Horizon Blue Cross Blue Shield of New Jersey

Small Employer Group Application Instructions

Instructions

The attached forms should be completed with the assistance of your authorized Broker or Horizon Blue Cross Blue Shield of New Jersey Sales Representative.
Please complete all necessary forms in their entirety. Please print in ink or type your responses.

Ensure that all areas requiring a **signature and date are complete.** The Officer, Partner, Owner and / or Correspondent signing the application must be listed on the New Jersey Small Employer Certification.

Completed enrollment application forms should be sent to your authorized Broker or Horizon BCBSNJ Sales Representative **prior to your effective date.**

Documents Included

Attached you will find the forms that must be completed and submitted for each New Jersey small employer group applying for standard health insurance coverage:

- Application for a Small Employer Health Benefits Policy.
- New Jersey Small Employer Certification.
- Small Employer Health Benefits Waiver of Coverage – One form is needed for each employee waiving or refusing coverage. This form may be photocopied as needed.

Other Required Documents

In addition to the forms listed above, **depending on group size / composition and preferred payment method, the following items may also be required:**

- Payroll verification through appropriate tax documentation, i.e., WR30 (required for groups of five or fewer eligible).
- Owner payroll documentation (K-1, Schedule C and/or 1120).
- Automatic Pay Plan Application (#8977).

When submitting your paperwork as required above, **you must also submit the following:**

- Enrollment Change / Request Form (#6803) – One form is needed for each employee enrolling. Your authorized Broker or Horizon BCBSNJ Sales Representative will provide these forms.
- First month's premium – All new cases must be submitted with a company check for the first month's premium payable to Horizon BCBSNJ. If a case is submitted without a premium check, the case will be returned.
- Prior / Current Carrier's most recent billing statement – Required if replacing group medical coverage.
- Rate Quote – The rate quote generated for the group should match the product(s) selected in Section II of the Application for a Small Employer Health Benefits Policy.

Rate Quotes

The rate quote is an estimate based on information provided by your authorized Broker or Horizon BCBSNJ Sales Representative. If there is inaccurate or missing information on the original quote, the rate may change based on an official review of the paperwork submitted to Horizon BCBSNJ.

Submission of Application to Horizon BCBSNJ

Your authorized Broker will submit this Application to Horizon BCBSNJ.

RESET

Horizon Blue Cross Blue Shield of New Jersey

APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

Please print or type Policy Number: _____ ☐ New Policy ☐ Change in Policy Requested Effective Date: _____

Note: The Effective Date will be on or after the date Horizon Blue Cross Blue Shield of New Jersey approves the application.

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): _____

2. Tax Identification Number: _____

3. Main Address: _____
Street City State ZIP

Mailing Address: _____
Street City State ZIP

Telephone: _____ Facsimile: _____ Email Address: _____

Contract information should be provided: ☐ electronically or ☐ hard copy. Check one.

4. Correspondent: _____ Title: _____

5. Type of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain): _____

6. Nature of Business (specify): _____ SIC Code: _____

7. Number of full-time employees in your company: _____
Refer to the New Jersey Small Employer Certification for the definition of a full-time employee.

8. Number of full-time employees to be insured: _____ 9. Class or classes to be excluded: _____

10. Insurance Requested For:
☐ Employees Only ☐ Employees and Dependents including Spouse ☐ Employees and Dependents excluding Spouse

Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? ☐ Yes ☐ No
If yes, should the plan provide coverage for coverage of children of a covered domestic partner? ☐ Yes ☐ No

11. Is the employer subject to the requirements of COBRA? ☐ Yes ☐ No

12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? ☐ Yes ☐ No
Due to disability? ☐ Yes ☐ No

13. Orientation Period? ☐ Yes ☐ No

14. Waiting period before employees become insured: (may not exceed 90 days)
Present Employees : ☐ no waiting period ☐ one month ☐ two months ☐ 90 days
New or Rehired Employees: ☐ no waiting period ☐ one month ☐ two months ☐ 90 days

15. Period for Annual Employee Open Enrollment Period: _____

16. What percentage of the premium will the employer pay? _____

17. Deposit $ _____

Premium Paid: ☐ Monthly ☐ Automatic checking withdrawal
Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	No. of full-time employees in this company	No. of full-time employees to be insured

SECTION II: SPECIFICATIONS FOR COVERAGE

Please select desired health benefits option and stand alone pediatric dental option.

