

Product:

BlueCard PPO

Group Name:

MONTCLAIR BOARD OF EDUCATION

Group Number:

**087916-025
8360-1**

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INTRODUCTION

This Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) BlueCard PPO Program gives you and your covered Dependents broad protection to help meet the cost of Illnesses and Accidental Injuries. This Program offers the highest level of benefits when services are obtained from a Hospital or other Provider designated as a BlueCard PPO In-Network Provider either in New Jersey or in another Blue Cross and Blue Shield service area.

In this Booklet, you'll find the important features of your group's BlueCard PPO benefits provided by Horizon BCBSNJ. You should keep this Booklet in a safe place and read it carefully so that you become familiar with the benefits that are available to you and your family. This Booklet replaces any booklets and/or certificates you may previously have received.

Coverage under this Program is provided according to the Group Policy for each Covered Person. Your Booklet's Schedule of Covered Services and Supplies shows the Policyholder and the Group Policy Number(s).

Benefits and Amounts:

The available benefits and the amounts of insurance are described in the Booklet.

This Booklet is an important document and should be kept in a safe place. When you become covered under the Program, you will receive a Certificate of Coverage. You should attach the Certificate of Coverage to this Booklet. Together, they form your Group Insurance Certificate.

The Booklet is made part of the Group Policy, which is delivered in and governed by the laws of the State of New Jersey. Future changes in coverage will be described in either a Booklet Notice of Change or in a new Booklet. All benefits are subject in every way to the entire Group Policy, which includes this Booklet.

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

**3 Penn Plaza East
Newark, New Jersey 07105-2200**

HORIZON HEALTHCARE SERVICES, INC
CERTIFICATE OF COVERAGE

Horizon Healthcare Services, Inc. (Horizon BCBSNJ) certifies that insurance is provided according to the applicable Group Policy for each insured Employee. Your Booklet's Schedule of Covered Services and Supplies shows the Group Policyholder and the Group Policy Number.

Insured Employee: You are insured under the Group Policy. This Certificate of Coverage together with your Booklet forms your Group Insurance Certificate.

Your Booklet and this Certificate of Coverage replace any older booklets and certificates issued to you for the coverage described in your Booklet. The Booklet and Certificate of Coverage are made part of the Group Policy, which is delivered in and governed by the laws of the State of New Jersey. Future changes in coverage will be described in either a Booklet Notice of Change or new Booklet. All benefits are subject in every way to the entire Group Policy, which includes this Group Insurance Certificate.

Horizon Healthcare Services, Inc.
3 Penn Plaza East
Newark, New Jersey 07105-2200

DEFINITIONS

This section defines certain important terms used in this Booklet. The meaning of each defined word, whenever it appears in this Booklet, is governed by its definition below.

Act of War: Any act peculiar to military, naval or air operations in time of War.

Active: Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

Admission: Days of Inpatient services provided to a Covered Person.

Affidavit of Domestic Partner/Statement of Domestic Partnership: A formal instrument executed by two persons documenting their status as Domestic Partners. Submission of an Affidavit of Domestic Partnership/ Statement of Domestic Partnership to the Group and Horizon BCBSNJ is required prior to Domestic Partner coverage becoming effective. In order to be a valid Affidavit of Domestic Partnership/ Statement of Domestic Partnership for purposes of your group's Policy, the definition of Domestic Partners contained therein must be identical to the definition contained in the definition of Domestic Partner.

Affiliated Company: A corporation or other business entity affiliated with the Policyholder through common ownership of stock or assets; or as otherwise defined by the Policyholder and Horizon BCBSNJ.

Alcoholism: The abuse of or addiction to alcohol.

Allowance: An amount determined by Horizon BCBSNJ as the least of the following amounts: (a) the actual charge made by the provider for the service or supply; or (b) in the case of In-Network Providers, the amount that the provider has agreed to accept for the service or supply; or (c) in the case of Out-of-Network Providers, and except as provided in the next sentence, the amount determined for the service or supply based on the Resource Based Relative Value System (RBRVS) promulgated by the Centers for Medicare and Medicaid Services; or (d) in the case of Out-of-Network Providers, an amount determined for the service or supply based on: (i) profiles compiled by Horizon BCBSNJ based on the usual and prevailing payments made to providers for similar services or supplies in specific geographical areas; or (ii) similar profiles compiled by outside vendors. With respect to parts (c) or (d), as applicable, the amount determined as the Allowance for services and supplies provided by Out-of-Network Ambulatory Surgical Centers shall be 160% of the amount that would be reimbursed for them under the 2010 RBRVS.

The above methods for determining an Allowance do not apply with respect to the Program coverage of Orthotic and Prosthetic Devices. The Allowance for any such covered device shall be the greater of: (a) the reimbursement rate for the device in the federal Medicare reimbursement schedule; and (b) in the case of In-Network Providers, the amount that the Provider has agreed to accept for the device. If there is no such rate for the device, the amount determined for (a) shall be the Medicare reimbursement rate for the most similar device.

Alternate Payee:

- a. A custodial parent, who is not an Employee under the terms of the Program, of a Child Dependent; or
- b. The Division of Medical Assistance and Health Services in the New Jersey Department of Human Services, which administers the State Medicaid Program.

Ambulance: A certified transportation vehicle that: (a) transports ill or injured people; and (b) contains all life-saving equipment and staff as required by state and local law.

Ambulatory Surgical Center: A Facility mainly engaged in performing Outpatient Surgery.

- a. It must:
 - 1. be staffed by Practitioners and Nurses under the supervision of a physician;
 - 2. have permanent operating and recovery rooms;
 - 3. be staffed and equipped to give Medical Emergency care; and
 - 4. have written back-up arrangements with a local Hospital for Medical Emergency care.
- b. Horizon BCBSNJ will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
 - 1. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
 - 2. approved for its stated purpose by Medicare.

Horizon BCBSNJ does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Approved Cancer Clinical Trial: A scientific study of a new therapy or intervention for the treatment, palliation or prevention of cancer in human beings, as defined by the New Jersey Cancer Clinical Trials Work Group.

Approved Hemophilia Treatment Center: A health care Facility licensed by the State of New Jersey for the treatment of hemophilia, or one that meets the same standards if located in another state.

Benefit Day: Each of the following:

- a. Each midnight the Covered Person is registered as an Inpatient; or
- b. Each day when Inpatient Admission and discharge occur on the same calendar day or

c. Two Inpatient days in a Skilled Nursing Facility.

Benefit Month: The one-month period beginning on the Effective Date of the Group Policy and each succeeding monthly period.

Benefit Period: The twelve-month period starting on **January 1st and ending on December 31st**. The first and/or last Benefit Period may be less than a calendar year. The first Benefit Period begins on the Employee's Coverage Date. The last Benefit Period ends when the Employee is no longer covered.

Birthing Centers: a Facility, which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-time delivery, and the immediate post-partum period.

a. It must:

1. provide full-time Skilled Nursing Care by or under the supervision of Nurses;
2. be staffed and equipped to give Medical Emergency care; and
3. have written back-up arrangements with a local Hospital for Medical Emergency care.

b. Horizon BCBSNJ will recognize it if:

1. it carries out its stated purpose under all relevant state and local laws; or
2. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
3. it is approved for its stated purposes by Medicare.

Horizon BCBSNJ does not recognize a Facility as a Birthing Center if it is part of a Hospital.

BlueCard PPO Provider: A Provider, not in New Jersey, which has a written agreement with another Blue Cross and/or Blue Shield plan to provide care to both that plan's subscribers and other Blue Cross and/or Blue Shield plans' subscribers. For purposes of this Program, a BlueCard PPO Provider is an In-Network Provider.

Booklet: A detailed summary of benefits covered.

Brand Name Drugs: Drugs as determined by the Food and Drug Administration and listed in the formulary of the State in which they are dispensed; and protected by the trademark registration of the pharmaceutical company, which produces them.

Calendar Year: A year starting January 1.

Care Manager: A person or entity designated by Horizon BCBSNJ to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.

Certified Registered Nurse Anesthetist (C.R.N.A.): A Registered Nurse, certified to administer anesthesia, who is employed by and under the supervision of a physician anesthesiologist.

Child Dependent: A person who: has not attained the age of 23; is unmarried; and is:

- The natural born child or stepchild of you, your Spouse, Domestic Partner regardless of where or with whom the child lives;
- A child who is: (a) legally adopted by you, your Spouse, Domestic Partner, regardless of where or with whom such child lives; or (b) placed with you for adoption. But, proof of such adoption or placement satisfactory to Horizon BCBSNJ must be furnished to us when we ask;
- You, your Spouse's, Domestic Partner's legal ward who: (a) resides with you in a regular parent-child relationship; and (b) is chiefly dependent on you for support and maintenance. But, proof of guardianship satisfactory to Horizon BCBSNJ must be furnished to us when we ask.

Civil Union: A union that is either established pursuant to New Jersey law or recognized by the State of New Jersey as a Civil Union.*

Civil Union Partner: A person who has established and is in a Civil Union*

*See Rider form GRP 2007 (NJ-Civil Union HSC) at the end of the Booklet for information about Civil Unions.

Clean Claim: A claim for benefits that: (a) is an eligible claim for a Covered Service or Supply rendered by an eligible Provider; (b) has no material defect or impropriety (including, but not limited to, missed coding or missing documentation; (c) is not disputed; (d) has not been submitted fraudulently, as determined by Horizon BCBSNJ; and (e) does not need special treatment that might prevent timely payment.

Coinsurance: The percent applied to Covered Charges (not including Deductibles) for certain Covered Services or Supplies in order to calculate benefits under the Program. These are shown in the Schedule of Covered Services and Supplies. The term does not include Copayments. For example, if Horizon BCBSNJ's Coinsurance for an item of expense is **70%**, then the Covered Person's Coinsurance for that item is **30%**. Unless the context indicates otherwise, the Coinsurance percents shown in this Booklet are the percents that Horizon BCBSNJ will pay.

Coinsurance Charge Limit: The total amount of charges for Covered Services and Supplies that a Covered Person must Incur during a Benefit Period before no further Coinsurance is required for the remainder of that Benefit Period.

Copayment: A specified dollar amount a Covered Person must pay for certain Covered Services or Supplies or for a certain period of time, as described in the Schedule of Covered Services and Supplies.

Cosmetic Services: Services (including Surgery) rendered to refine or reshape body structures or surfaces that are not functionally impaired. They are: (a) to improve appearance or self-esteem; or (b) for other psychological, psychiatric or emotional reasons. The following are not considered "cosmetic":

- a. Surgery to correct the result of an Injury;
- b. Surgery to treat a condition, including a birth defect, which impairs the function of a body organ;
- c. Surgery to reconstruct a breast after a mastectomy is performed.
- d. Treatment of newborns to correct congenital defects and abnormalities.
- e. Treatment of cleft lip.

The following are some procedures that are always considered "cosmetic":

- a. Surgery to correct gynecomastia;
- b. Breast augmentation procedures, including their reversal for women who are asymptomatic;
- c. Reversal of breast augmentation procedures for asymptomatic women who had reconstructive Surgery or who previously had breast implants for cosmetic purposes;
- d. Rhinoplasty, except when performed to treat an Injury;
- e. Lipectomy;
- f. Ear or other body piercing.

Coverage Date: The date on which coverage under this Program begins for the Covered Person.

Covered Charges: The authorized charges, up to the Allowance, for Covered Services and Supplies. A Covered Charge is Incurred on the date the Covered Service or Supply is furnished. Subject to all of the terms of this Program, Horizon BCBSNJ provides coverage for Covered Services or Supplies Incurred by a Covered Person while the person is covered by this Program.

Covered Person: You and your Dependents who are enrolled under this Program.

Covered Services and/or Supplies: The types of services and supplies described in the Covered Services and Supplies section of this Booklet. Except as otherwise provided in this Booklet, the services and supplies must be:

- a. Furnished or ordered by a Provider; and
- b. For Preventive Care, or Medically Necessary and Appropriate to diagnose or treat an

Illness (including Mental or Nervous Disorders) or Injury.

Creditable Coverage: With respect to a person, prior coverage of the person under any of the following: a group health plan; a group or individual health benefits plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of said Title XIX (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a public health plan, as defined by federal regulation; or a health benefits plan under section 5(e) of the "Peace Corps Act".

"Creditable Coverage" does not include coverage which consists solely of the following: coverage only for accident or disability income insurance (or any combination of them); coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage (as specified in federal regulation) under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of health benefits plan, as defined in C.17B:27A-19, et seq.

Current Procedural Terminology (C.P.T.): The most recent edition of an annually revised listing published by the American Medical Association, which assigns numerical codes to procedures and categories of medical care.

Custodial Care: Care that provides a level of routine maintenance for the purpose of meeting personal needs. This is care that can be provided by a layperson who does not have professional qualifications or skills.

Custodial Care includes, but is not limited to: help in walking or getting into or out of bed; help in bathing, dressing and eating; help in other functions of daily living of a similar nature; administration of or help in using or applying creams and ointments; routine administration of medical gasses after a regimen of therapy has been set up; routine care of a patient, including functions such as changes of dressings, diapers and protective sheets and periodic turning and positioning in bed; routine care and maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags and indwelling catheters; routine tracheostomy care; general supervision of exercise programs, including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled services.

Even if a Covered Person is in a Hospital or other recognized Facility, Horizon BCBSNJ does not cover care if it is custodial in nature.

Deductible: The amount of Covered Charges that a Covered Person must pay before this Program provides any benefits for such charges. The term does not include Coinsurance, Copayments and Non-Covered Charges. See the Schedule of Covered Services and Supplies

section of this Booklet for details.

Dependent: A Spouse, Domestic Partner, or Child Dependent whom the Employee enrolls for coverage under this Program, as described in the General Information section of this Booklet.

Detoxification Facility: A Facility licensed by the State of New Jersey as a Detoxification Facility for the treatment of Alcoholism, or one that meets the same standards if located in another state.

Diagnostic Services: Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

- a. radiology, ultrasound and nuclear medicine;
- b. lab and pathology; and
- c. EKG's, EEG's and other electronic diagnostic tests.

Domestic Partners: Persons who meet these criteria:

- (1) Both persons have a common residence and are otherwise jointly responsible for each other's common welfare, as evidenced by joint financial arrangements or joint ownership of real property, which shall be demonstrated by at least one of the following:
 - (a) A joint deed, mortgage agreement or lease;
 - (b) A joint bank account;
 - (c) Designation of one of the persons as a primary beneficiary in the other's will;
 - (d) Designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
 - (e) joint ownership of a motor vehicle;
- (2) Both persons agree to be jointly responsible for each other's basic living expenses during the Domestic Partnership;
- (3) Neither person is in a marriage recognized by New Jersey law or a member of another Domestic Partnership;
- (4) Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;
- (5) Both persons are at least 18 years of age;
- (6) Both persons file jointly an Affidavit of Domestic Partnership; and
- (7) Neither person has been a partner in a Domestic Partnership that was terminated less than

180 days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died; and in all cases in which a person registered a prior Domestic Partnership, the Domestic Partnership shall have been terminated.

Domestic Partnership: A relationship between the Employee and another person as the Employee that meets the requirements set forth under this Program. Proof that such a relationship exists, as determined by Horizon BCBSNJ, must be given to Horizon BCBSNJ when requested. Horizon BCBSNJ has the right to determine eligibility for coverage under this Program.

Durable Medical Equipment: Medically Necessary and Appropriate equipment which Horizon BCBSNJ determines to fully meet these requirements:

- a. It is designed for and able to withstand repeated use;
- b. It is primarily and customarily used to serve a medical purpose;
- c. It is generally not useful to a person in the absence of an Illness or Injury; and
- d. It is suitable for use in the home.

Some examples are: walkers; wheelchairs (manual or electric); hospital-type beds; breathing equipment; and apnea monitors.

Some examples of services and supplies that are not considered to be Durable Medical Equipment are: adjustments made to vehicles; furniture; scooters; all terrain vehicles (ATVs); non-hospital-type beds; air conditioners; air purifiers; humidifiers; dehumidifiers; elevators; ramps; stair glides; emergency alert equipment; handrails; hearing aids, heat appliances; improvements made to the home or place of business; waterbeds; whirlpool baths; and exercise and massage equipment.

Employee: A person employed by the Employer; a proprietor or partner of the Employer.

Employer: Collectively, all employers included under the Group Policy.

Enrollment Date: A person's Coverage Date or, if earlier, the first day of any applicable Waiting Period.

Experimental or Investigational: Any: treatment; procedure; Facility; equipment; drug; device; or supply (collectively, "Technology") which, as determined by Horizon BCBSNJ, fails to meet any one of these tests:

- a. The Technology must either be: (a) approved by the appropriate federal regulatory agency and have been in use for the purpose defined in that approval (in the case of a Prescription Drug, for at least six months); or (b) proven to Horizon BCBSNJ's satisfaction to be the standard of care.

This applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from: (i) the FDA; or (ii) any other federal government body with authority to regulate the Technology. But, such approval does not imply that the Technology will automatically be deemed by Horizon BCBSNJ as Medically Necessary and Appropriate and the accepted standard of care.

- b. There must be sufficient proof, published in peer-reviewed scientific literature, that confirms the effectiveness of the Technology. That proof must consist of well-designed and well-documented investigations. But, if such proof is not sufficient or is questionable, Horizon BCBSNJ may consider opinions about and evaluations of the Technology from appropriate specialty advisory committees and/or specialty consultants.
- c. The Technology must result in measurable improvement in health outcomes, and the therapeutic benefits must outweigh the risks, as shown in scientific studies. "Improvement" means progress toward a normal or functional state of health.
- d. The Technology must be as safe and effective as any established modality. (If an alternative to the Technology is not available, Horizon BCBSNJ may, to determine the safety and effectiveness of a Technology, consider opinions about and evaluations of the Technology from appropriate specialty advisory committees and/or specialty consultants.)
- e. The Technology must demonstrate effectiveness when applied outside of the investigative research setting.
- f. Services and supplies that are furnished for or in connection with an Experimental or Investigational Technology are not Covered Services and Supplies under this Program, even if they would otherwise be deemed Covered Services and Supplies. But, this does not apply to: (a) services and supplies needed to treat a patient suffering from complications secondary to the Experimental or Investigational Technology; or (b) Medically Necessary and Appropriate services and supplies that are needed by the patient apart from such a Technology.

Regarding a., above, Horizon BCBSNJ will evaluate a Prescription Drug for uses other than those approved by the FDA. For this to happen, the drug must be recognized to be Medically Necessary and Appropriate for the condition for which it has been prescribed in one of these:

- The American Hospital Formulary Service Drug Information.
- The United States Pharmacopeia Drug Information.

Even if such an "off-label" use of a drug is not supported in one or more of the above compendia, Horizon BCBSNJ may still deem it to be Medically Necessary and Appropriate if supportive clinical evidence for the particular use of the drug: (a) is given in a clinical study or published in a major peer-reviewed medical journal; and (b) meets Horizon BCBSNJ's criteria. But, in no event will this Program cover any drug that the FDA has determined to be Experimental, Investigational or contraindicated for the treatment for which it is prescribed.

Also, regardless of anything above, this Program will provide benefits for services and supplies furnished to a Covered Person for medical care and treatment associated with an Approved Cancer Clinical Trial in Horizon BCBSNJ's Service Area. This coverage includes, to the extent coverage would be provided other than for an Approved cancer Clinical Trial: (a) Practitioners' fees; (b) lab fees; (c) Hospital charges; (d) treating and evaluating the Covered Person during the course of treatment or regarding a complication of the underlying Illness; and (e) other routine costs related to the patient's care and treatment, to the extent that these services are consistent with usual and customary patterns and standards of care furnished whenever a Covered Person receives medical care associated with an Approved Cancer Clinical Trial.

