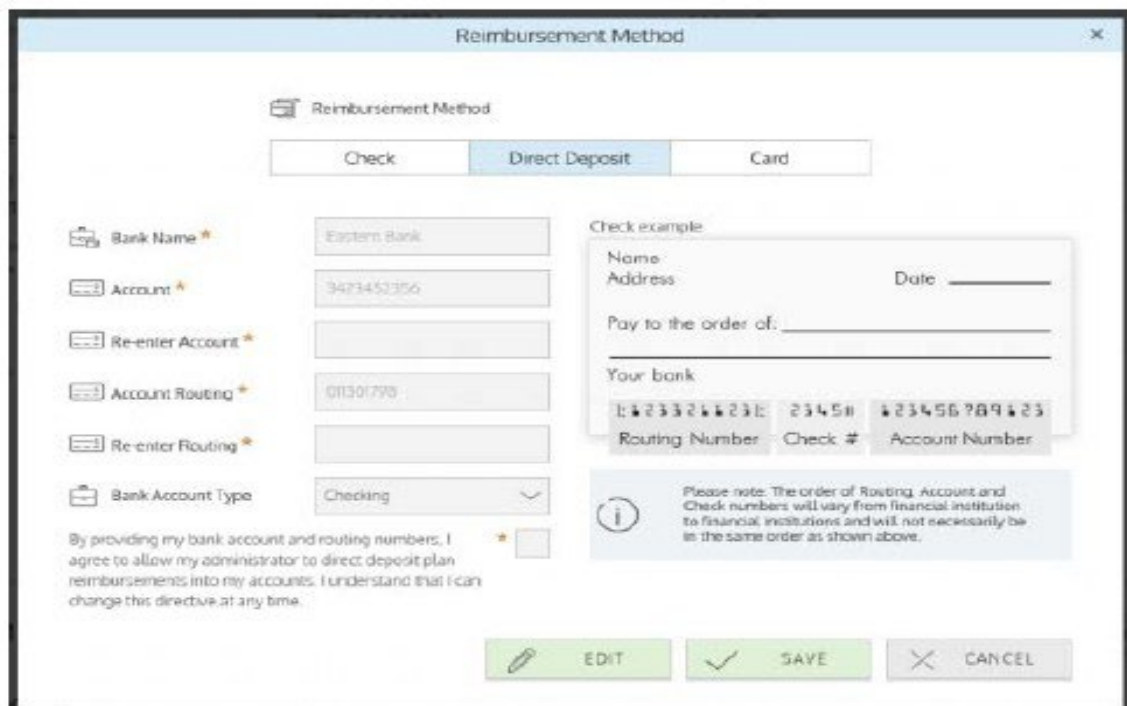


Get Reimbursed Faster

Add your bank account for direct deposit reimbursement

+ ADD

Click the “Add” button and fill in the account information as shown below:



Reimbursement Method

Reimbursement Method

Check Direct Deposit Card

Bank Name * Eastern Bank

Account * 3473452356

Re-enter Account *

Account Routing * 011301790

Re-enter Routing *

Bank Account Type Checking

By providing my bank account and routing numbers, I agree to allow my administrator to direct deposit plan reimbursements into my accounts. I understand that I can change this directive at any time.

Check example

Name _____ Date _____

Address _____

Pay to the order of: _____

Your bank

1 2 3 3 2 1 2 3 1 2 3 4 5 6 7 8 9 1 2 3

Routing Number Check # Account Number

Please note: The order of Routing, Account and Check numbers will vary from financial institution to financial institutions and will not necessarily be in the same order as shown above.

EDIT SAVE CANCEL



Questions or Concerns? Please call Point-C at 855-408-6507 or e-mail flex@pointhealth.com

PO Box 25247 Overland Park, KS 66225

Direct Deposit—Micro Validation

Once you have filled out your direct deposit information, two small credits and one offsetting debit will be processed against the bank account entered. These credits are random amounts between \$0.05 and \$0.25.

The screenshot shows a web form for direct deposit micro-validation. It includes fields for 'Account Routing *' (021000021), 'Re-enter Routing *', 'Bank Account Type' (Saving), and 'Account Status' (Validation Required). A green 'VALIDATE ACCOUNT' button is highlighted with an orange box. To the right, there are input fields for 'Routing Number', 'Check #', and 'Account Number' with sample numbers. A note states: 'Please note: The order of Routing, Account and Check numbers will vary from financial institution to financial institutions and will not necessarily be in the same order as shown above.' At the bottom, there is a checkbox for agreement and buttons for 'EDIT', 'SAVE', and 'CANCEL'.

When the credits have been processed, an e-mail will be generated to the e-mail on file (be sure your information is up to date!) letting you know to validate your account. You will need to check your bank account to obtain the credit and debit amounts.

Then you will log back into the Wealthcare Portal or Mobile app and enter the transaction amounts on the reimbursement settings page. If the amounts are correct, you will have successfully validated your account and are ready to receive direct deposits!

The screenshot shows the 'Reimbursement Method' form. It has a section titled 'Enter the amounts to validate bank account' with three input fields: 'Amount 1 *' (0.18), 'Amount 2 *' (0.29), and 'Amount 3 *' (0.11). A green 'SUBMIT' button is at the bottom left. To the right, a confirmation message is displayed in a box: 'Validation was successful. Now your direct deposit bank account is active.' Below this message is a green 'OK' button.

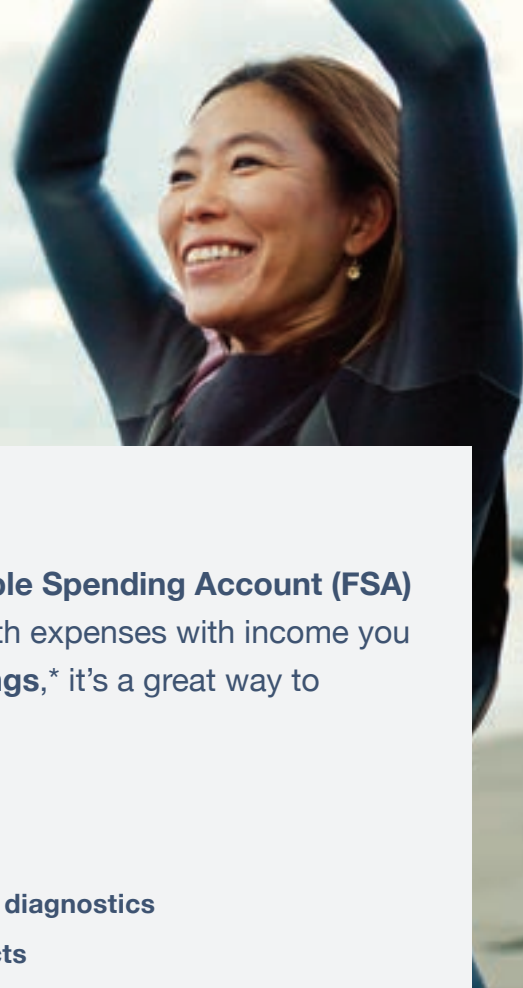


Questions or Concerns? Please call Point-C at 855-408-6507 or e-mail flex@pointhealth.com

PO Box 25247 Overland Park, KS 66225



Enroll in an FSA — and keep more of your money



Stretch your dollars and save more

Who wouldn't like to keep more of their income? Enrolling in a **Flexible Spending Account (FSA)** can help you do just that. An FSA lets you pay for many of your health expenses with income you won't be taxed on. That's right, **with an estimated 30% in tax savings,*** it's a great way to reduce your taxes and effectively **increase your take-home pay.**

Use an FSA to pay for:

- ✓ Doctor visits
- ✓ Prescription eyeglasses & contacts
- ✓ Prescription & over-the-counter meds
- ✓ Dental care
- ✓ Health trackers & diagnostics
- ✓ Menstrual products
- ✓ SPF & skincare products
- ✓ First aid & pain relief, and much more!

Benefits you can see immediately

You can contribute up to \$3,300 to your FSA

Bonus: FSA benefits extend to your spouse and dependents as well.

*Assumes average tax rates, including state, federal and FICA taxes.
For illustrative purposes only. Individual earnings may vary.
†Check with your HR representative for details on your plan.

Explore what an FSA
can do for you at
FSAsore.com

Enjoy extra savings on us



100% ELIGIBILITY
GUARANTEED



ALL FSA CARDS
ACCEPTED



2,500+ FSA ELIGIBLE
PRODUCTS

\$5 OFF[‡]

USE CODE **TAKE24EN**

Visit **FSAsore.com**
to redeem your offer.

[‡]One use per customer.
Exp. 6/30/2025. See Terms for details.