HEALTH BENEFITS

Advantage Direct Access

☐ Platinum 100/70 - $20/$40 copay, $10/$25/$50 Rx, with Blue Card

☐ Gold 100/80/60 - $20/$40 copay, $15/$40/$75 Rx, with Blue Card

Advantage EPO

☐ Gold 100% - $25/$45 copay, $25/$50/$75 Rx
☐ with Blue Card ☐ without Blue Card

☐ Gold 100% - $30/$50 copay, $15/60%/50% Rx
☐ with Blue Card ☐ without Blue Card

☐ Gold 100/80 - $20/$40 copay, $10/$25/$50 Rx
☐ with Blue Card ☐ without Blue Card

☐ Silver 100/70 - $30/$50 copay, $25/$50/$75 Rx
☐ with Blue Card ☐ without Blue Card

☐ Silver 100/50 - $30/$50 copay, $15/50%/50% Rx
☐ with Blue Card ☐ without Blue Card

OMNIA

☐ OMNIA Platinum, $5/90%/70%/70% Rx, without Blue Card
☐ OMNIA Gold, $10/60%/50%/50% Rx, without Blue Card
☐ OMNIA Silver, $15/50% after Tier 1 deductible/50% after Tier 1 deductible Rx, without Blue Card

HSA plans

☐ OMNIA Silver HSA, Tier 1 deductible & 60% Rx, without Blue Card
☐ OMNIA Bronze HSA, Tier 1 deductible & 50% Rx, without Blue Card
☐ HSA Advantage Direct Access Silver 100/80/60 - $30/$50 copay, 60% CDHRx, with Blue Card
☐ HSA Advantage EPO Bronze 100% - $30/50 copay, 50% CDHRx
☐ with Blue Card ☐ without Blue Card

☐ **Other:** _____

STAND ALONE PEDIATRIC DENTAL

☐ Horizon Young Grins (only provides benefits for members under age 19)
☐ Horizon Family Grins
☐ Horizon Family Grins Plus

STAND ALONE PEDIATRIC DENTAL OPTIONS

The Patient Protection and Affordable Care Act (PPACA) permits plans outside of the Small Employer Business Health Options (SHOP) Program to issue coverage without pediatric dental benefits only if reasonably assured that the applicant has purchased an exchange-certified stand-alone dental plan (SAPD) covering the pediatric dental benefits as required by PPACA. In order to receive reasonable assurance from you, we require the following information if you did not select a Stand Alone Pediatric Dental Plan listed above:

☐ Proof of coverage or other documentation reasonably acceptable to the Health Insurance Issuers evidencing your enrollment in an exchange certified SAPD. Proof acceptable may be a copy of enrollment confirmation from the SAPD issuer or a copy of your coverage document (for example, a certificate of coverage).

☐ The contact information of your SAPD issuer that we may verify your enrollment with, which you expressly grant our ability to verify your enrollment:

Name of SAPD Issuer: _____

Policy Number: _____

Name of Contract Holder: _____

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   - now in force and to be continued? ☐ Yes ☐ No
   - currently being applied for? ☐ Yes ☐ No

   If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s):_____

   _____

2. Name of present or prior group carrier: _____

   Effective date of prior coverage: _____ Cancellation/termination date: _____

   Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No

   If "Yes", give reason _____

   Plan being replaced: _____

3. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

4. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start	Continuation Dates End

If additional space is needed, attach a separate sheet, signed and dated.

5. To the best of your knowledge:
   a. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   b. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

6. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
   (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

SECTION IV: AGENT/PRODUCER INFORMATION AND UNDERWRITING GROUP ENROLLMENT USE

Agent Producer Information (This information must be answered completely)

BROKER SIGNATURE ____________ DATE ____________ VENDOR NUMBER ____________

BROKER-NAME ____________ NAME OF AGENCY ____________ TELEPHONE NUMBER ____________

STREET ____________ CITY ____________ STATE ____________ ZIP CODE ____________

SUB-PRODUCER INFORMATION AND COMMISSION SPLIT

Sub-Producer Information (This information must be answered completely)