This coverage does not include: (a) the cost of Experimental or Investigational drugs or devices themselves; (b) non-health services that the patient needs to receive the care and treatment; (c) the costs of managing the research; or (d) any other services, supplies or charges that this Program would not cover for treatment that is not Experimental or Investigational.

Eye Examination: A comprehensive medical exam of the eye performed by a Practitioner, including: a diagnostic ophthalmic exam, with or without definitive refraction as medically indicated, with medical diagnosis and initiation of diagnostic and treatment programs; prescription of medication and lenses; post-cycloplegic Visit if needed; and verification of lenses if prescribed.

Facility: An entity or institution: (a) which provides health care services within the scope of its license, as defined by applicable law; and (b) which Horizon BCBSNJ either: (i) is required by law to recognize; or (ii) determines in its sole discretion to be eligible under the Program.

Family or Medical Leave of Absence: A period of time of predetermined length, approved by the Policyholder, during which the Employee does not work, but after which the Employee is expected to return to Active service. Any Employee who has been granted an approved leave of absence in accordance with the Family and Medical Leave Act of 1993 shall be deemed to be Active for purposes of eligibility for coverage under this Program.

FDA: The Food and Drug Administration.

Generic Prescription Drug: An equivalent Prescription Drug containing the same active ingredients as a Brand Name Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

Government Hospital: A hospital operated by a government or any of its subdivisions or agencies, including but not limited to: a federal; military; state; county; or city hospital.

Group Health Plan: An Employee welfare benefit plan, as defined in Title I of section 3 of P.L. 93-406 (ERISA), to the extent that the plan provides medical care and includes items and services paid for as medical care to Employees and/or their dependents directly or through insurance, reimbursement or otherwise.

Home Area: The 50 states of the United States of America, the District of Columbia and Canada.

Home Health Agency: A Provider which mainly provides care for an ill or injured person in the person's home under a home health care program designed to eliminate Hospital stays. Horizon BCBSNJ will recognize it if it: (a) is licensed by the state in which it operates; or (b) is certified to take part in Medicare as a Home Health Agency.

Home Health Care: Nursing and other Home Health Care services rendered to a Covered Person in his/her home. For Home Health Care to be covered, these rules apply:

- a. The care must be given on a part-time or intermittent basis, except if full-time or 24-hour services are Medically Necessary and Appropriate on a short-term basis.
- b. Continuing Inpatient stay in a Hospital would be needed in the absence of Home Health Care.
- c. The care is furnished under a physician's order and under a plan of care that: (a) is established by that physician and the Home Health Care Provider; (b) is established within 14 days after Home Health Care starts; and (c) is periodically reviewed and approved by the physician.

Home Health Care Services: Any of these services needed for the Home Health Care plan: nursing care; physical therapy; occupational therapy; medical social work; nutrition services; speech therapy; home health aide services; medical appliances and equipment, drugs and medicines, lab services and special meals, to the extent these would have been Covered Services and Supplies if the Covered Person was a Hospital Inpatient; diagnostic and therapeutic services (including Surgical services) performed in a Hospital Outpatient department, a physician's office, or any other licensed health care Facility, to the extent these would have been Covered Services and Supplies under this Program if furnished during a Hospital Inpatient stay.

Horizon BCBSNJ: Horizon Blue Cross Blue Shield of New Jersey.

Hospice: A Provider which mainly provides palliative and supportive care for terminally ill or terminally injured people under a Hospice Care Program. Horizon BCBSNJ will recognize a Hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

- a. approved for its stated purpose by Medicare; or
- b. accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospice Care Program: A health care program which provides an integrated set of services designed to provide Hospice care. Hospice services are centrally coordinated through an interdisciplinary team directed by a Practitioner.

Hospital: A Facility which mainly provides Inpatient care for ill or injured people. Horizon BCBSNJ will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

- a. accredited as a hospital by the Joint Commission: or

b. approved as a hospital by Medicare.

Among other things, a Hospital is not any of these: a convalescent home; a rest or nursing Facility; an infirmary; a Hospice; a Substance Abuse Center; or a Facility (or part of it) which mainly provides: domiciliary or Custodial Care; educational care; non-medical or ineligible services or supplies; or rehabilitative care. A facility for the aged is also not a Hospital. "Hospital" shall also not include a satellite facility of a Hospital for which a separate facility license is required by law, unless the satellite also meets this definition in its own right.

Horizon BCBSNJ will pay benefits for Covered Services and Supplies Incurred at Hospitals operated by the United States government only if: (a) the services or supplies are for treatment on an emergency basis; or (b) the services or supplies are provided in a hospital located outside of the United States or Puerto Rico.

The above limitations do not apply to military Retirees, their dependents, and the dependents of active-duty military personnel who: (a) have both military health coverage and Horizon BCBSNJ coverage; and (b) receive care in facilities run by the Department of Defense or Veteran's Administration.

Illness: A sickness or disease suffered by a Covered Person.

Incurred: A charge is Incurred on the date a Covered Person receives a service or supply for which a charge is made.

Inherited Metabolic Disease: A disease caused by an inherited abnormality of body chemistry for which testing is mandated pursuant to P. L. 1977, c. 321.

Injury: All damage to a person's body due to accident, and all complications arising from that damage.

In-Network: A Provider, or the Covered Services and Supplies provided by a Provider, who has an agreement to furnish Covered Services or Supplies under this Program.

In-Network Coverage: The level of coverage, shown in the Schedule of Covered Services and Supplies, which is provided if (a) an In-Network Provider provides the service or supply.

Inpatient: A Covered Person who is physically confined as a registered bed patient in a Hospital or other Facility, or the services or supplies provided to such Covered Person, depending on the context in which the term is used.

Joint Commission: The Joint Commission on the Accreditation of Health Care Organizations.

Late Enrollee: A person who requests enrollment under this Program more than 31 days after first becoming eligible. However, a person will not be deemed a Late Enrollee under certain conditions. See the General Information section of this Booklet for more details.

Low Protein Modified Food Product: A food product that is: (a) specially formulated to have less than one gram of protein per serving; and (b) intended to be used under the direction of a

physician for the dietary treatment of an Inherited Metabolic Disease. The term does not include a natural food that is naturally low in protein.

Mail-Order Pharmacy: A Pharmacy which, during the course of its daily business, dispenses Prescription Drugs primarily by mail, as determined by Horizon BCBSNJ, or any other Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the participating Mail Order Pharmacy agreement.

Maintenance Therapy: That point in the therapeutic process at which no further improvement in the gaining or restoration of a function, reduction in disability or relief of pain is expected. Continuation of therapy at this point would be for the purpose of holding at a steady state or preventing deterioration.

Medical Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to: severe pain; psychiatric disturbances; and/or symptoms of Substance Abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in: (a) placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of a bodily organ or part.

With respect to a pregnant woman who is having contractions, a Medical Emergency exists where: (a) there is not enough time to make a safe transfer to another Hospital before delivery; or (b) the transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of a Medical Emergency include, but are not limited to: heart attacks; strokes; convulsions; severe burns; obvious bone fractures; wounds requiring sutures; poisoning; and loss of consciousness.

Medical Food: A food that is: (a) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and (b) formulated to be consumed or administered entirely under direction of a physician.

Medically Necessary and Appropriate: This means or describes a health care service that a health care Provider, exercising his/her prudent clinical judgment, would provide to a Covered Person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Covered Person's illness, injury or disease; not primarily for the convenience of the Covered Person or the health care Provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Covered Person's illness, injury or disease.

"Generally accepted standards of medical practice", as used above, means standards that are based on:

a. credible scientific evidence published in peer-reviewed medical literature generally

- recognized by the relevant medical community;
- b. physician and health care Provider specialty society recommendations;
 - c. the views of physicians and health care Providers practicing in relevant clinical areas; and
 - d. any other relevant factor as determined by the New Jersey Commissioner of Banking and Insurance by regulation.

Medicaid: The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medicare: Part A and Part B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

Medicare Alternate Deductible: An amount equal to the Deductible plus the amounts that Medicare Part B would have paid had the Covered Person been covered by Medicare, as such. The Medicare Alternate Deductible applies to a Covered Person who: (a) is eligible for Medicare Part B; but (b) is not insured by Part B when Medicare should be the primary payer.

Member: A person who meets all rules to take part in a health and welfare benefit plan offered through a labor union or other qualified organization.

Mental Health Center: A Facility, which mainly provides treatment for people with mental health problems. Horizon BCBSNJ will recognize such a place if: (1) it carries out its stated purpose under all relevant state and local laws; and (2) it is:

- a. accredited for its stated purpose by the Joint Commission;
- b. approved for its stated purpose by Medicare; or
- c. accredited or licensed by the state in which it is located to provide mental health services.

Mental or Nervous Disorders: Conditions which manifest symptoms that are primarily mental or nervous (whether organic or non-organic, biological or non-biological, chemical or non-chemical in origin and irrespective of cause, basis or inducement) for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication. Mental or Nervous Disorders include, but are not limited to: psychoses; neurotic and anxiety disorders; schizophrenic disorders; affective disorders; personality disorders; and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental or Nervous Disorder, Horizon BCBSNJ may refer to the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (the "Manual"). But in no event shall the following be considered Mental or Nervous Disorders:

- (1) Conditions classified as V-codes in the most current edition of the Manual. These include

relational problems such as: parent-child conflicts; problems related to abuse or neglect when intervention is focused on the perpetrator; situations not attributable to a diagnostic disorder, including: bereavement, academic, occupational, religious, and spiritual problems.

- (2) Conditions related to behavior problems or learning disabilities, except as may be required by law with respect to the treatment of biologically-based mental illness.
- (3) Conditions that Horizon BCBSNJ determines to be due to developmental disorders. These include, but are not limited to: mental retardation; academic skills disorders; or motor skills disorders. But, this does not apply: (i) to the treatment required by law of biologically-based mental illness; or (ii) to the extent needed to provide newly born dependents with coverage for Injury or Illness, including the necessary care and treatment of medically diagnosed congenital defects and abnormalities.
- (4) Conditions that Horizon BCBSNJ determines to lack a recognizable III-R classification in the most current edition of the Manual. This includes, but is not limited to, treatment for: adult children of alcoholic families; or co-dependency.

Non-Covered Charges: Charges for services and supplies which: (a) do not meet this Program's definition of Covered Charges; (b) exceed any of the coverage limits shown in this Booklet; or (c) are specifically identified in this Booklet as Non-Covered Charges.

Nurse: A Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), or a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

- a. is properly licensed or certified to provide medical care under the laws of the state where he/she practices; and
- b. provides medical services which are: (a) within the scope of his/her license or certificate; and (b) are covered by this Program.

Out-of-Hospital: Services or supplies provided to a Covered Person other than as an Inpatient or Outpatient.

Out-of-Network: A Provider, or the services and supplies furnished by a Provider, who does not have an agreement with Horizon BCBSNJ to provide Covered Services or Supplies, depending on the context in which the term is used.

Out-of-Network Benefits: The coverage shown in the Schedule of Covered Services and Supplies which is provided if an Out-of-Network Provider provides the service or supply.

Out-of-Pocket Maximum: The maximum dollar amount that a Covered Person must pay as Deductible, Copayments and/or Coinsurance for Covered Services and Supplies during any Benefit Period. Once that dollar amount is reached, no further such payments are required for the remainder of that Benefit Period.

Outpatient: Either: (a) a Covered Person at a Hospital who is other than an Inpatient; or (b) the

services and supplies provided to such a Covered Person, depending on the context in which the term is used.

Partial Hospitalization: Intensive short-term non-residential day treatment services that are: (a) for Mental or Nervous Disorders; chemical dependency; or Alcoholism; and (b) rendered for any part of a day for a minimum of four consecutive hours per day.

Per Lifetime: During the lifetime of a person.

Pharmacy: A Facility: (a) which is registered as a Pharmacy with the appropriate state licensing agency; and (b) in which Prescription Drugs are dispensed by a pharmacist.

Physical Rehabilitation Center: A Facility, which mainly provides therapeutic and restorative services to ill or injured people. Horizon BCBSNJ will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

- a. accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
- b. approved for its stated purpose by Medicare.

Policyholder: The employer or other entity that: (a) purchased the Group Policy; and (b) is responsible for paying the premiums for it.

Practitioner: A person that Horizon BCBSNJ is required by law to recognize who:

- a. is properly licensed or certified to provide medical care under the laws of the state where he/she practices; and
- b. provides medical services which are: (a) within the scope of the license or certificate; and (b) are covered by this Program.

Practitioners include, but are not limited to, the following; physicians; chiropractors; dentists; optometrists; pharmacists; chiropodists; psychologists; physical therapists; audiologists; speech language pathologists; certified nurse mid-wives; registered professional nurses; nurse practitioners; and clinical nurse specialists.

Prescription Drugs: Drugs, biological and compound prescriptions which: (a) are dispensed only by prescription; and (b) are required to show on the manufacturer's label the words: "Caution-Federal Law Prohibits Dispensing Without A Prescription." The term includes: prescription female contraceptives; insulin; and may include other drugs and devices (e.g., syringes; glucometers; over-the-counter drugs mandated by law), as determined by Horizon BCBSNJ. For the purpose of this provision, "prescription female contraceptives" are drugs or devices, including, but not limited to, birth control pills and diaphragms, that: (i) are used for contraception by a female; (ii) are approved by the FDA for that purpose; and (iii) can only be purchased with a prescription written by a health care professional licensed or authorized to write prescriptions.

Prescription Drug Network: The network of Pharmacies, as determined by Us and identified as such, to provide Prescription Drug benefits under this Program at a negotiated rate.

Prescription Order: The request for drugs issued by a Practitioner licensed to make the request in the course of his/her professional practice.

Preventive Care: Services or supplies that are not provided for the treatment of an Injury or Illness. It includes, but is not limited to: routine physical exams, including: related X-rays and lab tests; immunizations and vaccines; screening tests; well-baby care; and well adult care.

Prior Authorization: Authorization by Horizon BCBSNJ for a Practitioner to provide specified treatment to Covered Persons. After Horizon BCBSNJ gives this approval, Horizon BCBSNJ gives the Practitioner a certification number. Benefits for services that are required to be, but are not, given Prior Authorization are subject to reduction as described in the "Utilization Review and Management" section of this Booklet.

Program: The plan of group health benefits described in this Booklet.

Provider: A Facility or Practitioner of health care in accordance with the terms of this Program.

Routine Foot Care: The cutting, debridement, trimming, reduction, removal or other care of: corns; calluses; flat feet; fallen arches; weak feet; chronic foot strain; dystrophic nails; excrescences; helomas; hyperkeratosis; hypertrophic nails; non-infected ingrown nails; dermatomes; keratosis; onychia; onychocryptosis; tylomas; or symptomatic complaints of the feet.

Routine Nursing Care: The appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Skilled Nursing Care: Services which: (a) are more intensive than Custodial Care; (b) are provided by an R.N. or L.P.N.; and (c) require the technical skills and professional training of an R.N. or L.P.N.

Skilled Nursing Facility: A Facility, which mainly provides full-time Skilled Nursing Care for ill or injured people who do not need to be in a Hospital. Horizon BCBSNJ will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

- a. accredited for its stated purpose by the Joint Commission; or
- b. approved for its stated purpose by Medicare. In some places, a Skilled Nursing Facility may be called an "Extended Care Center" or a "Skilled Nursing Center."

Special Care Unit: A part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff and special equipment and supplies on hand at all times. Some types of Special Care Units are:

- a. intensive care units;

- b. cardiac care units;
- c. neonatal care units; and
- d. burn units.

Special Enrollment Period: A period, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), during which you may enroll yourself and your Dependents for the coverage under this Program.

Specialty Pharmaceuticals: Oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These Prescription Drugs must be dispensed through Specialty Pharmaceutical Providers.

Examples of Prescription Drugs that qualify as Specialty Pharmaceuticals include those used to treat the following conditions: Crohn's Disease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; and Gaucher's Disease.

Specialty Pharmaceutical Provider: A vendor recognized by Horizon BCBSNJ that provides Specialty Pharmaceuticals.

Spouse: The person who is legally married to the Employee. Proof of legal marriage must be submitted to Horizon BCBSNJ when requested.

Substance Abuse: The abuse or addiction to drugs or controlled substances, not including alcohol.

Substance Abuse Centers: Facilities that mainly provide treatment for people with Substance Abuse problems or Alcoholism. Horizon BCBSNJ will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

- a. accredited for its stated purpose by the Joint Commission; or
- b. approved for its stated purpose by Medicare.

Surgery/Surgical:

- a. The performance of generally accepted operative and cutting procedures, including: surgical diagnostic procedures; specialized instrumentations; endoscopic exams; and other invasive procedures;
- b. The correction of fractures and dislocations;
- c. Pre-operative and post-operative care; or
- d. Any of the procedures designated by C.P.T. codes as Surgery.

Therapeutic Manipulation: The treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves, causing discomfort. Some examples of such treatment are: manipulation or adjustment of the spine; hot or cold packs; electrical muscle stimulation; diathermy; skeletal adjustments; massage, adjunctive, ultra-sound, Doppler, whirlpool or hydrotherapy; or other treatments of a similar nature.

Therapy Services: The following services and supplies when they are:

- a. ordered by a Practitioner;
- b. performed by a Provider;
- c. for a Covered Person who is a Hospital Inpatient or Outpatient, or a recipient of care given by a Home Health Agency; and
- d. Medically Necessary and Appropriate for the treatment of a Covered Person's Illness or Accidental Injury.

Chelation Therapy: The administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy: The treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy: Retraining the brain to perform intellectual skills that it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment: The treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy: The administration of antibiotic, nutrient, or other therapeutic agents by direct infusion.

Occupational Therapy: The treatment to develop or restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy: The treatment by physical means to: relieve pain; develop or restore normal function; and prevent disability following Illness, Injury or loss of limb.

Radiation Therapy: The treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes the rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy: The introduction of dry or moist gases into the lungs.

Speech Therapy: Therapy that is by a qualified speech therapist and is described below:

- a. Speech therapy to restore speech after a loss or impairment of a demonstrated, previous ability to speak. Two examples of speech therapy that will not be covered are: (a) therapy to correct pre-speech deficiencies; and (b) therapy to improve speech skills that have not fully developed.
- b. Speech therapy to develop or improve speech to correct a defect that both: (a) existed at birth; and (b) impaired or would have impaired the ability to speak.

Total Disability or Totally Disabled: Except as otherwise defined in this Booklet, a condition wherein an Employee, due to Illness or Accidental Injury: (a) cannot perform any duty of any occupation for which he or she is, or may be, suited by education, training and experience; and (b) is not, in fact, engaged in any occupation for wage or profit. A Dependent is Totally Disabled if he or she cannot engage in the normal activities of a person in good health and/or of like age and sex. The Covered Person who is Totally Disabled must be under the regular care of a Practitioner.

Urgent Care: Outpatient and Out-of-Hospital medical care which, as determined by Horizon BCBSNJ or an entity designated by Horizon BCBSNJ, is needed due to an unexpected Illness, Injury or other condition that is not life threatening, but that needs to be treated by a Provider within 24 hours.

Visit: An occasion during which treatment or consultation services are rendered in a Provider's office, in the Outpatient department of an eligible Facility, or by a Provider on the staff of (or under contract or arrangement with) a Home Health Agency to provide covered Home Health Care services or supplies.

Waiting Period: The period of time between enrollment in the Program and the date when a person becomes eligible for benefits.

We, Us and Our: Horizon BCBSNJ.

You, Your: An Employee .