Employee Election/Salary Reduction Form Flexible Spending Account

1. EMPLOYEE INFORMATION						
Last Name:		First Name:		M.I.:	Employer:	
Address:				Date of Hire:		Hours/wk:
City:			State:	Zip:	SSN:	
Home Phone:		Business Phone #		Ext.:	Date of Birth	
Email Address:			Marital Status: ☐ Married ☐ Single		Gender: ☐ Male ☐ Female	
Plan Year:		Effective Date:		☐ Waive Coverage		
Election Effective Date:				Date Payroll Deduction Begins:		
Payroll Period: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly						
2. FLEXIBLE SPENDING ACCOUNT (FSA) PRE-TAX BENEFIT ELECTIONS						
FSA Plan Maximum Contribution \$3,300		Rollover Amount \$660 (Your Plan may not offer this option)				
Please Select One:		FSA Payroll Contribution:		FSA Employer Contribution:		
☐ Flexible Spending Account – Health ☐ Limited Flexible Spending Account*		Per Pay Contribution \$ Annual Contribution \$		Per Pay Contribution \$ (Your Plan may not offer this option)		
*NOTE:	If you or your spouse have a Health Savings Account (HSA), FSA benefits are limited to Dental and Vision Expenses ONLY or Post Deductible expenses. Do you have an HSA?					☐ Yes ☐ No
3. DEPENDENT CARE ACCOUNT (DCA) PRE-TAX BENEFIT ELECTIONS						
Dependent Care Maximum Contribution \$5,000		If Married Filing Separately \$2,500				
☐ Flexible Spending Account – Dependent Care Per Pay Contribution \$ Annual Contribution \$				FSA Dependent Care Employer Contribution: Per Pay Contribution \$ (Your Plan may not offer this option)		
3. DEPENDENT INFORMATION						
Last Name	First Name	M.I.	Social Security	Date of Birth	Gender	F/T Student
Spouse:					☐ M ☐ F	☐ Y ☐ N
Child:					☐ M ☐ F	☐ Y ☐ N
Child:					☐ M ☐ F	☐ Y ☐ N
Child:					☐ M ☐ F	☐ Y ☐ N
Child:					☐ M ☐ F	☐ Y ☐ N
4. CERTIFICATION						
I am electing the benefit(s) as indicated above. I understand that: - FSA contributions will be deducted from my paycheck on a pre-tax basis. - The Plan Sponsor may reduce my election to prevent the plan from becoming discriminatory. - The election(s) I make will remain in effect until the end of the plan year. Changes will only be permitted if there is a relevant change in family status (e.g. marriage, divorce, death of spouse, birth or adoption of child, or if you or your spouse experience a change in employment). - I understand that FSA salary reductions must be reimbursed for qualified expenses incurred during the plan year (or applicable grace period) and may not be carried over (unless your employer has elected the carry over option). If at the end of the plan year, the total reduction in compensation exceeds the substantiated expenses, the difference in amount reverts to the plan sponsor. I authorize my employer to make the required pre-tax payroll deduction(s) for the FSA benefit(s) elected and acknowledge that my Social Security Benefits may be reduced due to my election.						
Signature		Date		Employer Approval		Date

Qualified Expense Worksheet

HEALTH CARE EXPENSE WORKSHEET (Includes Medical, Dental and Vision Expenses Not Covered by Insurance)	
Co-Payments/Co-Insurance/Deductibles	\$
Dental Expenses (braces, exams, preventative, crowns, etc.)	\$
Vision Expenses (eye exams, glasses, contacts & supplies)	\$
Hearing Expenses (exams, hearing aids, batteries)	\$
Prescription and Over-The-Counter Drugs (OTC drugs must be prescribed as of 01/01/2011 to be eligible)	\$
Other Medically Necessary Un-Reimbursed Expenses (IRS Publication 502 section 213)	\$
Total anticipated health-related expenses for the Plan Year	\$
Divide total anticipated expenses by # of pay periods	\$
Deduction Amount Per Pay Period	\$

DEPENDENT CARE EXPENSE WORKSHEET	
Total Day Care Expenses for:	
First Quarter (January – March)	\$
Second Quarter (April – June)	\$
Third Quarter (July – September)	\$
Fourth Quarter (October – December)	\$
Total Expenses for Dependent Care Services (IRS Pub. 503)	\$
Total planned dependent care expenses for the Plan Year	\$
Divide total planned expenses by # of pay periods	\$
Deduction Amount Per Pay Period	\$

Transportation & Parking Account Enrollment Form

Transportation Management Account allows employees to elect to contribute pre-tax dollars for commuting expenses. This form is to be completed to enroll, stop or make changes to your elected salary deductions for your Transportation Management Account. Please print all information completely, sign and date and return to your employer as soon as possible.

Employee First Name	M.I.	Last Name	Date of Birth	
Email			Effective Date	
Home Street Address	City	State	Zip	
Name of Employer				
Worksite Street Address	City	State	Zip	
Social Security Number	Telephone Number			

I. ELECTION OF QUALIFIED TRANSPORTATION BENEFIT

Please elect one or more of the following qualified transportation benefits. Mass transit includes any public transit including subway and buses, suburban buses, van pools and ferry services. Private car pools, mileage, tolls, etc. are **not** covered in transit expenses. ***The limits are subject to change based on IRS regulations.***

☐ Mass Transit: I authorize my Employer to deduct \$ _____ per month (up to \$325.00 a month maximum) on a pre-tax basis from my paycheck.	
☐ Mass Transit: I authorize my Employer to deduct \$ _____ per month on a post-tax basis from my paycheck.	
☐ Commuter Highway Vehicle/Van Pooling: A commuter highway vehicle must have seating capacity for at least six adults (not including the driver) and at least 80% of the mileage must be expected to be used for the purpose of commuting with three adults (not including the driver) actually riding in the vehicle.	
I authorize my Employer to deduct \$ _____ per month (up to \$325.00 a month maximum) on a pre-tax basis from my paycheck.	
Name of Organization or Person providing the Commuter Highway Vehicle:	
<i>Note: The combinations of Mass Transit and Van Pooling have a combined maximum election amount of \$325.00 per month.</i>	
☐ Qualified Parking: I authorize my Employer to deduct \$ _____ per month (up to \$325.00 a month maximum) on a pre-tax basis from my paycheck for parking.	
Total monthly deduction amount for transportation and parking amount (cannot exceed \$325/month for Mass Transit and/or Vanpooling combined + \$325/month parking)	(maximum)

Transportation & Parking Account Enrollment Form

II. CHANGE IN QUALIFIED TRANSPORTATION BENEFIT

Complete the **CHANGE** section only if you want to change or cease the dollar amount of your payroll deduction. It **is not** necessary to complete this section if you are only changing your **method** of transportation or parking location.

☐ **Change of Deduction** - I elect to **change** my deduction in the program:

☐ from \$ _____ for **Mass Transit** to \$ _____ per month.

☐ from \$ _____ for **Commuter Highway Vehicle** to \$ _____ per month.

☐ from \$ _____ for **Qualified Parking** to \$ _____ per month.

☐ **Change in Name and/or Address**

☐ **I elect to cease participation in the program:** I understand that my Employer will cease my payroll deduction for the program as soon as possible.

CERTIFICATION & SIGNATURE

Date

I agree that any unclaimed amount deducted from my paychecks under the Transportation Management Account will be forfeited. I hereby certify that I have elected the above Qualified Transportation Benefit, and will use that Benefit only for the purposes of commuting to and from work at the Employer.

Signature of the Employee

Date

EMPLOYER USE ONLY

THIS FORM WILL NOT BE PROCESSED UNLESS COMPLETED BY EMPLOYER REPRESENTATIVE

☐ Election for Qualified Transportation Benefit

Employee effective date: _____

Salary reduction amount will begin on: _____

☐ Change in Deductions

Effective payroll date: _____

Change amount from \$ _____ to \$ _____ for Mass Transit.

Change amount from \$ _____ to \$ _____ for Commuter Highway Vehicle.

Change amount from \$ _____ to \$ _____ for Qualified Parking Account.

☐ Termination of employment:

Date of Termination: _____

Last Payroll Date: _____

Year to date contribution \$ _____

Signature of Employer Representative

Date



Po Box 25247 Overland Park, KS 66225

FSA Claim Form Documentation

Important Claim Submission Information

FSA's do not allow advance reimbursement.

All services must have been provided before you submitted for reimbursement.

Expenses that are reimbursable by other insurance or programs are not eligible for reimbursement.

All documentation should show date of service, procedure performed and prove the claim was initially processed by your health care carrier.

IMPORTANT: WE MUST BE ABLE TO AUTHENTICATE WHOM IS SUBMITTING A CLAIM.

You may include any of the following 3 points to be identified OR the last 4 Digits of your card number is acceptable itself.

Member full name, member email address, member full address, employer name, phone number, date of birth, last 4 of social.

Acceptable Documentation for Reimbursement

Medical

A copy of the Explanation of Benefits (EOB).

Prescription

A copy of the pharmacy Prescription Medication detail sheet.

Dental and Vision

A copy of the statement or itemized bill showing the date of service, procedure/items purchased and name of the person receiving the service/items.

Over-the-Counter Purchases (OTC)

A copy of the itemized register receipt. If the receipt abbreviates product names provide the name of the product to ensure a timely reimbursement.

Claims will not be processed if the claim form is not completed or if the proper documentation is not received.

If you have questions regarding an expense, please feel free to contact us.



Dependent Care Account Claim Form

Employer Name			
Last name		First name	Social #
Address ☐ Check box if this is a new address			
City		State	Zip
Email	Phone	☐ Check if Point C Benefits Card was Used	

All requested information on this form must be provided along with a copy of your statement/receipt from your dependent care provider. Incomplete forms will not be processed.

Provider Name		Provider Tax ID	
Provider Address			
Name of Child(ren)	Date of Birth	Dates of Service	Total

I hereby certify that the above information is correct and authorize payment through my Dependent Care Flexible Spending Account. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim, which is provided by the undersigned. Unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense.

I further certify that these expenses did in fact occur within the current plan year and have not been reimbursed under this or any other plan and I will not seek reimbursement for them under any other plan. I understand that reimbursed expenses are not eligible for any federal income tax deduction or credit (such as Dependent Care Tax Credit). I agree to file IRS Form 2441 with my tax return and provide any day care provider taxpayer identification number required thereon. Misrepresentation may lead to adverse employment action and taxable W-2 income.