SUB-PRODUCER SIGNATURE ____________ DATE ____________ NPN NUMBER ____________

SUB-PRODUCER NAME ____________ NAME OF AGENCY ____________ TELEPHONE NUMBER ____________

STREET ____________ CITY ____________ STATE ____________ ZIP CODE ____________

____________%
Sub-Producer Commission Percentage

SUB-PRODUCER SIGNATURE ____________ DATE ____________ NPN NUMBER ____________

SUB-PRODUCER NAME ____________ NAME OF AGENCY ____________ TELEPHONE NUMBER ____________

STREET ____________ CITY ____________ STATE ____________ ZIP CODE ____________

____________%
Sub-Producer Commission Percentage

SUB-PRODUCER SIGNATURE ____________ DATE ____________ NPN NUMBER ____________

SUB-PRODUCER NAME ____________ NAME OF AGENCY ____________ TELEPHONE NUMBER ____________

STREET ____________ CITY ____________ STATE ____________ ZIP CODE ____________

____________%
Sub-Producer Commission Percentage

SUB-PRODUCER SIGNATURE ____________ DATE ____________ NPN NUMBER ____________

SUB-PRODUCER NAME ____________ NAME OF AGENCY ____________ TELEPHONE NUMBER ____________

STREET ____________ CITY ____________ STATE ____________ ZIP CODE ____________

____________%
Sub-Producer Commission Percentage

SPECIAL INSTRUCTIONS

For Internal Underwriting Use

☐ Approved for _____ Number of Subscribers _____

☐ Declined

Underwritten By _____ Date _____

For Internal Group Enrollment Use

	ADV DA	ADV EPO	OMNIA	HSA ADV DA	HSA ADV EPO	OMNIA HSA	OTHER	Rx	DENTAL	SAPD
COVERAGE CODE c/o										
TOTAL APPLICATIONS SUBMITTED										
TRANSFER FROM GROUP # _____										
REFUSALS/WAIVERS LISTING ATTACHED (IF APPLICABLE)										
EMPLOYER CONTRIBUTION										
EFFECTIVE DATE										
FUTURE RATE RENEWAL DATE										

APPROVED BY: _____ _____

REVIEWER SIGNATURE DATE APPROVED

SECTION V: SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. (Refer to the definition on the New Jersey Employer Certification.) It is further understood that no agent has power on behalf of Horizon Blue Cross Blue Shield of New Jersey to make or modify any request or application for insurance or to bind Horizon Blue Cross Blue Shield of New Jersey by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Horizon Blue Cross Blue Shield of New Jersey. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

It is understood that I am responsible to provide Horizon Blue Cross Blue Shield of New Jersey with timely and accurate information regarding the date of hire for new employees and that the requested effective date of coverage will properly apply any orientation period and waiting period requirements applicable to my plan. It is further understood that any retroactive termination requests must be limited to those for which no premium or contribution has been paid for the termination period by the employee or dependent whose coverage is to be retroactively terminated.

☐ Please read this statement and check to confirm. I confirm that I have received the Summary of Benefits and Coverage (SBC) documents associated with the plan or plans I selected on this application. I confirm I will provide SBCs to plan participants and beneficiaries as required by federal regulations and guidance related to the distribution of the SBC, including the requiring for timing and delivery.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at _____ on _____

_____ _____

Print name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

_____

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification

Horizon

Horizon Blue Cross Blue Shield of New Jersey

NEW JERSEY SMALL EMPLOYER CERTIFICATION

Legal Name and Address of Employer: _____
Name

_____
Street City State ZIP

Group Policy Number or Group Number: _____
(if a current customer)

For purposes of certification as a New Jersey Small Employer, an Employer is considered to be a Small Employer if the Employer satisfies the definition set forth below.

Employee and Small Employer Definitions
The definition of Small Employer counts employees as defined below.

Employee means an employee of the Policyholder. An individual and his or her legal spouse when the business is owned by the individual or by the individual and his or her legal spouse, partners in a partnership, sole proprietors, a 2-percent S corporation shareholder and independent contractors are **not** employees of the Policyholder.

Small Employer means in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding Calendar Year and who employs at least 1 employee on the first day of the Plan Year.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 employees. For purposes of this calculation:

a) Employees working 30 or more hours per week are full-time employees and each full-time employee counts as 1;

b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.

Add the number of full-time employees to the number that results from the part-time employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 employees.

Please note: Small Employer includes an employer that employs more than 50 full-time employees if the employer's workforce exceeds 50 full-time employees for no more than 120 days during the calendar year and the Employees in excess of 50 who were employed during such 120-day or fewer period were seasonal workers.

Full-Time Employee Definition
The definition of Full-time Employee is used to determine eligibility for coverage under a small employer plan. Full-time employees are counted when determining participation for a small employer.

Full-Time Employee means an employee who works a normal work week of 25 or more hours. Work must be at the Policyholder's regular place of business or at another place to which an employee must travel to perform his or her regular duties for his or her full and normal work hours.

Please note that the above definition of Small Employer above considers full-time to be 30 hours per week and that definition of full-time is used solely for determining whether an employer is a Small Employer. For purposes of determining which employees are eligible for insurance under a Small Employer plan and whether the Small Employer meets the participation requirement, full-time is defined as 25 hours per week.

Please indicate below the number of employees by work location/State. Refer to the definition of "employee" on page 1. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

Work Location (list by State)	Number of Employees or Former Employees			
	Full-time	Part-time	COBRA or State Continuees	Other

The following information will be used to calculate the **participation** rate. Refer to the definition of "full-time employee" on page 1 that counts employees working 25 or more hours per week.