SCHEDULE OF COVERED SERVICES AND SUPPLIES

POLICYHOLDER: MONTCLAIR BOARD OF EDUCATION

GROUP POLICY NO.: 087916

BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS PROGRAM ARE SUBJECT TO ANY AND ALL DEDUCTIBLE(S), COPAYMENT(S), COINSURANCE(S) AND MAXIMUM(S) STATED IN THIS SCHEDULE AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

NOTE: OUR BENEFITS WILL BE REDUCED FOR NON-COMPLIANCE WITH THE UTILIZATION REVIEW AND MANAGEMENT PROVISIONS OF THIS PROGRAM.

REFER TO THE "EXCLUSIONS" AND "SUMMARY OF COVERED SERVICES AND SUPPLIES" SECTIONS OF THIS BOOKLET TO SEE WHAT SERVICES AND SUPPLIES ARE NOT COVERED.

Horizon BCBSNJ will provide the coverage described in this Schedule of Covered Services and Supplies. That coverage is subject to the terms, conditions, limitations and exclusions stated in this Booklet.

Services and supplies provided by an In-Network Provider, are covered at the In-Network level. Services and supplies provided by an Out-of-Network Provider, are covered at the Out-of-Network level. However, this does not apply to services and supplies provided by an Out-of-Network Provider in a case where: (a) the Covered Person is an Inpatient in a Hospital; (b) the admitting physician was a Network Practitioner; and (c) the Covered Person and/or the Covered Person's Practitioner complied with this Program's rules with respect to Prior Authorization or notification. In this case, the Covered Services and Supplies provided by Out-of-Network Providers during the Inpatient stay will be covered at the In-Network level.

Please note that you may be responsible for paying charges which exceed our Allowance, when services are rendered by an Out-of-Network Provider.

The laws of the State of New Jersey, at N.J.S.A. 45:9-22.4 et seq. mandate that a physician, chiropractor or podiatrist inform his/her patients of any significant financial interest he/she may have in a Provider when making a referral to that Provider. If you want more information about this, contact your physician, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 or (800) 242-5846.

Different In-Network Providers have agreed to be paid in different ways. Your Provider may be paid: (a) each time he/she treats you (fee-for-service); or (b) a set fee each month for each Covered Person that the Provider treats, whether or not the Covered Person actually receives services (capitation). These payment methods may also include financial incentive agreements whereby some Providers are paid more (bonuses) or less (withholds), based on many factors. Some of these factors are: member satisfaction; quality of care; control of costs; and use of

services. If you want more information about how our Providers in our Network are paid, please call us at 1-800-355-2583 or write Horizon BCBSNJ, 3 Penn Plaza East, Newark, NJ 07105.

Coinsurance 100% of Covered Basic Charges.
In-Network 80% of Covered Supplemental Charges.

Coinsurance 70% of Covered Basic Charges.
Out-of-Network 80% of Covered Supplemental Charges.

Coinsured Charge Limit \$2,000/Covered Person.
\$4,000 individually met by two covered Family members

Applies to Out-of-Network and Supplemental Services.

Note: The Coinsured Charge Limit cannot be met with:

- Non-Covered Charges
- Deductibles
- Copayments

Out-of-Pocket Maximum After \$5,000/Covered Person.
Applies to In- \$10,000/Family.
Network Services. We provide 100% of Covered Allowance.

Note: The Out-of-Pocket Maximum cannot be met with:

- Non-Covered Charges

Deductible

Out-of-Network \$250 /Covered Person
two/Family
Deductible does not apply to Preventive Care.

Applies to Basic/Supplemental Services.

Common Accident Deductible - If two or more Covered Persons in the same family are injured in the same accident, only one Deductible will be applied in a Benefit Period to the Covered Services and Supplies due to the accident.

Fourth Quarter Deductible Carry-over - Covered Services and Supplies Incurred within the last three months of a Benefit Period which were applied against the Deductible may be carried over and applied against the Deductible for the following Benefit Period.

BENEFIT PERIOD MAXIMUM

In-Network and Unlimited. Applies to all Covered Services and Supplies.
Out-of-Network

PER LIFETIME MAXIMUM

In-Network and Out-of-Network **Unlimited.** Applies to all Covered Services and Supplies.

A. COVERED BASIC SERVICES AND SUPPLIES

ALCOHOLISM

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

ALLERGY TESTING AND TREATMENT

In-Network Subject to **\$20.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

AMBULATORY SURGICAL CENTER

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

ANESTHESIA

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

AUDIOLOGY SERVICES

In-Network Subject to **\$20.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

DENTAL CARE AND TREATMENT

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

DIAGNOSTIC X-RAY AND LAB

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

DIALYSIS CENTER CHARGES

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

EMERGENCY ROOM

**In-Network and
Out-of-Network** Subject to **\$35.00** Copayment and **100%** Coinsurance.

FACILITY CHARGES 365 days Inpatient Hospital Care.

**In-Network
Inpatient** Subject to Prior Authorization, **100%** Coinsurance.

**In-Network
Outpatient** Subject to **100%** Coinsurance.

**Out-of-Network
Inpatient** Subject to Prior Authorization, and Deductible, and **70%** Coinsurance.

**Out-of-Network
Outpatient** Subject to Deductible, and **70%** Coinsurance.

FERTILITY SERVICES

In-Network Subject to Prior Authorization, **\$20.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Prior Authorization, Deductible, and **70%** Coinsurance.

HEALTH WELLNESS

a. COLORECTAL CANCER SCREENING

In-Network Subject to **\$20.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to **70%** Coinsurance.

b. GYNECOLOGICAL EXAMINATIONS

In-Network Subject to **\$20.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to **70%** Coinsurance.

Limited to one exam per Benefit Period, combined In-Network and Out-of-Network.

c. MAMMOGRAPHY

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to **70%** Coinsurance.

d. PAP SMEARS

In-Network Subject to **\$20.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to **70%** Coinsurance.

Limited to one exam per Benefit Period, combined In-Network and Out-of-Network.

e. ROUTINE PROSTATE CANCER SCREENING

In-Network Subject to **\$20.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to **70%** Coinsurance.

f. ROUTINE ADULT PHYSICALS

In-Network Subject to **\$20.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to **70%** Coinsurance.\

g. WELL-CHILD IMMUNIZATIONS, LEAD POISONING SCREENING AND TREATMENT, NEWBORN HEARING SCREENING AND MONITORING

In-Network Subject to **\$20.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to **70%** Coinsurance.

h. WELL-CHILD CARE

In-Network Subject to **\$20.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to **70%** Coinsurance.

Subject to \$300 Benefit Period maximum.

HEARING AIDS AND RELATED SERVICES (Not applicable to hearing screening and monitoring for newborns, covered elsewhere.)

In-Network For Child Dependents 15 years of age or younger:

For the purchase of a hearing aid, benefits subject to **100%** Coinsurance, up to a maximum benefit combined In-Network and Out-of-Network of **\$1,000** per hearing aid, for each hearing-impaired ear, during any period of 24 consecutive months.

For other covered related services, benefits payable the same as for an office Visit to a PCP/Practitioner who is a doctor specializing in: family practice; general practice; internal medicine; pediatrics.

For Other Covered Persons:

No benefit.

Out-of-Network

For Child Dependents 15 years of age or younger:

For the purchase of a hearing aid, benefits subject to Deductible and **70%** Coinsurance, up to a maximum benefit combined In-Network and Out-of-Network of **\$1,000** per hearing aid, for each hearing-impaired ear, during any period of 24 consecutive months.

For other covered related services, benefits subject to Deductible, then payable the same as for an office Visit to a PCP/Practitioner who is a doctor specializing in: family practice; general practice; internal medicine; pediatrics.

For Other Covered Persons:

No benefit.

HOME HEALTH CARE

In-Network

Subject to Prior Authorization and **100%** Coinsurance.

Out-of-Network

Subject to Prior Authorization, Deductible, and **70%** Coinsurance.

Combined In-Network and Out-of-Network benefits subject to a **90** Visit maximum and a **\$4500** maximum per Benefit Period.

HOSPICE CARE

In-Network

Subject to Prior Authorization and **100%** Coinsurance.

Out-of-Network

Subject to Prior Authorization, Deductible, and **70%** Coinsurance.

INPATIENT PHYSICIAN SERVICES

In-Network

Subject to **100%** Coinsurance.

Out-of-Network

Subject to Deductible, and **70%** Coinsurance.

MATERNITY/OBSTETRICAL CARE

In-Network

Professional Office Care Subject to **\$20.00** Copayment for the initial visit and **100%** Coinsurance.

Facility and Professional Outpatient Care Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

MENTAL OR NERVOUS DISORDERS

In-Network Inpatient Subject to Prior Authorization, and **100%** Coinsurance.

Out-of-Network Inpatient Subject to Prior Authorization, Deductible, and **70%** Coinsurance.

In-Network Outpatient and Out-of-Hospital Subject to **\$20.00 Copayment and 100%** Coinsurance.

Out-of-Network Outpatient and Out-of-Hospital Subject to Deductible, and **70%** Coinsurance.

PHYSICAL REHABILITATION CENTER

In-Network Inpatient Subject to Prior Authorization, and **100%** Coinsurance.

Out-of-Network Inpatient Subject to Prior Authorization, Deductible, and **70%** Coinsurance.

PRACTITIONER'S CHARGES FOR NON-SURGICAL CARE AND TREATMENT

In-Network Subject to **\$20.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

PRACTITIONER'S CHARGES FOR SURGERY

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

PRE-ADMISSION TESTING

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

PROSTHETIC OR ORTHOTIC DEVICES

In-Network and Out-of-Network Benefits payable are the same as for an office Visit to a Provider who is a doctor specializing in: family practice, general practice, internal medicine, or pediatrics.

SECOND OPINION CHARGES

In-Network Subject to **\$20.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

SKILLED NURSING FACILITY CHARGES

In-Network Subject to Prior Authorization and **100%** Coinsurance.

Out-of-Network Subject to Prior Authorization, Deductible, and **70%** Coinsurance.

Subject to **120 day** Benefit Period maximum.

SURGICAL SERVICES

In-Network

Inpatient Subject to Prior Authorization, and **100%** Coinsurance.

Out-of-Network

Inpatient Subject to Prior Authorization, Deductible, and **70%** Coinsurance.

In-Network

Outpatient Subject to Prior Authorization, **100%** Coinsurance.

Out-of-Network

Outpatient Subject to Prior Authorization, Deductible and **70%** Coinsurance.

THERAPEUTIC MANIPULATIONS

In-Network Subject to **\$20.00** Copayment, and **100%** Coinsurance.

The Program does not cover more than **30** Visits, combined In-Network and Out-of-Network per Benefit Period.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

The Program does not cover more than **30** Visits, combined In-Network and Out-of-Network per Benefit Period.

THERAPY SERVICES

a. CHELATION THERAPY

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

b. CHEMOTHERAPY

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

c. COGNITIVE REHABILITATION THERAPY

In-Network Subject to **\$20.00** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

Combined In-Network and Out-of-Network benefits subject to a **30** Visit maximum per Benefit Period.

d. DIALYSIS TREATMENT

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

e. INFUSION THERAPY

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

f. OCCUPATIONAL THERAPY

In-Network Subject to **\$20.00** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

Combined In-Network and Out-of-Network benefits subject to a **30** Visit maximum per Benefit Period.

g. PHYSICAL THERAPY

In-Network Subject to **\$20.00** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

Combined In-Network and Out-of-Network benefits subject to a **30** Visit maximum per Benefit Period.

Limited to no more than **three** modalities per Visit.

h. RADIATION TREATMENT

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

i. RESPIRATION THERAPY

In-Network Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

j. SPEECH THERAPY

In-Network Subject to **\$20.00** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **70%** Coinsurance.

Combined In-Network and Out-of-Network benefits subject to a **30** Visit maximum per Benefit Period.

TRANSPLANT BENEFITS

In-Network Subject to Prior Authorization, and **100%** Coinsurance.

Out-of-Network Subject to Prior Authorization, Deductible, and **70%** Coinsurance.

WILM'S TUMOR

In-Network Subject to Prior Authorization, and **100%** Coinsurance.

Out-of-Network Subject to Prior Authorization, Deductible, and **70%** Coinsurance.

B. COVERED SUPPLEMENTAL SERVICES AND SUPPLIES

AMBULANCE SERVICES

In-Network Subject to Deductible, and **80%** Coinsurance.

Out-of-Network Subject to Deductible, and **80%** Coinsurance.

BLOOD

In-Network Subject to Deductible, and **80%** Coinsurance.

Out-of-Network Subject to Deductible, and **80%** Coinsurance.

DIABETES BENEFITS

In-Network Subject to Deductible, and **80%** Coinsurance.

Out-of-Network Subject to Deductible, and **80%** Coinsurance.

DURABLE MEDICAL EQUIPMENT

In-Network Subject to Deductible, and **80%** Coinsurance.

Out-of-Network Subject to Deductible, and **80%** Coinsurance.

HOME INFUSION THERAPY

In-Network Subject to Prior Authorization, Deductible, and **80%** Coinsurance.

Out-of-Network Subject to Prior Authorization, Deductible, and **80%** Coinsurance.

INHERITED METABOLIC DISEASE

In-Network Subject to Deductible, and **80%** Coinsurance.

Out-of-Network Subject to Deductible, and **80%** Coinsurance

OXYGEN AND ADMINISTRATION

In-Network Subject to Deductible, and **80%** Coinsurance.

Out-of-Network Subject to Deductible, and **80%** Coinsurance.

PRESCRIPTION DRUGS

In-Network Subject to Deductible, and **80%** Coinsurance.

Out-of-Network Subject to Deductible, and **80%** Coinsurance.

PRIVATE DUTY NURSING

In-Network Subject to Prior Authorization, Deductible, and **80%** Coinsurance.

This Program covers **240** hours per Benefit Period of home Private

Duty Nursing Care for outpatient care only.

Out-of-Network Subject to Prior Authorization, Deductible, and **80%** Coinsurance.

This Program covers **240** hours per Benefit Period of home Private Duty Nursing Care for outpatient care only.

SPECIALIZED NON-STANDARD INFANT FORMULAS

In-Network Subject to Deductible, and **80%** Coinsurance.

Out-of-Network Subject to Deductible, and **80%** Coinsurance.

WIGS

Out-of-Network Subject to Deductible, and **80%** Coinsurance.

Benefits subject to a **\$500.00** maximum per Benefit Period.

GENERAL INFORMATION

How To Enroll

If you meet your Employer's and Horizon BCBSNJ's eligibility rules, including any Waiting Period established by the Employer, you may enroll by completing an enrollment card. If you enroll your eligible Dependents at the same time, their coverage will become effective on the same date as your own. Except as otherwise provided below, if you or an eligible Dependent is not enrolled within 31 days after becoming eligible for the coverage under this Program, that person is deemed a Late Enrollee.

Your Identification (ID) Card

You will receive an ID card to show to the Hospital, physician or other Provider when you receive services or supplies. Your ID card shows: (a) the group through which you are enrolled; (b) your type of coverage; and (c) your ID number. All of your covered Dependents share your identification number as well.

Always carry this card and use your ID number when you or a Dependent receive Covered Services or Supplies. If you lose your card, you can still use your coverage if you know your ID number. The inside back cover of this Booklet has space to record your ID number, along with other information you will need when asking about your benefits. You should, however, contact your benefits representative quickly to replace the lost card.

You cannot let anyone other than you or a Dependent use your card or your coverage.

Types Of Coverage Available

You may enroll under one of the following types of coverage:

- **Single** – provides coverage for you only.
- **Family** – provides coverage for you, your Spouse or Domestic Partner and your Child Dependents.
- **Parent and Child(ren)** – provides coverage for you and your Child Dependents, but not your Spouse or Domestic Partner.

Dual Coverage

If you and your Spouse are both: (a) Employees of the Employer; and (b) eligible for coverage under this Policy, each can cover the other as a Dependent and enroll for Husband and Wife Coverage. If you and your Spouse also have Child Dependents who are eligible for coverage under this Policy, each of you can cover the other as a Dependent and enroll for Family Coverage under this Policy.

Change In Type Of Coverage

If you want to change your type of coverage, see your benefits representative. If you marry, you should arrange for enrollment changes within 31 days before or after your marriage.

If: (a) you gain or lose a member of your family; or (b) someone covered under this Program changes family status, you should check this Booklet to see if coverage should be changed. This can happen in many ways, e.g., due to the birth or adoption of a child, divorce, or death of a Spouse.

For example:

- If you are already enrolled, your newborn infant or adopted child is automatically included. However, if you are enrolled for Family or Parent and Child(ren) coverage, you must still submit an enrollment form to notify us of the addition. If you are enrolled for Single coverage, you must enroll your child and pay any required additional premium within 31 days in order to continue the child's coverage beyond that period.
- If you have Single coverage and marry, or acquire a Domestic Partner, your new Spouse or Domestic Partner will be covered from the date you marry or meet the rules for covering Domestic Partners if you apply for or Family coverage within 31 days.

Except as provided below, anyone who does not enroll within a required time will be considered a Late Enrollee. Late Enrollees may enroll only during the next open-enrollment month. Coverage will be effective on the first day of the month next following the open-enrollment month.

Enrollment of Dependents

Horizon BCBSNJ cannot deny coverage for your Child Dependent on the grounds that:

- The Child Dependent was born out of wedlock;
- The Child Dependent is not claimed as a dependent on your federal tax return; or
- The Child Dependent does not reside with you or in the Service Area.

If you are the non-custodial parent of a Child Dependent, Horizon BCBSNJ will:

- Provide such information to the custodial parent as may be needed for the Child Dependent to obtain benefits through this Program;
- Permit the custodial parent, or the Provider, with the authorization of the custodial parent, to submit claims for the Child Dependent for Covered Services and Supplies, without your approval; and

- Make payments on such claims directly to: (a) the custodial parent; (b) the Provider; or (c) the Division of Medical Assistance and Health Services in the Department of Human Services, which administers Medicaid, as appropriate.

If you are a parent who is required by a court or administrative order to provide health coverage for your Child Dependent, Horizon BCBSNJ will:

- Permit you to enroll your Child Dependent, without any enrollment restrictions;
- Permit: (a) the Child Dependent's other parent; (b) the Division of Medical Assistance and Health Services; or (c) the Division of Family Development as the State IV-D agency, in the Department of Human Services, to enroll the Child Dependent in this Program, if the parent who is the Covered Person fails to enroll the Child Dependent; and
- Not terminate coverage of the Child Dependent unless the parent who is the Covered Person provides Horizon BCBSNJ with satisfactory written proof that:
 - the court or administrative order is no longer in effect: or
 - the Child Dependent is or will be enrolled in a comparable health benefits plan which will be effective on the date coverage under this Program ends.

Special Enrollment Periods

Persons who enroll during a Special Enrollment Period described below are not considered Late Enrollees.

Individual Losing Other Coverage

If you and/or an eligible Dependent, are eligible for coverage, but not enrolled, you and/or your Dependent must be allowed to enroll if each of the following conditions is met:

- a. The person was covered under a group or other health plan at the time coverage under this Program was previously offered.
- b. You stated in writing that coverage under the other plan was the reason for declining enrollment when it was offered.
- c. The other health coverage:
 - (i) was under a COBRA (or other state mandated) continuation provision and the COBRA or other coverage is exhausted; or
 - (ii) was not under such a provision and either: (a) coverage was terminated as a result of: loss of eligibility for the coverage (including as a result of legal separation; divorce; death; termination of employment; or reduction in the number of hours of employment); or (b) employer contributions toward such coverage ended.

