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. 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/Inspira members or by calling 1-833-876-3827 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 1-833-876-3827 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** for Inner Circle providers. **$2,000.00** individual/**$4,000.00** family for OMNIA Tier 1 providers. **$2,500.00** individual/**$5,000.00** family for Tier 2 providers. Aggregate family.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the Common Medical Events chart for how much you pay for covered services after you meet the deductible.
Are there 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?	Yes, For Health Inner Circle providers, Tier 1 providers and Tier 2 providers **$5,750.00** individual/**$11,500.00** 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, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. For a list of in-network **providers**, see www.HorizonBlue.com/Inspira or call 1-833-876-3827. Benefits provided by in-network providers other than OMNIA Tier 1 providers are at the Tier 2 level of benefits, such as Tier 2 and BlueCard PPO providers.	You pay the least if you use a provider in Inspira Health's Inner Circle. You pay more if you use a Participating Provider in the Horizon Omnia Network. Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

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
		Your Cost If You Use an Inner Circle Provider (you will pay the least)	Your Cost If You Use an OMNIA Tier 1 Provider (You will pay more)	Your Cost If You Use an OMNIA Tier 2 Provider (You will pay more)	Your Cost If You Use an Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0.00 Copayment per visit for Office.	$25.00 Copayment per visit for Office. Deductible does not apply.	$80.00 Copayment per visit for Office. Deductible does not apply.	Not Covered.	_____none_____
	Specialist visit	$30.00 Copayment per visit for Office, Specialist.	$50.00 Copayment per visit for Office, specialist. Deductible does not apply.	$160.00 Copayment per visit for Office, specialist. Deductible does not apply.	Not Covered.	
	Preventive care/screening/immunization	No Charge.	No Charge. Deductible does not apply.	No Charge. Deductible does not apply.	Not Covered.	One per contract period. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Laboratory: No charge for Office, Independent Laboratory, Outpatient Hospital. X-ray: No charge for Office, Independent Laboratory, Outpatient Hospital.	Lab: $30 Copayment Charge for Office, 50% Coinsurance Outpatient Hospital after Deductible. X-ray: $40 Copayment for Office, Outpatient Hospital	Lab: $30 Copayment for Office, 60% Coinsurance Outpatient Hospital after Deductible. X-Ray: 60% Coinsurance for Office, Outpatient Hospital after Deductible.	Not Covered.	Labwork done in Office Setting/Lab Corp and Quest - $30 copay then 100% for Tier 1 & 2. No coverage for freestanding labs other than Labcorp and Quest. Does not apply to the inner circle.
	Imaging (CT/PET scans, MRIs)	No charge for Outpatient Hospital.	$250 Copayment /service. Deductible does not apply.	60% Coinsurance after Deductible	Not Covered.	_____none_____
If you need drugs to treat your illness or condition	Generic drugs	N/A	Retail: $5 copay Mail: $12.50 copay	Retail: $5 copay Mail: $12.50 copay	Not Covered.	Covers up to a 30-day supply from an In-network retail pharmacy or a 90-day supply from the Caremark mail order or CVS retail pharmacy.
	Preferred brand drugs	N/A	Retail: $45 copay Mail: $112.50 copay	Retail: $45 copay Mail: $112.50 copay	Not Covered.	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Your Cost If You Use an Inner Circle Provider (you will pay the least)	Your Cost If You Use an OMNIA Tier 1 Provider (You will pay more)	Your Cost If You Use an OMNIA Tier 2 Provider (You will pay more)	Your Cost If You Use an Out-of-network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at www.caremark.com	Non-preferred brand drugs	N/A	Retail: $65 copay Mail: $162.50 copay	Retail: $65 copay Mail: $162.50 copay	Not Covered.	Specialty drugs are not available at a retail pharmacy If you order a brand-name drug when a generic version is available, you will pay the generic cost share plus the price difference between the brand and generic medication.
	Specialty drugs	N/A	Mail: $125 copay (30-day supply)	Mail: $125 copay (30-day supply)	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge for Outpatient Hospital, Ambulatory Surgical Center.	$500.00 Copayment for Ambulatory Surgical Center, Outpatient Hospital, and 50% Coinsurance after deductible.	$500.00 Copayment for Ambulatory Surgical Center, Outpatient Hospital, and 60% Coinsurance after deductible.	Not Covered.	_____none_____
	Physician/surgeon fees	No Charge for Outpatient Hospital, Ambulatory Surgical Center.	50% Coinsurance for Ambulatory Surgical Center, Outpatient Hospital after deductible.	60% Coinsurance for Ambulatory Surgical Center, Outpatient Hospital after deductible.	Not Covered.	50% Coinsurance after deductible (OMNIA tier 1). 60% Coinsurance after deductible (OMNIA tier 2) for anesthesia.
If you need immediate medical attention	Emergency room care	$100.00 Copayment per visit for Outpatient Hospital.	$100.00 Copayment per visit for Outpatient Hospital. Deductible does not apply.	$100.00 Copayment per visit for Outpatient Hospital. Deductible does not apply.	$100.00 Copayment per visit for Outpatient Hospital. Deductible does not apply.	Copayment waived if admitted within 24 hours. The listed benefits only apply to true medical emergencies and accidental injuries rendered in the emergency room only.
	Emergency medical transportation	No Charge.	No Charge. Deductible does not apply.	No Charge. Deductible does not apply.	Not Covered.	_____none_____
	Urgent care	$20 copay	$60.00 Copayment per visit for Office;	$100.00 Copayment per visit for Office; Deductible does not apply.	Not Covered.	_____none_____

