About Your Benefits

OMNIA℠ Health Plan Guidebook

HorizonBlue.com/shbp

Horizon

Welcome!

This handbook can help you understand your health insurance plan.

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We're happy to have you as a member! Are you ready to get the most from your OMNIA℠ Health Plan?

Follow these steps…

1 Get the Horizon Blue App

On the Horizon Blue app, you'll have 24/7 access to all your plan information, talk to a doctor and much more. Text **GetApp** to **422-272**. There's no charge to download the Horizon Blue app, but rates from your wireless provider may apply.

2 Register at HorizonBlue.com/shbp

Use the same username and password to register on **HorizonBlue.com/shbp**, where you can enroll in NJWELL, find benefit details, helpful health and wellness tools, and more.

3 Carry your member ID card

It's the key to all your Horizon BCBSNJ benefits. Your member ID card is available digitally on the Horizon Blue app. Show it when you see your doctor, or go to a hospital or other health care professional. **Note:** Your member ID card was mailed separately.

4 Get to know your plan

Start with this handbook. It will help you understand what's covered and what's not, as well as how to use your benefits. Not sure? Call your Horizon Health Guide at **1-800-414-SHBP (7427)**.

5 Choose a doctor

Your plan covers care from doctors who are in the Horizon Managed Care Network and hospitals in the Horizon Hospital Network. Start by choosing an OMNIA Tier 1-designated doctor to take care of you when you're sick, and help you stay healthier all year round. When you do, you'll pay less for your care.

See page 10 to find out how to choose an OMNIA Tier 1-designated doctor

6 Save money

Enjoy member-exclusive discounts on fitness and healthy living services. Visit **Blue365deals.com** for details.

Horizon

24/7 Support

Horizon Blue app
HorizonBlue.com/shbp

Numbers to Know

Horizon Health Guide
1-800-414-SHBP (7427)
TTY 711

Representatives are available weekdays, 8 a.m. to 9 p.m., Eastern Time (ET).

Plan Facts

Name

OMNIA Health Plan

Participating Health Care Professionals
Refer to **Section Two: Understanding Your Coverage** for details.

Out-of-Network Services
Except for emergency care, services provided by doctors, hospitals and other health care professionals that don't participate in OMNIA Health Plans are not covered.

Connect with us!

@HorizonBCBSNJ

Horizon Blue App

The Horizon Blue app gives you 24/7 access to care and support in the palm of your hand. Download the Horizon Blue App for free by texting **GetApp** to **422-272**.

You can check plan benefits, find a doctor and even display your Horizon BCBSNJ member ID card, all on the screen of your web-enabled mobile device.

Available on the App Store

GET IT ON Google play

There is no charge to download the app, but rates from your wireless provider may apply.

Secure, online access 24/7

Our secure website, **HorizonBlue.com/shbp**, is available to you 24 hours a day, seven days a week.

As a registered user, you can:

- Chat or send a message to a Horizon Health Guide.
- Video chat with a doctor.
- Talk with a nurse.
- See detailed information about your plan.
- View eligibility and benefits.
- View claim status.
- View authorizations and referrals.
- Show, print or request your member ID card.
- Update your other health insurance coverage information.
- Take advantage of health and wellness tools, educational resources and more.
- Use helpful tools from WebMD®[1] to securely store and track your personal health information.

[1] WebMD is independent from and not affiliated with Horizon BCBSNJ.

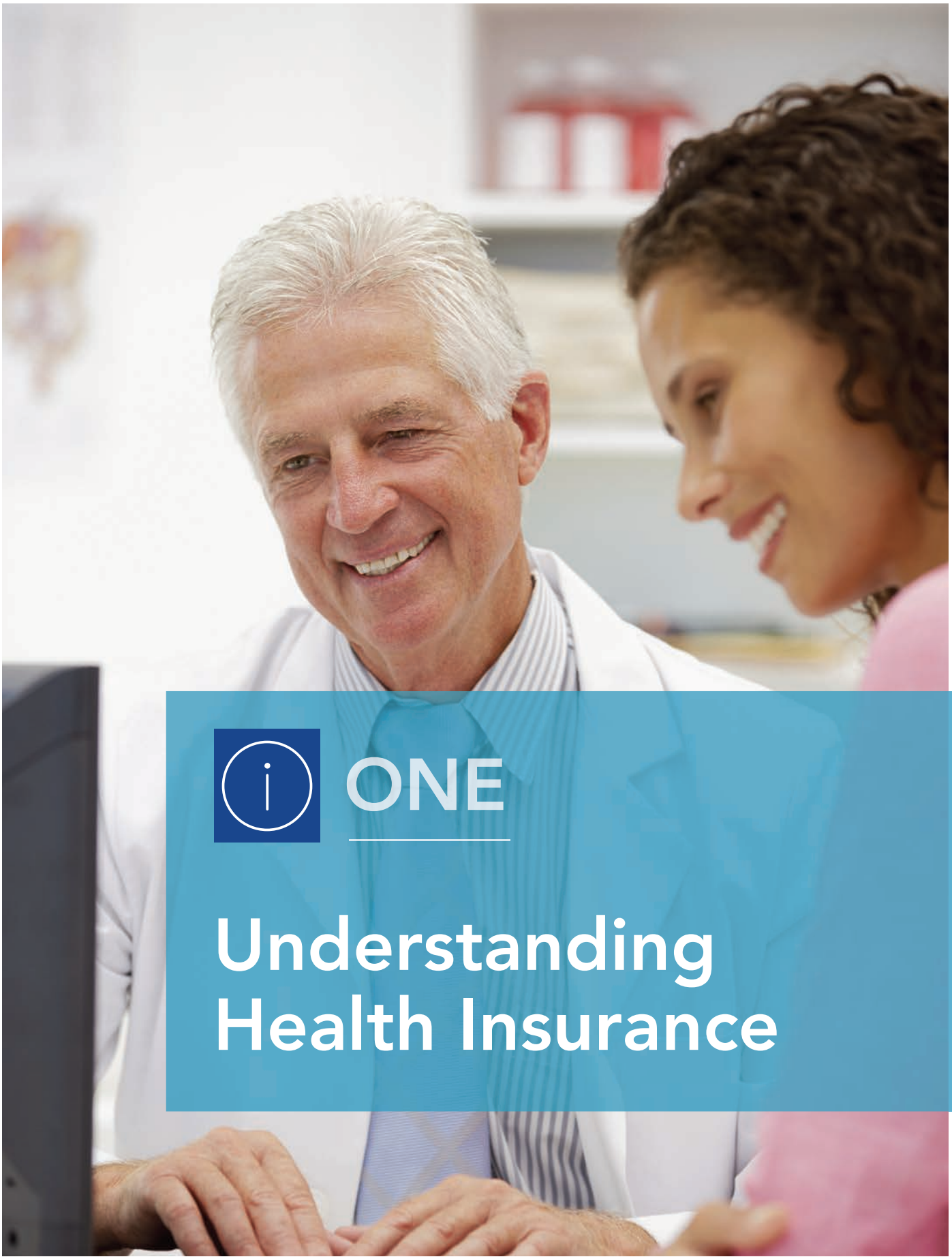
Horizon Health Guide

With a Horizon Health Guide, your health care experience will be even easier, with convenience and support like never before. Your Horizon Health Guide can help with all your health care needs:

- Answering questions
- Solving issues
- Helping with claims
- Finding care
- Scheduling appointments
- Making health and wellness benefit suggestions tailored to you

They'll also provide care support if you have a chronic health condition.

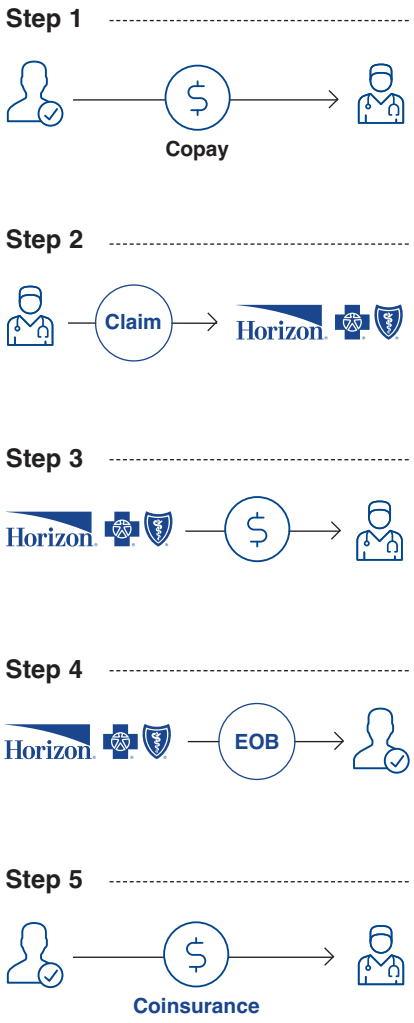
Speak to a Horizon Health Guide at **1-800-414-SHBP (7427)**, or chat after signing in at **HorizonBlue.com/shbp**.



ONE

Understanding Health Insurance

Health insurance may seem complicated and confusing, but it doesn't have to be. We want to help you understand your health insurance plan – how it works, how to use it and how you can get the most out of it.



What to expect

If you've never had health insurance before, you may not know what to expect. In general, here's how it works:

Copay – A copay – a fixed amount you pay for each medical visit – may be due when you see an in-network doctor or other health care professional **(Step 1)**.

Claims – The doctor or other health care professional's office files a claim **(Step 2)**, showing which services you received. We process each claim according to the terms of your plan.

If we owe a payment for covered services, we pay the in-network doctor or other health care professional directly **(Step 3)**.

Explanation of Benefits (EOB) – After we process your in-network doctor's or other health care professional's claims, you'll get a Horizon BCBSNJ Explanation of Benefits statement, or EOB **(Step 4)**.

This EOB statement shows what we paid the doctor or other health care professional for each service, and any amount you may still owe in coinsurance to the doctor or other health care professional **(Step 5)**.

We'll send you an email or text, whichever you prefer, when your claim is processed so you can sign in to **HorizonBlue.com/shbp**, click the claim number and view your EOB.

Medical Bills – After you see an in-network doctor or health care professional, you may not get a medical bill. But you should expect one if you owe a copay or coinsurance, or if there are charges for services that aren't covered under your plan. **Nonemergent services provided by out-of-network doctors, hospitals and facilities are not covered under your plan, and you will be responsible for the total cost of those services**.