- d. Enrollment is requested within 31 days after: (a) the date of exhaustion of the coverage described in item (c)(i) above; or (b) termination of the coverage or employer contributions as described in item (c)(ii) above.

In this case, coverage under this Program will be effective as of the date that the prior health coverage ended.

New Dependents

If the following conditions are met, Horizon BCBSNJ will provide a Dependent Special Enrollment Period during which the Dependent (or, if not otherwise enrolled, you) may enroll or be enrolled:

- a. You are covered under the Program (or have met any Waiting Period and are eligible to enroll but for a failure to enroll during a previous enrollment period).
- b. The person becomes your dependent through marriage, birth, or adoption (or placement for adoption).

The Dependent Special Enrollment Period is a period of no less than 31 days starting on the later of: (a) the date dependent coverage is made available pursuant to this section; or (b) the date of the marriage, birth, or adoption/placement.

Special Enrollment Due to Marriage

You may enroll a new Spouse under this Program. If you are eligible, but previously declined coverage, you are also eligible to enroll at the same time that your Spouse is enrolled.

You must request enrollment of your Spouse within 31 days after the marriage.

The coverage becomes effective not later than the first day of the month next following the date of the completed request.

Special Enrollment Due to Newborn/Adopted Children

You may enroll a newly born or newly adopted Child Dependent. Horizon BCBSNJ will cover your newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31-day period as stated below:

- (a) If you are already covered for dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for the coverage is still paid.
- (b) If you are not covered for dependent child coverage on the date the child is born, you must:
 - make written request to enroll the child; and

- pay the premium for the coverage within 31 days after the date of birth.

If you do not make the request and the premium is not paid within such 31-day period, the newborn child will be a Late Enrollee.

Multiple Employment

If you work for both the Policyholder and an Affiliated Company, or for more than one Affiliated Company, Horizon BCBSNJ will treat you as if employed only by one Employer. You will not have multiple coverage.

Eligible Dependents

Your eligible Dependents are your Spouse or Domestic Partner and your Child Dependents.

To enroll a Domestic Partner, you must provide proof that a Domestic Partnership exists by providing the Policyholder and Horizon BCBSNJ with an acceptable proof of the Domestic Partnership.

Your Child Dependent is a person who: has not attained the age of **23**; is unmarried; and is:

- The natural born child or stepchild of you and/or your Spouse or Domestic Partner, regardless of where or with whom the child lives;
- A child who is: (a) legally adopted by you and/or your Spouse or Domestic Partner, regardless of where or with whom such child lives; or (b) placed with you for adoption. But, proof of such adoption or placement satisfactory to Horizon BCBSNJ in its sole discretion must be furnished to us when we ask;
- You, your Spouse's or Domestic Partner's legal ward who: (a) resides with you in a regular parent-child relationship; and (b) is chiefly dependent on you for support and maintenance. But, proof of guardianship satisfactory to Horizon BCBSNJ in its sole discretion must be furnished to us when we ask.

Coverage for your Spouse will end: (a) on the date of your Spouse's death; (b) at the end of the Benefit Month in which you divorce; or (c) at the end of the Benefit Month in which you tell us to delete your Spouse from coverage following marital separation.

Coverage for a Domestic Partner will end when the Domestic Partnership ends.

Coverage for a Child Dependent ends at the first to occur of the following: (a) the last day of the Benefit Month in which the Child Dependent marries; (b) the last day of the Calendar Year in which the Child Dependent reaches age **23**; or (c) the date on which the Child Dependent becomes employed and eligible for health coverage due to that employment.

Coverage will continue for a Child Dependent beyond the age of **23** if, immediately prior to reaching that age, he/she was enrolled under this Program and is incapable of self-sustaining employment by reason of mental retardation or physical handicap. For your handicapped Child

Dependent to remain covered, you must submit proof of his/her inability to engage in self-sustaining employment by reason of mental retardation or physical handicap within 31 days of the child's attainment of age 23. The proof must be in a form that meets our approval. Such proof must be resubmitted every two years within 31 days before or after the Child Dependent's birth date.

Coverage for a handicapped Child Dependent will end on the last day of the Benefit Month in which the first of these occurs: (a) the end of your coverage; (b) the failure of your Child Dependent to meet the definition of Child Dependent for any reason other than age; or (c) the end of your Child Dependent's inability to engage in self-sustaining employment by reason of mental retardation or physical handicap.

If your child was enrolled as a handicapped Child Dependent under prior coverage with Horizon BCBSNJ and there has been no interruption in coverage, the child may be covered as a Child Dependent under this Program, regardless of age.

When Coverage Ends

Your coverage under this Program ends when the first of these occurs:

- The end of the Benefit Month in which you cease to be eligible due to termination of your employment or any other reason.
- The date on which the Group Policy ends for the class of which you are a member.
- You fail to make, when due, any required contribution for the coverage.

Coverage for a Dependent ends:

- When your coverage ends.
- When coverage for Dependents under this Program ends.
- When you fail to make, when due, any required contribution for the Dependent coverage.
- As otherwise described under "Eligible Dependents" , above.

In addition to the above reasons for the termination of coverage under the Program, an act or omission by a Covered Person which, as determined by Horizon BCBSNJ shows intent to defraud Horizon BCBSNJ (such as: (a) the intentional and/or repeated misuse of Horizon BCBSNJ's services; or (b) the omission or misrepresentation of a material fact on a Covered Person's application for enrollment, health statement or similar document) will result in the immediate cessation of the Covered Person's coverage under this Program. Such an act includes, but is not limited to:

- The submission of any claim and/or statement with materially false information.
- Any information which conceals for the purpose of misleading.

- Any act which could constitute a fraudulent insurance act.

Any termination for fraud will be retroactive to the Coverage Date. Horizon BCBSNJ retains the right to recoup from any involved person all payments made and/or benefits paid on his/her behalf.

Also, coverage under this Program will end for any Covered Person who misuses an ID card issued by Horizon BCBSNJ.

Benefits After Termination

If you or a Dependent are confined as an Inpatient in a Facility on the date coverage ends, the Program's benefits will be paid, subject to the Program's terms, for Covered Services and Supplies furnished during the uninterrupted continuation of that stay.

If You Leave Your Group Due To Total Disability

If you lose your job or become ineligible due to Total Disability, you can arrange to continue the Program's coverage for you and your covered Dependents, if any, if:

- You were continuously enrolled under the Program for the three months immediately prior to the date your employment or eligibility ended;
- You notify your Employer in writing that you want to continue your coverage (within 31 days of the date your coverage would otherwise end);
- You make any required contribution toward the group rate for the continued coverage.

The continued coverage under this Program for you and your covered Dependents, if any, will end at the first of these to occur:

- Failure by you to make timely payment of any contribution required by your Employer. If this happens, coverage stops at the end of the period for which contributions were made.
- The date you become employed and eligible for benefits under another group health plan; or, in the case of a Dependent, the date the Dependent becomes employed and eligible for such benefits.
- The date this Program ends for the class of which you were a member.
- In the case of a Dependent, the date that he/she ceases to be an eligible Dependent.

Coverage under this Program is also available to you (and any eligible Dependents), subject to the above requirements, if you are a Totally Disabled former Employee whose group health coverage for you and those Dependents under your Employer's plan provided by another carrier was continued without interruption pursuant to state law.

Extension Of Coverage Due To Termination of the Group Policy

This applies if you or a covered Dependent are Totally Disabled on the date coverage under this Program ends due to termination of the Group Policy. In this event, benefits will continue to be available for that person for Covered Services and Supplies needed due to the Illness or Injury that caused the disability. Benefits will continue to be paid during the uninterrupted period of the disability, but not for more than 12 months from the date the coverage ends.

Continued Coverage Under The Federal Family And Medical Leave Act

If you take a leave that qualifies under the Federal Family and Medical Leave Act (FMLA) (e. g., to care for a sick family member, or after the birth or adoption of a Child Dependent), you may continue coverage under this Program. You may also continue coverage for your Dependents.

You will be subject to the same Program rules as an Active Employee. But, your legal right to have your Employer pay its share of the required premium, as it does for Active Employees, is subject to your eventual return to Active work.

Coverage that continues under this law ends at the first to occur of the following:

- The date you again become Active.
- The end of a total leave period of 12 weeks in any 12 month period.
- The date coverage for you or a Dependent would have ended had you not been on leave.
- Your failure to make any required contribution.

Consult your benefits representative for application forms and further details.

Continued Coverage For Surviving Dependents

Covered Dependents of a deceased Employee may have coverage continued under this Program until the first to occur of the following:

- The date which is 180 days after the Employee's death.
- The date the Dependent fails to make any required contribution for the continued coverage.
- The date on which the Dependent is no longer an eligible Dependent.
- The date the Program's coverage for the deceased Employee's class ends.

Consult your benefits representative for further details.

Continuation of Coverage under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you and your enrolled Dependents, and any newborn or newly adopted

child may have the opportunity to continue group health care coverage which would otherwise end, if any of these events occur:

- Your death;
- Your work hours are reduced;
- Your employment ends for a reason other than gross misconduct.*

Each of your enrolled Dependents has the right to continue coverage if it would otherwise end due to any of these events:

- Your death;
- Your work hours are reduced;
- Your employment ends for reasons other than gross misconduct;*
- You became entitled to Medicare benefits;
- In the case of your Spouse, the Spouse ceased to be eligible due to divorce or legal separation; or
- In the case of a Child Dependent, he/she ceased to be a Child Dependent under this Program's rules.

* (See "If You Leave Your Group Due To Total Disability" above for your continuation rights if your employment ends due to total disability.)

You or your Dependent must notify your benefits representative of a divorce or legal separation, or when a child no longer qualifies as a Child Dependent. This notice must be given within 60 days of the date the event occurred. If notice is not given within this time, the Dependent will not be allowed to continue coverage.

You will receive a written election notice of the right to continue the insurance. In general, this notice must be returned within 60 days of the later of: (a) the date the coverage would otherwise have ended; or (b) the date of the notice. You or the other person asking for coverage must pay the required amount to maintain it. The first payment must be made by the 45th day after the date the election notice is completed.

If you and/or your Dependents elect to continue coverage, it will be identical to the health care coverage for other members of your class. It will continue as follows:

- Up to 18 months in the event of the end of your employment or a reduction in your hours. Further, if you or a covered Dependent are determined to be disabled, according to the Social Security Act, at the time you became eligible for COBRA coverage, or during the first 60 days of the continued coverage, that person and any other person then entitled to the continued coverage may elect to extend this 18-month period for up to an extra 11

months. To elect this extra 11 months, the person must give the Employer written proof of Social Security's determination before the first to occur of: (a) the end of the 18 month continuation period; or (b) 60 days after the date the person is determined to be disabled.

- Up to 36 months for your Dependent(s) in the event of: your death; your divorce or legal separation; your entitlement to Medicare; or your child ceasing to qualify as a Child Dependent.

Continuation coverage for a person will cease before the end of a maximum period just described if one of these events occurs:

- This Program ends for the class you belong to.
- The person fails to make required payments for the coverage.
- The person becomes covered under any other group health plan. But, coverage will not end due to this rule until the end of any period for which pre-existing conditions are excluded, or benefits for them are limited, under the other plan.
- The person becomes entitled to Medicare benefits.

If: a person's COBRA coverage was extended past 18 months due to total disability; and there is a final determination (under the Social Security Act) that the person, before the end of the additional continuation period of 11 months, is no longer disabled, the coverage will end on the first of the month that starts more than 30 days after that determination.

The above is a general description of COBRA's requirements. If coverage for you or a Dependent ends for any reason, you should immediately contact your benefits representative to find out if coverage can be continued. Your Employer is responsible for providing all notices required under COBRA.

If you get divorced, your former Spouse may also have the option to transfer to direct payment coverage at the end of this extended period of coverage. See the "Conversion Coverage" section below.

Continuation of Coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If the Employee is absent from work due to performing service in the uniformed services, this federal law gives the Employee the right to elect to continue the health coverage under this Policy (for himself/herself and the Employee's Dependents, if any). If the Employee so elects, the coverage can be continued, subject to the payment of any required contributions, until the first to occur of the following:

- The end of the 24-month period starting on the date the Employee was first absent from work due to the service.
- The date on which the Employee fails to return to work after completing service in the

uniformed services, or fails to apply for reemployment after completing service in the uniformed services.

- The date on which this Policy ends.

If the Employee elects to continue the coverage, the Employee's contributions for it are determined as follows:

- a) If the Employee's service in the uniformed services is less than 31 days, his/her contribution for the coverage will be the same as if there were no absence from work.
- b) If the service extends for 31 or more days, the Employee's contribution for the coverage can be up to 102% of the full premium for it.

For the purposes of this provision, the terms "uniformed services" and "service in the uniformed services" have the following meanings:

Uniformed services: The following:

1. The Armed Services.
2. The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty.
3. The commissioned corps of the Public Health Service.
4. Any other category of persons designated by the President in time of war or national emergency.

Service in the uniformed services: The performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority. This includes:

1. Active duty.
2. Active and inactive duty for training.
3. National Guard duty under federal statute.
4. A period for which a person is absent from employment: (a) for an exam to determine the fitness of the person to perform any such duty; or (b) to perform funeral honors duty authorized by law.
5. Service as: (a) an intermittent disaster-response appointee upon activation of the National Disaster Medical System (NDMS); or (b) a participant in an authorized training program in support of the mission of the NDMS.

Continued Coverage for Over-Age Dependents

Under this provision, an Employee's Over-Age Dependent has the opportunity to elect continued coverage under this Policy after his/her group health coverage ends due to attainment of a specific age.

For the purposes of this provision, an "Over-Age Dependent" is an Employee's child by blood or law who:

- is 30 years of age or younger;
- is not married, or in a Civil Union or Domestic Partnership;
- has no dependents of his/her own;
- is either a New Jersey resident or enrolled as a full-time student at an accredited school;
- is not covered under any other group or individual health benefits plan; group health plan; church plan; or health benefits plan; and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

If a Dependent Is Over the Limiting Age for Dependent Coverage

If a Child Dependent is over the limiting age for dependent coverage under this Policy, and:

- (a) the Dependent's group health benefits are ending or have ended due to his/her attainment of that age; or
- (b) the Dependent has proof of prior Creditable Coverage or receipt of benefits,

he/she may elect to be covered under this Policy until his/her 31st birthday, subject to the following subsections.

Conditions for Election

An Over-Age Dependent is only entitled to make an election for continued coverage pursuant to this provision if both of these conditions are met.

- The Over-Age Dependent must provide evidence of prior Creditable Coverage or receipt of benefits under: a group or individual health benefits plan; group health plan; church plan; health benefits plan; or Medicare. Such prior coverage must have been in effect at some time prior to making an election for this Over-Age Dependent coverage.
- Unless a parent of an Over-Age Dependent has no other Dependents eligible for coverage under this Policy, or has a Spouse or Civil Union or Domestic Partner who is covered elsewhere, the parent must be enrolled for Dependents coverage under this Policy at the time the Over-Age Dependent elects continued coverage.

Election of Continuation

To continue group health benefits, the Over-Age Dependent must make written election to Horizon BCBSNJ. If this is done, the effective date of the continued coverage will be the latest of these dates:

- The date the Over-Age Dependent gives written notice to Horizon BCBSNJ.
- The date the Over-Age Dependent pays the first premium for it.
- The date the Over-Age Dependent would otherwise lose coverage due to attainment of the limiting age.

For a Dependent whose coverage has not yet terminated due to attainment of the limiting age, the written election must be made within 30 days prior to termination of the coverage due to that attainment if the child seeks to maintain continuous coverage. The written election may be made later, but if this is done, there will be a lapse in coverage.

For a Dependent who was not covered on the date he/she reached the limiting age, the written election may be made at any time.

For a person who did not qualify as an Over-Age Dependent due to failure to meet the requirements to be an Over-Age Dependent, but who later meets all of those requirements, the written election may be made at any time after the requirements are met.

Payment of Premiums

Horizon BCBSNJ will set the premiums for the continued coverage, in a manner that is consistent with the requirements of applicable New Jersey law.

The first month's premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

Subsequent premiums must be paid monthly, in advance, and will be remitted by the Policyholder.

Grace Period for the Payment of Premiums

An Over-Age Dependent's premium payment is timely as follows:

- With respect to the first due payment, if it is made within 30 days after the election for continued coverage;
- With respect to later payments, if they are made within 30 days of the date they become due.

Scope of Continued Coverage

The continued coverage will be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an Employee under this Policy and will be evidenced by a separate

Booklet and ID card being issued to the Over-Age Dependent. Subject to the following subsection, if this Policy's coverage for other dependents who are Covered Persons is modified, the coverage for Over-Age Dependents will be modified in like manner. Evidence of insurability is not required for the continued coverage.

Single Coverage for Over-Age Dependents

The continued coverage for an Over-Age Dependent is single coverage. Any Deductible, Coinsurance and/or Copayment required of and payable by an Over-Age Dependent during a period of continued coverage pursuant to this provision is independent of any Deductible, Coinsurance and/or Copayment required of and payable by the other covered family members. Regardless of anything above to the contrary, any current or future provision of this Policy allowing for a family deductible limit, family out-of-pocket maximum or any other similar provision that aggregates the experience of a covered family does not apply to the continued coverage for the Over-Age Dependent.

When Continuation Ends

An Over-Age Dependent's continued coverage ends as of the first to occur of the following:

- The date on which the Over-Age Dependent fails to meet any one of the conditions to be an Over-Age Dependent.
- The end of a period during which a required premium payment for the continued coverage is not made when due, subject to the "Grace Period for the Payment of Premiums" subsection above.
- The date on which the Employee's coverage ends.
- The date on which this Policy coverage for Dependents is ended.
- The date on which the Employee waives this Policy's Dependents coverage. However, if the Employee has no other Dependents, the Over-Age Dependent's coverage under this Policy will not end due to that waiver.

Inapplicability of Other Continuation Provisions

Regardless of anything in this Policy to the contrary, for an Over-Age Dependent who has continued coverage pursuant to this provision, this provision supersedes any other continuation right(s) that would otherwise be available to him/her under this Policy. Such an Over-Age Dependent is not entitled to continuation under any such other provision either while this provision's continuation is in force or after it ends.

Continued Coverage Pursuant to Michelle's Law

This provision applies to a Child Dependent who was a Covered Person under the Policy on the basis of being a student at a postsecondary educational institution (e.g., a college, university or vocational school) immediately before the first day of a Medically Necessary Leave of Absence.

For the purpose of this provision, a Medically Necessary Leave of Absence is a leave of absence from the postsecondary educational institution, or any other change in the Child Dependent's enrollment in the institution, that:

- (a) starts while the Child Dependent is suffering from a serious Illness or Injury;
- (b) is medically necessary; and
- (c) causes the Child Dependent to lose student status for the purposes of the coverage under the Policy.

Pursuant to the federal "Michelle's Law" and regardless of anything in the Policy to the contrary, if the Child Dependent's physician certifies in writing to Horizon BCBSNJ that: (i) the Child Dependent is suffering from a serious Illness or Injury; and (ii) the leave of absence or other change in enrollment is medically necessary, then the Child Dependent's coverage under this Policy shall not end until the earlier of the following dates:

- (1) the date on which the Child Dependent's coverage under the Policy would otherwise end, e.g., due to the Child Dependent's attainment of a maximum age limit;
- 2) the date that is one year after the first day of the Medically Necessary Leave of Absence.

Conversion Coverage

If coverage under this Program for your Spouse ends due to divorce, the former Spouse may apply to Horizon BCBSNJ for individual non-group health care coverage. To do so, he/she must apply to Horizon BCBSNJ in writing no later than 31 days after the coverage under this Program ends.