Total # Full-time Employees _____

Total # Full-time Employees applying/enrolling for health benefits coverage _____

Total # Full-time employees waiving health benefits coverage under the policy with coverage under their spouse's or parent's group coverage, Medicare, Medicaid, or NJ FamilyCare or Tricare or any other group Health Benefits Plan **through a different employer** _____

Total # Full-time employees waiving health benefits coverage under the policy with coverage under a Health Benefits Plan **issued by another carrier and offered by the small employer**: _____

Please separately list the name(s) of the other carrier(s) and the number of employees covered under each:

_____ _____

_____ _____

Total # Full-time employees waiving health benefits coverage under the policy without coverage under a spouse's or parent's group coverage; Medicare, Medicaid, or NJ FamilyCare or Tricare or any other Health Benefits Plan _____

Total # Employees in an ineligible class or classes _____

The following information will be used to determine how certain federal laws apply to the Small Employer.

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? ☐ Yes ☐ No

(You may be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)

If yes, provide the number of full-time and part-time employees you employed for at least 20 or more weeks in the current or prior calendar year. _____

For purposes of this question "employee" includes: full-time employees, part-time employees, seasonal employees, temporary employees, employees who are union members, owners, partners, officers and excludes self-employed persons, independent contractors (1099), directors

Is your firm subject to the requirements of the federal COBRA law? ☐ Yes ☐ No

(You may be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

For purposes of this question "employee" includes: full-time employees, part-time employees, seasonal employees, temporary employees, employees who are union members, owners, partners, officers and excludes self-employed persons, independent contractors (1099), directors.

If yes, provide the number of full-time and part-time employees you employed during 50% or more of the working days during the previous calendar year. _____

Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full-time.

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY
For a Group Health Benefits Plan

Please sign and date appropriate section indicating whether or not you meet the definition of a small employer .

☐ I certify that I qualify as a Small Employer in the State of New Jersey.)

AND

☐ I certify that the information provided to Horizon Blue Cross Blue Shield of New Jersey is true and complete. I understand that if the above information is not complete or is not provided to Horizon BCBSNJ, in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

☐ I certify that I have obtained and maintain a stand-alone pediatric dental plan for all employees and dependents enrolling for health benefits coverage.

_____

Signature of Officer, Partner or Owner *Title*

_____

Print Name of Officer, Partner or Proprietor Date

_____

Signature of Witness Date

☐ **I certify that I am NOT a Small Employer in the State of New Jersey, as defined above.**

_____

Signature of Officer, Partner or Proprietor *Title*

_____

Print Name of Officer, Partner or Proprietor Date

_____

Signature of Witness Date

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

Complete this section if you have certified that the Employer is a Small Employer

***CENSUS INFORMATION**

Please include the following persons in the following list:

a. employees, owners, partners, and officers who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b. employees, owners, partners and officers who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

O: Owner, partner or officer
F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
S: Seasonal employee (employee works 120 days or fewer per year)
D: Totally Disabled employee
C: Continuee under state or federal law
U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Name	Job Title	Date of Employment	Hours Worked Per Week	Status	Work Location (State)	Date of Birth
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

*If additional space is needed, attach a separate sheet.

Horizon

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

SMALL GROUP ENROLLMENT/ CHANGE REQUEST

RESET

Mail to: Horizon BCBSNJ
Attn: Small Group Enrollment
P.O. Box 607 Department A
Newark, NJ 07101-0607
Email to: small_group_maintenance_enrollment_team@HorizonBlue.com
Fax (973) 274-2227
HorizonBlue.com

Group Information – to be completed by Employer.

Group Name: _____ Group Number: _____

Sub Group Number: _____ ☐ Enrollment of a new Subscriber

Date of Hire: _____/_____/_____ Effective Date/Date of Event: _____/_____/_____

Reason for Change: _____

A. Type of Activity – to be completed by Employer.

Refer to instructions before completing this form. Print clearly.

☐ ADD ☐ REMOVE ☐ OTHER CHANGE	Effective Date/Date of Event	Reason for Change
☐ Spouse	_____/_____/_____	_____
☐ Civil Union Partner (CUP)	_____/_____/_____	_____
☐ Domestic Partner (DP)	_____/_____/_____	_____
☐ Dependent Child	_____/_____/_____	_____
☐ Over-Age Child as a Dependent Under 31 *(please complete Coverage Continuation section)*	_____/_____/_____	_____
☐ Name Change	_____/_____/_____	_____
☐ Change Plan	_____/_____/_____	_____
☐ Other	_____/_____/_____	_____

COVERAGE CONTINUATION

☐ **For Employee** Billing: ☒ Group

Date of Loss of Coverage _____/_____/_____ Qualifying Event #** _____ Date of Qualifying Event _____/_____/_____

☐ Total Disability* ☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29

**Attach proof of disability*

☐ **For Spouse/Civil Union Partner*/Domestic Partner** Billing: ☒ Group

Date of Loss of Coverage _____/_____/_____ Qualifying Event #** _____ Date of Qualifying Event _____/_____/_____