Before you pay any in-network doctor's or health care professional's medical bill, check it against your EOB statement to see how much we paid and how much you may owe. You can see current and past claims any time by signing in at **HorizonBlue.com/shbp**.

If you get a bill and need a claim form, you can download one at **HorizonBlue.com/shbpmedicalforms** or call **1-800-414-SHBP (7417)**. Mail your completed claim form and bill to the address shown on the form.

Always keep a copy of your medical bills for your records.

Note: In-network doctors, hospitals and other health care professionals are not permitted to "balance bill" you for any difference between their charges and Horizon BCBSNJ's maximum allowed amount for a covered service. For example, say your doctor charges $200 for a service, and we allow $100 for that service. Because your doctor accepts a discounted rate from Horizon BCBSNJ, the total your doctor gets – our payment, plus your coinsurance and any copay – is $100. Your doctor can't bill you for the $100 balance.

What do you pay?

Each insurance plan is different. That's why understanding *your* plan and benefits is important. Knowing about your coverage will help you make the best health care choices and avoid unexpected expenses.

Generally, this is how your health insurance works:

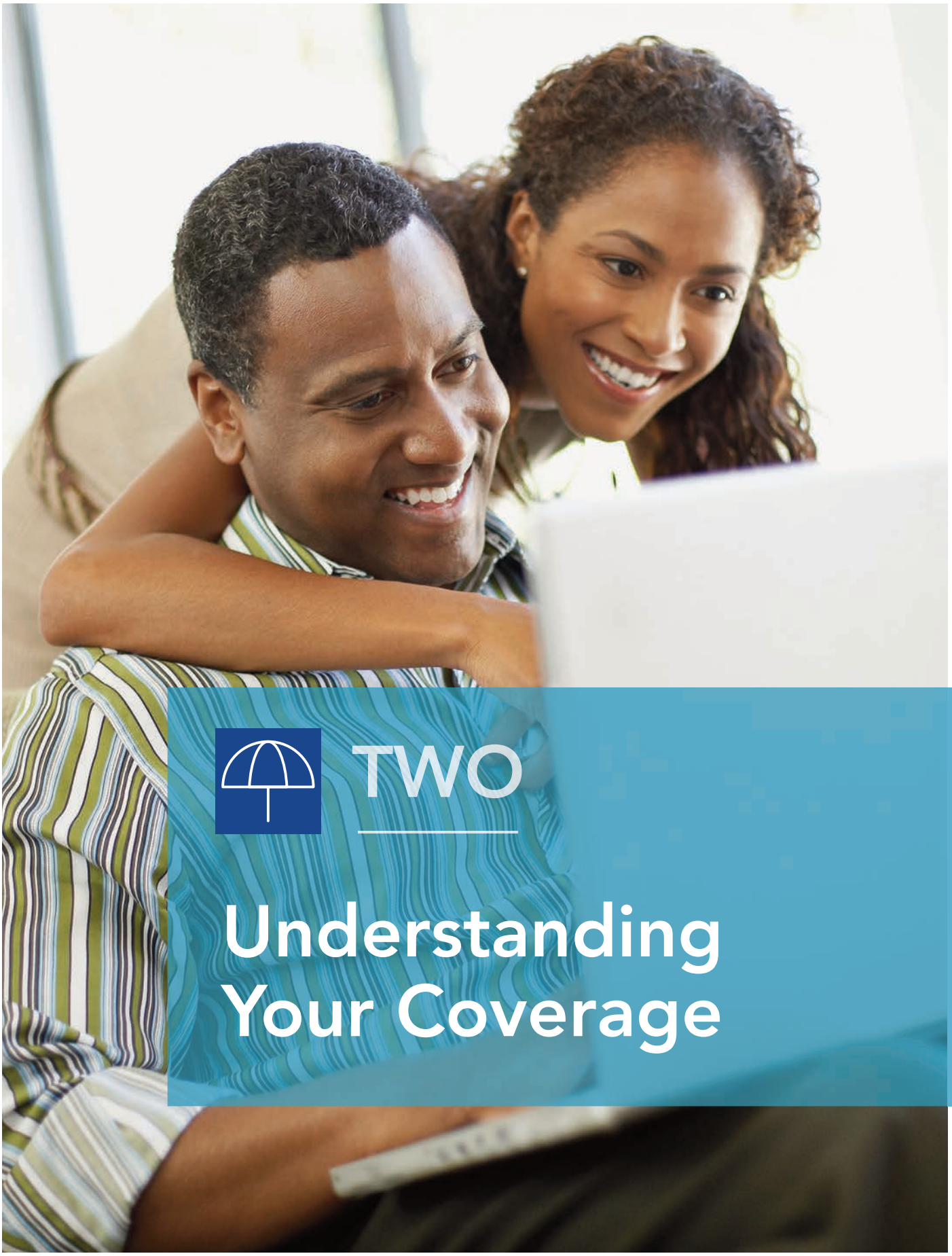
- You pay us a **monthly premium** for coverage. Because you get your insurance through your employer, you pay your premium through payroll contributions.
- Each time you see an in-network doctor, hospital or other health care professional, you may be asked to pay a fixed amount called a **copay**.
- For some services, you may pay a **coinsurance** – a set percent based on how much we agree to cover for a service (also known as our **allowed amount**). For example, if we allow a $100 charge for a covered service and your plan has 70 percent coinsurance, we would pay $70 and you would be responsible for $30 for that service.
- Finally, your coverage may have an **out-of-pocket maximum limit**. If it does, this amount is the most you'll have to pay "out of your pocket" in copays, deductibles and coinsurance for certain covered health care services in a single year.

IMPORTANT TERMS

Copay – The amount you must pay for each medical visit to an in-network doctor, hospital or other health care professional. Your copay amounts are listed on your Horizon BCBSNJ member ID card.

Coinsurance – The percentage of a covered charge that Horizon BCBSNJ pays. For example, if your plan has 70 percent coinsurance, you are responsible for 30 percent of covered charges. Coinsurance does not include deductibles, copays and charges for noncovered services.

Deductible – The amount you must pay each year before benefits are paid by us.



TWO

Understanding Your Coverage

2020 OMNIA Health Plan Benefit Highlights		
Access and Cost Sharing	**OMNIA Tier 1**	**Tier 2**
Referrals Required?	No	No
Where you can get care	In NJ Only	Outside NJ (BlueCard & Global Core)
Deductible	$0	$1,500 individual/$3,000 family
Coinsurance	Not Applicable	20%
Maximum Out-of-Pocket (MOOP)	$2,500 individual/$5,000 family	$4,500 individual/$9,000 family
Health Care Services	**OMNIA Tier 1**	**Tier 2**
Primary Care Physician (PCP) office visit	$5 copay	$20 copay
Specialist office visits and consultations	$15 copay	$30 copay
Preventive care, screenings, immunizations	No copay or deductible	No copay or deductible
Tests & Imaging	**OMNIA Tier 1**	**Tier 2**
Laboratory: freestanding	No charge	No charge
Laboratory: hospital outpatient	$15 copay	Deductible then coinsurance
Radiology: freestanding	No charge	No charge
Radiology: hospital outpatient	$15 copay	Deductible then coinsurance
Imaging (CT/PET scans, MRIs): freestanding	No charge	No charge
Imaging (CT/PET scans, MRIs): hospital outpatient	$15 copay	Deductible then coinsurance
Outpatient Surgery	**OMNIA Tier 1**	**Tier 2**
Professional charges	No charge	Deductible then coinsurance
Facility charges	$150 copay	Deductible then coinsurance
Inpatient Services	**OMNIA Tier 1**	**Tier 2**
Professional charges	No charge	Deductible then coinsurance
Facility charges	$150 per admission	Deductible then coinsurance
Urgent & Emergency Medical Services	**OMNIA Tier 1**	**Tier 2**
Urgent care	$15 copay	$30 copay
Emergency Room	$100 copay	$100 copay
Maternity Services	**OMNIA Tier 1**	**Tier 2**
Prenatal and postnatal care	$15 copay *(applies to 1st visit only)*	$30 copay *(applies to 1st visit only)*
Delivery and all inpatient services	No copay	Deductible then coinsurance
Behavioral Health & Substance Abuse Services	**OMNIA Tier 1**	**Tier 2**
Outpatient services (facility)	$15 copay	Deductible then coinsurance
Outpatient services (office)	$15 copay	$30 copay
Inpatient services	No copay	Deductible then coinsurance
Recovery/Special Health Services	**OMNIA Tier 1**	**Tier 2**
Home health care	$5 copay	$5 copay
Skilled nursing care	$150 per admission	$150 per admission
Durable medical equipment (DME)	No charge	No charge
Hospice services	No copay	No charge
Ambulance	No charge	No charge

IMPORTANT TERMS

OMNIA Tier 1 – When you get care from an OMNIA Tier 1 doctor, hospital or other health care professional, you can save money.

Tier 2 – Under your OMNIA Health Plan, you are still covered at an in-network benefit level when you get care from a Tier 2 doctor, hospital or other health care professional.

All other doctors in the Horizon Managed Care Network, the nationwide BlueCard Program and Global Core program are designated Tier 2.

Your plan

While your OMNIA Health Plan encourages you to get care from OMNIA Tier 1-designated doctors, hospitals and other health care professionals, your plan covers all medically necessary care and services provided or arranged by doctors and other health care professionals who are in the Horizon Managed Care Network, and all hospitals in the Horizon Hospital Network.

Find an in-network doctor, hospital or other health care professionals using the **Horizon Blue** app or signing in to **HorizonBlue.com/shbp** and selecting *Doctors and Care*. The doctors profile will show OMNIA Tier 1 or Tier 2.

Under your plan, you don't have to choose a Primary Care Physician (PCP). But when you select and see an OMNIA Tier 1-designated doctor, he or she can help you get the most appropriate care in the right setting.

Questions? Use the **Horizon Blue** app or sign in to **HorizonBlue.com/shbp** to review your coverage information, chat with us or send a secure email. You can also call your Horizon Health Guide at **1-800-414-SHBP (7427)**.

Services provided by doctors, hospitals and other health care professionals that do not participate in OMNIA Health Plans are not covered. You'll be responsible for the total cost of any of the out-of-network services you receive (except in an emergency).