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Your Cost If You Use an Inner Circle Provider (you will pay the least)	Your Cost If You Use an OMNIA Tier 1 Provider (You will pay more)	Your Cost If You Use an OMNIA Tier 2 Provider (You will pay more)	Your Cost If You Use an Out-of-network Provider (You will pay the most)	
			Deductible does not apply.			
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge for Inpatient Hospital.	$1,000 Copayment per admission, and 50% Coinsurance for Inpatient Hospital after deductible.	$1,000 Copayment per admission, and 60% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. In-network inpatient separation period is 90 days in-network.
	Physician/surgeon fees	No Charge for Inpatient Hospital.	50% Coinsurance for Inpatient Hospital after deductible.	60% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	50% Coinsurance after deductible (OMNIA tier 1). 60% Coinsurance after deductible (OMNIA tier 2) for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge for Outpatient Hospital.	$25.00 Copayment for Office, Outpatient Hospital. Deductible does not apply.	$80.00 Copayment for Office. Deductible does not apply. 60% Coinsurance for Outpatient Hospital after Deductible.	Not Covered.	_____none_____
	Inpatient services	No Charge for Inpatient Hospital.	$1,000 Copayment per admission, and 50% Coinsurance for Inpatient Hospital after deductible.	$1,000 Copayment per admission, and 60% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. In-network inpatient separation period is 90 days in-network.
If you are pregnant	Office visits	No Copayment per visit for Primary Care Visit. $30.00 Copayment per visit for Office, Specialist. Deductible does not apply.	$25.00 Copayment per visit for Primary Care Visit. $50.00 Copayment per visit for Office, Specialist. Deductible does not apply.	$80.00 Copayment per visit for Primary Care Visit. $160.00 Copayment per visit for Office, Specialist. Deductible does not apply.	Not Covered.	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound). Prenatal and postnatal care – copay only applies to initial visit.
	Childbirth/delivery professional services	No Charge.	50% Coinsurance after deductible.	60% Coinsurance after deductible.		_____none_____

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Your Cost If You Use an Inner Circle Provider (you will pay the least)	Your Cost If You Use an OMNIA Tier 1 Provider (You will pay more)	Your Cost If You Use an OMNIA Tier 2 Provider (You will pay more)	Your Cost If You Use an Out-of-network Provider (You will pay the most)	
	Childbirth/delivery facility services	No Charge for Inpatient Hospital.	$1,000 Copayment per admission, and 50% Coinsurance for Inpatient Hospital after deductible.	$1,000 Copayment per admission, and 60% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	In-network tier 1 tier 2 inpatient separation period is 90 days in-network.
If you need help recovering or have other special health needs	Home health care	No Charge.	50% Coinsurance after deductible.	60% Coinsurance after deductible.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance.
	Rehabilitation services	No Charge for Inpatient Hospital.	$1,000 Copayment per admission, and 50% Coinsurance for Inpatient Hospital after deductible.	$1,000 Copayment per admission, and 60% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. Inpatient physical rehabilitation visit limit – 60 days combined across all 3 tiers.
	Habilitation services	No Charge for Inpatient Hospital.	$1,000 Copayment per admission, and 50% Coinsurance for Inpatient Hospital after deductible.	$1,000 Copayment per admission, and 60% Coinsurance for Inpatient Hospital after deductible.	Not Covered.	
	Skilled nursing care	No Charge.	50% Coinsurance after deductible.	60% Coinsurance after deductible.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. Inpatient skilled nursing facility day limit is 100 days per benefit period combine across all tiers.
	Durable medical equipment	No Charge.	No Charge. Deductible does not apply.	No Charge. Deductible does not apply.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance.
	Hospice services	No Charge.	50% Coinsurance after deductible.	60% Coinsurance after deductible.	Not Covered.	Requires pre-approval; 20% penalty applies for non-compliance. Respite care benefits are limited to a maximum of ten days per Covered Person per Contract period. Diagnosis of terminal illness and life expectancy of 6 months or less