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36

**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ **For Dependent or Over-aged Child**

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36 Billing: ☒ Group

Date of Loss of Coverage _____/_____/_____ Qualifying Event #** _____ Date of Qualifying Event _____/_____/_____

☐ Dependent Under 31 Billing: ☒ Home

Date of Loss of Coverage _____/_____/_____ Qualifying Event #** _____ Date of Qualifying Even _____/_____/_____

Home Address: _____

***Qualifying event #s: see list in Instructions.*

B. Employee Information – to be completed by Employee.

☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

If a name change, indicate prior name: _____

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____/_____/_____ Sex _____

Home Address _____ Apt. _____ City _____ State _____ Zip Code _____

Home Phone _____ E-Mail Address _____

Employer Name _____ Employment Date _____/_____/_____

Employer Address _____ City _____ State _____ Zip Code _____

Hours Worked Per Week _____ Work Phone _____ E-Mail Address _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

The Employee Copy of this application may be used as a temporary ID card for thirty days from the effective date if authorized by Employer. Coverage must be verified with Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. prior to visiting a physician or admission to a hospital.

C. Race/Ethnicity – to be completed by the Employee, at his/her option.

NOTE: Your response is appreciated but NOT required! *Choose a category that most closely describes you:*

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin
☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

D. Plan Option – to be completed by the Employee. Please refer to the Instructions for available continuation rights.

Medical Plan Option ***Check One:***

☐ Horizon Advantage Direct Access ☐ PCMH Advantage EPO
☐ Horizon Advantage Direct Access (HSA) ☐ OMNIA
☐ Horizon Advantage EPO (HSA) ☐ OMNIA (HSA)
☐ Horizon Advantage EPO ☐ Other _____

Select one coverage option: ☐ S ☐ F ☐ H/W ☐ CUP ☐ DP ☐ P/C

Pediatric Dental and Family Pediatric Dental ***Check One:***

☐ Horizon Young Grins (only provides benefits for members under 19)
☐ Horizon Family Grins
☐ Horizon Family Grins Plus

Select one coverage option: ☐ S ☐ F ☐ H/W ☐ CUP ☐ DP ☐ P/C

Family Dental ***Check One:***

☐ Horizon Dental Option Plan ☐ Horizon Dental Choice
☐ Horizon Dental PPO ☐ Horizon Healthy Smiles
☐ Horizon Dental PPO Access ☐ Horizon Healthy Smiles Plus
☐ Horizon Dental Companion

Select one coverage option: ☐ S ☐ F ☐ H/W ☐ CUP ☐ DP ☐ P/C

Vision Plan Option ***Check One:***

☐ Horizon Expanse V ☐ Horizon Panorama IV (Alt A) ☐ Horizon Vista II
☐ Horizon Expanse VII (Alt A) ☐ Horizon Panorama IV (Alt B) ☐ Horizon Vista III
☐ Horizon Expanse VII (Alt B) ☐ Horizon Vista IV
☐ Horizon Expanse VIII

Select one coverage option: ☐ S ☐ F ☐ H/W ☐ CUP ☐ DP ☐ P/C

S = Single F = Family H/W = Husband/Wife CUP = Civil Union Partners DP = Domestic Partners P/C = Parent/Child(ren)

E. Other Individuals Covered – to be completed by Employee.

Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof of disability.

SPOUSE/CUP/DP ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUE SPOUSE (COBRA/NJSGC)**
☐ **CONTINUE CU PARTNER (NJSGC)** ☐ **CONTINUE DP (NJSGC)**

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____/_____/_____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

Employed? ☐ Yes ☐ No *If yes, Complete Section F*

1. Child ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____/_____/_____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section G*

2. Child ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____/_____/_____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section G*

F. Additional Spouse/CUP/DP Information – to be completed by Employee. *If not applicable mark as N/A.*

1. Employer Name _____ Employer Phone _____

   Employer Address _____

   City _____ State _____ Zip Code _____

G. Additional Child Information – to be completed by Employee.

Provide information below about children listed in Section E, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

_____

2. Child ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____/_____/_____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Dentist Office ID number (if applicable) _____ Current Patient ☐ Yes ☐ No

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section G*

F. Additional Spouse/CUP/DP Information – to be completed by Employee. *If not applicable mark as N/A.*

1. Employer Name _____ Employer Phone _____

   Employer Address _____

   City _____ State _____ Zip Code _____

G. Additional Child Information – to be completed by Employee.

Provide information below about children listed in Section E, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: _____ Date: _____/_____/_____

I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete.
I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form.
I hereby agree to make premium payments required from me for the Dependent Under 31 Continuation Election.

Signature: _____ Date: _____/_____/_____

J. Employer Verification

The requested activity is believed eligible and is approved by the Employer.