See page 11 for information on finding in-network doctors, hospitals and other health care professionals outside of New Jersey.

Coverage wherever you go

With the BlueCard® Program as part of your OMNIA Health Plan, you have access to the largest health care network in the nation, linking more than 1.3 million doctors, facilities and other health care professionals. You also have access to laboratory testing services across the country.

When you travel outside the country, Global Core provides you with access to care almost anywhere in the world, including hospitals in more than 40 countries.

It's as simple as presenting your Horizon BCBSNJ member ID card to any participating BlueCard or Global Core doctor, other health care professional or hospital. When using participating Blue Cross and/or Blue Shield doctors, you are only responsible for your Tier 2 office visit copay. A deductible and/or coinsurance may also apply.

Choose *National Doctor & Hospital Finder* at **HorizonBlue.com/doctorfinder.** or call **1-800-810-BLUE (2583)** to locate a participating Blue Cross and/or Blue Shield doctor or hospital. Outside the U.S., you can call collect at **1-804-673-1177.**

What is Patient-Centered Care?

Patient-centered care helps you get the quality health care you need at a more affordable cost. Your OMNIA Health Plan offers you the benefits of patient-centered care, along with access to all doctors and other health care professionals in the Horizon Managed Care Network, and all hospitals in the Horizon Hospital Network.

Patient-centered care is all about you. The doctors and practices that participate in OMNIA Health Plans have committed themselves to achieving quality health outcomes and increasing patient satisfaction.

When you see an OMNIA Tier 1-designated doctor as your doctor, you can expect:

- A doctor who takes overall responsibility for your care
- A team of health professionals, led and directed by your doctor, that closely monitors your health and responds to your specific needs
- Wellness services and preventive care based on national guidelines, including wellness support and resources
- Preventive services, screenings and immunizations that are fully covered when you receive them from your doctor or another in-network doctor

When you select and see an OMNIA Tier 1-designated doctor, he or she can help you get the most appropriate care in the right setting. See **Section Three: Getting Routine Care** to learn more.

Horizon Connect Retail Centers

If you're in the area, stop by and meet the team of experts at our retail center, *Horizon Connect*.

Where:

1680 Nixon Drive, Moorestown, New Jersey

Monday through Friday
9 a.m. to 7 p.m.
Saturday, 9 a.m. to 4 p.m.

3196 John F. Kennedy Blvd. Union City, New Jersey

Monday, Wednesday and Friday
10 a.m. to 3 p.m.
Tuesday and Thursday
10 a.m. to 7 p.m.

To make an appointment and register for events, visit **HorizonBlue.com/connect**.

At *Horizon Connect*, you can:

- Get answers to questions you may have about your plan and benefits.
- Pick up informational materials.
- Learn all about our health and wellness tools.
- Attend health fairs and special events with local doctors, nurses, pharmacists and other health care professionals.

FORMS AT YOUR FINGERTIPS

Need a claim form? Download one at **HorizonBlue.com/shbpmedicalforms** or call your Horizon Health Guide at **1-800-414-SHBP (7427)**. Mail your completed claim form and bill to the address shown on the form.

Enrollment

You are not covered until you enroll in the State Health Benefits Program (SHBP). You must fill out a Health Benefits Program Application and provide all the information requested.

If you do not enroll all eligible members of your family within 60 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so.

Open Enrollment periods generally occur once a year usually during the month of October. Information about the dates of the Open Enrollment period and effective dates for coverage is announced by the New Jersey Division of Pensions and Benefits.

Eligible Dependents

Your eligible dependents are your spouse, civil union partner or eligible same-sex domestic partner, and your eligible children.

Spouse – A person to whom you are legally married. A photocopy of the marriage certificate and additional supporting documentation are required for enrollment.

Civil union partner – A person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey Civil Union Certificate or a valid certification from another jurisdiction that recognizes same-sex civil unions and additional supporting documentation are required for enrollment. The cost of a civil union partner's coverage may be subject to federal tax (see your employer or **Fact Sheet #75**, *Civil Unions and Domestic Partnerships*, for details).

Domestic partner – A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity that adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage. A photocopy of the New Jersey Certificate of Domestic Partnership dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners) and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or **Fact Sheet #75**, *Civil Unions and Domestic Partnerships*, for details).

Children – Under the Affordable Care Act (ACA), coverage is extended for children until age 26. This includes natural children under age 26 regardless of the child's marital, student or financial dependency status. A photocopy of the child's birth certificate that includes the covered parent's name is required for enrollment.

For a stepchild, provide a photocopy of the child's birth certificate showing the spouse/partner's name as a parent and a photocopy of marriage/partnership certificate showing the names of the employee and spouse/partner.

Foster children and children in a guardian-ward relationship under age 26 are also eligible. A photocopy of the child's birth certificate and additional supporting legal documentation are required with enrollment forms for these cases. Documents must attest to the legal guardianship by the covered employee.

Coverage for an enrolled child ends on December 31 of the year in which he or she turns age 26.

Dependent children with disabilities – If a child is not capable of self-support when he or she reaches age 26 due to mental illness, mental retardation or a physical disability, he or she may be eligible for a continuance of coverage.

To request continued coverage, call the Office of Client Services at **1-609-292-7524** or write to the **New Jersey Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, NJ 08625**, for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end.

Since coverage for children ends on December 31 of the year they turn 26, you have until January 31 to file the *Continuance for Dependent with Disabilities* form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP, (2) the child continues to be disabled, (3) the child is unmarried, (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.

Over-age children until age 31 – Certain children over age 26 may be eligible for coverage until age 31 under the provisions of Chapter 375, P.L. 2005, as amended by Chapter 38, P.L. 2008. This includes a child by blood or law who is under the age of 31; is unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.

Under Chapter 375, an over-age child **does not** have any choice in the selection of benefits but is enrolled for coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. The covered parent or child is responsible for the entire cost of coverage. There is no provision for dental or vision benefits.

Coverage for an enrolled over-age child will end when the child no longer meets any one of the eligibility requirements or if the required payment is not received. Coverage will also end when the covered parent's coverage ends. Coverage ends on the first of the month following the event that makes the dependent ineligible or up until the paid through date in the case of nonpayment.

See **Fact Sheet #74**, *Health Benefits Coverage of Children until Age 31 under Chapter 375*, for details.

Supporting documentation required for enrollment of dependent

The SHBP is required to ensure that only eligible employees and their dependents receive health care coverage under the program. Employees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents and over-age children continuing coverage) must submit supporting documentation in addition to the enrollment application.

Audit of dependent coverage

Periodically, the New Jersey Division of Pensions and Benefits performs an audit using a random sample of members to determine if enrolled dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union or birth certificates, or tax returns are required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of ALL coverage and may include financial restitution for claims paid. Members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law.

Multiple coverage under the SHBP is prohibited

State statute specifically prohibits two members who are each enrolled in SHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP as an employee or be covered as a dependent.

Eligible children may only be covered by one participating subscriber.

For example, a husband and wife both have SHBP coverage based on their employment and have children eligible for coverage. One may choose Family coverage, making the spouse and children the dependents and ineligible for any other SHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

Medicare coverage while employed

In general, it's not necessary for a Medicare-eligible employee, spouse, civil union or domestic partner, or dependent child(ren) to be covered by Medicare while the employee is actively at work. However, if you or your dependents become eligible for Medicare due to End Stage Renal Disease (ESRD), and the 30-month coordination of benefits period has ended, you and/or your dependents must enroll in Medicare Parts A and B even though you are actively at work.

For more information, visit the **New Jersey Division of Pensions and Benefits'** website at **nj.gov/treasury/pensions**.

Pharmacy Benefits

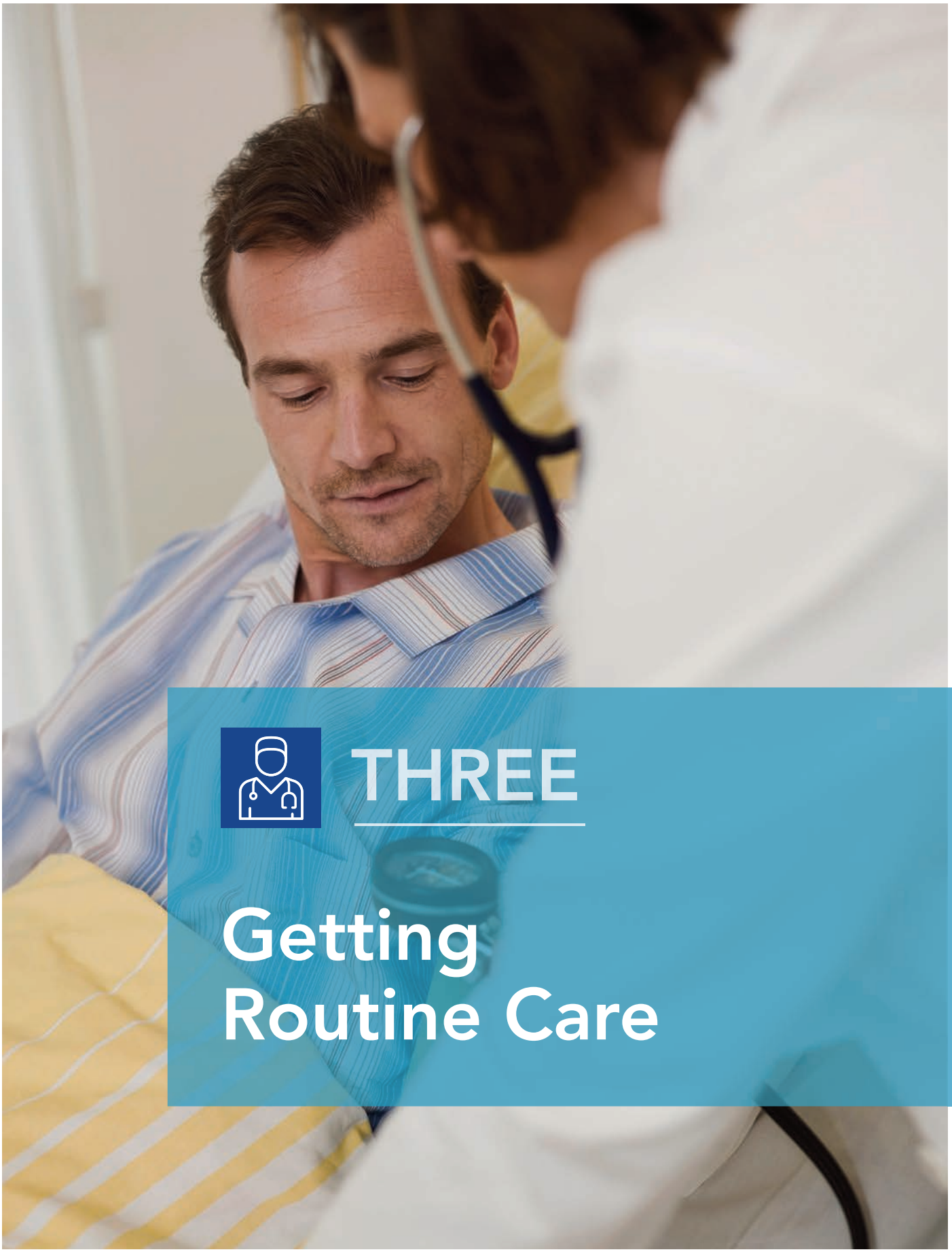
All covered SHBP members are offered Prescription Drug benefits. Contact your benefits administrator/employer for details.