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Your Cost If You Use an Inner Circle Provider (you will pay the least)	Your Cost If You Use an OMNIA Tier 1 Provider (You will pay more)	Your Cost If You Use an OMNIA Tier 2 Provider (You will pay more)	Your Cost If You Use an Out-of-network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered.	Not Covered.	Not Covered.	Not Covered.	_____none_____
	Children's glasses	Not Covered.	Not Covered.	Not Covered.	Not Covered.	_____none_____
	Children's dental check-up	Not Covered.	Not Covered	Not Covered.	Not Covered.	_____none_____

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 (Adult)
- Hearing Aids
- Long Term Care
- Most coverage provided outside the United States. (tier 1 level of benefit)
- Non-emergency care when traveling outside the U.S. (tier 1 level of benefit)
- Routine eye care (Adult, Optometrist/ Ophthalmologist office. For verification of coverage on routine vision services, please see your policy or plan document)
- Routine foot care
- Weight Loss Programs

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
- Infertility treatment
- Most coverage provided outside the United States. See www.HorizonBlue.com/Inspira (tier 2 level of benefit)
- Non-emergency care when traveling outside the U.S. See www.HorizonBlue.com/Inspira (tier 2 level of benefit)
- Private-duty nursing

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.HealthCare.gov or call 1-800-318-2596.

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: 1-833-876-3827 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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 inner circle pre-natal care and a hospital delivery)

The plan's overall deductible	**$0.00**
Specialist *Copayment*	**$30.00**
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	$12,731.00

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0.00
Copayments*	$20.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions**	$60.00
The total Peg would pay is	**$80.00**

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

The plan's overall deductible	**$0.00**
Specialist *Copayment*	**$30.00**
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	$7,389.00

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0.00
Copayments*	$800.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions**	$55.00
The total Joe would pay is	**$855.00**

Mia's Simple Fracture
(inner circle emergency room visit and follow up care)

The plan's overall deductible	**$0.00**
Specialist *Copayment*	**$30.00**
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	$1,925.00

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0.00
Copayments*	$310.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions**	$0.00
The total Mia would pay is	**$310.00**

Example assumes member is seeing an Inspira Inner Circle Provider.

*Includes prescription drug copays
**Includes over-the-counter drugs not covered by the plan

Horizon Blue Cross Blue Shield of New Jersey

If you need help understanding this Horizon Blue Cross Blue Shield of New Jersey information, you have the right to get help in your language at no cost to you. To talk to an interpreter, please call **1-800-355-BLUE (2583)** during normal business hours.

Spanish (Español): Si necesita ayuda para comprender esta información de Horizon Blue Cross Blue Shield of New Jersey, usted tiene el derecho de obtener ayuda en su idioma sin costo alguno. Para hablar con un intérprete, sírvase llamar al **1-855-477-AZUL (2985)** durante el horario normal de trabajo.

Chinese (中文)：如果您需要幫助來理解這份新澤西州地平線藍十字藍盾 (Horizon Blue Cross Blue Shield of New Jersey)資料，您有權免費獲得以您的語言提供的協助。欲聯絡翻譯人員，請於上班時間致電 **1-800-355-BLUE (2583)**。

Korean (한국어): 가입자는 Horizon Blue Cross Blue Shield of New Jersey에 관한 정보를 이해하기 위해 주로 사용하는 언어로 무료로 도움을 받을 권리가 있습니다. 통역사의 도움을 받으려면 정상 업무 시간 동안에 **1-800-355-BLUE (2583)**로 전화해 주십시오.

Portuguese (Português): Se precisar de ajuda para entender estas informações da Horizon Blue Cross Blue Shield of New Jersey, você tem o direito de receber gratuitamente assistência no seu idioma. Para falar com um intérprete, ligue para: **1-800-355-BLUE (2583)** no horário normal de trabalho.

Gujarati (ગુજરાતી): જો તમને આ ન્યુ જર્સી માહિતીનાં હોરાઈઝન્સ બ્લૂ ક્રોસ બ્લૂ શીલ્ડને સમજવા મદદની જરૂર હોય તો, તમને તમારી ભાષામાં કોઈ પણ ખર્ચ વગર મદદ મેળવવાનો અધિકાર છે. કોઈ દુભાષિયા સાથે વાત કરવા, કૃપા કરીને સામાન્ય બિઝનેસ કલાકો દરમિયાન **1-800-355-BLUE (2583)** પર ફોન કરો .

Polish (Polski): Jeżeli potrzebujesz pomocy, aby zrozumieć informacje planu Horizon Blue Cross Blue Shield of New Jersey, masz prawo poprosić o bezpłatną pomoc w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer **1-800-355-BLUE (2583)** podczas normalnych godzin pracy.