Employer Representative: _____ Date: _____/_____/_____

Representative's Title: _____

Instructions

Employers

You must complete the Group Information and sections A and J in order for this application to be processed.

Employees

You must complete sections B through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her Medical and/or Family Dental coverage beyond age 26, you do not have to make a COBRA or NJSGC or Dependent Under 31 election. Instead select "Other" in Section A and attach proof of total disability.
- For Pediatric Dental and Family Pediatric Dental plans, Total Disability and COBRA are available continuation options; NJSGC and Dependent Under 31 continuation are not available. For Vision plans, Total Disability and COBRA are available continuation options; NJSGC and Dependent Under 31 continuation are not available.
- For Horizon Dental Option, Horizon Dental PPO, Horizon Dental PPO Access and Horizon Dental Choice, if a dependent is a full-time college student, you must attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).
- You can obtain the providers' correct names from the appropriate provider directory. You may also obtain each provider's NPI and LOC Code number from the provider directory or at: **www.HorizonBlue.com.** Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.
- If the Plan Option selected is Horizon Dental Choice-from the appropriate Provider directory, locate the alphanumeric office ID code for the dentist. Indicate office ID number selection(s) and NPI Number on the form.
- If you are a current patient, please check the "Current Patient" box. (only applicable if the Plan Option selected is Horizon Dental Choice).
- If the Horizon Young Grins plan is selected, only enrollees under age 19 can receive benefits.
- If Vision Plan Option is selected, all enrollees must be age 19 or over to qualify for benefits.

Qualifying Events

COBRA and NJSGC

C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC) or termination of domestic partnership (NJSGC)
C4. Death of employee
C5. Loss of dependent child status (aged out) under the plan.
C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status (aged out) and otherwise eligible
D2. Re-establish eligibility: residency
D3. Re-establish eligibility: nonresident full-time student
D4. Re-establish eligibility: change in marital status
D5. Re-establish eligibility: change in parental status
D6. Re-establish eligibility: termination of other coverage

Conditions of Enrollment - Applicant Acknowledgements and Agreements

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Horizon BCBSNJ[1], or any consumer reporting agency acting on behalf of Horizon BCBSNJ, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Horizon BCBSNJ has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Horizon BCBSNJ will provide coverage in accordance with the terms of the contract for the group plan/policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan/policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

Misrepresentations

Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

Notices

General Notice of Special Enrollment Rights

If you are declining enrollment under your group health plan for yourself and/or your dependents (if your plan includes coverage for dependents) because of other health insurance or other group health plan coverage, you may be able to enroll yourself and those dependents in this group health plan if you or the dependents lose eligibility for that other coverage (or if the other employer stops contributing toward your or your dependents' other coverage). However, if the other coverage was continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you must request enrollment within 30 days after the COBRA coverage ends. If the other coverage was not COBRA continuation coverage, you must request enrollment within 90 days after your or your dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if this plan includes coverage for dependents and you acquire a new dependent as a result of marriage, birth, adoption, placement for adoption, or placement in foster care you may be able to enroll yourself and your dependents under this plan after declining its coverage. However, you must request enrollment within 31 days after the child's birth or within 30 days after the marriage, adoption, placement for adoption, or placement in foster care.

If you decline group health coverage under this plan, you will be asked to state in writing whether the declination was due to the existence of other health coverage.

To request special enrollment or obtain more information about it, contact your benefits manager, if available, or your employer.

Notice on Dependent Under 31 Continuation

Horizon Blue Cross Blue Shield of New Jersey will bill over- age dependents directly and enrollees will remit the premium directly to Horizon BCBSNJ. When Dependent Under 31 Continuation is selected, the home address must be completed under Section "A - Type of Activity" even when it is the same as the employee's address.

Important Note:

- Although the employee must continue eligibility under the dependent's plan for continued coverage of the dependent, in addition to the additional applicable eligibility criteria, coverage for the dependent will be issued as stand-alone coverage. All cost-sharing requirements and limitations will apply and will not be combined with the employee's policy. Consequently, covered expenses incurred by the over-age dependent will not contribute to family deductibles and out-of-pocket maximums, nor will family incurred expenses contribute to the over-age dependent's deductibles or out-of-pocket maximums.

Group Subscriber on behalf of itself and its participants hereby expressly acknowledges its understanding this agreement constitutes a contract solely between Subscriber and Horizon BCBSNJ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Horizon BCBSNJ to use the Blue Cross and Blue Shield Service Marks in the State of New Jersey, and that Horizon BCBSNJ is not contracting as the agent of the Association. Group Subscriber on behalf of itself and its participants further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Horizon BCBSNJ and that no person, entity, or organization other than Horizon BCBSNJ shall be held accountable or liable to Group Subscriber for any of Horizon BCBSNJ's obligations to Group Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Horizon BCBSNJ other than those obligations created under other provisions of this agreement.