LIMITATIONS AND EXCLUSIONS

Prior authorization: Under your plan, Horizon BCBSNJ must authorize all non-emergency hospitalizations and some specialty care services (except for routine Ob/Gyn) before you receive these types of services.

Non-covered services: Your OMNIA Health Plan does not pay for services or supplies that are not covered under your policy.

Please call **1-800-414-SHBP (7427)** to speak with a Horizon Health Guide if you have questions.



THREE

Getting Routine Care

Doctor Responsibilities

The doctor you choose will be your main resource for health care services. He or she will:

- Handle most of your medical care in his or her own office.
- Perform most of your annual wellness and preventive health exams.
- Take care of your urgent care needs when possible.
- Get prior authorizations from us for medically necessary services.
- Help coordinate the care you get from specialists and other in-network health care professionals.
- Be available on call (or appoint a covering doctor to be available) 24 hours a day, seven days a week.

Making an appointment

ACCESS STANDARDS

To make sure you can get the medical care you need when you need it, we developed Physician Access Standards for in-network doctors in select specialties.[1] These health care professionals follow our Physician Access Standards[2] when scheduling appointments with you.

- **EMERGENCY CARE – Immediate care**
  Includes "a medical condition of such severity that a prudent layperson would call for immediate medical attention and care." To learn more, please see **Section Four: Getting Urgent & Emergency Care**.
- **URGENT CARE – Care within 24 hours**
  Includes medically necessary care for an unexpected illness or injury.
- **ROUTINE CARE – Care within two weeks**[3]
  Any condition or illness that does not require urgent attention or is not life-threatening, as well as routine gynecological care.
- **ROUTINE PHYSICAL EXAM – Care as soon as possible, but not to exceed four months from the date of your call**
  Includes an annual health assessment, as well as routine gynecological exams, for new and established patients.

OFFICE WAITING TIME

Horizon BCBSNJ's in-network doctors are expected to keep office waiting room time to 30 minutes or less from the time of your scheduled appointment, or when you arrive at the office, whichever is later.

If your wait is longer than 30 minutes, you should be given the choice to reschedule or continue waiting.

[1] Applies to doctors who are directly under contract with Horizon BCBSNJ.

[2] Standards apply to first available appointment, not first convenient appointment.

[3] Specialists must offer an appointment for routine care within three weeks.

Horizon CareOnline℠

Medical Care

Get urgent medical care 24/7 from U.S. board-certified, licensed doctors for conditions such as colds, the flu, stomach pain and more.

Behavioral Health Care

Talk to a licensed psychiatrist, psychologist or social worker for treatment for anxiety, depression, attention deficit/hyperactivity disorder (ADHD) and more.

Professionals are available by appointment from 7 a.m. to 11 p.m., Eastern Time, every day.

NIGHTS AND WEEKENDS

If you need urgent care after your doctor's office hours or on weekends, your doctor should be reachable 24 hours a day, seven days a week.

When your doctor is not available, he or she should refer you to a covering doctor who can help you.

If you believe your condition requires emergency care, follow the medical emergency procedures in Section Four: Getting Urgent & Emergency Care.

Virtual visit with a doctor anytime

Too sick to go to a doctor? Travelling out of the area? You can speak to a doctor anytime using **Horizon CareOnline℠**. Connect with a doctor whenever and wherever the need arises for care that is:

- **Dependable**: 24/7/365 access
- **Flexible**: Access to licensed, U.S. board-certified doctors
- **Convenient**: No appointment needed, no waiting
- **Confidential**: Private and secure; compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

WHO ARE THE DOCTORS?

Clinical services are provided by doctors who:

- Are U.S. board certified, licensed and credentialed.
- Average 15 years' experience in primary and urgent care.
- Are rated by other patients.

REGISTER NOW

Register at **HorizonCareOnline.com** and select *Horizon Blue Cross Blue Shield of New Jersey* as your health plan. When prompted, enter the service key *SHBP*.

You can also use the **Horizon Blue** app or call **1-877-716-5657** to speak to a doctor.

With Horizon CareOnline, you'll pay the same amount as a primary care visit. A $5 charge will be applied to your credit or debit card at the time of the visit.

This service is offered as a convenience. It does not replace your relationship with your personal doctor.

For more information, visit **info.americanwell.com/where-can-I-see-a-doctor-online**. American Well is an independent company that supports Horizon Blue Cross Blue Shield of New Jersey in the administration of telemedicine services.

How to get specialist care

A specialist is a doctor who "specializes" in taking care of a particular bodily system or disease. Cardiologists (heart care) and oncologists (cancer care) are two common types, but there are many more kinds of specialists.

With your OMNIA Health Plan, you don't need a referral to see a specialist.

PRIOR AUTHORIZATION

"Prior authorization" means that Horizon BCBSNJ must approve certain specialty services before you receive them. Without proper authorization, you might receive services that are not covered by your plan, leaving you responsible for the total cost.

Please call your Horizon Health Guide at **1-800-414-SHBP (7427)** for more details.

GETTING BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER CARE

Please see page 23 for more information.

How to get a lab test

Laboratory Corporation of America® (LabCorp) and Quest Diagnostics are the in-network clinical laboratory providers for members enrolled in OMNIA Health Plans. When you need lab work, your doctor may collect specimens at his or her office or send you to a LabCorp or Quest patient service center, or a lab authorized to perform a specialized service.

If you use a lab outside of New Jersey, the lab must be in network with the local Blue Cross Blue Shield plan; the service will be covered at the Tier 2 benefit level.

Lab services performed in an in-network facility are not subject to this policy. Members who are admitted to an in-network hospital may have their lab services performed at the facility.

LAB LOCATIONS:

Find an in-network lab near you and make an appointment:

- LabCorp: **labcorp.com/labs-and-appointments**.
- Quest Diagnostics: **questdiagnostics.com/appointment**.

ADVANCED IMAGING SERVICES (AIS) AND CARDIOLOGY IMAGING PROCEDURES

Your doctor must call eviCore healthcare before you receive any of these advanced procedures:

- CT/CTA scans
- Diagnostic left-heart catheterization
- Echo stress tests
- Echocardiograms
- MRIs/MRAs
- Nuclear medicine studies (including nuclear cardiology)
- PET scans

How to get an X-ray or imaging scan (radiology)

Horizon BCBSNJ works with eviCore healthcare[1] for nonemergency, outpatient radiology and diagnostic imaging services. eviCore healthcare will help schedule and manage your office and outpatient radiology and diagnostic imaging, determine whether a service is medically necessary and confirm a location for the service.

[1] eviCore healthcare is independent from and not affiliated with Horizon BCBSNJ.

SCHEDULING YOUR TESTS

If your doctor decides that you need general radiology (e.g., X-ray, mammogram, ultrasound, etc.), he or she will ask you to call eviCore healthcare's easy-to-use Scheduling Line. The eviCore healthcare scheduling staff will coordinate with the in-network imaging center or hospital outpatient department of your choice to schedule your exam and provide you with a confirmation number. You won't need a doctor referral for radiology services.

To make an appointment, you or your doctor should call the eviCore healthcare Scheduling Line at **1-866-969-1234**, weekdays, between 7 a.m. and 7 p.m., Eastern Time.

What if you need to be hospitalized?

Your OMNIA Health Plan offers coverage at in-network New Jersey hospitals.

To find an in-network hospital, use the **Horizon Blue** app or sign in to **HorizonBlue.com/shbp** and select *Doctors & Care*.

Except for emergency care, services provided by hospitals that do not participate in OMNIA Health Plans are not covered. You'll be responsible for the total cost of any services you get from out-of-network hospitals.

How to get help with a serious condition

When you're facing a chronic or complex health condition, a Horizon Health Guide is your link to Horizon BCBSNJ, helping you navigate your coverage to get the right care at what could be a difficult, stressful time. A Horizon Health Guide can help you take better care of your health, understand your care choices and improve your well-being.

A Horizon Health Guide educates you about your condition, helps you get quality medical care, secures appropriate authorizations and connect you to valuable resources. If your medical condition requires hospitalization, your Horizon Health Guide will see to it that your follow-up needs are met when you leave the hospital.

Your Horizon Health Guide can also help you improve your health, work with you to prevent complications, help you live within the boundaries of a new health status, and help you and your family adjust to a new lifestyle that optimizes your quality of life.

If you face a challenging medical condition, let a Horizon Health Guide help – at no additional cost to you. You can reach a Horizon Health Guide at **1-800-414-SHBP (7427)**, weekdays, from 8 a.m. to 9 p.m.

HOSPITAL STAYS AND PRIOR AUTHORIZATION

For your inpatient or outpatient[1] hospitalization to be covered, your doctor must contact us for prior authorization, and you must get care at an in-network facility.

If you receive care at an out-of-network hospital when it's not an emergency, you'll be responsible for the total cost of care.

[1] Not all outpatient hospital services require prior authorization.

Maternity Care

If you become pregnant, your Horizon BCBSNJ health plan will be with you and your obstetrician every step of the way, with comprehensive prenatal and maternity coverage.

