

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 Dependent children are eligible for maternity/obstetrical benefits.	100% after \$30 copay Copay applies to 1st visit only
Allergy Testing and Treatment	100% outpatient facility 100% in office setting* *Copay only applies to office visit if billed.	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

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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%	80% after deductible
	Limited to 30 visits per benefit period (8-hour shifts)	
Skilled Nursing Facility/Extended Care Center	\$150 per admission	80% after deductible
	Limited to 100 days per benefit period	
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	

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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.cciio.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	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

	as Tier 2 and BlueCard PPO providers.	with your <u>provider</u> before you get services.
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.	\$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/immunization</u>	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. 20% <u>Coinsurance</u> for Tier 2 anesthesia.
If you need immediate medical attention	<u>Emergency room care</u>	\$100.00 <u>Copayment</u> per visit for Outpatient Hospital.	\$100.00 <u>Copayment</u> per visit for Outpatient Hospital. <u>Deductible</u> does not apply.	\$100.00 <u>Copayment</u> per visit for Outpatient Hospital. <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.	<u>Deductible</u> applies.	Not Covered.	—none—
	<u>Urgent care</u>	\$15.00 <u>Copayment</u> per visit for Specialist.	\$30.00 <u>Copayment</u> per visit for Specialist. <u>Deductible</u> does not apply.	Not Covered.	—none—
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.

* 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)	
	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. Services must be rendered by a contracted ISC provider to be eligible for reimbursement. Locate a provider www.Horizonblue.com/member-ISC .
	Inpatient services	No Charge for Inpatient Hospital.	20% <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.
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.	In-network inpatient separation period is limited to 90 days.
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 period is limited to 90 days.
	Habilitation services	\$150.00 <u>Copayment</u> per admission for Inpatient Hospital.	20% <u>Coinsurance</u> for Inpatient Hospital.	Not Covered.	

* 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)	
	Skilled nursing care	\$150.00 Copayment per admission for Inpatient Facility.	20% Coinsurance 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.
	Durable medical equipment	No Charge.	20% Coinsurance.	Not Covered.	Prior authorization required for DME purchases regardless of the amount. 20% penalty applies for non-compliance.
	Hospice services	No Charge for Inpatient Facility.	20% Coinsurance 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, Deductible does not apply.	Not Covered.	This benefit is administered by Davis Vision. In-network OMNIA Tier 1 Tier 2 routine vision exam visit limit. Coverage is limited to 1 visit in-network.
	Children's glasses	Amounts greater than \$150.00 for non-collection frames.	Amounts greater than \$150.00 for non-collection frames. Deductible does not apply.	Not Covered.	This benefit is administered by Davis Vision. Not covered - for adult. In-network OMNIA Tier 1 Tier 2 routine Vision hardware child dollar limit. Coverage is limited to \$150.00. 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
- 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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 plan's overall deductible \$0.00
- Specialist Copayment \$15.00
- Hospital (facility) Coinsurance 0%
- Other Coinsurance 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	\$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 plan's overall deductible \$0.00
- Specialist Copayment \$15.00
- Hospital (facility) Coinsurance 0%
- Other Coinsurance 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

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 plan's overall deductible \$0.00
- Specialist Copayment \$15.00
- Hospital (facility) Coinsurance 0%
- Other Coinsurance 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	\$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.

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



Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Horizon BCBSNJ provides free aids and services to people with disabilities (e.g. qualified sign language interpreters and information in other formats) and to those whose primary language is not English (e.g. information in other languages) to communicate effectively with us.

Contacting Member Services

Please call Member Services at **1-800-355-BLUE (2583) (TTY 711)** or the phone number on the back of your member ID card, if you need the free aids and services noted above and for **all other Member Services issues**.

Filing a Section 1557 Grievance

If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated against you for one of the reasons described above, you can file a discrimination complaint also known as a Section 1557 Grievance. **Horizon BCBSNJ's Civil Rights Coordinator** can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address: **Horizon BCBSNJ
Civil Rights Coordinator
PO Box 820, Newark, NJ 07101.**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail at **U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201** or by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**. OCR Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language assistance

Si habla un idioma diferente al inglés, hay ayuda disponible gratis. Llame al número que aparece al reverso de su tarjeta de identificación.

如果您讲英语以外的语言，可获取免费帮助。请拨打您的身份证背面的号码。

영 어 이외의 언어를 사용하는 경우, 무료 지원 서비스를 받을 수 있습니다. ID 카드 뒷면에 있는 번호로 전화하십시오.

Se você fala um idioma diferente do inglês, a ajuda está disponível gratuitamente. Ligue para o número no verso do seu bilhete de identidade.

જો તમે અંગ્રેજી સિવાયની ભાષા બોલતા હોવ, તો મફતમાં મદદ ઉપલબ્ધ છે. તમારા આઈડી કાર્ડની પાછળ આપેલા નંબર પર કોલ.

Jeśli mówisz w języku innym niż angielski, pomoc udzielana jest bezpłatnie. Zadzwoń pod numer podany na odwrocie dowodu osobistego.

Se parli una lingua diversa dall'inglese, è disponibile un servizio di assistenza gratuito. Chiama il numero sul retro della tua carta d'identità.

Kung nagsasalita ka ng isang wika maliban sa Ingles, magagamit ang tulong nang walang bayad. Tumawag sa numerong nasa likod ng iyong ID card.

Если вы не говорите по-английски, вам помогут бесплатно. Позвоните по телефону, указанному на обратной стороне вашей ID-карты.

Si ou pale on lòt lang ke Anglè, gen èd ki disponib gratis. Rele nan nimewo ki ekri nan do kat idantifyan w lan.

यदि आप अंग्रेज़ी से भिन्न कोई अन्य भाषा बोलते हैं, तो निःशुल्क सहायता उपलब्ध है। अपने आईडी कार्ड के पीछे दिए गए नंबर पर ।

Nếu bạn nói ngôn ngữ khác ngoài tiếng Anh, thì chúng tôi có thể giúp bạn miễn phí. Hãy gọi số ở mặt sau thẻ ID của bạn.

Si vous parlez une langue autre que l'anglais, l'aide est gratuite. Appelez le numéro au dos de votre carte d'identité.

إذا كنت تتحدث لغة أخرى غير الإنجليزية، نوفر لك المساعدة مجانًا. يُمكنك الاتصال بالرقم الموجود على ظهر بطاقة الهوية
اگر آپ انگریزی کے علاوہ کوئی دوسری زبان بول سکتے ہیں تو مفت مدد دستیاب ہے۔ براہ مہربانی شناختی کارڈ کی پچھلی طرف درج شدہ نمبر پر کال کریں۔