[1] Horizon BCBSNJ refers to Horizon Healthcare Services, Inc., doing business as Horizon Blue Cross Blue Shield Of New Jersey or any of its wholly owned subsidiaries including Horizon Insurance Company, Horizon Healthcare Dental, Inc., and Horizon Healthcare of New Jersey, Inc., doing business as Horizon NJ Health.

Horizon

Horizon Blue Cross Blue Shield of New Jersey

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No.: _____

Policyholder Name: _____

Employee Name: _____
Last First MI

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Employment: _____ Date of Birth: _____

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Horizon Blue Cross Blue Shield of New Jersey. I *refuse* the following:

☐ Employee, Spouse and Child(ren) coverage

☐ Spouse coverage

☐ Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

☐ other fully-insured Group Health Plan sponsored by this employer

☐ other Group Health Plan sponsored by my spouse's employer

☐ other group coverage sponsored by another organization

☐ covered under Medicare

☐ other reasons (please explain) _____

Please identify Group Health Plan(s) and provide names(s) of policyholder(s), carrier(s) and policy number(s).

Policyholder/Name: _____ _____ _____
Last First MI

Carrier: _____ Policy Number: _____

Policyholder/Name: _____ _____ _____
Last First MI

Carrier: _____ Policy Number: _____

Policyholder/Name: _____ _____ _____
Last First MI

Carrier: _____ Policy Number: _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 90 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form.

_____ Date: ____ / ____ / _____
Signature of Employee MM DD YYYY

_____ Date: ____ / ____ / _____
Signature of Witness MM DD YYYY

Horizon
Horizon Blue Cross Blue Shield of New Jersey

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

Confirmation of HSA Selection

Your selection of this Horizon Blue Cross Blue Shield of New Jersey health plan enables your employees to benefit from a Health Savings Account for tax-free saving and health care spending. Horizon BCBSNJ offers the Horizon MyWay HSA product at no cost to you or your employees. Please review the benefits of the Horizon MyWay HSA below.

Horizon *MyWay*™ HSA Advantages	
• Integrated with ACS|BNY Mellon (nation's leading HSA administrator)	• No account setup fee*
• Free online bill pay and debit card	• No monthly account fee*
• Free checkbook and check writing	• No enrollment forms
• Same premium as compatible plan	• No claim forms
• Simple online account opening	• No employer involvement required
• Investment options available	• No cross-selling of other banking products

**While an active member in the Horizon MyWay plan, Horizon BCBSNJ pays these fees for fully insured client groups.*

☐ Yes, I would like the **Horizon *MyWay*™** HSA Product

☐ No, I would like the Compatible HSA Product. I may utilize a separate HSA administrator and be responsible for all fees, enrollment and administration. I understand that the HSA will not be integrated with Horizon BCBSNJ.

Signing of this form reflects agreement to funding arrangement selected for one year and must be adhered to. This **cannot be changed** until the following renewal.

Agreed to funding checked off above by:

Group Administrator: _____ Date: _____ / _____ / _____
MM DD YYYY

Name of Group: _____

Witnessed by Broker: _____ Date: _____ / _____ / _____
MM DD YYYY

HORIZON HEALTHCARE SERVICES, INC.

DECLARATION OF UNDERSTANDING

New Jersey law requires that contract holders that apply for or renew a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223) receive a "Declaration of Understanding" that describes certain features of the plan. Accordingly, following is a brief description of some significant features of your Horizon Healthcare Services, Inc. (Horizon BCBSNJ) high deductible health plan.

DEDUCTIBLES: This is a high deductible plan. Except for covered preventive services, the deductible must be satisfied before benefits are payable under this plan. The deductible arrangements available to you are described in the application for group coverage or the proposal. If your plan is already in force, the arrangement you selected is described in the contract issued by Horizon BCBSNJ. The applicable deductible must be met each calendar year before benefits (in-network or out-of-network, as the case may be) are paid.

COVERED SERVICES AND SUPPLIES: Under this plan, covered services and supplies can be obtained from in-network or out-of-network providers. Following is a list of some of the plan's major covered services and supplies, some of which may be subject to frequency or dollar limits.

- Facility charges for inpatient and outpatient care (hospitals; skilled nursing facilities; birthing centers; physical rehabilitation centers).
- Physicians' charges for surgical procedures and other medical care.
- Ambulance services.
- Diagnostic X-rays; lab tests.
- Home health care.
- Hospice care.
- Prescription drugs.
- Preventive care (gynecological care and exams; mammographies; screenings (prostate cancer; colorectal cancer; newborn hearing and lead poisoning); routine adult physicals; immunizations; well-child care).
- Certain prosthetic devices; durable medical equipment.
- Private duty nursing.
- Certain therapy services.