PARTNERING WITH YOUR OB/GYN

Horizon BCBSNJ supports the American College of Obstetricians and Gynecologists' recommendation for 12 obstetrical visits during a normal pregnancy. Your doctor will decide how many visits are right for you.

MATERNITY HOSPITAL STAYS

New mothers are certified for a hospital stay of 48 hours following a vaginal delivery or 96 hours following a caesarean section. Your hospital stay may be extended if your doctor thinks it's medically necessary. To be covered, your doctor will need to contact us for approval of the additional days.

Your doctor may decide that you're ready to leave the hospital early – within one day after a vaginal delivery or within two days after a caesarean section. If you do leave early, you become eligible for a home care visit to support your move from hospital to home. To be covered, your doctor must schedule the visits to occur within seven (nurse/lactation consultant) to 14 (home health aide) days after you've left the hospital.

Precious Additions®

As an expectant parent, you may have questions and concerns about pregnancy and delivery. That's why we developed the **Precious Additions** program.

Precious Additions[1] is an educational program where eligible members can get information about pregnancy, childbirth, the postpartum period and their child's first year of life. The program will help provide guidance for making healthy and safe choices during this special time.

Eligible members can enroll in **Precious Additions** by visiting **HorizonBlue.com/PreciousAdditions** or calling **1-800-414-SHBP (7427)**.

[1] Some products and services included in the Precious Additions program materials are provided by independent companies. These companies are solely responsible for their products and services.

What if you need behavioral health care?

Your OMNIA Health Plan includes behavioral health, including mental health and substance use disorder coverage. Horizon Behavioral Health℠ provides assistance with a wide range of emotional and relationship issues, depression, alcoholism, addictions and more, through an extensive network of health care professionals and facilities.

AVAILABLE SERVICES

Horizon Behavioral Health professionals offer a full range of counseling services, including:

- Individual and group psychotherapy
- Family counseling and crisis intervention
- Addiction recovery programs
- Autism care management program

GETTING BEHAVIORAL HEALTH CARE

For routine behavioral health care[1], please call Horizon Behavioral Health at **1-800-991-5579**. Behavioral health and substance use disorder care is available 24 hours a day, seven days a week. All calls are confidential.

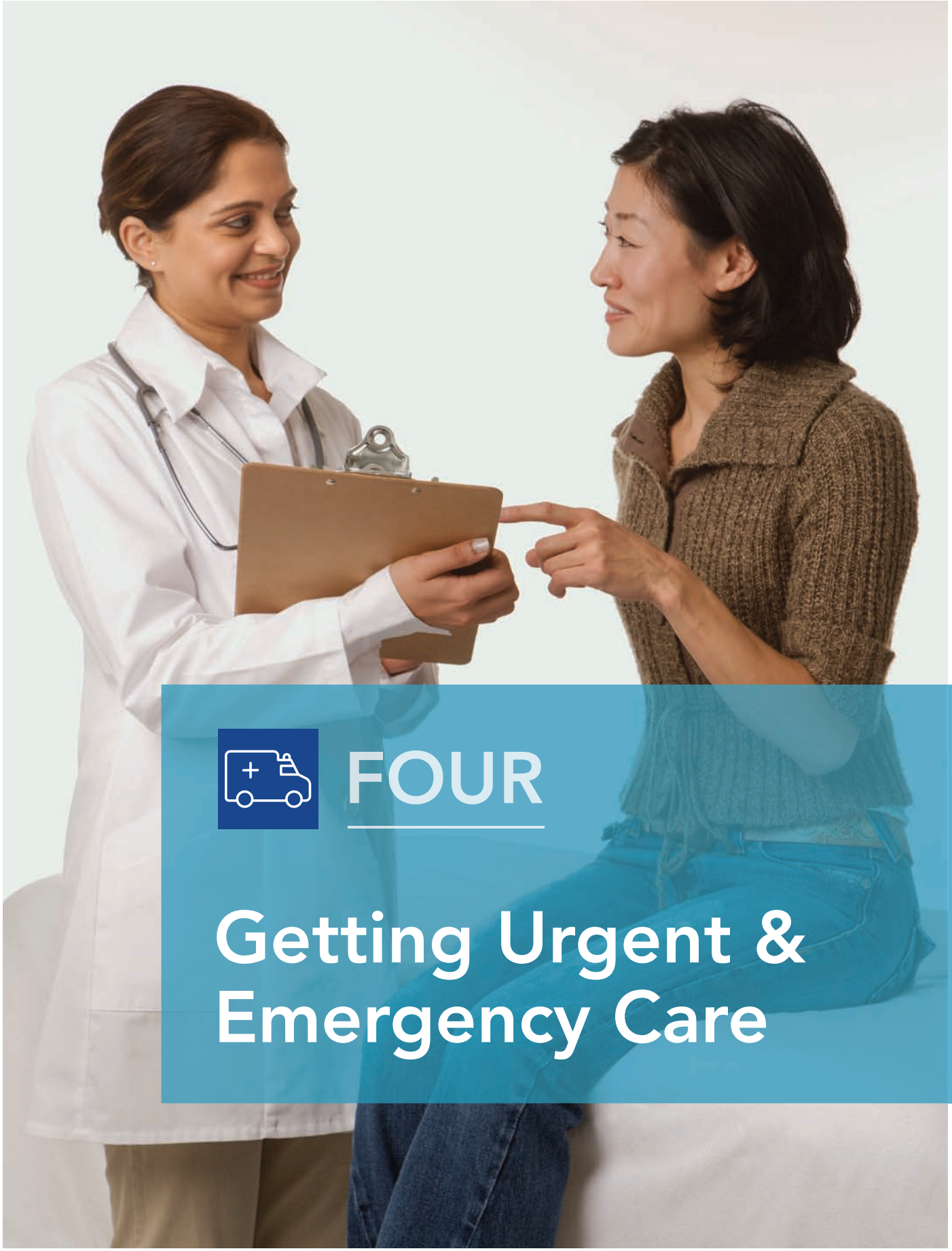
Prior authorization is required for all inpatient behavioral health and substance use disorder care.

[1] Due to the confidential nature of these services, you may need to authorize the disclosure of treatment information during or after your course of treatment. Authorization might also be needed to allow any individual (including family members) to get a member's behavioral health/substance use disorder treatment information.

HORIZON BCBSNJ HEALTH TIP

Don't miss out on your preventive care benefits. Be sure to make appointments for physical exams and related services well in advance.

See **Section Five: Taking Care of Yourself & Your Family** for more on preventive care benefits and guidelines.



FOUR

Getting Urgent & Emergency Care

IS IT REALLY AN EMERGENCY?

Knowing the difference between urgent care and a medical emergency can save you time and money.

Urgent care situations include:

- Sprains
- Moderate fever
- Sore throat

This is not a complete list of urgent care situations. For these and other common medical conditions, call your doctor, visit an urgent care center or use Horizon CareOnline.

Medical emergencies include:

- Severe burns
- Heart attacks and strokes
- Poisoning
- Obvious bone fractures
- Wounds requiring sutures
- Loss of consciousness

This is not a complete list of emergency situations. For these and other serious or life-threatening conditions, seek immediate treatment by going to an ER, or call **911**.

Immediate care

You may have an urgent medical condition – one that can't wait for a normal appointment but is not a true medical emergency, either.

For urgent care, contact your doctor or his or her covering doctor first. He or she can help you determine the type of care that is best for you.

YOUR URGENT CARE OPTIONS:

Your Doctor

Call first, especially if you're not sure it's really an emergency. Your doctor may tell you how to treat the condition yourself, send you to the nearest urgent care center or make an appointment to see you as soon as possible.

Horizon CareOnline℠

Video chat with a doctor 24/7 wherever you are. Register at **HorizonCareOnline.com** and select *Horizon Blue Cross Blue Shield of New Jersey* as your health plan. When prompted, enter the service key *SHBP.* See page 18 for more information.

Urgent Care Center

An urgent care center is a good alternative when you need care right away. You'll probably have a much shorter wait for non-critical care than at an Emergency Room (ER), and your out-of-pocket costs may be lower too. You can find an urgent care center by using the **Horizon Blue** app or signing in to **HorizonBlue.com/shbp** and selecting *Doctors & Care*.

Note: Routine office visits, annual physicals, sports physicals, routine obstetric services, occupational medicine and physical therapy are not covered at urgent care centers.

Emergency Room

For treatment of a severe illness or injury, go to the nearest ER right away, or call **911.**

Emergency care

In general, an emergency is defined as "a medical condition of such severity that a prudent layperson with average knowledge of health and medicine would call for immediate medical attention."

If you reasonably believe that a condition is a medical emergency:

1. **Go directly to the nearest ER or call 911.**
2. **Call your doctor.** In some situations, you may be able to call your doctor before you go to the ER. If you can't, call as soon as reasonably possible, or ask a family member or friend to call. It is important that your doctor be kept aware of your condition. Without this information, he or she cannot coordinate your follow-up care.

You do not need to notify us of a medical emergency.

MEDICAL EMERGENCY SCREENING EXAM

Sometimes, you may not be sure if your condition requires emergency care. Your plan covers a medical emergency screening exam, which is an evaluation performed in a hospital ER by qualified health care personnel, to determine if a medical emergency exists. We'll cover the cost of the emergency screening exam.

If the exam determines that an emergency does not exist, please follow up with your doctor.

If you continue to get care at the ER after you have been told that your condition is not a medical emergency, you will have to pay the total cost for any non-emergency-related services you receive.

EMERGENCY ROOM COPAYS

Even if your doctor refers you to the ER, **you'll have an ER copay and may also be responsible for a deductible and coinsurance**. Each time you are treated at an ER or are given a medical emergency screening exam, you will be responsible for a copay as well as any coinsurance your plan requires. But if you're admitted to the hospital as an inpatient within 24 hours, we'll waive the ER copay.

FOLLOW-UP CARE AFTER AN EMERGENCY ROOM VISIT

Contact your doctor. He or she should coordinate all medical emergency follow-up care.

FIVE

Taking Care of Yourself & Your Family

Getting preventive care

One of your most important Horizon BCBSNJ benefits is the one you use when you're not sick – your wellness and preventive care coverage. Taking advantage of covered preventive care services – checkups and counseling – may improve your health and help you avoid illness. Best of all, when you see your in-network doctor, routine preventive care is available at no additional cost to you.

