



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HorizonBlue.com or by calling **1-800-355-BLUE (2583)**. If you do not currently have coverage with Horizon and wish to view a sample plan document, they are available at http://www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html. Starting in January of 2016, once you have enrolled in coverage with Horizon, you may sign into our Member Services portal at www.HorizonBlue.com/Member to view your plan document. (Please note that document viewing availability is subject to NJDOBI regulatory procedures, enrollment and/or billing activities or other procedures preventing the display.)

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$3,000 self only coverage/ \$6,000 family coverage for in-network services.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see Common Medical Events chart for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For in-network health/pharmacy providers \$6,550 person/ \$13,100 family.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, 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 <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The Common Medical Events chart describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list on in-network providers, see www.HorizonBlue.com or call 1-800-355-BLUE (2583) .	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their network. See the Common Medical Events chart for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a written referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on the Services Your Plan Does Not Cover chart. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-800-355-BLUE (2583) or visit us at www.HorizonBlue.com

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	50% coinsurance after deductible \$15 copay after deductible/visit. Applies only to Office Visit Telemedicine	Not Covered	Applies to selected PCP. Telemedicine is a covered benefit only when provided through Horizon BCBSNJ's designated telemedicine provider.
	Specialist visit	50% coinsurance after deductible \$15 copay after deductible/visit. Applies only to Office Visit Telemedicine	Not Covered	Applies to non-selected PCP. Telemedicine is a covered benefit only when provided through Horizon BCBSNJ's designated telemedicine provider.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Other practitioner office visit	Outpatient facility: 50% coinsurance after deductible/ visit- short term therapy Office: 50% coinsurance after deductible short term therapy and therapeutic manipulations (chiropractic care)	Not Covered	Therapeutic manipulations limited to 30 visits per calendar year. Speech & Cognitive Therapy limited to 30 visits combined per calendar year & Physical & Occupational Therapy limited to 30 visits combined per calendar year. 30 visit limit does not apply to the treatment of autism.
	Preventive care/screening/immunization	No Charge	Not Covered	One routine physical per calendar year.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	Laboratory Services Office: Deductible Laboratory Services Outpatient Facility: 50% coinsurance after deductible Radiology Services Office: 50% coinsurance after deductible/ visit Radiology Services Outpatient Facility: 50% coinsurance after deductible	Not Covered	—————none—————
	Imaging (CT/PET scans, MRIs)	50% coinsurance after deductible	Not Covered	Requires pre-approval.

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Horizon BCBSNJ: Horizon HSA Advantage EPO (Off Exchange) Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: **All Coverage Types** Plan Type: **EPO**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at Prime Therapeutics LLC (Prime) Service Center www.MyPrime.com or 1-800-370-5088.</p> <p>View the formulary at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2016/2016_NJ_3T_HealthInsuranceMarketplaceAdvantage.pdf</p>	Generic drugs	50% coinsurance after deductible/retail and mail order	50% coinsurance after deductible/retail and mail order	Prior authorization may be required. Covers up to a 90 day supply (retail) and a 90 day supply (mail order).
	Preferred brand drugs	50% coinsurance after deductible/retail and mail order	50% coinsurance after deductible/retail and mail order	Prior authorization may be required. Covers up to a 90 day supply (retail) and a 90 day supply (mail order).
	Non-preferred brand drugs	50% coinsurance after deductible/retail and mail order	50% coinsurance after deductible/retail and mail order	Prior authorization may be required. Covers up to a 90 day supply (retail) and a 90 day supply (mail order).
	Specialty drugs	Covered at retail benefit in above applicable categories	Covered at retail benefit in above applicable categories	Prior authorization may be required. Covers up to a 90 day supply (retail) and a 90 day supply (mail order).
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	50% coinsurance after deductible	Not Covered	—————none—————
	Physician/surgeon fees	Deductible	Not Covered	—————none—————
<p>If you need immediate medical attention</p>	Emergency room services	50% coinsurance after deductible and \$100 copay/visit	50% coinsurance after deductible and \$100 copay/visit	Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.