The former Spouse does not need to prove he/she is in good health.

The coverage will be at least equal to the basic benefits under contracts then being issued by Horizon BCBSNJ to new non-group applicants of the same age and family status. This coverage is called "conversion coverage." The conversion coverage, if provided, may be different than the coverage provided by this Program. We will provide details of this conversion coverage upon request.

If Horizon BCBSNJ determines that the former Spouse is entitled to conversion coverage (according to the above rules), it will go into effect on the day after his/her coverage under this Program ends, if the application is furnished timely and the premium for the coverage is paid when due.

If the former Spouse is not located in New Jersey when he/she becomes eligible for this conversion coverage, we will provide information whereby the former Spouse can apply for any individual health coverage made available by the Blue Cross/Blue Shield plan in the area where the Spouse is located.

Continuation of Care

Horizon BCBSNJ will provide written notice to each Covered Person at least 30 business days prior to the termination or withdrawal from Horizon BCBSNJ's Network of a Covered Person's PCP or any other Provider currently treating the Covered Person, as reported to Horizon BCBSNJ. The 30 day prior notice may be waived in cases of immediate termination of a Provider based on: breach of contract by the Provider; a determination of fraud; or our medical director's opinion that the Provider is an imminent danger to the patient or the public health, safety or welfare.

Horizon BCBSNJ shall assure continued coverage of Covered Services and Supplies by a terminated Provider for up to four months in cases where it is Medically Necessary and Appropriate for the Covered Person to continue treatment with that Provider. In the case of pregnancy of a Covered Person: (a) the Medical Necessity and Appropriateness of continued coverage by that Provider shall be deemed to be shown; and (b) such coverage can continue to the postpartum evaluation of the Covered Person, up to six weeks after the delivery.

In the event that a Covered Person is receiving post-operative follow-up care, Horizon BCBSNJ shall continue to cover services rendered by the Provider for the duration of the treatment, up to six months. In the event that a Covered Person is receiving oncological or psychiatric treatment, Horizon BCBSNJ shall continue to cover services rendered by the Provider for the duration of the treatment, up to one year. If the services are provided in an acute care Facility, Horizon BCBSNJ will continue to cover them regardless of whether the Facility is under contract or agreement with Horizon BCBSNJ.

Covered Services and Supplies shall be covered to the same extent as when the Provider was employed by or under contract with Horizon BCBSNJ. Payment for Covered Services and Supplies shall be made based on the same methodology used to reimburse the Provider while the Provider was employed by or under contract with Horizon BCBSNJ.

Horizon BCBSNJ shall not allow continued services in cases where the Provider was terminated due to: (a) our Medical Director's opinion that the Provider is an imminent danger to a patient or to the public health, safety and welfare, (b) a determination of fraud; or (c) a breach of contract.

Medical Necessity And Appropriateness

We will make payment for benefits under this Program only when:

- Services are performed or prescribed by your attending physician;
- Services, in our judgment, are provided at the proper level of care (Inpatient; Outpatient; Out-of-Hospital; etc.);
- Services or supplies are Medically Necessary and Appropriate for the diagnosis and treatment of an Illness or Injury.

THE FACT THAT YOUR ATTENDING PHYSICIAN MAY PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE OR SUPPLY DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY AND APPROPRIATE FOR THE DIAGNOSIS

AND TREATMENT OF AN ILLNESS OR INJURY OR MAKE IT AN ELIGIBLE MEDICAL EXPENSE.

Cost Containment

If we determine that an eligible service can be provided in a medically acceptable, cost-effective alternative setting, we reserve the right to provide benefits for such a service when it is performed in that setting.

Managed Care Provisions

Member Services

The Member Services Representatives who staff Horizon BCBSNJ Member Services Departments are there to answer Covered Persons' questions about the Program and to assist in managing their care. To contact Member Services, a Covered Person should call the number on his/her Identification (ID) Card.

The Care Manager

In order to receive In-Network benefits, a Horizon BCBSNJ Care Manager must manage treatment for Mental or Nervous Disorders, Alcoholism and Substance Abuse. A Covered Person must contact the Care Manager when there is a need for these types of care. The phone number is shown on his/her ID card.

Miscellaneous Provisions

- a. This Program is intended to pay for Covered Services and Supplies as described in this booklet. Horizon BCBSNJ does not provide the services or supplies themselves, which may, or may not, be available.
- b. Horizon BCBSNJ is only required to provide its Allowance for Covered Services and Supplies, to the extent stated in the Group Policy. Horizon BCBSNJ has no other liability.
- c. Benefits are to be provided in the most cost-effective manner practicable. If Horizon BCBSNJ determines that a more cost-effective manner exists, Horizon BCBSNJ reserves the right to require that care be rendered in an alternate setting as a condition of providing payment for benefits.

YOUR HORIZON BCBSNJ PROGRAM

Your Horizon BCBSNJ PPO Program provides you with the freedom to choose any Provider; however, your choice of Providers will determine how your benefits are paid. Benefits provided by In-Network Providers will be paid at a higher benefit level than benefits provided for an Out-of-Network Provider. You will be responsible for any Deductible, Coinsurance and Copayments that apply; however, if you use In-Network Providers, you will not have to file claims. In-Network Providers will accept our payment as payment in full. Out-of-Network Providers may balance bill to charges, and you will generally need to file claims to receive benefits.

Your Program shares the cost of your health care expenses with you. This section explains what you pay, and how Deductibles, Coinsurance and Copayments work together.

Note: Coverage will be reduced if a Covered Person does not comply with the Utilization Review and Management and Prior Authorization requirements contained in this Program.

BENEFIT PROVISIONS

The Deductible

Each Benefit Period each Covered Person must have Covered Charges that exceed the Deductible before Horizon BCBSNJ provides coverage for that person. The Deductible is shown in the Schedule of Covered Services and Supplies. The Deductible cannot be met with Non-Covered Charges. Only Covered Charges Incurred by the Covered Person while covered by this Program can be used to meet this Deductible.

Once the Deductible is met, Horizon BCBSNJ provides benefits, up to its Allowance, for other Covered Charges above the Deductible Incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Benefit Period. But, all charges must be Incurred while that Covered Person is covered by this Program. Also, what coverage Horizon BCBSNJ provides is based on all the terms of this Program.

Family Deductible Limit

This Program has a family Deductible limit of **two** Deductibles for each Benefit Period. Once **two** Covered Persons in a family meet their individual Deductibles, in a Benefit Period, Horizon BCBSNJ provides benefits for other Covered Charges Incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Benefit Period.

Coinsured Charge Limit

This Program limits Coinsurance amounts each Benefit Period except as stated below. The Coinsured Charge Limit cannot be met with:

- a. Non-Covered Charges;
- b. Deductibles;
- c. Coinsurance paid by a Covered Person for the Outpatient treatment of Mental or Nervous Disorders and Substance Abuse and
- d. Copayments.

There are Coinsured Charge Limits for:

- a. each Covered Person; and
- b. each covered family.

The Coinsured Charge Limits are shown in the Schedule of Covered Services and Supplies.

Each Covered Person's Coinsurance amounts are used to meet his/her own Coinsured Charge Limit and are combined with Coinsurance amounts from other covered family members to meet the family's Coinsured Charge Limit. However, all amounts used to meet the Coinsured Charge Limit must actually be paid by a Covered Person out of his/her own pocket.

Once the Covered Person's Coinsurance amounts in a Benefit Period exceed the individual Coinsured Charge Limit, Horizon BCBSNJ will waive his/her Coinsurance for the rest of that Benefit Period.

Once two Covered Persons in a family meet their individual Coinsured Charge Limit, Horizon BCBSNJ will waive the family's Coinsurance for the rest of that Benefit Period.

Out-of-Pocket Maximum

Once a Covered Person Incurs, during a Benefit Period, an amount of Covered Charges for which no benefits are paid or payable under the Program equal to the Out-of-Pocket Maximum (see the Schedule of Covered Services and Supplies), Horizon BCBSNJ will waive any applicable Deductible, Copayment or Coinsurance with respect to Covered Charges Incurred by the Covered Person for the remainder of that Benefit Period.

An Out-of-Pocket Maximum cannot be met with Non-Covered Charges.

Payment Limits

Horizon BCBSNJ limits what it will pay for certain types of charges. We also limit what we will pay for all Illnesses and Injuries. See the Schedule of Covered Services and Supplies for these limits.

Benefits From Other Plans

The benefits Horizon BCBSNJ will provide may also be affected by benefits from

Medicare and other health benefit plans. Read The Effect of Medicare on Benefits and Coordination of Benefits and Services sections of this Booklet for an explanation of how this works.

If This Program Replaces Another Plan

The Policyholder that provides this Program may have purchased it to replace a prior plan of group health benefits.

The Covered Person may have Incurred charges for Covered Charges under that prior plan before it ended. If so, these Covered Charges will be used to meet this Program's Deductible if:

- a. they were Incurred during the Benefit Period in which this Program starts;
- b. this Program would have paid benefits for them, if this Program had been in effect;
- c. the Covered Person was covered by the prior plan when it ended and enrolled in this Program on its Effective Date; and
- d. this Program starts right after the prior plan ends.

SUMMARY OF COVERED SERVICES AND SUPPLIES

This section lists the types of services and supplies that Horizon BCBSNJ will consider as Covered Services or Supplies, up to its Allowance and subject to all the terms of this Program. These terms include, but are not limited to, Medical Necessity and Appropriateness, Utilization Review and Management features, the Schedule of Covered Services and Supplies, benefit limitations and exclusions.

A. COVERED BASIC SERVICES AND SUPPLIES

Alcoholism

This Program covers the treatment of Alcoholism the same way it would any other Illness, if the treatment is prescribed by a Practitioner.

Inpatient or Outpatient treatment may be furnished as follows:

- a. Care in a health care Facility licensed pursuant to P.L. 1971, c. 136 (N.J.S.A. 26:2H-1 et seq.);
- b. At a Detoxification Facility; or
- c. As an Inpatient or Outpatient at a licensed, certified or State approved residential treatment Facility, under a program which meets minimum standards of care equivalent to those prescribed by the Joint Commission.

Treatment or a stay at any Facility shall not prevent further or additional treatment at any other eligible Facility, if the Benefit Days used do not exceed the total number of Benefit Days provided for any other Illness under the Program.

Allergy Testing and Treatment

This Program covers allergy testing and treatment, including routine allergy injections and immunizations, but not if solely for the purpose of travel or as a requirement of a Covered Person's employment.

Ambulatory Surgery

This Program covers Ambulatory Surgery performed in a Hospital Outpatient department or Out-of-Hospital, a Practitioner's office or an Ambulatory Surgical Center in connection with covered surgery.

Anesthesia

This Program covers anesthetics and their administration.

Audiology Services

This Program covers audiology services rendered by a physician or licensed audiologist or licensed speech-language pathologist. The services must be: (a) determined to be Medically Necessary and Appropriate; and (b) performed within the scope of the Practitioner's practice.

Birthing Centers

As an alternative to the conventional Hospital delivery room care, Horizon BCBSNJ has entered into special agreements with certain Birthing Centers:

Deliveries in Birthing Centers, in many cases, are deemed an effective cost-saving alternative to Inpatient Hospital care. At a Birthing Center, deliveries take place in "birthing rooms," where decor and furnishings are designed to provide a more natural, home-like atmosphere.

All care is coordinated by a team of certified nurse-midwives and pediatric nurse-practitioners. Obstetricians, pediatricians and a nearby Hospital are available in case of complications. Prospective Birthing Center patients are carefully screened. Only low-risk pregnancies are accepted. High-risk patients are referred to a Hospital maternity program.

The Birthing Center's services, including pre-natal, delivery and post-natal care, will be covered. If complications occur during labor, delivery may take place in a Hospital because of the need for emergency and/or Inpatient care. If, for any reason, the pregnancy does not go to term, we will not provide payment to the Birthing Center.

Dental Care and Treatment

This Program covers:

- a. the diagnosis and treatment of oral tumors and cysts; and
- b. the surgical removal of bony impacted teeth; and
- c. Surgical and non-Surgical treatment of Temporomandibular joint dysfunction syndrome (TMJ) in a Covered Person. But, this Program does not cover charges for orthodontia, crowns or bridgework. "Surgery", if needed, includes the pre-operative and post-operative care connected with it.

This Program also covers charges for the treatment of Accidental Injury to sound natural teeth or the jaw that are Incurred within 12 months after the accident. But, this is only if the Injury was not caused, directly or indirectly, by biting or chewing. Treatment includes replacing sound natural teeth lost due to Injury. But, it does not include orthodontic treatment.

For a Covered Person who is severely disabled or who is a Child Dependent under age six, coverage shall also be provided for the following:

- a. general anesthesia and Hospital Admission for dental services; or
- b. dental services rendered by a dentist, regardless of where the dental services are rendered, for medical conditions that: (a) are covered by this Program; and (b) require a Hospital Admission for general anesthesia.

This coverage shall be subject to the same Utilization Review and Management rules imposed upon all Inpatient stays.

Diagnostic X-rays and Lab Tests

This Program covers diagnostic X-ray and lab tests.

Domestic Violence

Under this Program, coverage will not be denied for Covered Services and Supplies needed to treat a Covered Person's injuries sustained due to domestic violence.

Emergency Room

This Program covers services provided by a Hospital emergency room to treat a Medical Emergency or provide a Medical Screening Examination. Each time a Covered Person uses the Hospital emergency room, he/she must pay a Copayment, as shown in the Schedule of Covered Services and Supplies. But, this does not apply if the Covered Person is admitted to the Hospital within 24 hours. No benefits are payable if a Covered Person uses the Hospital emergency room for other than a Medical Emergency, unless previously authorized.

Facility Charges

This Program covers Hospital semi-private room and board and Routine Nursing Care provided by a Hospital on an Inpatient basis. Horizon BCBSNJ limits what it covers each day to the room and board limit shown in the Schedule of Covered Services and Supplies.

If a Covered Person Incurs charges as an Inpatient in a Special Care Unit, this Program covers the charges the same way it covers charges for any Illness.

This Program also covers: (a) Outpatient Hospital services, including services furnished by a Hospital Outpatient clinic; and (b) emergency room care, as described above.

If a Covered Person is an Inpatient in a Facility at the time this Program ends, this Program will continue to cover that Facility stay, subject to all other terms of this Program.

Fertility Services

This Program covers services relating to Infertility (defined below), including, but not limited to, the following services and procedures recognized by the American Society for

Reproductive medicine or the American College of Obstetricians and Gynecologists:

- a. Assisted hatching;
- b. Diagnosis and diagnostic tests;
- c. Four completed egg retrievals Per Lifetime of the Covered Person;
- d. Gamete intrafallopian transfer (requires Prior Authorization);
- e. Medications, including injectible infertility medications;
- f. Ovulation induction;
- g. Surgery, including microsurgical sperm aspiration;
- h. Artificial insemination;
- i. In vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate (requires Prior Authorization);
- j. Fresh and frozen embryo transfer;
- k. Zygote intrafallopian transfer (requires Prior Authorization);
- l. Intracytoplasmic sperm injections.

In addition to any applicable exclusions in the “Exclusions” section, the following limitations and exclusions apply solely to the coverage described in this subsection:

1. Regarding (c), above, any attempted egg retrievals for which benefits were paid or payable by any Carrier shall be counted towards the Per Lifetime limit.
2. Services for in vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer shall be limited to a Covered Person who:
 - (i) has used all reasonable, less expensive, and medically appropriate treatments for infertility
 - (ii) has not reached the Per Lifetime limit of four covered completed egg retrievals
 - (iii) and is 45 years of age or younger.
3. Coverage of Prescription Drugs is not included if Infertility medication benefits are provided under another group health insurance policy or contract issued to the Policyholder.
4. To be covered, the services described in this section must be provided at a Facility

that conforms to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

5. The following services are **not** covered:
- a. Medical services given to a surrogate, for purposes of childbearing, if the surrogate is not a Covered Person.
 - b. Medical costs of a live donor used in egg retrieval after the donor has been released by the reproductive endocrinologist.
 - c. Non-medical costs of an egg or sperm donor.
 - d. Ovulation kits and sperm testing kits and supplies.
 - e. Reversal of voluntary sterilization.
 - f. The cryopreservation and storage of sperm, eggs and embryos.

For the purposes of this subsection, the following definitions apply:

Artificial insemination: The introduction of sperm into a woman's vagina or uterus by noncoital methods for the purpose of conception. This includes intrauterine insemination.

Assisted hatching: A micromanipulation technique in which a hole is artificially created in the outer shell of an embryo to assist with the potential implantation of that embryo.

Carrier: A health service corporation, hospital service corporation, medical service corporation, insurance company or a health maintenance organization.

Completed egg retrieval: All office visits, procedures and laboratory and radiological tests performed in preparation for oocyte retrieval; the attempted or successful retrieval of the oocyte(s); and, if the retrieval is successful, culture and fertilization of the oocyte(s).

Cryopreservation: The freezing of embryos in liquid nitrogen until such time as required for a frozen embryo transfer, and includes the freezing of female gametes (ova) and male gametes (sperm).

Egg retrieval or oocyte retrieval: A procedure by which eggs are collected from a woman's ovarian follicles.

Egg transfer or oocyte transfer: The transfer of retrieved eggs into a woman's fallopian tubes through laparoscopy as part of gamete intrafallopian transfer.

Embryo: A fertilized egg that has: (a) begun cell division; and (b) completed the pre-embryonic stage.

Embryo transfer: The placement of an embryo into the uterus through the cervix, or, in the case of zygote intrafallopian tube transfer, the placement of an embryo in the fallopian tube. It includes the transfer of cryopreserved embryos and donor embryos.

Fertilization: The penetration of the egg by the sperm.

Gamete: A reproductive cell. In a male, gametes are sperm; in a female, gametes are eggs or ova.

Gamete intrafallopian tube transfer: The direct transfer of a sperm/egg mixture into the fallopian tube by laparoscopy, where fertilization takes place inside the fallopian tube.

Gestational carrier: A woman who has become pregnant with an embryo or embryos that are not part of her genetic or biologic entity, and who intends to give the child to the biological parents after birth.

Infertility: A disease or condition that results in the abnormal function of the reproductive system such that: (i) a male is unable to impregnate a female; (ii) a female under 35 years of age is unable to conceive after two years of unprotected sexual intercourse; (iii) a female 35 years of age and over is unable to conceive after one year of unprotected sexual intercourse; (iv) the male or female is medically sterile; or (v) the female is unable to carry a pregnancy to live birth. The term does not apply to a person who has been voluntarily sterilized, regardless of whether the person has attempted to reverse the sterilization.

Intracytoplasmic sperm injection: A micromanipulation procedure whereby a single sperm is injected into the center of an egg.

Intrauterine insemination: A medical procedure whereby sperm is placed into a woman's uterus to facilitate fertilization.

In vitro fertilization: An assisted reproductive technologies procedure whereby eggs are removed from a woman's ovaries and fertilized outside her body, and the resulting embryo is then transferred into a woman's uterus.

Microsurgical sperm aspiration: The techniques used to obtain sperm for use with intracytoplasmic sperm injection in cases of obstructive azoospermia. It can involve the extraction of sperm and fluid from epididymal tubules inside the epididymis or the provision of testicular tissue from which viable sperm may be extracted.

Oocyte: The female egg or ovum.

Ovulation induction: The use of drugs (oral or injected) to stimulate the ovaries to develop follicles and eggs.

Sexual intercourse: Sexual union between a male and a female.

Surrogate: A woman who carries an embryo that was formed from her own egg

inseminated by the sperm of a designated sperm donor.

Zygote: A fertilized egg before cell division begins.