****Note: Date and Provider signature is required AFTER services have been rendered, not at time of payment.**

Employee Signature: _____

Date: _____

Provider Signature: _____

Date: _____

(Required if separate receipt not submitted)

Dependent Care Reimbursement Instructions

Important Claim Submission Information

The following information **MUST** be included on your statement in order to receive payment:

Provider's name
Provider's address
Provider's Tax ID #
Child's name
Child's date of birth

You **MUST** provide receipts, statements or bills from your dependent care provider proving that expenses have been incurred.

Cost of the services provided on those dates.

Please Note

Canceled checks and credit card receipts will not be accepted.

Signature of dependent care provider is only needed if separate receipts are **NOT** submitted.

Employee signature must be provided.

If you have questions regarding an expense, please feel free to contact us.

This plan is governed by IRS guidelines. To satisfy IRS requirements documentation is needed to process your claim(s). When submitting for reimbursement, please complete and provide necessary documentation. This will quicken the processing time of your claim(s). Please visit our website <https://pointc.wealthcareportal.com/Page/Home> for additional forms.



Contact Information & Claim Submission:
855-408-6507
856-888-2855 (Fax)
1934 Olney Ave, Suite 200 Cherry Hill, NJ 08003
flex@pointchealth.com
<https://pointc.wealthcareportal.com>



Parking Account Claim Form

Employer Name		
Last name	First name	Social #
Address		☐ Check box if this is a new address
City	State	Zip
Email	Phone	☐ Check here if Point C Benefits Card USED 

Instructions: Complete the information below for Parking Expenses incurred or paid by you. You must provide bills, invoices, statements from an independent third party, parking receipts, or other evidence showing that the Expenses were incurred or paid (canceled checks will not be accepted). **All expenses must be submitted within 180 days of the date of purchase to be eligible for reimbursement under Code Section 132.** Be sure to provide all information requested by this Form. If the Form is incomplete, it will be returned to you. Please date and sign the Form, then send it along with your supporting documentation to the address at the top of this form.

	Expense # 1		Expense # 2		Expense # 3		Expense # 4	
Date Parking Expenses Provided or Paid								
Qualified Parking Proof of Expense Attached? IF not, explain why proof is not available in ordinary course of business.	Name: ☐ Qualified Parking ☐ Yes ☐ No		Name: ☐ Qualified Parking ☐ Yes ☐ No		Name: ☐ Qualified Parking ☐ Yes ☐ No		Name: ☐ Qualified Parking ☐ Yes ☐ No	
Reimbursement Requested								
Total Reimbursement Requested								

I authorize the above expenses to be reimbursed from my Parking Fringe Benefit Account. To the best of my knowledge and belief, my statements in this Form are complete and true. I certify all of the following. I used the Parking Benefit for which I am requesting reimbursement above only for purposes of commuting to and from work at the Employer. I have received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid Parking Expenses under the Plan. I have not been reimbursed under any other plan. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit, or to claim reimbursement under another plan. I authorize a deduction in my Parking Account in the amount of the reimbursement.

Employee Signature: _____
(Employee Signature **must** be provided in order to process this form)

Date: _____



2026 COLONIAL LIFE BENEFIT GUIDE

Monmouth County



Learn more about the benefits available to all County employees with Colonial Life.

- **Disability insurance**
- **Life insurance**
- **Accident insurance**
- **Cancer insurance**
- **Critical Illness insurance**
- **Hospital Confinement insurance**
- **Unum Long-Term Disability (LTD)**

Complimentary plans:

- **\$10,000 Accidental Death Life insurance (AD&D)**
- **WellCard Savings Plan**
- **Law Assure Legal Assistance plan**



**FOR MORE INFORMATION OR TO ENROLL:
SCAN QR CODE**

Morgan Lade

Call/Text: 856-242-0292

Email: morgan@colonialnj.com

Taylor Maciow

Call/Text: 856-242-0293

Email: taylor@colonialnj.com

Welcome to your supplemental benefits with Colonial Life



Protecting Yourself and Your Loved Ones with Supplemental Insurance with Colonial Life.

Unexpected accidents or illnesses can happen at any time and can significantly impact your finances. Fortunately, Colonial Life can help you prepare for such situations.

By offering benefits that complement your current insurance, Colonial Life helps pay for expenses like deductibles, copayments, and missed work days – expenses that can be overwhelming during tough times. Here are some of the benefits your company offers:

- **Disability insurance**
- **Life insurance**
- **Accident insurance**
- **Cancer insurance**
- **Critical Illness insurance**
- **Hospital Confinement insurance**
- **Unum Long-Term Disability (LTD)**

All employees are also eligible to enroll in complimentary benefits, such as:

- **\$10,000 Accidental Death Life insurance policy (AD&D)**- you must re-enroll in this plan every year to continue participation for the new plan year.
- **LawAssure™** – receive a year of access to legal document preparation
- **WellCard Savings Plan** – enjoy discounts on travel, entertainment, prescription drugs, vision, dental, and even veterinary services – available 24/7!

Why Colonial Life?

- You are not required to participate in any other company benefit to enroll.
- Coverage is available for your spouse and dependent children with most plans.
- Premiums will not increase once your coverage is issued.
- Keep your coverage at the same cost and benefit when you leave or retire.
- Benefits are paid directly to you, tax-free, regardless of your actual expenses.

What do you need to do?



Enrolling in our program is easy!

- Enroll on the phone with your benefits counselor

Scan the QR code to schedule a phone call or contact:

Morgan Lade

Call/Text: **856-242-0292**

Email: **morgan@colonialnj.com**

Taylor Maciow

Call/Text: **856-242-0293**

Email: **taylor@colonialnj.com**



IMPORTANT BENEFITS REMINDER:

Colonial Life: Your plans will automatically renew at the same cost and benefit. All current participants are encouraged to speak with a benefits counselor every year to update their policies due to salary increases and changes to family status.

Life changes but your policies will not unless you take 10 minutes to speak with your benefits counselor.

Colonial Life.

Short-Term Disability Insurance



Protect your most valuable asset,
your paycheck!



Can you afford not to protect your paycheck!

Customize a plan based on your individual needs and budget.

Individual Disability ISTD for NJ- 24 pays

- **12 MONTH BENEFIT PERIOD**- Off Job Accident & Sickness, with Psychiatric and Psychological Condition

Annual income range	Monthly Benefit	14 DAY WAIT			30 DAY WAIT		
		Ages 17-49	Ages 50-64	Ages 65-74	Ages 17-49	Ages 50-64	Ages 65-74
\$30,000 — \$31,999	\$1,500	\$24.00	\$31.95	\$50.55	\$17.18	\$24.00	\$35.63
\$32,000 — \$33,999	\$1,600	\$25.60	\$34.08	\$53.92	\$18.32	\$25.60	\$38.00
\$34,000 — \$35,999	\$1,700	\$27.20	\$36.21	\$57.29	\$19.47	\$27.20	\$40.38
\$36,000 — \$37,999	\$1,800	\$28.80	\$38.34	\$60.66	\$20.61	\$28.80	\$42.75
\$38,000 — \$39,999	\$1,900	\$30.40	\$40.47	\$64.03	\$21.76	\$30.40	\$45.13
\$40,000 — \$41,999	\$2,000	\$32.00	\$42.60	\$67.40	\$22.90	\$32.00	\$47.50
\$42,000 — \$43,999	\$2,100	\$33.60	\$44.73	\$70.77	\$24.05	\$33.60	\$49.88
\$44,000 — \$45,999	\$2,200	\$35.20	\$46.86	\$74.14	\$25.19	\$35.20	\$52.25
\$46,000 — \$47,999	\$2,300	\$36.80	\$48.99	\$77.51	\$26.34	\$36.80	\$54.63
\$48,000 — \$49,999	\$2,400	\$38.40	\$51.12	\$80.88	\$27.48	\$38.40	\$57.00
\$50,000 — \$51,999	\$2,500	\$40.00	\$53.25	\$84.25	\$28.63	\$40.00	\$59.38
\$52,000 — \$53,999	\$2,600	\$41.60	\$55.38	\$87.62	\$29.77	\$41.60	\$61.75
\$54,000 — \$55,999	\$2,700	\$43.20	\$57.51	\$90.99	\$30.92	\$43.20	\$64.13
\$56,000 — \$57,999	\$2,800	\$44.80	\$59.64	\$94.36	\$32.06	\$44.80	\$66.50
\$58,000 — \$59,999	\$2,900	\$46.40	\$61.77	\$97.73	\$33.21	\$46.40	\$68.88
\$60,000 — \$61,999	\$3,000	\$48.00	\$63.90	\$101.10	\$34.35	\$48.00	\$71.25
\$70,000 — \$71,999	\$3,500	\$56.00	\$74.55	\$117.95	\$40.08	\$56.00	\$83.13
\$80,000 — \$81,999	\$4,000	\$64.00	\$85.20	\$134.80	\$45.80	\$64.00	\$95.00
\$100,000 — \$101,999	\$5,000	\$80.00	\$106.50	\$168.50	\$57.25	\$80.00	\$118.75
\$120,000 — \$121,999	\$6,000	\$96.00	\$127.80	\$202.20	\$68.70	\$96.00	\$142.50

AVAILABLE OPTIONS:

Monthly Benefits are available from **\$400- \$6,500**

Benefit Periods: **6, 12 or 24 months**

Elimination Periods: **14, 30, 60, 90 or 180 days**



REMINDER

**CURRENT
POLICYHOLDERS
UPDATE YOUR POLICY**

- **Salary increases**
- **Changes to PTO**



32% of Americans said they can't pay an unexpected \$400 bill without taking out a loan or selling something.²



County of Monmouth

Long Term Disability Insurance



How does it work?

This coverage provides a monthly benefit if you have a covered illness or injury and you can't work for a year — or even longer.