COINSURANCE: This is the amount that Horizon BCBSNJ pays for covered services and supplies after a deductible is met. The percent that Horizon BCBSNJ pays is greater when services are obtained from in-network providers.

MAXIMUM OUT-OF-POCKET: Covered services and supplies are reimbursed at 100% after the applicable maximum is reached during a calendar year. Out-of-pocket deductible and coinsurance amounts (including those incurred for covered prescription drugs) will be applied toward these maximums.

CLAIM PROCEDURES: Covered persons do not need to file claims for covered services and supplies provided in-network. Claims for out-of-network services must be filed within one year after charges are incurred. Horizon BCBSNJ will pay claims within 30 days after the date the claims are received. If there is a dispute about the claim (or part of it) due to missing information, Horizon BCBSNJ will pay the claim (or the disputed part of it) within 30 days after the missing information is received.

****

By signing below, I confirm that I have read and understand this Declaration. I further understand that this Declaration provides only a brief summary of the Horizon BCBSNJ high deductible health plan. It is not a contract of insurance. The plan includes exclusions and limitations not described above. Full details of the plan are described in the group contract issued by Horizon BCBSNJ in connection with it.

Contract Holder: _____

By: _____

Title: _____

Date: _____

RE: <Group Name>
<Group Number>

ACS/Mellon Health Savings Account
Employer Discovery Document / Set-up Form

Please complete all requested information for each employer setup and submit an electronic copy (*Microsoft Word*) to the HSA Solution Employer Support Team at HSAEmployerSetup@acs-inc.com. The Security Challenge form should be returned along with this document. Alternatively, you may fax the documents to 201-633-0134.

On questions with check boxes, simply double-click on the appropriate box and change the "default value" to "checked; an X will then populate the box. For questions regarding the payroll process, please contact the HSA Solution Employer Support Team at (201) 553-6305.

Health Plan Name	Horizon Blue Cross Blue Shield of New Jersey
Health Plan Customer ID	502
Employer ID (3-digits assigned by Horizon)	

General Employer Information

Employer Name	
Employer Address – Line 1	
Employer Address – Line 2	
Employer City	
Employer State	
Employer ZIP Code	
Employer Funding Contact Name	
Employer Funding Contact Phone	
Employer Funding Contact E-mail	
Employer Technical Contact Name (regarding FTP set up)	
Employer Technical Contact Phone	
Employer Technical Contact E-mail	

1) High Deductible Health Plan Effective Date	
2) Number of Eligible Employees	

3) Expected Number of HSA Accounts	

4) Who Pays Account Set-up Fees?

☐ Health plan

5) Who Pays Account Maintenance Fees?

☐ Health plan

6) Will the Employer send contributions (Employer and/or Employee) to Mellon on behalf of the employees?

☑ Yes ☐ No *If no, question 7 is n/a.*

Note: *Employees always have the option of making deposits to their HSA themselves via deposit slips.*

7) How Will Mellon Receive Employee Contributions and Instructions?

Please refer to the ACS/Mellon Employer Guide for details on the funding/contribution options below. Employers with 50 or less employees use options 7a, 7b, or 7c.

7a: ☐ **Payroll on the Web (POW!) Method:** A lump sum transfer of funds accompanied by allocation instructions entered and submitted via POW! (Payroll on the Web) application.

Note: *This option is standard for Employers with less than 50 employees and recommended for groups of any size who anticipate less than 50 accounts.*

7b: ☐ **ACH Direct Deposit (via Individual ACH) Method:** Employer transmits funds directly to each employee's account via the Automated Clearing House (ACH). ***Note:*** *The employer will need to set this up with their payroll administrator or banking institution.*

7c: ☐ **N/A:** Employer will not transfer employee contributions to Mellon. Employees will only deposit funds via Mellon deposit slips.

7d: ☐ **Excel-to-Text File with FTP Connectivity:** A lump sum transfer of funds accompanied by allocation instructions in a set **Excel spreadsheet** format. (This approach requires FTP connectivity and four to eight weeks set-up time.)

7e: ☐ **Flat File with FTP Connectivity:** A lump sum transfer of funds accompanied by allocation instructions in our HSA Payroll Distribution File format. (This approach requires FTP connectivity and four to eight weeks set-up time.)

continued on next page

Security Challenge Questions

Please complete the attached Security Challenge Form

****

RETURN COMPLETED FORM TO:

HSA Solution Employer Support Team

Address: **500 Plaza Drive, 9th Floor**
Address: **Secaucus, NJ 07094**
Phone: **201-553-6305**
E-Mail: **HSAEmployerSetup@acs-inc.com**

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 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**.

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.

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 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 bąąh 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۔