Zygote intrafallopian tube transfer: A procedure whereby an egg is fertilized in vitro, and the zygote is transferred to the fallopian tube at the pronuclear stage before cell division takes place.

Health Wellness

This Program covers these tests and services:

- a. For all Covered Persons 20 years of age and older, annual tests to determine blood, hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density lipoprotein (LDL) level and high-density lipoprotein (HDL) level.
- b. For all Covered Persons 35 years of age or older, a glaucoma eye test every five years.
- c. For all Covered Persons 40 years of age or older, a yearly stool exam for presence of blood.
- d. For all Covered Persons 45 years of age or older, a left-sided colon exam of 35 to 60 centimeters every five years.
- e. For all adult Covered Persons recommended immunizations; and
- f. For all Covered Persons 20 years of age and older, a yearly consultation with a Provider to discuss lifestyle behaviors that promote health and well-being, including but not limited to: smoking control; nutrition and diet recommendations; exercise plans; lower back protection; weight control; immunization practices; breast self-exam; testicular self-exam; and seat belt usage in motor vehicles.
- g. For all female Covered Persons 20 years of age or older, a Pap smear. The term "Pap smear" means: an initial Pap smear; any confirmatory test when Medically Necessary and Appropriately and ordered by a Covered Person's physician; and all lab costs related to the initial Pap Smear and any such confirmatory test.
- h. For all female Covered Persons 40 years of age or older, a yearly mammogram exam.
- i. **Gynecological Examinations**

This Program covers routine gynecological examinations including Pap smears. The term "Pap smear" means: an initial Pap smear; any confirmatory test when Medically Necessary and Appropriate and ordered by a Covered Person's

physician; and all lab costs related to the initial Pap smear and any such confirmatory test.

j. **Mammography**

This Program covers charges made for mammograms provided to a female Covered Person according to the schedule below. Coverage will be provided, subject to all the terms of this Program, and these rules:

1. one baseline mammogram for female Covered Persons who are at least 35 but less than 40 years of age. (However, if the woman is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, Horizon BCBSNJ will cover a mammogram at such age and intervals as deemed needed by the woman's Practitioner.)
2. one mammogram each year for female Covered Persons age 40 and older.

k. **Pap Smears**

This Policy provides benefits for charges Incurred in conducting a Pap smear. This benefit, except as may be Medically Necessary and Appropriate for diagnostic purposes, shall be limited to one pap smear per Benefit Period. Coverage shall be provided for any confirmatory test when medically necessary and ordered by the women's physician.

l. **Prostate Cancer Screening**

This Program provides benefits for an annual medically recognized diagnostic exam, including, but not limited to: (a) a digital rectal exam; and (b) a prostate-specific antigen test, for male Covered Persons age 50 or over who are asymptomatic; and male Covered Persons age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.

m. **Well Child Immunizations and Lead Poisoning Screening and Treatment**

This Program covers Well Child immunizations and lead poisoning screening. To be covered:

(i) childhood immunizations must be as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health pursuant to Section 7. of P.L. 1995, Ch 316.

(ii) screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing must be as specified by the Department of Health pursuant to Section 7. of P.L. 1995, Ch 316. Medical evaluation and any necessary follow-up and treatment for lead-poisoned children are also covered.

n. **Colorectal Cancer Screening**

This Program covers colorectal cancer screening rendered at regular intervals for: (a) Covered Persons age 50 or over; and (b) Covered Persons of any age who are deemed to be at high risk for this type of cancer.

Covered tests include: a screening fecal occult blood test; flexible sigmoidoscopy; colonoscopy; barium enema; any combination of these tests; or the most reliable, medically recognized screening test available.

For the purposes of this part, "high risk for colorectal cancer" means that a Covered Person has: (a) a family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial, or colon cancer or polyps; (b) chronic inflammatory bowel disease; or (c) a background, ethnicity or lifestyle that the Covered Person's physician believes puts the Covered Person at elevated risk for colorectal cancer.

The method and frequency of screening shall be: (a) in accordance with the most recent published guidelines of the American Cancer Society; and (b) as deemed to be Medically Necessary and Appropriate by the Covered Person's physician, in consultation with the Covered Person.

o. **Newborn Hearing Screening**

This Program covers the screening, by appropriate electrophysiologic screening measures, of newborn Child Dependents for hearing loss; and tests for the periodic monitoring of infants for delayed onset hearing loss.

For the purposes of this part:

- a. "newborn" means a child up to 28 days old;
- b. "infant" means a child between the ages of 29 days and 36 months;
- c. "electrophysiologic screening measures" means the electrical result of the application of physiologic agents. This includes, but is not limited to: (i) the procedures currently known as: Auditory Brainstem Response testing (ABR); and Otoacoustic Emissions testing (OAE); and (ii) any other procedure adopted by New Jersey's Commissioner of Health and Senior Services.

p. **Well Child Care**

Well Child Care will not be covered beyond the child's twentieth birthday.

Hearing Aids and Related Services

This Program covers expenses Incurred for or in connection with the purchase of a hearing aid or hearing aids that have been prescribed or recommended by a Practitioner for a Child Dependent who is 15 years of age or younger.

For a Child Dependent who is 15 years of age or younger and for whom a Practitioner has recommended a hearing aid, such expenses include, but are not limited to, charges Incurred for the following:

- the purchase of the hearing aid;
- hearing tests;
- fittings;
- modifications; and
- repairs (but not battery replacement).

All such services shall be deemed to be Basic Services and Supplies.

Home Health Care

This Program covers Home Health Care services furnished by Home Health Agency.

The home health care plan must be established in writing by the Covered Person's Practitioner within 14 days after home health care starts and it must be reviewed by the Covered Person's Practitioner at least once every 60 days. In order for Home Health Agency charges to be considered Covered Charges the Covered Person's Admission to Home Health Agency care may be direct to Home Health Agency care with no prior Inpatient Admission.

Each Visit by a home health aide, Nurse, or other Provider whose services are authorized under the home health care plan can last up to 4 hours.

This Policy does not cover:

- a. services furnished to family members, other than the patient; or
- b. services and supplies not included in the Home Health Care plan; or
- c. services that are mainly Custodial Care.

Hospice Care

Hospice Care benefits will be provided for:

1. part-time professional nursing services of an R.N., L.P.N. or Licensed Viatical Nurse (L.V.N.);
2. home health aide services provided under the supervision of an R.N.;
3. medical care rendered by a Hospice Care Program Practitioner;

4. therapy services;
5. diagnostic services;
6. medical and Surgical supplies and Durable Medical Equipment if given Prior Authorization by Horizon BCBSNJ;
7. Prescription Drugs;
8. oxygen and its administration;
9. medical social services;
10. respite care;
11. psychological support services to the Terminally Ill or Injured patient;
12. family counseling related to the patient's terminal condition;
13. dietician services; and
14. Inpatient room, board and general nursing services.

No Hospice Care benefits will be provided for:

1. medical care rendered by the patient's private Practitioner;
2. volunteer services or services provided by others without charge;
3. pastoral services;
4. homemaker services;
5. food or home-delivered meals;
6. Private-Duty Nursing services;
7. dialysis treatment;
8. treatment not included in the Hospice Care Program;
9. services and supplies provided by volunteers or others who do not normally charge for their services;
10. funeral services and arrangements;
11. legal or financial counseling or services; or
12. bereavement counseling; or

13. any Hospice Care services that are not given Prior Authorization by Horizon BCBSNJ.

Respite care benefits are limited to a maximum of ten days per Covered Person per Benefit Period.

"Terminally Ill or Injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "Hospice Care Program".

Inpatient Physician Services

This Program provides benefits for Covered Services and Supplies furnished by a physician to a Covered Person who is a registered Inpatient in a Facility.

Mastectomy Benefits

This Program covers a Hospital stay of at least 72 hours following a modified radical mastectomy and a Hospital stay of at least 48 hours following a simple mastectomy. A shorter length of stay may be covered if the patient, in consultation with her physician, determines that it is Medically Necessary and Appropriate. The patient's Provider does not need to obtain Prior Authorization from Horizon BCBSNJ for prescribing 72 or 48 hours, as appropriate, of Inpatient care. But, any rule of this Program that the patient or her Provider notify Horizon BCBSNJ about the stay remains in force.

Benefits for these services shall be subject to the same Deductible, Copayments and/or Coinsurance as for other Hospital services covered under this Program.

Maternity/Obstetrical Care

Pursuant to both federal and state law, covered medical care related to pregnancy; childbirth; abortion; or miscarriage, includes: (a) the Hospital delivery; and (b) a Hospital Inpatient stay for at least 48 hours after a vaginal delivery or 96 hours after a cesarean section. This applies if: (a) the attending physician determines that Inpatient care is Medically Necessary and Appropriate; or (b) if it is requested by the mother (regardless of Medical Necessity and Appropriateness). For the purposes of this subsection and as required by state law, "attending physician" shall include the attending obstetrician, pediatrician or other physician attending the mother or newly born child. For the purposes of this provision and as required by federal law, a Hospital Inpatient stay is deemed to start:

- (a) at the time of delivery; or
- (b) in the case of multiple births, at the time of the last delivery; or
- (c) if the delivery occurs out of the Hospital, at the time the mother or newborn is admitted to the Hospital.

Services and supplies provided by a Hospital to a newborn child during the initial

Hospital stay of the mother and child are covered as part of the obstetrical care benefits. But, if the child's care is given by a different physician from the one who provided the mother's obstetrical care, the child's care will be covered separately.

If they are given Prior Authorization by Horizon BCBSNJ, this Program also covers Birthing Center charges (see above) made by a Practitioner for: (a) pre-natal care; (b) delivery; and (c) post-partum care for a Covered Person's pregnancy.

Maternity/Obstetrical Care for Child Dependents

This Program does not cover a Child Dependent's routine obstetrical care, including any services furnished to or for the Child Dependent's newborn. But, complications of the pregnancy and interruptions of the pregnancy, except for elective abortion, will be covered, subject to the Program's terms.

Medical Emergency

This Program covers charges relating to a Medical Emergency. This includes diagnostic X-ray and lab charges Incurred due to the Medical Emergency.

Benefits include coverage of trauma at any designated level I or II trauma center, as Medically Necessary and Appropriate. The coverage continues at least until, in the judgment of the attending physician, the Covered Person: (a) is medically stable; (b) no longer requires critical care; and (c) can be safely transferred to another Facility, if needed. Horizon BCBSNJ will also cover a medical screening exam that is: (a) rendered upon a Covered Person's arrival at a Hospital; (b) required under federal law to be performed by the Hospital; and (c) needed to determine whether a Medical Emergency situation exists.

In the event of a potentially life-threatening condition, the Covered Person should use the 911 emergency response system. Further 911 information is available on the Identification Card.

Mental or Nervous Disorders (including Group Therapy) and Substance Abuse

The Program covers treatment for Mental or Nervous Disorders and Substance Abuse.

A Covered Person may receive covered treatment as an Inpatient in a Hospital or a Substance Abuse Center. He/she may also receive covered treatment at a Hospital Outpatient Substance Abuse Center, or from any Practitioner (including a psychologist or social worker). The benefits for the covered treatment of Mental or Nervous Disorders or Substance Abuse are provided on the same basis and subject to the same terms and conditions as for other Illnesses.”

Orthotic Devices

The Policy covers an Orthotic Device that a Covered Person's physician has determined to be medically necessary. An Orthotic Device is a brace or support. But, the term does

not include: fabric and elastic supports; corsets; arch supports; trusses; elastic hose; canes; crutches; cervical collars; or dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

Physical Rehabilitation

This Program covers Inpatient treatment in a Physical Rehabilitation Center. Inpatient treatment will include the same services and supplies available to any other Facility Inpatient. The Schedule of Covered Services and Supplies shows limits on this coverage.

Practitioner's Charges for Non-Surgical Care and Treatment

This Program covers Practitioner's charges for the non-Surgical care and treatment of an Illness, Injury, Mental or Nervous Disorders or Substance Abuse. This includes Medically Necessary pharmaceuticals which in the usual course of medical practice are administered by a Practitioner, if the pharmaceuticals are billed by the Practitioner or by a Specialty Pharmaceutical Provider.

Practitioner's Charges for Surgery

This Program covers Practitioners' charges for Surgery. This Program does not cover Cosmetic Surgery. Surgical procedures include: (a) those after a mastectomy on one or both breasts; (b) reconstructive breast Surgery; and (c) Surgery to achieve symmetry between both breasts.

Pre-Admission Testing Charges

This Program covers Pre-Admission diagnostic X-ray and lab tests needed for a planned Hospital Admission or Surgery. To be covered, these tests must be done on an Outpatient or Out-of-Hospital basis within seven days of the planned Admission or Surgery.

This Program does not cover tests that are repeated after Admission or before Surgery. But, this does not apply if the Admission or Surgery is deferred solely due to a change in the Covered Person's health.

Prosthetic Devices

The Program covers a Prosthetic Device that a Covered Person's physician has determined to be medically necessary. Solely for the purposes of this subsection, a Prosthetic Device is an artificial device (not including dental prostheses or largely cosmetic devices (such as, wigs; artificial breasts; eyelashes; or other similar devices)) that: (a) is not surgically implanted; and (b) is used to replace a missing limb, appendage or any other external human body part. Devices excluded under this subsection (e.g., wigs; surgically implanted devices) may be covered under other parts of the Program.

Second Opinion Charges

If a Covered Person is scheduled for an Elective Surgical Procedure, this Program covers

a Practitioner's charges for a second opinion and charges for related diagnostic X-ray and lab tests. If the second opinion does not confirm the need for the Surgery, this Program will cover a Practitioner's charges for a third opinion regarding the need for the Surgery. This Program will cover charges if the Practitioner(s) who gives the opinion:

- a. are board certified and qualified, by reason of his/her specialty, to give an opinion on the proposed Surgery or Hospital Admission;
- b. are not a business associate of the Practitioner who recommended the Surgery; and
- c. does not perform or assist in the Surgery if it is needed.

Skilled Nursing Facility Charges

This Program covers bed and board (including diets, drugs, medicines and dressings and general nursing service) in a Skilled Nursing Facility. The Covered Person must be admitted to the Skilled Nursing Facility within 14 days of discharge from a Hospital, following an Inpatient stay of at least three days, for continuing medical care and treatment prescribed by a Practitioner. Benefits are available for 120 days of care during any one Benefit Period.

Surgical Services

This Program covers Surgery, subject to the following:

- a. Horizon BCBSNJ will not make separate payment for pre- and post-operative care.
- b. If more than one surgical procedure is performed during the same operation through only one route of access, Horizon BCBSNJ will cover the primary procedure only. There will be no payment for any other procedures performed at the same time.
- c. If more than one surgical procedure is performed during the same operation through more than one route of access, Horizon BCBSNJ will cover the primary procedure, plus **50%** of what Horizon BCBSNJ would have paid for each of the other procedures had those procedures been performed alone.

If a Covered Person is receiving benefits for a mastectomy, this Program will also cover the following, as determined after consultation between the attending physician and the Covered Person:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.

- The treatment of physical complications at all stages of the mastectomy, including lymphodemas.
- Prosthetic Devices.

Benefits for Covered Charges Incurred for a mastectomy (except for Prosthetic Devices) are subject to the same Deductible, Copayments and/or Coinsurance that apply to other covered Surgical and Practitioners' services. Benefits for Prosthetic Devices are payable the same as for an office Visit to a Practitioner who is a doctor specializing in: family practice; general practice; internal medicine; or pediatrics.

Also, see "Transplant Benefits", below.

Therapeutic Manipulation

This Program provides benefits for Therapeutic Manipulations.

Therapy Services

This Program covers all Therapy Services.

Transplant Benefits

This Program covers services and supplies:

- a. Cornea;
- b. Kidney;
- c. Lung;
- d. Liver;
- e. Heart;
- f. Heart valve;
- g. Pancreas;
- h. Small bowel;
- i. Chondrocyte (for knee);
- j. Heart/Lung;
- k. Kidney/Pancreas;
- l. Liver/Pancreas;
- m. Double lung;

- n. Heart/Kidney;
- o. Kidney/Liver;
- p. Liver/Small Bowel;
- q. Multi-visceral transplant (small bowel and liver with one or more of the following: stomach; duodenum; jejunum; ileum; pancreas; colon);
- r. Allogeneic bone marrow;
- s. Allogeneic stem cell;
- t. Non-myeloblastic stem cell;
- u. Tandem stem cell.

This Program also provides benefits for the treatment of cancer by dose-intensive Chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants. This applies only to transplants that are performed:

- a. by institutions approved by the National Cancer Institute; or
- b. pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists. Such treatment will be covered to the same extent as for any other illness.

When organs/tissues are harvested from a cadaver, this Program will also cover those charges for Surgical, storage and transportation services that: (a) are directly related to donation of the organs/tissues; and (b) are billed for by the Hospital where the transplant is performed.

This Program also covers the following services required for a live donor due to a covered transplant procedure.

- a. The search for a donor (benefits not to exceed **\$10,000** per transplant).
- b. Typing (immunologic).
- c. The harvesting of the organ tissue, and related services.
- d. The processing of tissue.

But, Horizon BCBSNJ will cover these services only if: (a) the recipient of the transplant is a Covered Person under this Program; and (b) benefits are not paid or payable for the services by reason of the donor's own coverage under any other group or individual health coverage.

Urgent Care

This Program provides benefits for Covered Services and Supplies furnished for Urgent Care of a Covered Person.

Wilm's Tumor

This Program covers treatment of Wilm's tumor the same way it covers charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard Chemotherapy treatment is unsuccessful. Coverage is available for this treatment even if it is deemed Experimental or Investigational.

B. COVERED SUPPLEMENTAL SERVICES AND SUPPLIES

Ambulance Services

This Program covers charges for transporting a Covered Person to:

- a. a local Hospital, if it can provide the needed care and treatment;
- b. the nearest Hospital that can furnish the needed care and treatment, if: (a) a local Hospital cannot provide it; and (b) the person is admitted as an Inpatient; or
- c. another Inpatient Facility when Medically Necessary and Appropriate.

The coverage can be by professional ambulance service ground or air only. The Program does not cover chartered air flights. The Program will not cover other travel or communication expenses of patients, Practitioners, Nurses or family members.

Blood

This Program covers: (a) blood; (b) blood products; (c) blood transfusions; and (d) the cost of testing and processing blood. This Program does not pay for blood that has been donated or replaced on behalf of the Covered Person.

Blood transfusions (including the cost of blood plasma and blood plasma expanders) are covered from the first pint. But, this is so only to the extent that the first pint and any additional pints to follow are not donated or replaced without charge through a blood bank or otherwise.

This Program also covers expenses Incurred in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia. The home treatment program must be under the supervision of a State approved hemophilia treatment center. A home treatment program will not preclude further or additional treatment or care at an eligible Facility. But, the number of home treatments, according to a ratio of home treatments to Benefit Days established by regulation by New Jersey's Commissioner of Insurance, cannot exceed the total number of Benefit Days allowed for any other Illness under this Program.

As used above: (a) “blood product” includes but is not limited to Factor VIII, Factor IX and cryoprecipitate; and (b) “blood infusion equipment” includes but is not limited to syringes and needles.

Diabetes Benefits

This Program covers dialysis services that are furnished by a dialysis center. This Program also provides benefits for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or nurse practitioner/clinical nurse specialist;

- a. blood glucose monitors and blood glucose monitors for the legally blind;
- b. test strips for glucose monitors and visual reading and urine testing strips;
- c. insulin;
- d. injection aids;
- e. cartridges for the legally blind;
- f. syringes;
- g. insulin pumps and appurtenances to them;
- h. insulin infusion devices; and
- i. oral agents for controlling blood sugar.