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Horizon BCBSNJ: Horizon HSA Advantage EPO (Off Exchange) Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: **All Coverage Types** Plan Type: **EPO**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Emergency medical transportation	Deductible	Deductible	Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Urgent care	50% coinsurance after deductible	50% coinsurance after deductible	No coverage for non-urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 copay after deductible/per day	Not Covered	Limited to \$100 copay for hospital inpatient per day, \$500 maximum per confinement. Requires pre-approval.
	Physician/surgeon fee	Deductible	Not Covered	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	50% coinsurance after deductible/visit	Not Covered	—————none—————
	Mental/Behavioral health inpatient services	\$100 copay after deductible/per day	Not Covered	Limited to \$100 copay for hospital inpatient per day, \$500 maximum per confinement. Requires pre-approval.
	Substance use disorder outpatient services	50% coinsurance after deductible/visit	Not Covered	—————none—————
	Substance use disorder inpatient services	\$100 copay after deductible/per day	Not Covered	Limited to \$100 copay for hospital inpatient per day, \$500 maximum per confinement. Requires pre-approval.
If you are pregnant	Prenatal and postnatal care	50% coinsurance after deductible	Not Covered	—————none—————
	Delivery and all inpatient services	\$100 copay after deductible/per day	Not Covered	Limited to \$100 copay for hospital inpatient per day, \$500 maximum per confinement.

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Horizon BCBSNJ: Horizon HSA Advantage EPO (Off Exchange) Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: **All Coverage Types** Plan Type: **EPO**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	50% coinsurance after deductible/visit	Not Covered	Requires pre-approval. Private-duty nursing is only covered under the Home health care benefit when required by a Home health care plan. Coverage is limited to 60 visits per calendar year.
	Rehabilitation services (Inpatient)	\$100 copay after deductible/per day	Not Covered	Limited to \$100 copay for hospital inpatient per day, \$500 maximum per confinement. Requires pre-approval.
	Habilitative services (Inpatient)	\$100 copay after deductible/per day	Not Covered	Limited to \$100 copay for hospital inpatient per day, \$500 maximum per confinement. Requires pre-approval.
	Skilled nursing care	\$100 copay after deductible/per day	Not Covered	Limited to \$100 copay for hospital inpatient per day, \$500 maximum per confinement. Requires pre-approval.
	Durable medical equipment	50% coinsurance after deductible	Not Covered	Requires pre-approval.
	Hospice service	50% coinsurance after deductible/visit	Not Covered	Requires pre-approval.
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per 12 months.
	Glasses	Amounts greater than \$125 for non-collection frames	Not Covered	This Benefit is administered by Davis Vision. Lenses and Hardware are covered once every 12 months. Limit includes 1 pair of frames from the select Davis Vision collection and \$125 allowance for non-collection frames.

More information about **vision coverage** is available at www.HorizonBlue.com or 1-800-278-7753.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Dental check-up	Not Covered	Not Covered	—————none—————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Hearing aids (Only covered for Members age 15 and younger) 	<ul style="list-style-type: none"> • Long-term care • Private-duty nursing • Routine eye care (Adult, Optometrist/Ophthalmologist office. For verification of coverage on routine vision services, please see your policy or plan document.) 	<ul style="list-style-type: none"> • Routine foot care • Weight loss programs

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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture when used as a substitute for other forms of anesthesia
- Bariatric surgery
- Chiropractic care
- Infertility treatment (Requires pre-approval)
- Most coverage provided outside the United States. See www.HorizonBlue.com
- Non-emergency care when traveling outside the U.S. See www.HorizonBlue.com

Your Rights to Continue Coverage:

“If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-355-BLUE (2583). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-800-355-BLUE (2583). 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

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Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-355-BLUE (2583).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-355-BLUE (2583).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-355-BLUE (2583).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-355-BLUE (2583).

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$1,280
- Patient pays \$6,260

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$6,000
Copays	\$100
Coinsurance	\$10
Limits or exclusions	\$150
Total	\$6,260

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

- Amount owed to providers: \$5,400
- Plan pays \$50
- Patient pays \$5,350

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$5,270
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$5,350

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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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 ક્લાકો 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.

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.

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 होराइजन 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 diitjìh bee shiká' a' doowoł nínízingo éí bee ná'ahoot'i' dóo doo bááh ílíní da. Ata' halne'é ła' bich'i' hadeesdzih nínízingo t'áá shóqdí **1-800-355-BLUE (2583)** jį' nida'anishgo oolkiłí bik'ehgo hodíłnih.

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۔



Horizon Blue Cross Blue Shield of New Jersey

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

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Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Horizon BCBSNJ does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Horizon BCBSNJ provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Information written in other languages

If you need these services, contact Horizon BCBSNJ's Director of Regulatory Compliance at the phone number, fax or email listed below.

If you believe that Horizon BCBSNJ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Horizon BCBSNJ – Director, Regulatory Compliance
Three Penn Plaza East, PP-16C
Newark, NJ 07105
Phone: 1-800-658-6781
Fax: 1-973-466-7759
Email: ComplianceAndEthicsOffice@HorizonBlue.com

You can file a grievance in person, or by mail, fax or email. If you need help filing a grievance, Horizon BCBSNJ's Director of Regulatory Compliance is available to help you.

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)

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