Well and preventive care coverage includes:

- Annual physical exams
- Well child care (including immunizations and lead screenings)
- Cancer screenings (including colorectal, breast, cervical and prostate)
- Tests (laboratory work, X-rays)

Visit your doctor for an annual physical. Early detection of any illness offers your best chance for recovery.

Preventive health care guidelines

Getting the right wellness and preventive care starts with a conversation between you and your doctor. Here's where to start:

For adults

- Schedule annual physical exams.
- Ask your doctor about any additional screenings, examinations and immunizations that may be appropriate for you.

For children

- Consult your child's doctor about specific recommendations for examinations, screenings, tests and vaccines.

For a complete list of the preventive health guidelines, visit **HorizonBlue.com/preventive.**

Please keep in mind:

- Horizon BCBSNJ preventive care guidelines are continually reviewed and may change.
- Always discuss your particular preventive care needs with your doctor. He or she will help you decide which preventive care services are right for you.
- Some of the services and supplies described in our preventive care guidelines may not be covered benefits under your health plan.

Please call your Horizon Health Guide at **1-800-414-SHBP (7427)** for more details.

CHILDHOOD IMMUNIZATIONS

Are your children up to date on immunizations?

The Centers for Disease Control and Prevention (CDC) has recommended catch-up schedules for children and adolescents who start late or fall behind on their immunizations. Usually, there's no need to restart a vaccine series regardless of the time between doses. Ask your child's pediatrician for guidance.

Visit **cdc.gov/vaccines** for:

- Reasons to vaccinate children and adolescents in high-risk groupss
- Recommended catch-up schedule
- Immunization charts in English and Spanish

NJWELL

NJWELL is the wellness program for actively employed SHBP/SEHBP employees and their covered spouses/partners.

Through NJWELL, you and your covered spouse/partner can earn Prepaid Visa® cards for completing activities geared toward health and wellness, including completing an online health assessment.

To complete the online health assessment and track your NJWELL progress, register and use our secure member web portal and *My Health Manager*, available on **HorizonBlue.com/shbp**.

Learn more about NJWELL on **HorizonBlue.com/shbp** and **nj.gov/njwell**.

Wellness programs

We take your health and wellness seriously and believe that wellness is key to happiness. That's why we make it easier for you to set and achieve your wellness goals. You access to:

Blue365®[1]

Get healthy living discounts from top national and local retailers delivered weekly right to your inbox. You'll get deals on:

- **Financial Health:** Cell phone service plans, home mortgages and more
- **Fitness:** Memberships, special events and apparel
- **Healthy Eating:** Weight-management programs and specialty food services
- **Lifestyle:** Hotels, retailers and more
- **Personal Care:** Products and services that can keep your body looking and feeling good
- **Wellness:** Services designed to help you live a healthier life

For more information, visit **Blue365deals.com**.

[1] Blue365 offers access to savings on items and services that members may purchase directly from independent vendors. The Blue Cross and Blue Shield Association (BCBSA) may receive payments from Blue365 vendors. Neither Horizon BCBSNJ nor the BCBSA recommend, warrant or guarantee any specific Blue365 vendor or discounted item or service.

SIX

Appeal Procedures

How to make inquiries, complaints and appeals

Your plan offers inquiry, complaint and appeal processes designed to provide prompt response and resolution to all requests.

These processes relate to:

- Medical issues
- Our utilization management decision making
- Other non-utilization management issues

If you are ever dissatisfied with any aspect of your health plan, you, a doctor or other health care professional or authorized representative, acting on your behalf (and with your consent), may file an inquiry, complaint or appeal with Horizon BCBSNJ. No member or doctor who makes an inquiry, files a complaint or pursues an appeal will be subject to disenrollment, discrimination or penalty by Horizon BCBSNJ.

If you have an inquiry or a complaint, call a Horizon Health Guide at **1-800-414-SHBP (7427**) or write to us. The address for inquiries and complaints is available at **HorizonBlue.com/inquiries**.

In most instances, we will resolve your initial inquiry or complaint within 30 days. If we require additional information, you and/or your doctor will have 45 days to send the requested information to us.

We will call you or write to you with our determination. Our final response to your inquiry or complaint will describe what further rights you may have regarding your inquiry or complaint.

Please call your Horizon Health Guide **1-800-414-SHBP (7427)** for more details.

Medical Appeal Procedures

An adverse benefit determination involving medical judgment is (a) a denial; or (b) a reduction from the application of clinical or medical necessity criteria; or (c) a failure to cover an item or service for which benefits are otherwise provided because Horizon BCBSNJ determines the item or service to be experimental or investigational, cosmetic, or dental, rather than medical.

When a member appeals an adverse benefit determination involving medical judgment made by Horizon BCBSNJ, it's called a medical appeal. Adverse benefit determinations involving medical judgment may usually be appealed up to three (3) times as outlined below:

- **First Level Medical Appeal –** The First Level Medical Appeal of an adverse benefit determination.
- **Second Level Medical Appeal –** The Second Level Medical Appeal of an adverse benefit determination available to you after completing a First Level Medical Appeal.

- **External Appeal –** The Third Level Medical Appeal of an adverse benefit determination, which, at your request, would generally follow a Second Level Medical Appeal. An External Appeal provides you the right to appeal to an Independent Review Organization (IRO).

An overview of the medical appeal procedure is provided below.

FIRST LEVEL MEDICAL APPEAL

First Level Medical Appeals may be submitted in writing or verbally. Verbal appeals may be directed to Horizon BCBSNJ Utilization Management at **1-888-221-6392**. Written appeals may be sent to:

Horizon BCBSNJ Medical Appeals
PP-12E
PO Box 420
Newark, NJ 07101-0420

The member, doctor or other authorized representatives acting on behalf of the member, and with the member's written consent to pursue an appeal of any adverse benefit determination involving a medical judgement made by Horizon BCBSNJ have one (1) year following your receipt of the initial adverse benefit determination letter to request a Medical Appeal.

To initiate a First Level Medical Appeal, the following information must be provided:

- Name and address of the member or provider(s) involved
- Member's identification number
- Date(s) of service
- Nature and reason behind your appeal
- Remedy sought
- Clinical documentation to support your appeal

First Level Medical Appeals will be reviewed and decided in the following time frames:

- Standard First Level Medical Appeals not related to substance use disorders, are reviewed and decided within 15 calendar days from Horizon BCBSNJ's receipt of the appeal.
- First Level Expedited (urgent and emergent) Medical Appeals are decided as soon as possible in accordance with the medical urgency of the case, but will not exceed 72 hours from Horizon BCBSNJ's receipt of the appeal request.
- First Level Medical Appeals related to pre-service substance use disorder claims are reviewed and decided within 24 hours from Horizon BCBSNJ's receipt of the appeal.

The member will receive a letter documenting Horizon BCBSNJ's first level medical appeal decision. The letter will include the specific reasons for the determination.

EXPEDITED REVIEW

Horizon BCBSNJ medical appeal procedures may be expedited in circumstances involving urgent or emergent care.

First and Second Level Medical Appeals are automatically handled in an expedited manner for all determinations regarding urgent or emergent care, an admission, availability of care, continued stay, or health care services for which the claimant received emergency services but has not been discharged from the facility. Furthermore, if you feel that the Horizon BCBSNJ adverse benefit determination decision will cause serious medical consequences in the near future, you have the right to an expedited medical appeal. You also have the right to an Expedited Medical Appeal if in the opinion of a physician with knowledge of your medical condition, your condition is as described above or that you will be subject to severe pain that cannot be adequately managed without receiving the denied medical services. Expedited Medical Appeals are initiated by calling a Horizon BCBSNJ Appeals Coordinator at **1-888-221-6392**.

SECOND LEVEL MEDICAL APPEALS

Except with respect to appeals related to substance use disorders, if you disagree with the First Level Medical Appeal decision, you have one (1) year following receipt of Horizon BCBSNJ's original determination letter to request a Second Level Medical Appeal. If you wish to make a Second Level Medical Appeal, you may do so by sending your appeal in writing to:

Horizon BCBSNJ Appeals Department
PP-12E
PO Box 420
Newark, NJ 07101-0420

You may also initiate a Second Level Medical Appeal by calling a Horizon BCBSNJ Appeals Coordinator at **1-888-221-6392**.

To initiate a Second Level Medical Appeal, the following information must be provided:

- Name and address of the member or provider(s) involved
- Member's identification number
- Date(s) of service
- Nature and reason behind your appeal
- Remedy sought
- Clinical documentation to support your appeal

If a Second Level Medical Appeal is received, it is submitted to the Horizon BCBSNJ Appeals Committee. The Appeals Committee is made up of Horizon BCBSNJ medical directors and staff, doctors from the community and consumer advocates. A smaller subcommittee reviews Expedited Second Level Medical Appeals.

The Appeals Coordinator will advise you of the date of your hearing. You have the option of attending the hearing in person or via telephone conference. You may also elect to have the Appeals Committee review and decide your Second Level Medical Appeal without your appearance.

Second Level Medical Appeals will be reviewed and decided in the following time frames:

- Standard Second Level Medical Appeals are reviewed and decided within 15 calendar days from Horizon BCBSNJ's receipt of the appeal.
- Second Level Expedited (urgent and emergent circumstances, as previously described) Medical Appeals are decided as soon as possible in accordance with the medical urgency of the case, but will not exceed 72 hours from Horizon BCBSNJ's receipt of your first level medical appeal request.

If you participate in the hearing, you will be notified of the Appeals Committee's decision verbally by telephone on the day of the hearing whenever possible. Written confirmation of the decision is sent to you and/or your doctor or other authorized representative who pursued the Second Level Medical Appeal on your behalf. If you choose not to appear at the hearing you will be notified of the Appeals Committee's decisions in writing within five (5) business days of the decision. Horizon BCBSNJ's letter will include the specific reasons for the determination.

If Horizon BCBSNJ's decision is not in your favor, you have the right to pursue an External Appeal through an Independent Review Organization (IRO).

Expedited Review of Second Level Medical Appeals

If the circumstances previously described in the "Expedited Review" section apply in your case, you have the same right to an expedited review of your Second Level Medical Appeal.