Subject to the terms below, this Program also covers diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of the Illness. This includes information on proper diet.

- a. Benefits for self-management education and education relating to diet shall be limited to Visits that are Medically Necessary and Appropriate upon:
 1. the diagnosis of diabetes;
 2. the diagnosis by a physician or nurse practitioner/clinical nurse specialist of a significant change in the Covered Person's symptoms or conditions which requires changes in the Covered Person's self-management; and
 3. determination of a physician or nurse practitioner/clinical nurse specialist that reeducation or refresher education is needed.
- b. Diabetes self-management education is covered when rendered by:
 1. a dietician registered by a nationally recognized professional association

of dieticians;

2. a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators; or
3. a registered pharmacist in New Jersey qualified with regard to management education for diabetes by any institution recognized by the Board of Pharmacy of the State of New Jersey.

Durable Medical Equipment

This Program covers charges for the rental of Durable Medical Equipment needed for therapeutic use. Horizon BCBSNJ may decide to cover the purchase of such items when it is less costly and more practical than to rent them. This Program does not cover:

- a. replacements or repairs; or
- b. the rental or purchase of any items that do not fully meet the definition of Durable Medical Equipment. Such items include: air conditioners; exercise equipment; saunas and air humidifiers.

Home Infusion Therapy

This Program covers home infusion therapy. "Home infusion therapy" is a method of administering intravenous (IV) medications or nutrients via pump or gravity in the home. The services and supplies that are covered are:

- a. Solutions and pharmaceutical additives.
- b. Pharmacy compounding and dispensing services.
- c. Ancillary medical supplies.
- d. Nursing services associated with: (a) patient and/or alternative caregiver training; (b) Visits needed to monitor intravenous therapy regimen; (c) Medical Emergency care (but not for administration of home infusion therapy).

Examples of home infusion therapy include: chemotherapy; intravenous antibiotic therapy; total parenteral nutrition; hydration therapy; continuous subcutaneous pain management therapies and continuous intrathecal pain management; gammaglobulin infusion therapy (IVIG); and prolactin therapy.

To be covered, home infusion therapy must be given Prior Authorization by Horizon BCBSNJ.

Inherited Metabolic Disease

This Program provides benefits for the therapeutic treatment of Inherited Metabolic

Diseases. This coverage includes the purchase of Medical Foods and Low Protein Modified Food Products that are determined to be Medically Necessary and Appropriate by the Covered Person's physician.

Oxygen and Its Administration

This Program covers oxygen and its administration.

Supplemental Prescription Drugs Benefits

This Program covers Prescription Drugs including contraceptives purchased from a Pharmacy for Out-of-Hospital use. They are covered:

- a. when prescribed for an FDA-approved treatment; or
- b. when prescribed for a non FDA-approved treatment. In this case, the drug must be deemed Medically Necessary and Appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia:
 1. The American Medical Association Drug Evaluations;
 2. The American Hospital Formulary Service Drug Information; or
 3. The United States Pharmacopeia Drug Information;

or: it must be recommended by a clinical study or review article in a major peer-reviewed professional journal. But, an Experimental or Investigational drug which the FDA has determined to be contraindicated for the specific treatment for which it has been prescribed is not covered.

A Prescription Drug identification card will be issued to the Covered Person, who will be required to use it to obtain Prescription Drug benefits.

When a Covered Person presents his identification card at a Network Pharmacy, the Pharmacy will charge the Allowance for each eligible Prescription Order, and the Covered Person will not be required to submit a claim form to obtain reimbursement from BCBSNJ. If the Covered Person uses an Out-of-Network Pharmacy to purchase Prescription Drugs, or when the Covered Person does not present his identification card to a Network Pharmacy, he will be required to submit a written claim form, and the Pharmacy may charge the Covered Person more than the Allowance.

Prescription Orders for Prescription Drugs determined to be Medically Necessary by Horizon BCBSNJ may be sold in supplies of up to no less than a 90 day supply.

Refills, as authorized under a Prescription Order, will be subject to the same requirements as in paragraph above of this Section. Benefits for authorized refills will not be provided beyond 1 year from the original prescription date.

How to Use Your Benefits at a Participating Pharmacy

To maximize your prescription drug benefit, you should utilize our participating pharmacies that have agreed to provide prescription drugs to Horizon Blue Cross Blue Shield of New Jersey subscribers at a discounted price. When you use a participating pharmacy, you pay less for your prescriptions because you are being charged a discounted price rather than the actual retail price.

To use your prescription drug benefits, simply present your identification card and your written prescription to the participating pharmacist and pay the discounted price for your prescription. You do **not** have to fill out a claim form when you use a participating pharmacy. You will receive reimbursement from Horizon BCBSNJ for your eligible prescriptions in the mail, subject to your program's Deductible and Coinsurance.

If you do not present your identification card at a participating pharmacy, you will receive the non-participating pharmacy level of benefits. See the non-participating pharmacy section below for details.

How to Use Your Benefits at a Non-Participating Pharmacy

If you do not use a participating pharmacy, or if you do not present your identification card at a participating pharmacy, you will have to pay the actual full retail price for your prescription and you will have to fill out a claim form, you may receive one by contacting Horizon BCBSNJ at **1-800-355-BLUE**. Your out-of-pocket expense is higher when you use a pharmacy that does not participate, so it is to your advantage to use participating pharmacies (and always present your identification card). You will receive reimbursement for Horizon BCBSNJ for your eligible prescriptions in the mail, subject to your program's Deductible and Coinsurance.

If you need help or have any questions concerning your prescription drug benefits, your Deductible and Coinsurance, or any other inquiries, please call the Horizon BCBSNJ Center at:

1-800-355-BLUE

Audits

Pharmacies and pharmacists shall be audited yearly. Once Pharmacies have been selected for audit, Covered Persons utilizing these Pharmacies may receive a letter indicating the drugs that they received during the audit period; Covered Persons are asked to confirm the accuracy of this printout and return the information to our auditor. Pharmacies and Covered Persons are randomly chosen. Pharmacies are notified approximately two (2) weeks before the audit is scheduled to occur. The notification shall include the date of the audit and informs the pharmacist he/she may contact us if he/she has any questions or needs to reschedule the audit. All audits shall take place at a time mutually agreeable to the Pharmacy or pharmacist and the auditor. All audits shall be conducted by a licensed pharmacist on behalf of Horizon BCBSNJ. Upon conclusion

of the audit, the auditor shall provide the pharmacist with a preliminary report and review the report with the pharmacist. Problems and remedies shall be discussed. Pursuant to N.J.A.C. §13.39-5.6(i), pharmacists shall be given three (3) business days to locate any missing documents and present them to our auditor. No audit shall include a review of any document relating to any person or prescription plan other than those reimbursable by Horizon BCBSNJ.

Neither Horizon BCBSNJ nor any agent or intermediary thereof, including any third party, shall restrict or prohibit, directly or indirectly, a Pharmacy from charging the Covered Person for services rendered by the Pharmacy that are in addition to charges for the drug, for dispensing the drug or for prescription counseling. Any such “additional charge” shall be subject to the approval of the Board of Pharmacy. A Pharmacy must disclose to a purchaser the charges for the additional services and the purchaser’s out-of-pocket cost for those services prior to dispensing the drug. A Pharmacy may not charge for any additional services that are required by the Board of Pharmacy or other law.

Specialty Pharmaceuticals

For Illnesses or Accidental Injuries where Specialty Pharmaceuticals as prescribed by a physician are required, such Prescription Drugs must be purchased through a Specialty Pharmaceutical Provider.

Drug Utilization, Cost Management and Rebates

We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. We may, from time-to-time, also enter into agreements that result in us receiving rebates or other funds (“Rebates”) directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drug products across all of our business and not solely on any one Member’s or one group’s utilization of Prescription Drugs. Rebates will not change or reduce the amount of any Copayment, Coinsurance or Deductibles applicable under our Prescription Drug coverage.

Limitations:

Horizon BCBSNJ will not pay for refills, as authorized under a Prescription, beyond one year from the original Prescription Order date or dispensed before **75%** of the prior Prescription Order or refill would be used or consumed when used or taken as directed.

Private Duty Nursing Care

This Program covers the services of a Nurse for Private Duty Nursing care. These conditions apply:

- a. The care must be ordered by a physician.

- b. The care must be furnished while: (i) intensive skilled nursing care is required in the treatment of an acute illness or during the acute period after an Accidental Injury; and (ii) the patient is not in a Facility that provides nursing care.

Requirement (b)(i), above, will not be deemed to be met if the care actually furnished is mainly Custodial Care or maintenance. Also, no benefits will be provided for the services of a Nurse who: (a) ordinarily resides in the patient's home; or (b) is a member of the patient's immediate family.

Specialized Non-Standard Infant Formulas

This Program covers specialized non-standard infant formulas, if these conditions are met:

- a. The covered infant's physician has diagnosed him/her as having multiple food protein intolerance;
- b. The physician has determined that the formula is Medically Necessary and Appropriate; and
- c. The infant has not responded to trials of standard non-cow milk-based formulas, including soybean and goat milk.

Wigs Benefit

This Program covers the cost of wigs, if needed due to a specific diagnosis of Chemotherapy induced Alopecia. This coverage is subject to the limitations shown in the Schedule of Covered Services and Supplies.

UTILIZATION REVIEW AND MANAGEMENT

IMPORTANT NOTICE - THIS NOTICE APPLIES TO ALL OF THE UTILIZATION REVIEW (UR) FEATURES UNDER THIS SECTION.

BENEFITS WILL BE REDUCED FOR NON-COMPLIANCE WITH THE UR REQUIREMENTS OF THIS SECTION. THIS PROGRAM DOES NOT COVER ANY INPATIENT ADMISSION, OR ANY OTHER SERVICE OR SUPPLY THAT IS NOT MEDICALLY NECESSARY AND APPROPRIATE. HORIZON BCBSNJ DETERMINES WHAT IS MEDICALLY NECESSARY AND APPROPRIATE UNDER THIS PROGRAM.

This Program has Utilization Review features described below. These features must be complied with if a Covered Person:

- a. is admitted, or is scheduled to be admitted, as an Inpatient or Outpatient to a Hospital or other Facility; or
- b. needs an extended length of stay; or
- c. plans to obtain a service or supply to which the section "Medical Appropriateness Review Procedure", below, applies.

If a Covered Person or his/her Provider does not comply with this Utilization Review section, he/she will not be eligible for full benefits under this Program.

Also, what Horizon BCBSNJ covers is subject to all of the other terms and conditions of this Program.

This Program has Individual Case Management features. Under these features, a case coordinator reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the Alternate Treatment Features description for details.

This Program has Centers of Excellence features. Under these features, a Covered Person may obtain needed care and treatment from Providers with whom Horizon BCBSNJ has entered into agreements. See the Centers of Excellence Features description for details.

UTILIZATION REVIEW-REQUIRED HOSPITAL STAY REVIEW

Notice of Hospital Admission Required

If a Covered Person plans to use an In-Network Hospital, the Hospital will usually make all needed arrangements for Pre-Admission Review. If a Covered Person plans to use an Out-of-Network Hospital, the Covered Person or his/her Provider must advise Horizon BCBSNJ of the Admission. The time and manner in which the notice must be given is described below. When a Covered Person or his/her Practitioner does not comply with this rule, Horizon BCBSNJ reduces benefits for the Covered Charges.

Pre-Admission Review (PAR)

All non-Medical Emergency Hospital and other Facility Admissions must be reviewed by Horizon BCBSNJ before they occur. The Covered Person or his/her Provider must notify Horizon BCBSNJ and request a PAR by phone. We must receive the notice and request at least five business days (or as soon as reasonably possible) before the Admission is scheduled to occur.

- a. When Horizon BCBSNJ receives the notice and request, We determine:
 - 1. the Medical Necessity and Appropriateness of the Admission;
 - 2. the anticipated length of stay; and
 - 3. the appropriateness of health care alternatives, like Home Health Care or other Outpatient or Out-of-Hospital care.

Horizon BCBSNJ notifies the Covered Person or his/her Provider, by phone, of the outcome of our review. If a review results in a denial, Horizon BCBSNJ confirms that outcome in writing.

- b. If Horizon BCBSNJ authorizes a Hospital or other Facility Admission, the authorization is valid for:
 - 1. the specified Provider;
 - 2. the named attending Practitioner;
 - 3. the specified Admission date;
 - 4. the authorized length of stay; and
 - 5. the diagnosis and treatment plan.
- c. The authorization becomes invalid, and the Covered Person's Admission must be reviewed by Horizon BCBSNJ again, if:
 - 1. he/she enters a Facility other than the specified Facility;
 - 2. he/she changes attending Practitioners;
 - 3. there is an alteration in condition or treatment plan.

Continued Stay Review

Horizon BCBSNJ has the right to conduct a continued stay review of any Inpatient Hospital Admission. To do this, Horizon BCBSNJ may contact the Covered Person's Practitioner or Facility by phone or in writing.

The Covered Person or his/her Provider must ask for a continued stay review whenever it is Medically Necessary and Appropriate to increase the authorized length of an Inpatient Hospital stay. This must be done before the end of the previously authorized length of stay.

The continued stay review will determine:

- a. the Medical Necessity and Appropriateness of the Admission;
- b. the anticipated length of stay and extended length of stay; and
- c. the appropriateness of health care alternatives.

Horizon BCBSNJ notifies the Practitioner and Facility by phone of the outcome of the review. We confirm in writing the outcome of a review that results in a denial. The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

- a. As a penalty for non-compliance with the Admission review features in this Program, Horizon BCBSNJ reduces what it otherwise pays for Covered Services and Supplies by **20%**:
 1. the Covered Person or his/her Provider does not request a PAR;
 2. the Covered Person or his/her Provider does not request a PAR five business days or as soon as reasonably possible before the Admission is scheduled to occur;
 3. Horizon BCBSNJ's authorization becomes invalid and the Covered Person or his/her Provider does not obtain a new one;
 4. the Covered Person or his/her Provider, does not request a continued stay review when necessary;
 5. the Covered Person or his/her Provider does not receive an authorization for such continued stay;
 6. The Covered Person does not otherwise comply with all the terms of this Program.
- b. Penalties cannot be used to meet this Program's:
 1. Deductible(s)
 2. Out-of-Pocket Limit(s)
 3. Copayment(s)

MEDICAL APPROPRIATENESS REVIEW PROCEDURE

This Program requires a Covered Person or his/her Provider to obtain Prior Authorization for certain Covered Services and Supplies. When a Covered Person or his/her Provider does not comply with this rule, Horizon BCBSNJ reduces benefits for Covered Charges Incurred with respect to that Covered Service or Supply. If Horizon BCBSNJ does not give its Prior Authorization, benefits for the Covered Service or Supply will be reduced by **20%**.

The Covered Person or his/her Provider must request a required review from Horizon BCBSNJ at least five business days before the Covered Service or Supply is scheduled to be furnished, or as soon before as reasonably possible. If the treatment or procedure is being performed in a Hospital on an Inpatient basis, only one authorization for both the Inpatient Admission and the treatment or procedure is needed. If Prior Authorization is required for a supply, the request must be made before the supply is obtained.

When Horizon BCBSNJ receives the request, We determine the Medical Necessity and Appropriateness of the treatment, procedure or supply, and either:

- a. approve the request, or
- b. require a second opinion regarding the need for the treatment, procedure or supply.

Horizon BCBSNJ notifies the Covered Person, his/her Practitioner or Hospital, by phone, of the outcome of the review. We also confirm the outcome of the review in writing.

The treatments, procedures and supplies needing Prior Authorization are listed in the Schedule of Treatments, Procedures and Supplies Requiring Prior Authorization, at the end of this Booklet.

ALTERNATE TREATMENT FEATURES/INDIVIDUAL CASE MANAGEMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment/Individual Case Management Plan recommended by Horizon BCBSNJ.

Definitions

"Alternate Treatment": Those services and supplies that meet both of these tests:

- a. They are determined, in advance, by Horizon BCBSNJ to be Medically Necessary and Appropriate and cost-effective in meeting the long-term or intensive care needs of a Covered Person: (a) in connection with a Catastrophic Illness or Injury; or (b) in completing a course of care outside of the acute Hospital setting (for example, completing a course of IV antibiotics at home).
- b. Benefits for charges Incurred for them would not otherwise be covered under this Program.

"Catastrophic Illness or Injury": One of the following:

- a. head injury requiring an Inpatient stay;
- b. spinal cord injury;
- c. severe burn over **20%** or more of the body;
- d. multiple injuries due to an accident;
- e. premature birth;
- f. CVA or stroke;

- g. congenital defect, which severely impairs a bodily function;
- h. brain damage due to: an Injury; or cardiac arrest; or a Surgical procedure;
- i. terminal Illness, with a prognosis of death within six months;
- j. Acquired Immune Deficiency Syndrome (AIDS);
- k. Substance Abuse;
- l. a Mental or Nervous Disorders; or
- m. any other Illness or Accidental Injury determined by Horizon BCBSNJ to be catastrophic.

Alternate Treatment/Individual Case Management Plan

Horizon BCBSNJ will identify cases of Catastrophic Illness or Injury. We will evaluate the appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received. To maintain or enhance the quality of patient care for the Covered Person, Horizon BCBSNJ will develop an Alternate Treatment/Individual Case Management Plan.

- a. An Alternate Treatment/Individual Case Management Plan is a specific written document. It is developed by Horizon BCBSNJ through discussion and agreement with:
 - 1. the Covered Person, or his/her legal guardian if necessary;
 - 2. the Covered Person's attending Practitioner; and
 - 3. Horizon BCBSNJ or its designee.
- b. The Alternate Treatment/Individual Case Management Plan includes:
 - 1. treatment plan objectives;
 - 2. a course of treatment to accomplish those objectives;
 - 3. the responsibility of each of these parties in carrying out the plan:
 - (a) Horizon BCBSNJ;
 - (b) the attending Practitioner;
 - (c) the Covered Person;
 - (d) the Covered Person's family, if any; and
 - 4. the estimated cost of the plan and savings.

If Horizon BCBSNJ, the attending Practitioner and the Covered Person agree in writing on an Alternate Treatment/Individual Case Management Plan, the services and supplies needed for it will be deemed to be Covered Charges under this Program.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment/Individual Case Management Plan will be counted toward any Benefit Period and/or Per Lifetime maximum that applies to the Covered Person.

Exclusion

Alternate Treatment/Individual Case Management does not include services and supplies that Horizon BCBSNJ determines to be Experimental or Investigational.

CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence": A Provider that has entered into an agreement with Horizon BCBSNJ to provide health benefit services for specific Procedures.

"Pre-Treatment Screening Evaluation": The review of past and present medical records and current X-ray and lab results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure": One or more Surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

- a. perform a pre-treatment screening evaluation; and
- b. determine that the procedure is Medically Necessary and Appropriate for the Covered Person's treatment.

Benefits for services and supplies at a Center of Excellence will be subject to the terms and conditions of this Program. The Utilization Review features described above will not apply.

SCHEDULE OF PROCEDURES REQUIRING PRIOR AUTHORIZATION

- All Admissions to a Skilled Nursing Facility or Subacute Facilities.
- All Possible Cosmetic or Plastic Services.
- Cardiac Catheterization.
- Computed Tomography - CT Scans (Outpatient).
- Elective Inpatient Admissions.
- Gamete Intra Fallopian Transfer (GIFT).
- Gastric Bypass/Bariatric Procedures.
- Home Health Care.
- Home IV Infusions.
- Hospice Care.
- Implantable Cardioverter/Defibrillators (ICD).
- In-Vitro Fertilization (IVF).
- Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA).
- Nuclear Medicine Imaging (including cardiac procedures).
- Pacemakers.
- Positron Emission Tomography (PET) Scans.
- Private Duty Nursing.
- Reconstructive Surgery.
- Sinus (Nasal) Surgery.
- Specialty Pharmaceuticals.
- Ultrasound Echo Stress and Echocardiography, including nuclear and gated studies.
- Zygote Intra Fallopian Transfer (ZIFT).