You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.

Why is this coverage so valuable?

You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

SPECIAL OPEN ENROLLMENT

Enroll up to your maximum benefit guaranteed issue!



Consider your expenses

Utilities	\$
Housing	\$
Groceries	\$
Transportation	\$
Child care/Elder care	\$
Medical/Personal care	\$
Education	\$
Insurance	\$

Long Term Disability Insurance can replace part of your income if a disability keeps you out of work for a long period of time

What else is included?

Survivor Benefit

If you die while you've been disabled and receiving benefits for at least 180 days, your family could get a benefit equal to 3 months of your gross disability payment.

Waiver of premium

If you're disabled and receiving benefit payments, Unum waives your cost until you return to work.

Work-life balance Employee Assistance Program

Get access to professional help for a range of personal and work-related issues, including counselor referrals, financial planning and legal support.

Monthly premiums per \$100 Monthly benefit

Age	Rates
15-24	\$0.050
25-29	\$0.100
30-34	\$0.200
35-39	\$0.367
40-44	\$0.550
45-49	\$0.683
50-54	\$0.883
55-59	\$1.050
60-64	\$0.933
65-69	\$0.717
70+	\$0.467

How much coverage can I get?

You*

You are eligible for coverage if you are an active employee in the United States working a minimum of 30 hours per week.

Choose from **\$200 to \$12,000** a month, in \$100 increments. You can cover up to 60% of your monthly income.

The monthly benefit may be reduced or offset by other sources of income.

*See the Legal Disclosures for more information.

This plan does not cover pre-existing conditions. See the disclosure section to learn more.

If you don't sign up now but decide to apply later, you may have to answer health questions.

Elimination period (EP) Your elimination period is 365 days. This is the number of days that must pass after a covered accident or illness before you can begin to receive benefits.

Benefit duration (BD)
This is the maximum length of time you can receive benefits while you're disabled. You can receive benefits up to the Social Security (SS) normal retirement age. If you become disabled after your normal retirement age, check with your employer for the maximum length of time applicable to you.

Calculate your Maximum Monthly benefit

Enter your annual earnings and calculate your maximum monthly benefit available.

ANNUAL INCOME / 12 = MONTHLY INCOME

x 60%

= MAXIMUM MONTHLY BENEFIT

(Max % of income covered)

(if the amount exceeds the plan max of \$12,000, enter \$12,000)

- Once enrolled, you are eligible every year at open enrollment to increase your monthly benefit to the maximum you are eligible for with NO HEALTH QUESTIONS.

Samples premiums- 24 pays

AGES	MONTHLY BENEFITS													
	\$1,500	\$1,600	\$1,700	\$1,800	\$1,900	\$2,000	\$2,100	\$2,200	\$2,300	\$2,400	\$2,500	\$2,600	\$2,700	\$2,800
15-24	\$0.38	\$0.40	\$0.43	\$0.45	\$0.48	\$0.50	\$0.53	\$0.55	\$0.58	\$0.60	\$0.63	\$0.65	\$0.68	\$0.70
25-29	\$0.75	\$0.80	\$0.85	\$0.90	\$0.95	\$1.00	\$1.05	\$1.10	\$1.15	\$1.20	\$1.25	\$1.30	\$1.35	\$1.40
30-34	\$1.50	\$1.60	\$1.70	\$1.80	\$1.90	\$2.00	\$2.10	\$2.20	\$2.30	\$2.40	\$2.50	\$2.60	\$2.70	\$2.80
35-39	\$2.75	\$2.94	\$3.12	\$3.30	\$3.49	\$3.67	\$3.85	\$4.04	\$4.22	\$4.40	\$4.59	\$4.77	\$4.95	\$5.14
40-44	\$4.13	\$4.40	\$4.68	\$4.95	\$5.23	\$5.50	\$5.78	\$6.05	\$6.33	\$6.60	\$6.88	\$7.15	\$7.43	\$7.70
45-49	\$5.12	\$5.46	\$5.81	\$6.15	\$6.49	\$6.83	\$7.17	\$7.51	\$7.85	\$8.20	\$8.54	\$8.88	\$9.22	\$9.56
50-54	\$6.62	\$7.06	\$7.51	\$7.95	\$8.39	\$8.83	\$9.27	\$9.71	\$10.15	\$10.60	\$11.04	\$11.48	\$11.92	\$12.36
55-59	\$7.88	\$8.40	\$8.93	\$9.45	\$9.98	\$10.50	\$11.03	\$11.55	\$12.08	\$12.60	\$13.13	\$13.65	\$14.18	\$14.70
60-64	\$7.00	\$7.46	\$7.93	\$8.40	\$8.86	\$9.33	\$9.80	\$10.26	\$10.73	\$11.20	\$11.66	\$12.13	\$12.60	\$13.06
65-69	\$5.38	\$5.74	\$6.09	\$6.45	\$6.81	\$7.17	\$7.53	\$7.89	\$8.25	\$8.60	\$8.96	\$9.32	\$9.68	\$10.04
70 +	\$3.50	\$3.74	\$3.97	\$4.20	\$4.44	\$4.67	\$4.90	\$5.14	\$5.37	\$5.60	\$5.84	\$6.07	\$6.30	\$6.54

AGES	MONTHLY BENEFITS													
	\$3,000	\$3,100	\$3,200	\$3,300	\$3,400	\$3,500	\$3,600	\$3,700	\$3,800	\$3,900	\$4,000	\$4,100	\$4,200	\$4,600
15-24	\$0.75	\$0.78	\$0.80	\$0.83	\$0.85	\$0.88	\$0.90	\$0.93	\$0.95	\$0.98	\$1.00	\$1.03	\$1.05	\$1.15
25-29	\$1.50	\$1.55	\$1.60	\$1.65	\$1.70	\$1.75	\$1.80	\$1.85	\$1.90	\$1.95	\$2.00	\$2.05	\$2.10	\$2.30
30-34	\$3.00	\$3.10	\$3.20	\$3.30	\$3.40	\$3.50	\$3.60	\$3.70	\$3.80	\$3.90	\$4.00	\$4.10	\$4.20	\$4.60
35-39	\$5.51	\$5.69	\$5.87	\$6.06	\$6.24	\$6.42	\$6.61	\$6.79	\$6.97	\$7.16	\$7.34	\$7.52	\$7.71	\$8.44
40-44	\$8.25	\$8.53	\$8.80	\$9.08	\$9.35	\$9.63	\$9.90	\$10.18	\$10.45	\$10.73	\$11.00	\$11.28	\$11.55	\$12.65
45-49	\$10.25	\$10.59	\$10.93	\$11.27	\$11.61	\$11.95	\$12.29	\$12.64	\$12.98	\$13.32	\$13.66	\$14.00	\$14.34	\$15.71
50-54	\$13.25	\$13.69	\$14.13	\$14.57	\$15.01	\$15.45	\$15.89	\$16.34	\$16.78	\$17.22	\$17.66	\$18.10	\$18.54	\$20.31
55-59	\$15.75	\$16.28	\$16.80	\$17.33	\$17.85	\$18.38	\$18.90	\$19.43	\$19.95	\$20.48	\$21.00	\$21.53	\$22.05	\$24.15
60-64	\$14.00	\$14.46	\$14.93	\$15.39	\$15.86	\$16.33	\$16.79	\$17.26	\$17.73	\$18.19	\$18.66	\$19.13	\$19.59	\$21.46
65-69	\$10.76	\$11.11	\$11.47	\$11.83	\$12.19	\$12.55	\$12.91	\$13.26	\$13.62	\$13.98	\$14.34	\$14.70	\$15.06	\$16.49
70 +	\$7.01	\$7.24	\$7.47	\$7.71	\$7.94	\$8.17	\$8.41	\$8.64	\$8.87	\$9.11	\$9.34	\$9.57	\$9.81	\$10.74

(Choose the age you will be when your coverage becomes effective on 01/01/2026.)

Exclusions and limitations

Active employee

You are considered in active employment, if on the day you apply for coverage, you are being paid regularly by your employer for the required minimum hours each week and you are performing the material and substantial duties of your regular occupation.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Benefit duration (BD)

The duration of your benefit payments is based on your age when your disability occurs. Your Long Term Disability benefits are payable while you continue to meet the definition of disability. Please refer to your plan document for the duration of benefits under this policy.

Definition of disability

You are considered disabled when Unum determines that:

- You are limited from performing the material and substantial duties of your regular occupation due to sickness or injury; and
- You have a 20% or more loss of indexed monthly earnings due to the same sickness or injury

After 24 months, you are considered disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

“Substantial and material acts” means the important tasks, functions and operations that are generally required by employers from those engaged in your usual occupation and that cannot be reasonably omitted or modified.

Unless the policy specifies otherwise, as part of the disability claims evaluation process, Unum will evaluate your occupation based on how it is normally performed in the national economy, not how work is performed for a specific employer, at a specific location or in a specific region.

Pre-existing conditions

You have a pre-existing condition if:

- You received medical treatment, consultation, care or services including diagnostic measures for the condition, or took prescribed drugs or medicines for it in the 3 months just prior to your effective date of coverage; and
- The disability begins in the first 12 months after your effective date of coverage.

Continuity of Coverage

If the employee was not insured under the plan continuity of coverage will not apply. If the employee was insured under the prior plan but is not in active employment on the Unum plan effective date (due to illness or injury), the person will be covered under the Unum plan, but payment will be limited to what would have been paid under the prior plan. Unum will reduce the payment by the prior carrier's liability. If the employee was insured under the prior plan and is in active employment on the Unum plan effective date, the person must satisfy the pre-ex provision under the Unum plan or the prior carrier's plan. If satisfied under the Unum plan, payment will be made according to the Unum plan. If satisfied under the prior plan (but not the Unum plan), payment will be administered under the Unum plan, but the payment will be the lesser of the Unum monthly benefit or the prior plan's monthly benefit.