APPEAL RIGHTS EXCLUSIVE TO SUBSTANCE USE DISORDER

A member (or a provider acting for the member, with the member's consent) may appeal an adverse benefit determination with respect to substance use disorder. The appeal process for adverse benefit determinations involving medical judgment with respect to substance use disorder consists of the following:

(a) an internal review by Horizon BCBSNJ (a "Substance Use Disorder First Level Appeal"); and

(b) for appeals related to inpatient care beyond the first 28 days, an expedited internal review and a formal expedited external review with the Independent Health Care Appeals Program at the New Jersey Department of Banking and Insurance (DOBI) (a "Substance Use Disorder External Appeal"); and

(c) for all other substance use disorder appeals, a second level internal appeal as discussed under the Second Level Medical Appeals section above; and

(d) an external appeal for appeals denied at the second level internal appeal; and

(e) a Commission Appeal as detailed on page 40.

Substance Use Disorder First Level Appeal

A member (or a provider acting for the member, with the member's consent) can file a Substance Use Disorder First Level Appeal by calling or writing Horizon BCBSNJ at the telephone number and address in the First Level Medical Appeal section above. At the Substance Use Disorder First Level Appeal, a member may discuss the adverse benefit determination directly with the Horizon BCBSNJ doctor who made it, or with the medical director designated by Horizon BCBSNJ.

To submit a Substance Use Disorder First Level Appeal, the member must include the following information:

(1) the name(s) and address(es) of the member or provider(s) involved;

(2) the member's identification number;

(3) the date(s) of service;

(4) the details regarding the actions in question;

(5) the nature of and reason behind the appeal;

(6) the remedy sought; and

(7) the documentation to support the appeal.

First Level Appeals will be reviewed and decided in the time frames described in First Level Medical Appeals above except First Level Medical Appeals related to inpatient care beyond the first 28 days will be reviewed and decided within 24 hours of receipt. Horizon BCBSNJ will provide the member and/or the provider with: (a) written notice of the outcome; (b) the reasons for the decision; and (c) if the initial adverse benefit determination is upheld, instructions for filing a Substance Use Disorder Second Level Appeal.

Substance Use Disorder Second Level Appeal

This section applies to all substance use disorder appeals with the exception of appeals related to inpatient care beyond the first 28 days. A member (or a provider acting for the member, with the member's consent) who is dissatisfied with the results of Horizon BCBSNJ's internal appeal process with respect to an adverse benefit determination can pursue a Substance Use Disorder Second Level Appeal. The procedures for filing a Substance Use Disorder Second Level Appeal are the same as in those set forth in the Second Level Medical Appeals section above.

Substance Use Disorder Appeals specific to Inpatient Care after the first 28 days

This section applies to all substance use disorder appeals related to inpatient care beyond the first 28 days. A member (or a provider acting for the member, with the member's consent) who is dissatisfied with the results of Horizon BCBSNJ's internal appeal process with respect to an adverse benefit determination can pursue a Substance Use Disorder External Appeal, an expedited external appeal with an Independent Review Organization (IRO) assigned by DOBI. All appeals filed in accordance with this paragraph must be filed with the Independent Health Care Appeals Program in DOBI.

The IRO will complete its review of the Substance Use Disorder Second Level Appeal and issue its decision in writing within 24 hours from its receipt of the request for the review.

Commission Appeal

Once all appeal options have been exhausted through the Horizon BCBSNJ, the member may appeal to the State Health Benefits Commission/School Employees' Health Benefits Commission (Commission). For more information, see page 40.

External Appeal Rights

STANDARD EXTERNAL APPEALS

If you are dissatisfied with the results of Horizon BCBSNJ's internal appeals process, and you wish to pursue an External Appeal with an IRO, you must submit a written request within four (4) months from your receipt of Horizon BCBSNJ's final adverse benefit determination of your appeal. To initiate a standard External Appeal, you should submit a written request to:

Horizon BCBSNJ Appeals Department
PP-12E
P.O. Box 420
Newark, NJ 07101-0420

Upon receipt of your written request, a preliminary review will be conducted by Horizon BCBSNJ and completed within five (5) business days to determine:

- Your eligibility under your group health plan at the time the service was requested or provided
- That the adverse benefit determination does not relate to your failure to meet eligibility requirements under the terms of your group health plan (e.g., worker classification or similar)
- The internal appeals process has been exhausted (if required)
- You have provided all the information and forms required to process the external review

After this preliminary review, written notification will be issued informing you of Horizon BCBSNJ's determination regarding the eligibility of your request for external review. If your request for an external review meets the eligibility requirements, your appeal will be assigned to an IRO by Horizon BCBSNJ. The IRO will notify you in writing of your request's eligibility and acceptance for external review. The IRO will review all of the information and documents received and will provide its written final external review decision to the claimant and Horizon BCBSNJ within 45 days after the IRO first received the request for the external review. Upon receipt of a final external review decision reversing an adverse benefit determination, Horizon BCBSNJ will provide coverage or payment for the claim(s) or service(s) involved. If the final external review decision upholds the adverse benefit determination, no further action is taken and the medical appeals process is complete.

The standard External Appeal rights described may be expedited in the following circumstances:

The initial adverse benefit determination involving medical judgment concerns a medical condition such that the completion of a standard internal appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function, and the member has filed a request for an expedited Internal Appeal,

OR

The final adverse benefit determination (decision upon appeal) involving medical judgment concerns a medical condition such that the completion of a standard External Appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function, or if final adverse benefit determination involving medical judgment concerns an admission, availability of care, continued stay or a health care item or service for which the member received emergency services, but has not been discharged from the facility.

In instances of an expedited request, your request can be made by calling a Horizon BCBSNJ Appeals Coordinator at **1-888-221-6392**. For expedited external review requests, the final notice of the decision must be provided as expeditiously as the member's medical condition or circumstances require, but in no event shall exceed 72 hours from the IRO's receipt of the request for expedited external review.

External Appeal rights related to substance use disorders

If you are dissatisfied with the results of Horizon BCBSNJ's internal appeals process with respect to a substance use disorder claim and you wish to pursue an External Appeal with an IRO, you must submit a written request in accordance with the procedures outlined in the External Appeal Rights section above. The IRO will review all of the information and documents received and will provide its written final external review decision to the claimant and Horizon BCBSNJ within 24 hours from the IRO's receipt of the request for external review.

Administrative Appeal Procedure

The member or the member's authorized representative may appeal and request that Horizon BCBSNJ reconsider any claim or any portion(s) of a claim for which they believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be on an administrative nature. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Examples of administrative appeals include:

- Visits beyond the 25-visit chiropractic limit
- Benefits beyond the reasonable and customary allowance
- Routine vision services rendered out of network
- Benefits for a wig that exceed the $500/24-month limit
- Hearing aid for a 60-year-old member

Adverse benefit determinations involving the application of plan benefits may usually be appealed up to three (3) times as outlined below:

- **First Level Administrative Appeal –** The First Level Administrative Appeal of an adverse benefit determination.
- **Second Level Administrative Appeal –** The Second Level Administrative Appeal of an adverse benefit determination available to you after completing a First Level Administrative Appeal.
- **Commission Appeal –** The Third Level Administrative Appeal of an adverse benefit determination, which, at your request, would generally follow a Second Level Administrative Appeal. A Commission Appeal provides you the right to appeal to the State Health Benefits Commission (Commission).

An overview of the administrative appeal process is provided below.

FIRST LEVEL ADMINISTRATIVE APPEAL

The member may request an administrative appeal by calling **1-800-414-SHBP (7427)** or submitting a written appeal to:

Horizon BCBSNJ
OMNIA Health Plan Appeals
PO Box 820
Newark, NJ 07101-0820

The member has one (1) year following the receipt of the initial adverse benefit determination letter to request an administrative appeal.

The First Level Administrative Appeal should include the following information:

- Name and address of the patient and the OMNIA Health Plan member
- Member's identification number
- Date(s) of service(s)
- Provider's name and identification number
- Physician's name and identification number
- The reason you think the claim/service should be reconsidered
- All documentation supporting your appeal

You will receive a written response to your First Level Administrative Appeal within 30 days. If you are not satisfied with this written determination, a Second Level Administrative Appeal may be requested.

SECOND LEVEL ADMINISTRATIVE APPEAL

The member may request a Second Level Administrative Appeal within one (1) year following receipt of the initial adverse benefit determination letter by calling **1-800-414-SHBP (7427)**, or by writing to the address noted on page 39. The member may also send an appeal via fax to **1-973-274-4599**.

During the Second Level Administrative Appeal, Horizon BCBSNJ will review any additional evidence the member wished to supply in support of the appeal. The member will receive a written determination of the final decision within 30 days. This will complete the Horizon BCBSNJ appeal options.

COMMISSION APPEAL

Once all appeal options have been exhausted through Horizon BCBSNJ, the member may appeal to the State Health Benefits Commission (Commission). If dissatisfied with a final Horizon BCBSNJ decision on an administrative appeal, you have one (1) year from the date of the final adverse benefit determination letter to request a Commission Appeal. Only the member or the member's legal representative may appeal, in writing, to the Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf.

Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to:

Appeals Coordinator
State Health Benefits Commission
PO Box 299
Trenton, NJ 08625-0299

The member will be advised by the Commission how to arrange a hearing date, the date of the hearing and the option to attend and appear before the Commission.

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps he or she may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request in writing to the Commission, within 45 days, that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so, the case will be forwarded to the Office of Administrative Law. An Administrative Law Judge (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify or reject.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. The member will be responsible for any expenses involved in gathering evidence or material that will support the grounds for appeal. The member will be responsible for any court filing fees or related costs that may be necessary during the appeal process. If an attorney or expert medical testimony is required, the member will be responsible for any fees or costs incurred.

If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals may be made to the Superior Court of New Jersey, Appellate Division.

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Important Information

Your rights

As a Horizon BCBSNJ member, you have the right to:

- Be provided with information in a way that works for you (in languages other than English and in alternate formats, such as large print). If you need help understanding this Horizon BCBSNJ information, you have the right to get help in your language at no cost to you. To speak with an interpreter, call **1-800-414-SHBP (7427)** during normal business hours.
- Timely access to covered services and medications, as applicable.
- Receive information about Horizon BCBSNJ and it services, policies and procedures, products, doctors, appeal procedures, member rights and responsibilities, coverage limitations, and other information about the organization and care provided.
- Be provided with the information needed to understand your benefits and obtain care.
- Receive prompt notification of termination of your Primary Care Physician (PCP), if applicable, or material changes in benefits, services or network within 30 days prior to the date of any change or termination, as appropriate.
- Obtain information about whether a referring doctor has a financial interest in the facility or services to which a referral is being made.
- Choose and change your PCP, as applicable, within the limits of your benefits and the doctor's availability.
- Go to an Emergency Room (ER) without prior approval when it appears to you that serious harm could result from not obtaining immediate treatment.