Russian (Русский язык): Если вам необходима помощь в разъяснении этой информации, предоставленной компанией Horizon Blue Cross Blue Shield of New Jersey, у вас есть право на получение помощи на вашем родном языке бесплатно. Для связи с переводчиком звоните по номеру телефона **1-800-355-BLUE (2583)** в обычные рабочие часы.

Haitian Creole (Kreyòl ayisyen): Si ou bezwen èd pou konprann enfòmasyon sou Horizon Blue Cross Blue Shield of New Jersey, ou gen dwa pou jwenn èd nan lang natifnatal ou gratis. Pou pale avèk yon entèprèt, tanpri rele nimewo **1-800-355-BLUE (2583)** pandan lè nòmal biznis.

Hindi (हिंदी): यदि आपको न्यू जर्सी की इस होराइज़न ब्लू क्रॉस ब्लू शील्ड सूचना को समझने में सहायता की ज़रूरत है, तो आपके पास मुफ्त में अपनी भाषा में सहायता पाने का अधिकार है। किसी दुभाषिए से बात करने के लिए, कृपया सामान्य कार्य समय के दौरान **1-800-355-BLUE (2583)** पर कॉल करें।

Vietnamese (Tiếng Việt): Nếu cần được giúp đỡ để hiểu rõ thông tin này của Horizon Blue Cross Blue Shield of New Jersey, quý vị có quyền được giúp đỡ bằng ngôn ngữ của mình miễn phí. Xin gọi số **1-800-355-BLUE (2583)** trong giờ làm việc để nói chuyện với người thông dịch.

French (Français): Si vous avez besoin d'assistance pour comprendre ces informations au sujet de Horizon Blue Cross Blue Shield of New Jersey, vous avez le droit d'obtenir de l'aide dans votre langue, sans aucun frais. Pour parler avec un interprète, veuillez appeler le **1-800-355-BLUE (2583)** pendant les heures normales de bureau.

Navajo (Diné): Díí New Jersey bił hahoodzo Horizon Blue Cross Blue Shield, t'áá ninizaad k'ehjí baa hane'íí bik'i diitįįh bee shiká' a'doowoł nínízingo éí bee ná'ahoot'i' dóó doo bą́ą́h ílíní da. Ata' halne'é ła' bich'į' hadeesdzih nínízingo t'áá shǫǫdí **1-800-355-BLUE (2583)**jį' nida'anishgo oolkiłíí bik'ehgo hodíílnih.

Arabic (عربي): إذا كنت بحاجة إلى المساعدة في فهم معلومات Horizon Blue Cross Blue Shield of New Jersey، لديك الحق في الحصول على المساعدة بلغتك دون تحملك أية تكلفة. للتكلم مع مترجم، يرجى الاتصال خلال ساعات العمل العادية بالرقم **1-800-355-BLUE (2583)**.

Urdu (**اردو**)**:** اگر آپ کو نیوجرسی انفارمیشن کے اس آسمانی نیلے رنگ والے تیز نیلے رنگ والے شیلڈ کو سمجھنے میں مدد کی ضرورت ہے تو، آپ کو اپنی زبان میں بغیر کسی خرچ کے مدد حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، براہ کرم، معمول کے کاروباری اوقات میں **1-800-355-BLUE (2583)** پر کال کریں۔

Italian (Italiano): Se vi serve aiuto per capire queste informazioni della Horizon Blue Cross Blue Shield of New Jersey, avete diritto ad assistenza gratis nella vostra lingua. Per parlare con un interprete, siete pregati di telefonare al numero **1-800-355-BLUE (2583)** durante le normali ore d'ufficio.

Tagalog (Tagalog): Kung kailangan mo ng tulong sa pag-unawa nitong impormasyon ng Horizon Blue Cross Blue Shield of New Jersey, may karapatan kang humingi ng tulong sa iyong wika nang walang gastos sa iyo. Upang makipag-usap sa isang taga-interpret, mangyaring tumawag sa **1-800-355-BLUE (2583)** sa loob ng karaniwang mga oras ng negosyo.

CMC0007942 (0516)

Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza East
Newark, NJ 07105-2200
HorizonBlue.com

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 to communicate effectively with us, such as qualified sign language interpreters and information written in other languages.

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

- **Claim, benefits or enrollment inquiries**
- **Lost/stolen ID cards**
- **Address changes**
- **Any other inquiry related to your benefits or health plan**

Filing a Section 1557 Grievance
If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin, age or disability you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address:

Horizon BCBSNJ – Civil Rights Coordinator
PO Box 820
Newark, NJ 07101

If you are not a Horizon BCBSNJ member, you may contact Horizon BCBSNJ's Civil Rights Coordinator by calling **1-866-660-6528** (TTY/TDD **711**) or by writing to Horizon BCBSNJ's Civil Rights Coordinator at the above-referenced address.You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

Office for Civil Rights Headquarters
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 or **1-800-537-7697** (TDD)

OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.