Deductible sources of income

Your disability benefit may be reduced by deductible sources of income and any earnings you have while you are disabled, including such items as group disability benefits or other amounts you receive or are entitled to receive:

- Workers' compensation or similar occupational benefit laws, including a temporary disability benefit under a workers' compensation law
- State compulsory benefit laws
- Other group insurance plans
- A group plan sponsored by your employer
- Governmental retirement system
- Salary continuation or sick leave plans, if applicable
- Retirement payments
- Social Security or similar governmental programs

Exclusions and limitations Your plan does not cover any disabilities caused by, contributed to by, or resulting from your: • Intentionally self-inflicted injuries; • Active participation in a riot; • Loss of a professional license, occupational license or certification; • Participation in a felony or which you have been convicted; or • Pre-existing conditions (See the disclosure section to learn more). Your plan will not cover a disability due to war, declared, or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

Termination of coverage

Your coverage under the policy ends on the earliest of the following:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim that occurs while you are covered under the policy or plan. Unum's LTD contracts standardly include a provision called the Social Security Claimant Advocacy Program. With this feature, claimants can receive expert advice and assistance from us regarding their Social Security Disability claim during the application and appeal process. Social Security advocacy services are provided by GENEX Services, LLC or Brown & Brown Absence Services Group. Referral to one of our advocacy partners is determined by Unum.

The work-life balance employee assistance program, provided by HealthAdvocate, is available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al. or contact your Unum representative.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

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Term Life and Whole Life Insurance

Peace of mind for you and your loved ones



You want what's best for your family, and that includes making sure they're prepared for the future. With life insurance from Colonial Life & Accident Insurance Company, you can provide financial security to help them cover their ongoing living expenses.

Advantages of term life insurance

- ✓ Lower cost when compared to cash value life insurance
- ✓ Same benefit payout throughout the duration of the policy
- ✓ Several term period options for flexibility during high-need years
- ✓ Benefit for the beneficiary that is typically tax free

Advantage of whole life insurance

- ✓ Choose the age when your premium payments end — Paid-Up at Age 70 or Paid-Up at Age 100-Guaranteed lifetime protection
- ✓ Guaranteed premiums that will NEVER increase once coverage is issued
- ✓ Permanent coverage that stays the same through the life of the policy
- ✓ Premiums will not increase due to changes in health or age
- ✓ Guaranteed cash value accumulation based on a nonforfeiture interest rate of 3.75%
- ✓ Policy loans available, which can be used for emergencies
- ✓ Provides cash surrender value at age 100 (when the policy ends)



44% of Americans say their household would face financial hardship within six months should a wage earner die unexpectedly.

LIMRA, 2022 Life Insurance Barometer Study.

Benefits and features of Colonial Life policies:

- Coverage is available for your spouse and dependent children (with or without your participation)
- Keep your coverage at the same cost and benefit when you leave or retire
- Premiums are locked in and will not increase once your coverage is issued
- Coverage is available without blood work or exam

Semi-monthly premiums (24 pays)

Individual Term Life (ITL5000)- NON-SMOKER PREMIUMS

Rates are for illustrative purposes only. For the cost at your exact age, additional face amounts and smoker rates- TALK TO YOUR BENEFITS COUNSELOR

10 Year Term

ISSUE AGE	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000
25	\$3.32	\$5.30	\$5.11	\$6.66	\$8.21
30	\$3.53	\$5.83	\$5.11	\$6.66	\$8.21
35	\$3.79	\$6.47	\$5.63	\$7.44	\$9.25
40	\$3.99	\$6.98	\$7.02	\$9.53	\$12.04
45	\$4.59	\$8.46	\$9.31	\$12.97	\$16.63
50	\$5.86	\$11.65	\$12.79	\$18.19	\$23.58
55	\$8.09	\$17.22	\$18.19	\$26.28	\$34.38
60	\$11.68	\$26.20	\$26.98	\$39.47	\$51.96
65	\$17.44	\$22.67	\$43.33	\$64.00	\$84.67
70	\$27.69	\$38.06	\$74.12	\$110.19	\$146.25

15 Year Term

ISSUE AGE	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000
25	\$3.34	\$5.35	\$5.19	\$6.78	\$8.38
30	\$3.55	\$5.87	\$5.19	\$6.78	\$8.38
35	\$3.81	\$6.51	\$5.71	\$7.56	\$9.42
40	\$4.01	\$7.02	\$7.13	\$9.69	\$12.25
45	\$4.60	\$8.50	\$9.54	\$13.31	\$17.09
50	\$5.90	\$11.74	\$13.42	\$19.13	\$24.83
55	\$8.23	\$17.57	\$19.29	\$27.94	\$36.58
60	\$12.17	\$27.43	\$29.54	\$43.31	\$57.08
65	\$18.59	\$25.79	\$49.58	\$73.37	\$97.17
70	\$29.83	\$44.08	\$86.17	\$128.25	\$170.33

20 Year Term

ISSUE AGE	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000
25	\$3.36	\$5.39	\$5.27	\$6.91	\$8.54
30	\$3.56	\$5.91	\$5.27	\$6.91	\$8.54
35	\$3.85	\$6.62	\$5.79	\$7.69	\$9.59
40	\$4.12	\$7.29	\$7.71	\$10.56	\$13.42
45	\$4.84	\$9.11	\$10.90	\$15.35	\$19.79
50	\$6.34	\$12.85	\$15.79	\$22.69	\$29.58
55	\$9.03	\$19.57	\$23.17	\$33.75	\$44.33
60	\$13.42	\$30.55	\$36.00	\$53.00	\$70.00
65	\$20.50	\$30.77	\$59.54	\$88.31	\$117.08

30 Year Term

ISSUE AGE	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000
25	\$3.37	\$5.43	\$5.75	\$7.63	\$9.50
30	\$3.58	\$5.95	\$5.92	\$7.88	\$9.84
35	\$3.98	\$6.94	\$7.19	\$9.78	\$12.38
40	\$4.49	\$8.22	\$9.81	\$13.72	\$17.63
45	\$5.54	\$10.85	\$14.21	\$20.31	\$26.42
50	\$7.41	\$15.53	\$20.92	\$30.38	\$39.83



Understanding the Benefits of Supplemental Health Insurance

Colonial Life®

Colonial Life can pay YOU!

To help you pay for expenses that are not covered by your current benefits to ensure you are fully protected.

- Deductibles
- Co-payments
- Missed time from work

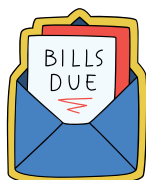


Protect Yourself from Unexpected Medical Costs with Colonial Life

It's no secret that unexpected accidents, illnesses, or serious medical conditions can be financially devastating. Fortunately, Colonial Life offers a range of insurance plans to help cover the costs of these unforeseen circumstances. Our insurance plans include:

- Accident insurance
- Cancer insurance
- Critical Illness insurance
- Hospital Confinement insurance

Don't let unexpected medical costs catch you off guard – let Colonial Life help you prepare for the unexpected.



Colonial Life can help you focus on what's important, your care and recovery and not how you're going to pay your expenses if something unexpected happens.



Health Screening Benefits

Included with the following plans in NJ:

- Cancer\$100
- Accident\$ 50
- Critical Illness\$ 50

**per covered person, per calendar year.*



Provided when one of the tests listed below is performed after the waiting period and while the policy is in force. Payable once per calendar year, per covered person. **NO WAIT PERIOD FOR NJ PLANS ONLY.**

CANCER WELLNESS TESTS

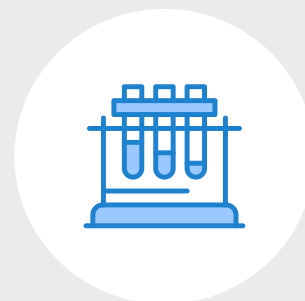
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography³
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Skin biopsy
- Thermography
- ThinPrep® Pap test⁴
- Virtual colonoscopy

HEALTH SCREENING TESTS

- Blood test for triglycerides
- Carotid Doppler
- Echocardiogram (ECHO)
- Electrocardiogram (EKG, ECG)
- Fasting blood glucose test
- **Serum cholesterol test for HDL and LDL levels**
- **Stress test on a bicycle or treadmill**

Part two: Cancer wellness – additional invasive diagnostic test or surgical procedure- **included with Cancer Assist plan only**

Provided when a doctor performs a diagnostic test or surgical procedure after the waiting period as the result of an abnormal result from one of the covered cancer wellness tests in part one. We will pay the benefit regardless of the test results. Payable once per calendar year, per covered person.



To encourage early detection, many of our supplemental health insurance plans offer benefits for wellness and health screening tests.



File online at:
www.coloniallife.com

Login and choose "file a claim".
No need to wait for a check.
You can choose to have a direct deposit as your payment method.



Hospital Confinement

Get help with rising health care costs

If you're admitted to the hospital because of an accident or sickness (including pregnancy), it's important to focus on your recovery- not your finances. That's easier said than done if you have costly expenses coming your way because of deductibles and copayments.

Hospital confinement indemnity insurance from Colonial Life can help you pay for medical expenses that health insurance won't cover.

Product Features

- Benefits are paid directly to you, regardless of actual expenses
- Premiums will not increase once your coverage is issued
- Coverage is available for your spouse and dependent children up to age 26
- Keep your coverage at the same cost and benefit when you leave or retire

How much does this plan pay for an average hospital stay?