Your responsibilities

As a Horizon BCBSNJ member, you have the responsibility to:

- Read and understand this handbook, your policy and all other materials about your plan and coverage.
- Be considerate and courteous to doctors and staff.
- Coordinate nonemergency care through your PCP.
- Supply information (to the extent possible) that the organization and its practitioners and providers need to provide care.
- Follow plans and instructions for care that you have agreed to with your doctors.
- Pay for charges, including copays, deductibles and coinsurance as stated in your plan, as well as for any charges you incur for noncovered care.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

This is a partial list of your member rights and responsibilities. For a complete list of rights and responsibilities, along with more information about your relationship with Horizon BCBSNJ, please visit **HorizonBlue.com/rights** or call a Horizon Health Guide. Member Rights and Responsibilities are provided annually to members and upon enrollment for new members.

If you do not have access to the internet, please call your Horizon Health Guide at **1-800-414-SHBP (7427)**.

How to make inquiries, complaints and appeals

Your plan offers inquiry, complaint and appeal processes designed to provide prompt response and resolution to all requests.

These processes relate to:

- Medical issues
- Our utilization management decision making
- Other non-utilization management issues

If you are ever dissatisfied with any aspect of your health plan, you, a doctor or other health care professional or authorized representative, acting on your behalf (and with your consent), may file an inquiry, complaint or appeal with Horizon BCBSNJ. No member or doctor who makes an inquiry, files a complaint or pursues an appeal will be subject to disenrollment, discrimination or penalty by Horizon BCBSNJ.

If you have an inquiry or a complaint, call a Horizon Health Guide at **1-800-414-SHBP (7427)** or write to us. The address for inquiries and complaints is available at **HorizonBlue.com/inquiries**.

In most instances, we will resolve your initial inquiry or complaint within 30 days. If we require additional information, you and/or your doctor will have 45 days to send the requested information to us.

We will call you or write to you with our determination. Our final response to your inquiry or complaint will describe what further rights you may have regarding your inquiry or complaint.

Please call your Horizon Health Guide at **1-800-414-SHBP (7427)** for more details.

Coordination of benefits with other health coverage

If you or a covered member of your family also has health coverage under Medicare or with any other insurer, you must let us know.

To avoid duplication of coverage, we coordinate your Horizon BCBSNJ plan benefits with those provided by Medicare or the other insurer. Depending on your policy, either Horizon BCBSNJ or your other insurer is considered **primary**.

- If your Horizon BCBSNJ plan is **primary**, we process your claims first without regard to any other insurance coverage.
- If your other plan is primary, claims go to that plan first. In this case, Horizon BCBSNJ's coverage would be **secondary** – we consider each claim for payment after it has been processed by the other plan.

In any case, Horizon BCBSNJ won't pay more for claims than we would have if we had been your only health care plan.

To update your other insurance coverage information, sign in to **HorizonBlue.com/shbp**, choose *Benefits & Coverage*, then *Benefits Overview.*

If you have questions, call your Horizon Health Guide at **1-800-414-SHBP (7427)**.

Results of independent satisfaction surveys

You can get results of independent consumer satisfaction surveys and analysis of quality outcomes for health care services provided under managed care plans in New Jersey.

Send your request to:

Actuarial Bureau
New Jersey Department of Banking and Insurance
20 West State Street, 11th Floor
PO Box 325
Trenton, NJ 08625-0325

Or call:

1-609-292-7272

Continuation-of-care benefits

If you are receiving covered services (other than obstetrical care, post-operative care, oncological treatment or psychiatric treatment) from a terminated health care professional who was under contract with us at the time your treatment started, you may continue care or services with that health care professional for up to four months where medically necessary.

If you are receiving obstetrical care, post-operative care, oncological treatment or psychiatric treatment from a terminated health care professional who was under contract with us at the time your treatment started, you may continue to be treated by that health care professional for the duration of the treatment or care:

- **Pregnancy**: Coverage of services will continue through the postpartum evaluation, up to six weeks after delivery.
- **Post-operative follow-up care**: Coverage of services may continue for up to six months from the date of the health care professional's termination.
- **Oncological treatment**: Coverage of services may continue for up to one year from the date of the health care professional's termination.
- **Psychiatric treatment**: Coverage of services may continue for up to one year from the date of the doctor or health care professional's termination.

These guidelines do not apply if the health care professional is terminated immediately under any of these circumstances:

- In the opinion of Horizon BCBSNJ's medical director, the health care professional is an imminent danger to a patient or the public health, safety and welfare.
- There has been a determination of fraud or a breach of contract by the health care professional.
- The health care professional is the subject of disciplinary action by the State Board of Medical Examiners.

Please call your Horizon Health Guide at **1-800-414-SHBP (7427)** if you have questions about your continuation-of-care benefits. As always, your benefits are subject to policy limits and normal Horizon BCBSNJ policies and procedures, including prior authorization and utilization management requirements.

Medical technology

We regularly review new medical technology to decide if it is eligible for coverage.

Our review incorporates input from the professional and medical community (including medical practitioners in New Jersey), as well as the research results published in the medical literature. We also review our current policies related to existing technology and amend them as appropriate.

Physician compensation

In general, Horizon BCBSNJ pays participating doctors and other health care professionals in two ways:

- **Fee for Service**: Payment for services each time a member is seen or treated
- **Capitation**: Payment of a monthly per-patient fee, whether or not a member receives services in any given month

These payment methods may include financial incentive agreements. Doctors and other health care professionals may be paid more (rewards) or less (withholds) based on many factors, including member satisfaction, quality of care, control of costs and use of services. (Horizon BCBSNJ does not have withholds as a method of payment.)

You have the right to ask your doctor and other health care professionals about how they are compensated for their services by Horizon BCBSNJ so you will know if there could be any financial incentives or disincentives tied to their medical decisions.

The laws of the State of New Jersey at N.J.S.A. 45:9-22.4 et seq., require that a doctor, chiropractor or podiatrist, who is permitted to make referrals to other health care professionals or facilities in which he or she has a significant financial interest, inform his or her patients of that financial interest when making such a referral.

For more information about compensation, ask your doctor or other health care professional. If you believe that you are not receiving the information to which you are entitled, you may call the New Jersey Division of Consumer Affairs at **1-800-242-5846** or **1-973-504-6200**.

Utilization management

Horizon BCBSNJ's Utilization Management (UM) Program monitors your health care – the care you receive and the care your doctor proposes for you – to assess its medical necessity and appropriateness. Utilization management also lets us help doctors to manage the care they provide in medically appropriate and cost-effective ways. Through UM, we identify best practices that produce high-quality care and health outcomes, and share that knowledge with members, in-network doctors, health care professionals and employers through continuing education.

In particular, we watch for:

- **Underutilization**: Not getting annual checkups or preventive vaccinations as recommended
- **Overutilization**: Getting medical care, medications, laboratory testing or surgical procedures when they are not medically necessary

OUR UTILIZATION MANAGEMENT PRINCIPLES

- We make UM decisions based only on the necessity and appropriateness of care and services within the provisions of the member's benefit package.
- We don't compensate anyone responsible for UM decisions in a way that rewards him or her for denying coverage for medically necessary and appropriate covered services.
- We don't offer incentives to anyone responsible for UM determinations to encourage denials of coverage or services, and we don't provide financial incentives to doctors to withhold covered health care services that are medically necessary and appropriate.
- We emphasize the delivery of medically necessary, appropriate and cost-effective health care services to members, and we encourage the reporting, investigation and elimination of underutilization.

ABORTION COVERAGE

This plan covers certain abortion services. Please call your Horizon Health Guide at **1-800-414-SHBP (7427)** for more details.

Notice of information privacy practices

Horizon Blue Cross Blue Shield of New Jersey and its affiliated companies[1] want you to know that we are legally obligated to keep information about you secure and confidential. Unlike many other financial and health institutions, we do not sell information about you and we do not share your information except to conduct our business.

As required by law, we publish this Notice to explain the information that we collect and how we maintain, use and disclose it in administering your benefits. We will abide by the statements made in this Notice. Except as permitted by law and as explained in this Notice, we do not disclose any information about our past, present or future customers to anyone. Uses and disclosures not described in this Notice will be made only with your written authorization. When we use the term "Customer Information," we are referring to financial or health information that is "nonpublic," including any information from which a judgment could possibly be made about you. When we use the term "Protected Health Information" or "PHI," we are referring to individually identifiable oral, written and electronic information concerning the provision of, or payment for, health care to you. We refer to Customer Information and PHI collectively as "Private Information."

Read the complete *privacy notice* on **HorizonBlue.com/privacy-policy**.

[1] The Horizon Blue Cross Blue Shield of New Jersey affiliated companies, all of which are independent licensees of the Blue Cross and Blue Shield Association, are:

Horizon Healthcare Services, Inc. d/b/a/ Horizon Blue Cross Blue Shield of New Jersey.

Horizon Healthcare of New Jersey, Inc., including its Horizon NJ Health (Medicaid/NJ FamilyCare) line of business.

Horizon Insurance Company

Horizon Healthcare Dental, Inc.

Horizon Casualty Services, Inc. (This affiliate is not a covered entity subject to the federal privacy rules.)

Women's Health and Cancer Rights Act of 1998

Under federal legislation, notification of this benefit is required to all members.

In 1998, the federal government enacted a law that mandates certain health coverage for breast reconstructive surgery in any health program that provides medical and surgical benefits for mastectomies. This law is known as The Women's Health and Cancer Rights Act.

If a covered person is receiving benefits in connection with a mastectomy and elects to have breast reconstruction along with that mastectomy, the policy must provide in a manner determined in consultation with the attending physician and the patient, coverage for the following:

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

These benefits will be provided subject to deductibles and coinsurance to the same extent as for any other illness under your coverage.

All other features and benefits of this program remain the same and are not impacted by this notification.

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。
영어 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 આઇડી કાર્ડની પાછળ આપેલા નંબર પર કૉલ.
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'identificazione.
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۔

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