Add this plan to your Disability insurance to provide benefits during the waiting period until your benefits begin.

3-day hospital stay = \$1,100 benefit!

5-day hospital stay = \$1,200 benefit!



Individual Medical Bridge for NJ- Premiums (24 pays)

- **\$1,000 Hospital Admission benefit**, with \$50 daily confinement benefit

Issue Age	Individual	Employee/ Spouse	Employee/ Child(ren)	Family
17-49	\$6.90	\$13.68	\$10.10	\$16.88
50-59	\$9.68	\$19.03	\$12.88	\$22.23
60-64	\$13.48	\$26.58	\$16.68	\$29.78
65-99	\$18.25	\$35.95	\$21.45	\$39.15

Premiums are based on issue age and **will NOT increase** as you get older!

Colonial Life.

Accident Insurance

Accidents can happen to anyone, at any time

You can't predict if you or someone you love will be impacted by an accident, but Colonial Life's Accident insurance can help you be financially prepared.

Even with health insurance the expenses can add up. The benefits from this plan can help pay for expenses such as deductibles, co-payments, and missed time from work so you can focus on what's important, healing.

With this coverage:

- A set amount is payable based on the injury you suffer and the treatment you receive
- Enroll with no medical questions
- Unlike workers' compensation, which only covers you on the job, this plan covers you on & off the job
- Coverage is available for you, your spouse and eligible dependent children up to age 26

How much could you receive from this plan?

SAMPLE CLAIM PAYMENT:

Broken leg (no surgery)

Accident emergency treatment
• (doctor's office, ER, Urgent Care) \$125

Ambulance \$250

Leg fracture (non-surgical) \$1,250

X-ray \$40

Medical equipment (crutches) \$125

Physical therapy (10 visits) \$450

Accident follow-up treatment (6 visits) \$330

Laceration \$60

Total: \$2,630

Semi-monthly premiums- 24 pays

Individual Accident (IAC4000) for NJ

Preferred plan- On & Off job benefits and \$50 Health Screening

- One insured (Employee, spouse or child).....\$ 9.67
- Employee & Spouse.....\$16.31
- Employee or Spouse with Child(ren).....\$19.66
- Family\$26.30

(Ages 0-80)

Colonial Life.

Cancer Insurance



How would cancer impact your finances?

Hopefully, you and your family will never face cancer. If you do, having a financial safety net can help you and your family focus on what matters most-recovery.

The last thing you should worry about is how you're going to pay for what your health insurance doesn't. Cancer insurance can also help with expenses not covered by your health insurance such as:

- Missed time from work
- Childcare
- Transportation and meals
- Experimental treatments and much more!

How much could you receive?

SAMPLE BENEFITS PAID FOR 4 MONTHS OF TREATMENT

Initial Diagnosis Benefit.....	\$5,000
Radiation/Chemotherapy (16 weeks)	\$8,000
Anti-nausea medication (4 months)	\$ 640
Family Care	\$2,000
Wig.....	\$200
Hospital Confinement (5 days)	\$750
Second Medical Opinion	\$200
Surgical Procedures	\$3,000
Reconstructive surgery	\$2,500
Outpatient surgery.....	\$200
Medical imaging.....	\$250

TOTAL AMOUNT PAID\$22,740

Cancer insurance provides benefits to help with cancer expenses - from diagnosis to recovery.

Semi-monthly premiums- 24 pays

Cancer Assist for NJ

Level 2 with \$5,000 initial diagnosis benefit & \$100 health screening

- Employee only **\$13.91**
- Employee & Spouse..... **\$22.10**
- Employee or Spouse with Child(ren)..... **\$14.31**
- Family **\$22.50**

• *Speak to your benefits counselor for premiums for additional states*

Colonial Life.

Specified Critical Illness Insurance

If you're diagnosed with a covered critical illness, specified critical illness insurance from Colonial Life can help with your expenses, so you can concentrate on what's most important - your treatment, care and recovery.

Choose a Face amount from \$5,000 - \$100,000

Upon diagnosis of any of the covered illness listed below, you receive the percentage of the face amount you choose.

COVERED CRITICAL ILLNESSES²

- Heart attack (myocardial infarction)
- Stroke
- End-stage renal (kidney) failure
- Major organ failure
- Permanent paralysis due to a covered accident
- Coma
- Blindness
- Occupational infectious: HIV or hepatitis B, C or D³
- Coronary artery disease

Subsequent diagnosis of a different critical illness²

If you receive a benefit for a critical illness, and are later diagnosed with a different critical illness, 100% of the coverage amount may be payable for that particular critical illness.

Subsequent diagnosis of the same critical illness²

If you receive a benefit for a critical illness, and are later diagnosed with the same critical illness,³ 25% of the coverage amount may be payable for that critical illness.

Semi-monthly premiums- 24 pays Critical Illness 1.0 for NJ

HSA Compliant with subsequent diagnosis & \$50 Health Screening Benefit

\$5,000 FACE AMOUNT

Issue Age	NON-SMOKER		SMOKER	
	ONE INSURED	HUSBAND/WIFE	ONE INSURED	HUSBAND/WIFE
All plans include dependent children up to age 26				
17-24	\$1.07	\$1.64	\$1.25	\$1.92
25-29	\$1.20	\$1.87	\$1.47	\$2.29
30-34	\$1.37	\$2.14	\$1.82	\$2.84
35-39	\$1.87	\$2.87	\$2.52	\$3.87
40-44	\$2.15	\$3.29	\$3.15	\$4.84
45-49	\$2.72	\$4.19	\$4.00	\$6.14
50-54	\$3.50	\$5.39	\$5.07	\$7.82
55-59	\$4.27	\$6.57	\$6.45	\$9.89
60-64	\$5.35	\$8.22	\$7.85	\$12.04

Premiums are based on issue age and **will not increase** once your coverage is issued. Speak to your benefits counselor for premiums for additional face amounts and other states.

**FOR MORE
INFORMATION**

**OR TO
ENROLL**

**SPEAK WITH YOUR
BENEFITS COUNSELOR**



**SCAN FOR MORE
INFORMATION**



CONTACT US

Morgan Lade

Call/Text: **856-242-0292**

Email: **morgan@colonialnj.com**

Taylor Maciow

Call/Text: **856-242-0293**

Email: **taylor@colonialnj.com**



Peace of Mind *and*
Real Cash Benefits



DENTAL INSURANCE

DE

Aflac.

We've got you under our wing.*

DENTAL INSURANCE

Policy Series A82000

This brochure accompanies Schedule of Dental Procedures A82ES75SCHRNJ.

DE^E

Smile. We've got you under our wing.*

Millions of people believe a smile is the most important physical attribute—more so than hair, eyes, or figure.¹ The best way to maintain or improve your smile is to brush and floss your teeth daily, visit your dentist, and apply for an Aflac Dental Insurance policy.

Aflac Dental provides benefits for periodic checkups and cleanings, X-rays, fillings, crowns, and much more. It's your smile and your policy; Aflac Dental gives you control.

- **You choose your dentist.** Because Aflac doesn't use a network of dentists, you can go to any dentist you choose.
- **You and your dentist choose the best treatment for you.** Aflac Dental doesn't have precertification requirements. If the treatment is covered by your policy, you don't need Aflac's permission to receive it.²

Aflac Dental is different from many other dental plans you may have seen.

- **You know what you're getting with Aflac Dental.** The plan spells out the benefits for both wellness and other diagnostic/treatment services. There are no gray areas. Each covered procedure has a specific benefit amount.
- **Aflac Dental doesn't have an annual deductible.** Other dental plans may require you to meet an annual deductible before benefits are payable.
- **Aflac Dental pays benefits regardless of any other plan.** Even if you have other coverage, you'll receive your full Aflac benefit amount.³

With Aflac Dental's **Annual Maximum Building Benefit**, you can receive even more benefits. Aflac will increase each Covered Person's Policy Year Maximum by \$100 after each 12 consecutive months the policy is in force up to a maximum of \$500 per Covered Person.

¹"The Public Speaks Up on Oral Health Care: An ADA and Crest/Oral-B Survey," American Dental Association, October 2008.

²Subject to applicable Waiting Periods.

³If the applicant retains existing dental coverage with another company, only the Essentials plan can be offered.

Aflac Dental pays benefits for seven categories of dental treatments and hundreds of procedures. The benefit amounts within each category vary based on the procedure received and are subject to a Policy Year Maximum. Benefit amounts and the Policy Year Maximum are per Covered Person.

BENEFIT CATEGORIES	Essentials	WAITING PERIOD	BENEFIT AMOUNTS
Preventive (Wellness and X-Ray)		None	\$15–\$25
Fillings and Basic Services		3 Months	\$10–\$225
Pain Management and Adjunctive Services		3 Months	\$25–\$120
Other Preventive Services		6 Months	\$15–\$100
Oral Surgery, Gum Treatments, and Prosthetic Repair		6 Months	\$20–\$750
Crowns and Major Services		12 Months	\$15–\$350
Major Prosthetic Services		12 Months	\$40–\$450
POLICY YEAR MAXIMUM			\$1,200

THIS BROCHURE IS FOR ILLUSTRATIVE PURPOSES ONLY.
REFER TO THE POLICY FOR COMPLETE DEFINITIONS, DETAILS, LIMITATIONS, AND EXCLUSIONS.
FOR MORE INFORMATION ABOUT THE BENEFITS AVAILABLE, PLEASE SEE THE SCHEDULE OF DENTAL PROCEDURES.
AFLAC HEREIN MEANS AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS.

AFLAC DENTAL INSURANCE - SUPPLEMENTAL PLAN

Policy Series A82000

This brochure accompanies Schedule of Dental Procedures A82175SCHRNJ.

DE¹

Smile.

The best way to maintain or improve your smile is to brush and floss your teeth daily, visit your dentist, and apply for an Aflac Dental-Supplemental Plan.

Aflac Dental-Supplemental Plan provides benefits for periodic checkups and cleanings, X-rays, fillings, crowns, and much more. It's your smile and your policy; Aflac Dental-Supplemental Plan gives you control.

- **You choose your dentist.** Because Aflac Dental-Supplemental Plan doesn't use a network of dentists, you can go to any dentist you choose.
- **You and your dentist choose the best treatment for you.** Aflac Dental-Supplemental Plan doesn't have precertification requirements. If the treatment is covered by your policy, you don't need Aflac's permission to receive it.¹

Aflac Dental-Supplemental Plan is different from many other dental plans you may have seen.

- **You know what you're getting with Aflac Dental-Supplemental Plan.** The plan spells out the benefits for both wellness and other diagnostic/treatment services. There are no gray areas. Each covered procedure has a specific benefit amount.
- **Aflac Dental-Supplemental Plan doesn't have an annual deductible.** Other dental plans may require you to meet an annual deductible before benefits are payable.
- **Aflac Dental-Supplemental Plan pays benefits regardless of any other plan.** Even if you have other coverage, you'll receive your full Aflac benefit amount.²

With Aflac Dental-Supplemental Plan's **Annual Maximum Building Benefit**, you can receive even more benefits. Aflac will increase each covered person's policy year maximum by \$100 after each 12 consecutive months the policy is in force up to a maximum of \$500 per covered person.

¹Subject to applicable waiting periods.

²If the applicant retains existing dental coverage with another company, only the Essentials plan can be offered.

Aflac Dental-Supplemental Plan pays benefits for seven categories of dental treatments and hundreds of procedures. The benefit amounts within each category vary based on the procedure received and are subject to a policy year maximum. Benefit amounts and the policy year maximum are per covered person.

BENEFIT CATEGORIES Option 1	WAITING PERIOD	BENEFIT AMOUNTS
Preventive (Wellness and X-Ray)	None	\$35-\$50
Fillings and Basic Services	3 Months	\$15-\$250
Pain Management and Adjunctive Services	3 Months	\$30-\$130
Other Preventive Services	6 Months	\$20-\$110
Oral Surgery, Gum Treatments, and Prosthetic Repair	6 Months	\$30-\$850
Crowns and Major Services	12 Months	\$15-\$375
Major Prosthetic Services	12 Months	\$45-\$550
POLICY YEAR MAXIMUM		\$1,400

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AFLAC HEREIN MEANS AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS.

AFLAC DENTAL INSURANCE - SUPPLEMENTAL PLAN

Policy Series A82000

This brochure accompanies Schedule of Dental Procedures A82275SCHRNJ.

DE²

Smile.

The best way to maintain or improve your smile is to brush and floss your teeth daily, visit your dentist, and apply for an Aflac Dental-Supplemental Plan.

Aflac Dental-Supplemental Plan provides benefits for periodic checkups and cleanings, X-rays, fillings, crowns, and much more. It's your smile and your policy; Aflac Dental-Supplemental Plan gives you control.

- **You choose your dentist.** Because Aflac Dental-Supplemental Plan doesn't use a network of dentists, you can go to any dentist you choose.
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Aflac Dental-Supplemental Plan is different from many other dental plans you may have seen.

- **You know what you're getting with Aflac Dental-Supplemental Plan.** The plan spells out the benefits for both wellness and other diagnostic/treatment services. There are no gray areas. Each covered procedure has a specific benefit amount.
- **Aflac Dental-Supplemental Plan doesn't have an annual deductible.** Other dental plans may require you to meet an annual deductible before benefits are payable.
- **Aflac Dental-Supplemental Plan pays benefits regardless of any other plan.** Even if you have other coverage, you'll receive your full Aflac benefit amount.²

With Aflac Dental-Supplemental Plan's **Annual Maximum Building Benefit**, you can receive even more benefits. Aflac will increase each covered person's policy year maximum by \$100 after each 12 consecutive months the policy is in force up to a maximum of \$500 per covered person.

¹Subject to applicable waiting periods.

²If the applicant retains existing dental coverage with another company, only the Essentials plan can be offered.

Aflac Dental-Supplemental Plan pays benefits for seven categories of dental treatments and hundreds of procedures. The benefit amounts within each category vary based on the procedure received and are subject to a policy year maximum. Benefit amounts and the policy year maximum are per covered person.

BENEFIT CATEGORIES Option 2	WAITING PERIOD	BENEFIT AMOUNTS
Preventive (Wellness and X-Ray)	None	\$35-\$50
Fillings and Basic Services	3 Months	\$15-\$275
Pain Management and Adjunctive Services	3 Months	\$35-\$140
Other Preventive Services	6 Months	\$20-\$120
Oral Surgery, Gum Treatments, and Prosthetic Repair	6 Months	\$30-\$975
Crowns and Major Services	12 Months	\$20-\$425
Major Prosthetic Services	12 Months	\$45-\$650
POLICY YEAR MAXIMUM		\$1,600

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AFLAC DENTAL INSURANCE - SUPPLEMENTAL PLAN

Policy Series A82000

This brochure accompanies Schedule of Dental Procedures A82375SCHRNJ.

DE³

Smile.

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- **You choose your dentist.** Because Aflac Dental-Supplemental Plan doesn't use a network of dentists, you can go to any dentist you choose.
- **You and your dentist choose the best treatment for you.** Aflac Dental-Supplemental Plan doesn't have precertification requirements. If the treatment is covered by your policy, you don't need Aflac's permission to receive it.¹

Aflac Dental-Supplemental Plan is different from many other dental plans you may have seen.

- **You know what you're getting with Aflac Dental-Supplemental Plan.** The plan spells out the benefits for both wellness and other diagnostic/treatment services. There are no gray areas. Each covered procedure has a specific benefit amount.
- **Aflac Dental-Supplemental Plan doesn't have an annual deductible.** Other dental plans may require you to meet an annual deductible before benefits are payable.
- **Aflac Dental-Supplemental Plan pays benefits regardless of any other plan.** Even if you have other coverage, you'll receive your full Aflac benefit amount.²

With Aflac Dental-Supplemental Plan's **Annual Maximum Building Benefit**, you can receive even more benefits. Aflac will increase each covered person's policy year maximum by \$100 after each 12 consecutive months the policy is in force up to a maximum of \$500 per covered person.

¹Subject to applicable waiting periods.

²If the applicant retains existing dental coverage with another company, only the Essentials plan can be offered.

Aflac Dental-Supplemental Plan pays benefits for seven categories of dental treatments and hundreds of procedures. The benefit amounts within each category vary based on the procedure received and are subject to a policy year maximum. Benefit amounts and the policy year maximum are per covered person.

BENEFIT CATEGORIES Option 3	WAITING PERIOD	BENEFIT AMOUNTS
Preventive (Wellness and X-Ray)	None	\$35-\$75
Fillings and Basic Services	3 Months	\$15-\$325
Pain Management and Adjunctive Services	3 Months	\$35-\$150
Other Preventive Services	6 Months	\$30-\$130
Oral Surgery, Gum Treatments, and Prosthetic Repair	6 Months	\$35-\$1,100
Crowns and Major Services	12 Months	\$25-\$450
Major Prosthetic Services	12 Months	\$50-\$800
POLICY YEAR MAXIMUM		\$1,800

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FOR MORE INFORMATION ABOUT THE BENEFITS AVAILABLE, PLEASE SEE THE SCHEDULE OF DENTAL PROCEDURES.

AFLAC HEREIN MEANS AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS.



TERMS YOU NEED TO KNOW

COVERED PERSON: Covered person includes any person insured under the coverage type you applied for.

Please see the Schedule of Dental Procedures for a complete and comprehensive definition.

GUARANTEED-RENEWABLE: The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class.

POLICY YEAR MAXIMUM: The policy year maximum is the total dollar amount of benefits payable per policy year, per covered person.

WAITING PERIOD: The waiting period is the period after the effective date of coverage for which benefits are not payable. If the policy is reinstated, all covered persons will be subject to new waiting periods beginning with the date of reinstatement. If a dependent is added by endorsement, the waiting period for such dependent will begin on the effective date of the addition. The waiting period will vary based on the benefit category.

WHAT IS NOT COVERED

Aflac will not pay benefits for losses caused by or resulting from any procedure not shown on the Schedule of Dental Procedures; services that are not recommended by a dentist or that are not required for the preservation or restoration of oral health; treatment received while outside the territorial limits of the United States or, if outside the United States, the territorial limits of the place where your policy was issued; or treatment received prior to the effective date of coverage or treatment received during a benefit's waiting period.

No benefits will be paid for replacement of teeth missing before the effective date of coverage.

Aflac will not pay benefits for services rendered by you or a member of the immediate family of a covered person.

Aflac will not pay benefits whenever coverage provided by the policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

Please see the Schedule of Dental Procedures for procedure-specific limitations and exclusions.

AFLAC DENTAL
PAYROLL PREMIUM RATES

Essentials
Policy Series A82100

	AGES	MTHLY	QTRLY	SEMI- ANNUAL	ANNUAL	8-MONTH	9-MONTH	10-MONTH	BI-WEEKLY	SEMI- MTHLY	WKLY
Individual	18-70	\$24.83	\$74.49	\$148.98	\$297.96	\$37.25	\$33.11	\$29.80	\$11.46	\$12.42	\$5.73
One-Parent Family	18-70	\$43.29	\$129.87	\$259.74	\$519.48	\$64.94	\$57.72	\$51.95	\$19.98	\$21.65	\$9.99
Insured/Spouse	18-70	\$43.68	\$131.04	\$262.08	\$524.16	\$65.52	\$58.24	\$52.42	\$20.16	\$21.84	\$10.08
Two-Parent Family	18-70	\$62.40	\$187.20	\$374.40	\$748.80	\$93.60	\$83.20	\$74.88	\$28.80	\$31.20	\$14.40

Level 1
Policy Series A82200

	AGES	MTHLY	QTRLY	SEMI- ANNUAL	ANNUAL	8-MONTH	9-MONTH	10-MONTH	BI-WEEKLY	SEMI- MTHLY	WKLY
Individual	18-70	\$32.24	\$96.72	\$193.44	\$386.88	\$48.36	\$42.99	\$38.69	\$14.88	\$16.12	\$7.44
One-Parent Family	18-70	\$61.88	\$185.54	\$371.28	\$742.56	\$92.82	\$82.51	\$74.26	\$28.56	\$30.94	\$14.28
Insured/Spouse	18-70	\$62.79	\$188.37	\$376.74	\$753.48	\$94.19	\$83.72	\$75.35	\$28.98	\$31.40	\$14.49
Two-Parent Family	18-70	\$93.60	\$280.80	\$561.60	\$1,123.20	\$140.40	\$124.80	\$112.32	\$43.20	\$46.80	\$21.60

Level 2
Policy Series A82300

	AGES	MTHLY	QTRLY	SEMI- ANNUAL	ANNUAL	8-MONTH	9-MONTH	10-MONTH	BI-WEEKLY	SEMI- MTHLY	WKLY
Individual	18-70	\$39.39	\$118.17	\$236.34	\$472.68	\$59.09	\$52.52	\$47.27	\$18.18	\$19.70	\$9.09
One-Parent Family	18-70	\$76.70	\$230.10	\$460.20	\$920.40	\$115.05	\$102.27	\$92.04	\$35.40	\$38.35	\$17.70
Insured/Spouse	18-70	\$77.22	\$231.66	\$463.32	\$926.64	\$115.83	\$102.96	\$92.66	\$35.64	\$38.61	\$17.82
Two-Parent Family	18-70	\$115.44	\$346.32	\$692.64	\$1,385.28	\$173.16	\$153.92	\$138.53	\$53.28	\$57.72	\$26.64

Level 3
Policy Series A82400

	AGES	MTHLY	QTRLY	SEMI- ANNUAL	ANNUAL	8-MONTH	9-MONTH	10-MONTH	BI-WEEKLY	SEMI- MTHLY	WKLY
Individual	18-70	\$57.07	\$171.21	\$342.42	\$684.84	\$85.61	\$76.09	\$68.48	\$26.34	\$28.54	\$13.17
One-Parent Family	18-70	\$112.58	\$337.74	\$675.48	\$1,350.96	\$168.87	\$150.11	\$135.10	\$51.96	\$56.29	\$25.98
Insured/Spouse	18-70	\$113.75	\$341.25	\$682.50	\$1,365.00	\$170.63	\$151.67	\$136.50	\$52.50	\$56.88	\$26.25
Two-Parent Family	18-70	\$169.13	\$507.39	\$1,014.78	\$2,029.56	\$253.70	\$225.51	\$202.96	\$78.06	\$84.57	\$39.03

Aflac Pet Insurance

POWERED BY **trupanion**[™]



Pets can be unpredictable. Their coverage shouldn't be

Two of the biggest names in insurance — for people and pets — have partnered to offer an employee benefit that gives furry family members protection from unexpected veterinary expenses.

Aflac helps provide financial protection to more than 50 million* people in the U.S. and Japan, and for more than 60 years Aflac insurance policies have helped customers focus on recovery, not financial stress.¹ Trupanion, medical insurance for pets, has over 20 years of experience protecting pets in the U.S., Canada and Australia from unexpected injuries and illnesses — with over 800,000 pets insured.²

Our new pet insurance offers three distinct plans to give employees the flexibility to choose the perfect fit for their family.

Unlimited Accident & Illness no caps on payout amounts or number of claims	Basic Accident & Illness	Accident only
✓ Covers certain pre-existing conditions like allergies, dermatitis and skin conditions. ✓ Covers new unexpected illnesses or injuries. ✓ 24/7 telehealth veterinary support. ✓ Coverage starts on the first of the month following the group effective date — no waiting periods for non-cruciate related illnesses and injuries.	✓ Covers new unexpected illnesses or injuries. ✓ 24/7 telehealth veterinary support. ✓ Coverage starts on the first of the month following the group effective date — no waiting periods.	✓ Covers new unexpected injuries. ✓ Coverage starts on the first of the month following the group effective date — no waiting periods.

Pet Owner Support Rider

Basic or Premium Pet Owner Support Rider; These riders cover additional pet care and wellness expenses such as vaccinations, flea and tick prevention, boarding and even the cost of health certificates for international travel.

Powered by Trupanion

Two decades of experience and over \$2 billion paid in veterinary invoices have given Trupanion expertise in helping protect pets. Aflac Pet Insurance, powered by Trupanion, policies are backed by:



Patented software that can pay veterinarians directly at the time of checkout.**



24/7 member support.



Territory Partner support nationwide to boost uptake, help educate veterinary professionals, and support members when needed.

Easy enrollment

Aflac and Trupanion have made enrollment easy for employees without adding stress to Human Resources.

- ✓ Year-round enrollment outside the benefit administration platform also available.
- ✓ Simple setup for automated payroll deductions.

CONTACT YOUR LOCAL AFLAC SALES REPRESENTATIVE TO LEARN MORE.

Aflac Pet Insurance
POWERED BY **trupanion**

*Aflac Incorporated

**Available at participating hospitals.

IMPORTANT NOTICE: ¹Aflac may include American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, Continental American Insurance Company (marketed as "Aflac Group"), Tier One Insurance Company, and any other affiliated companies (collectively, "Aflac"), as applicable to the entity from whom insurance services are received.

²This Trupanion policy is sold and administered by Trupanion Managers USA, Inc. ("TMUI") (licenses available at <https://trupanion.com/site/terms-of-use>) and underwritten by American Pet Insurance Company ("APIC"), with its main office at 6100 4th Ave S, Seattle, WA 98108. Aflac Benefits Advisors, Inc. (d/b/a Aflac Insurance Solutions), a subsidiary of Aflac Incorporated and a licensed insurance producer (NPN 16512385) (California License #0H86831), has limited authority to advertise this Trupanion policy, will not administer this Trupanion policy on behalf of APIC, and does not have authority to bind coverage on behalf of APIC. Aflac Benefits Advisors, Inc. may receive marketing fees or other compensation from TMUI for insurance policies sold by TMUI. TMUI, APIC, and their affiliates are separate, independent of, and distinct from Aflac Incorporated, Aflac Benefits Advisors, Inc., and their affiliates.

Our new pet insurance offers three distinct plans to give employees the flexibility to choose the perfect fit for their family.

What is covered?		Accident Only	Basic Accident & Illness	Unlimited Accident & Illness no caps on payout amounts or number of claims
Annual Max		\$10k	\$10k	Unlimited
Deductible		\$75 / \$250 / \$500	\$75 / \$250 / \$500	\$75 / \$250 / \$500
Payout		90%	90%	90%
Rider Included		No	Optional Rider	Optional Rider
Telehealth		No	Yes	Yes
Cover PreEx Allergy/Dermatitis/Otis		No	No	Yes
Exam Fees		No	No**	No**
Waiting Periods	Accident	No waiting period	No waiting period	No waiting period
	Illness	N/A	No waiting period	No waiting period
	Cruciate Tears	N/A, not covered	N/A, not covered	6 months

BASIC SERVICES***

Diagnostics	Yes	Yes	Yes
Allergies	No	Yes	Yes
Cuts and Scrapes	Yes	Yes	Yes

MAJOR SERVICES***

Cranial Cruciate Repair	No	No	Yes
Hip Dysplasia	No	Yes	Yes
Cancer	No	Yes	Yes
Foreign Body Ingestion	Yes	Yes	Yes

Pet Owner Support Rider

Employees who enroll in either Basic or Unlimited Accident & Illness policies can add a Basic or Premium Pet Owner Support Rider. These riders cover additional pet care and wellness expenses such as vaccinations, flea and tick prevention, boarding and even the cost of health certificates for international travel.

Aflac Pet Insurance
POWERED BY **trupanion**

*Available at participating hospitals. **Optional Rider includes some coverage. ***Pre-existing coverage will be adjudicated per selected policy. Pending pre-existing conditions, FHL and Giardia will be subject to review per our policy.

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Aflac Pet Insurance
POWERED BY **tru**panion™



Scan the QR Code below to see the Aflac Insurance Plans

Aflac helps with expenses
health insurance doesn't cover,
so you can focus more on
everything else.



Or, visit your benefits page at:
www.aflacenrollment.com/CountyofMonmouth/qqq031429134



Aflac's family of insurers American Family Life Assurance Company of Columbus and/or American Family Life Assurance Company of New York, and/or Continental American Insurance Company (CAIC) and/or Continental American Life Insurance Company.

Aflac WWHQ | 1932 Wynnton Road | Columbus, GA 31999 | 800.992.3522

Continental American Insurance Company | Columbia, SC | 800.433.3036

Aflac New York | 22 Corporate Woods Boulevard, Suite 2 | Albany, NY 12211 | 800.366.3436

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Monmouth County Aflac Contact



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