EXCLUSIONS

The following are not Covered Services and Supplies under this Program. Horizon BCBSNJ will not pay for any charges Incurred for, or in connection with:

Acupuncture.

Administration of oxygen, except as otherwise stated in this Booklet.

Ambulance, in the case of a non-Medical Emergency.

Anesthesia and consultation services when they are given in connection with Non-Covered Charges.

Any part of a charge that exceeds the Allowance.

Any therapy not included in the definition of Therapy Services.

Blood or blood plasma or other blood derivatives or components that are replaced by a Covered Person.

Broken appointments.

Charges Incurred during a Covered Person's temporary absence from a Provider's grounds before discharge.

Completion of claim forms.

Consumable medical supplies.

Cosmetic Services. This includes the following connected with Cosmetic Services: procedures; treatments; drugs; biological products; and complications of cosmetic Surgery.

Court ordered treatment that is not Medically Necessary and Appropriate.

Custodial Care or domiciliary care, including respite care except as otherwise stated in this Booklet.

Dental care or treatment, except as otherwise stated in this Booklet. This includes, but is not limited to: (a) the restoration of tooth structure lost by decay, fracture, attrition, or erosion; (b) endodontic treatment of teeth; (c) Surgery and related services to treat periodontal disease; (d) osseous Surgery and any other Surgery to the periodontium; (e) replacing missing teeth; (f) the removal and re-implantation of teeth (and related services); (g) any orthodontic treatment; (h) dental implants and related services; and (i) orthognathic Surgery. For the purposes of this Program, orthognathic Surgery will always be deemed a dental treatment.

Diversional/recreational therapy or activity.

Employment/career counseling.

Expenses Incurred after any payment, duration or Visit maximum is or would be reached.

Experimental or Investigational treatments; procedures; hospitalizations; drugs; biological products; or medical devices, except as otherwise stated in this Booklet.

Eye Exams; eyeglasses; contact lenses; and all fittings, except as otherwise stated in this Booklet; orthoptic therapy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Eye refractions.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility.

Food products (including enterally administered food products). But, this exclusion does not apply to the foods, food products and specialized non-standard infant formulas that are eligible for coverage in accordance with the subsections "Inherited Metabolic Disease" and "Specialized Non-standard Infant Formulas" in this Booklet's "Summary of Covered Services and Supplies."

Home Health Care Visits: connected with administration of dialysis.

Hospice Services, except as otherwise stated in this Booklet.

Housekeeping services, except as an incidental part of Covered Services and Supplies furnished by a Home Health Agency.

Illness or Injury, including a condition which is the result of an Illness or Injury, which: (a) occurred on the job; and (b) is covered or could have been covered for benefits provided under a workers' compensation, employer's liability, occupational disease or similar law. However, this exclusion does not apply to the following persons for whom coverage under workers' compensation is optional, unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership; members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

Immunizations, except as otherwise stated in this Booklet.

Light box therapy, and the appliance that radiates the light.

Local anesthesia charges billed separately by a Practitioner for Surgery performed on an Outpatient basis.

Maintenance therapy for:

- Physical Therapy;
- Manipulative Therapy;

- Occupational Therapy; and
- Speech Therapy.

Marriage, career or financial counseling; sex therapy.

Membership costs for: health clubs; weight loss clinics; and similar programs.

Methadone maintenance.

Milieu Therapy:

Inpatient services and supplies which are primarily for milieu therapy even though covered treatment may also be provided.

This means that Horizon BCBSNJ has determined that:

1. the purpose of all or part of an Inpatient stay is chiefly to change or control a patient's environment; and
2. an Inpatient setting is not Medically Necessary and Appropriate for the treatment furnished, if any.

Non-medical equipment which may be used chiefly for personal hygiene or for the comfort or convenience of a Covered Person rather than for a medical purpose. This includes: air conditioners; dehumidifiers; purifiers; saunas; hot tubs; televisions; telephones; first aid kits; exercise equipment; heating pads; and similar supplies which are useful to a person in the absence of Illness or Injury.

Pastoral counseling.

Personal comfort and convenience items.

Prescription Drugs that in the usual course of medical practice are self-administered or dispensed by a retail or mail-order Pharmacy. But, this does not apply to Specialty Pharmaceuticals that are; (i) purchased from a Specialty Pharmaceutical Vendor or other pharmacy; and (ii) administered in a Practitioner's office or a Facility.

Private Duty Nursing, except as otherwise stated in this Booklet.

Psychoanalysis to complete the requirements of an educational degree or residency program.

Psychological testing for educational purposes.

Removal of abnormal skin outgrowths and other growths. This includes, but is not limited to, paring or chemical treatments to remove: corns; callouses; warts; hornified nails; and all other growths, unless it involves cutting through all layers of the skin. This does not apply to services needed for the treatment of diabetes.

Rest or convalescent cures.

Room and board charges for any period of time during which the Covered Person was not physically present in the room.

Routine exams (including related diagnostic X-rays and lab tests) and other services connected with activities such as the following: pre-marital or similar exams or tests; research studies; education or experimentation; mandatory consultations required by Hospital regulations.

Routine Foot Care, except as may be Medically Necessary and Appropriate for the treatment of certain Illnesses or Injuries. This includes treatment for: corns; calluses; flat feet; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet, except as otherwise stated in this Booklet.

Services and supplies related to: hearing exams to determine the need for hearing aids; the purchase, modification, repair and maintenance of hearing aids; and the need to adjust them, except as otherwise provided in "Hearing Aids and Related Services" and "Newborn Hearing Screening" in the Policy's/Booklet's "Summary of Covered Services and Supplies".

Services involving equipment or Facilities used when the purchase, rental or construction has not been approved in compliance with applicable state laws or regulations.

Services performed by any of these:

- a. A Hospital resident, intern or other Practitioner who: is paid by a Facility or other source; and is not allowed to charge for Covered Services and Supplies, whether or not the Practitioner is in training. But, Hospital-employed physician Specialists may bill separately for their services.
- b. Anyone who does not qualify as a Practitioner.

Services required by the Employer as a condition of employment; services rendered through a medical department, clinic, or other similar service provided or maintained by the Employer.

Services or supplies:

- eligible for payment under either federal or state programs (except Medicare and Medicaid when, by law, this Program is primary). This provision applies whether or not the Covered Person asserts his/her rights to obtain this coverage or payment for these services;
- for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
- for which the Provider has not received a certificate of need or such other approvals as are required by law;
- for which the Covered Person would not have been charged if he/she did not have health care coverage;

- furnished by one of these members of the Covered Person's family, unless otherwise stated in this Booklet: Spouse, or Domestic Partner, child, parent, in-law, brother or sister;
- connected with any procedure or exam not needed for the diagnosis or treatment of an Injury or Illness for which a bona fide diagnosis has been made because of existing symptoms;
- needed due to an Injury or Illness to which a contributing cause was the Covered Person's commission of, or attempt to commit, a felony; or to which a contributing cause was the Covered Person's engagement in an illegal occupation;
- provided by a Practitioner if the Practitioner bills the Covered Person directly for the services or supplies, regardless of the existence of any financial or contractual arrangement between the Practitioner and the Provider;
- provided by or in a government Hospital, or provided by or in a Facility run by the Department of Defense or Veteran's Administration for a service-related Illness or Injury unless law otherwise requires coverage for the services;
- provided by a licensed pastoral counselor in the course of his/her normal duties as a pastor or minister;
- provided by a social worker, except as otherwise stated in this Booklet;
- provided during any part of a stay at a Facility, or during Home Health Care, chiefly for: bed rest; rest cure; convalescence; custodial or sanatorium care, diet therapy or occupational therapy;
- provided to treat an Injury or Illness suffered: (a) as a result of War or an Act of War, if the injury or Illness occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization; and (b) as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the Injury or Illness occurs while the Covered Person is serving in such forces and is outside the Home Area.
- provided to treat an Injury or Illness suffered: (a) as a result of War or an Act of War while the Covered Person is serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and (b) as a result of the special hazards incident to such service, provided the Injury or Illness occurs while; (i) the Covered Person is serving in such unit; and (ii) is outside the Home Area.
- provided to treat an Injury or Illness suffered as a result of War or an Act of War while the Covered Person is not in the military, naval or air forces of any country, combination of countries or international organization or in any civilian non-combatant unit

supporting or accompanying such forces, if the Injury or Illness occurs outside the Home Area.

- rendered prior to the Covered Person's Coverage Date or after his/her coverage under this Program ends, except as otherwise stated in this Booklet;
- which are specifically limited or excluded elsewhere in this Booklet;
- which are not Medically Necessary and Appropriate; or
- for which a Covered Person is not legally obligated to pay.

Special medical reports not directly related to treatment of the Covered Person (e.g., employment physicals; reports prepared due to litigation.)

Stand-by services required by a Practitioner; services performed by surgical assistants not employed by a Facility.

Sterilization reversal.

Sunglasses, even if by prescription.

Surgery, sex hormones, and related medical and psychiatric services to change sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as Horizon BCBSNJ may request.

The administration or injection of any drugs; except that this will not apply to a drug that: (a) has been prescribed for a treatment for which it has not been approved by the FDA; and (b) has been recognized as being medically appropriate for such treatment in: the American Hospital Formulary Service Drug Information; the United States Pharmacopoeia Drug Information; or by a clinical study or review article in a major peer-reviewed professional journal.

TMJ syndrome treatment, except as otherwise stated in this Booklet.

Transplants, except as otherwise stated in this Booklet.

Transportation; travel, except as otherwise provided in this Booklet for ambulance service.

Vision therapy; vision or visual acuity training; orthoptics; pleoptics.

Vitamins and dietary supplements, except prenatal and children's vitamins requiring a Prescription.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods; food supplements; liquid diets; diet plans; or any related products, except as otherwise stated in this Booklet.

Wigs; toupees; hair transplants; hair weaving; or any drug used to eliminate baldness, except as otherwise stated in this Booklet.

COORDINATION OF BENEFITS AND SERVICES

PURPOSE OF THIS PROVISION

A Covered Person may be covered for health benefits or services by more than one plan. For instance, he or she may be covered by this Program as an Employee and by another plan as a Dependent of his or her Spouse. If he or she is, this provision allows Horizon BCBSNJ to coordinate what Horizon BCBSNJ pays or provides with what another plan pays or provides. This provision sets forth the rules for determining which is the primary plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all plans under which the Covered Person is covered.

DEFINITIONS

The terms defined below have special meanings when used in this provision. Please read these definitions carefully. Throughout the rest of this provision, these defined terms appear with their initial letter capitalized.

Allowable Expense: The charge for any health care service, supply or other item of expense for which the Covered Person is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

Horizon BCBSNJ will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

When this Program is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, Horizon BCBSNJ will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A Calendar Year, or portion of a Calendar Year, during which a Covered Person is covered by this Program and at least one other Plan and incurs one or more Allowable Expense(s) under such Plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

- a. Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- b. Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- c. Group or group-type coverage through a Health Maintenance Organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;

- d. Group hospital indemnity benefit amounts that exceed \$150.00 per day;
- e. Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

- a. Individual or family insurance contracts or subscriber contracts;
- b. Individual or family coverage through a Health Maintenance Organization HMO or under any other prepayment, group practice and individual practice plans;
- c. Group or group-type coverage where the cost of coverage is paid solely by the Covered Person except when coverage is being continued pursuant to a Federal or State continuation law;
- d. Group hospital indemnity benefit amounts of \$150.00 per day or less;
- e. School accident-type coverage;
- f. A State plan under Medicaid.

Primary Plan: A Plan under which benefits for a Covered Person's health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "a" or "b" below exist:

- a. The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
- b. All Plans which cover the Covered Person use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the Plan determines its benefit first.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

Secondary Plan: A Plan which is not a Primary Plan. If a Covered Person is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

Horizon BCBSNJ considers each Plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the Plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determines the order among the Secondary Plans. The Secondary Plan(s) will pay the person's remaining unpaid Allowable Expenses that have been Incurred during that Claim Determination Period, but no Secondary Plan will pay more in a Claim Determination Period than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the **Procedures to be Followed by the Secondary Plan to Calculate Benefits** section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for Medically Necessary and Appropriate services and supplies on the basis that pre-authorization, Pre-Approval, or Second Surgical Opinion procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the Covered Person as an Employee, Member, subscriber or Retiree shall be determined before those of the Plan that covers the Covered Person as a Dependent. The coverage as an Employee, Member, subscriber or Retiree is the Primary Plan.

The benefits of the Plan that covers the Covered Person as an Employee who is neither laid off nor retired, or as a Dependent of such person, shall be determined before those of the Plan that covers the Covered Person as a laid off or retired Employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the Covered Person as an Employee, Member, subscriber or Retiree, or as the Dependent of such person, shall be determined before those of the Plan that covers the Covered Person under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a Child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

- a. The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
- b. If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the Plan covering the parent for a shorter period of time.

- c. Birthday, as used above, refers only to month and day in a Calendar Year, not the year in which the parent was born.
- d. If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a Child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

- a. The benefits of the Plan of the parent with custody of the Child shall be determined first.
- b. The benefits of the Plan of the spouse of the parent with custody shall be determined second.
- c. The benefits of the Plan of the parent without custody shall be determined last.
- d. If the terms of a court decree state that one of the parents is responsible for the health care expenses for the Child, and if the entity providing coverage under that Plan has knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which Plan is the Primary Plan, the benefits of the Plan that covers the Employee, Member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

PROCEDURES TO BE FOLLOWED BY THE SECONDARY PLAN TO CALCULATE BENEFITS

In order to determine which procedure to follow it is necessary to consider:

- a. The basis on which the Primary Plan and the Secondary Plan pay benefits; and
- b. Whether the Provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the Provider bills a charge and the Covered Person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a Reasonable and Customary Charge is called a “Reasonable and Customary Charge Plan.”

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a Provider, called an In- Network Provider, bills a charge, the Covered Person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a “Fee Schedule Plan.” If the Covered Person uses the services of an Out-of-Network Provider, the Plan will be

treated as a Reasonable and Customary Charge Plan even though the Plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means that the carrier pays the Provider a fixed amount per member. The Covered Person is liable only for the applicable Deductible, Coinsurance and/or Copayment. In this section, a Plan that pays Providers based upon capitation is called a “Capitation Plan.”

In the rules below, “Provider” refers to the provider who provides or arranges the services or supplies.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the Provider is an In-Network Provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- a. The amount of any Deductible, Coinsurance and/or Copayment required by the Primary Plan; or
- b. The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the Provider receives from the Primary Plan, the Secondary Plan and the Covered Person shall not exceed the fee schedule of the Primary Plan. In no event shall the Covered Person be responsible for any payment in excess of the Copayment, Coinsurance and/or Deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Reasonable & Customary Plan

If the Provider is an In-Network Provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- a. The amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or
- b. The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Reasonable & Customary Plan or Fee Schedule Plan

If the Primary Plan is an HMO Plan that does not allow for the use of Out-of-Network Providers except in the event of Urgent Care or a Medical Emergency and the service or supply the Covered Person receives from an Out-of-Network Provider is not considered as Urgent Care or a Medical Emergency, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or Reasonable & Customary Plan

If the Covered Person receives services or supplies from a Provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

- a. The amount of any Deductible, Coinsurance and/or Copayment required by the Primary Plan; or
- b. The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or Reasonable & Customary Plan and Secondary Plan is Capitation Plan

If the Covered Person receives services or supplies from a Provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the Provider and shall not be liable to pay the Deductible, Coinsurance and/or Copayment imposed by the Primary Plan. The Covered Person shall not be liable to pay any Deductible, Coinsurance and/or Copayment of either the Primary Plan or the Secondary Plan

BENEFITS PAYABLE FOR AUTOMOBILE RELATED INJURIES

This section applies when expenses are Incurred by a Covered Person due to an Automobile Related Injury.

Definitions

"Automobile Related Injury": Bodily injury of a Covered Person due to an accident while occupying, entering into, alighting from or using an auto; or if the Covered Person was a pedestrian, caused by an auto or by an object propelled by or from an auto.

"Allowable Expense": A Medically Necessary and Appropriate, reasonable and customary item of expense that is at least in part a Covered Charge under this Program or PIP.

"Eligible Expense": That portion of expense Incurred for treatment of an Injury which is covered under this Program without application of Deductibles or Copayments, if any.

"Out-of-State Automobile Insurance Coverage" or "OSAIC": Any coverage for medical expenses under an auto insurance contract other than PIP. This includes auto insurance contracts issued in another state or jurisdiction.

"PIP": Personal injury protection coverage (i.e., medical expense coverage) that is part of an auto insurance contract issued in New Jersey.

Application of this Provision

When expenses are Incurred as a result of an Automobile Related Injury, and the injured person has coverage under PIP or OSAIC, this provision will be used to determine whether this Program provides coverage that is primary to such coverage or secondary to such coverage.

Determination of Primary or Secondary Coverage

This Program provides secondary coverage to PIP unless this Program's health coverage has been elected as primary by or for the Covered Person. This election is made by the named insured under a PIP contract. It applies to that person's family members who are not themselves named insured under other auto contracts. This Program may be primary for one Covered Person, but not for another if the persons have separate auto contracts and have made different selections regarding the primary of health coverage.

This Program is secondary to OSAIC. But, this does not apply if the OSAIC contains provisions that make it secondary or excess to the Covered Person's other health benefits. In that case, this Program is primary.

If the above rules do not determine which health coverage is primary, or if there is a dispute as to whether this Program is primary or secondary, this Program will provide benefits for Covered Charges as if it were primary.

Benefits This Program Will Pay if it is Primary to PIP or OSAIC

If this Program is primary to PIP or OSAIC, it will pay benefits for Covered Charges in

accordance with its terms. If there are other plans that: (a) provide benefits to the Covered Person; and (b) are primary to auto insurance coverage, then this Program's rules regarding the coordination of benefits will apply.

Benefits This Program Will Pay if it is Secondary to PIP

If this Program is secondary to PIP, the actual coverage will be the lesser of:

- a. the Allowable Expenses left uncovered after PIP has provided coverage (minus this Program's Deductibles, Copayments, and/or Coinsurance); or
- b. the actual benefits that this Program would have paid if it provided its coverage primary to PIP.

Medicare

To the extent that this Program provides coverage that supplements Medicare's, then this Program can be primary to automobile insurance only insofar as Medicare is primary to auto insurance.

THE EFFECT OF MEDICARE ON BENEFITS

IMPORTANT NOTICE

For the purposes of this Booklet's "Coordination of Benefits and Services" provision, the benefits for a Covered Person may be affected by whether he/she is eligible for Medicare and whether the "Medicare as Secondary Payer" rules apply to the Program. This section, on "Medicare as Secondary Payer", or parts of it, may not apply to this Program. The Employee must contact the Policyholder to find out if the Policyholder is subject to Medicare as Secondary Payer rules.

For the purpose of this section:

- a. "Medicare" means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
- b. A Covered Person is deemed to be eligible for Medicare by reason of age from the first day of the month during which he/she reaches age 65. But, if the Covered Person is born on the first day of a month, he/she is deemed to be eligible for Medicare from the first day of the month that is immediately prior to his/her 65th birthday. A Covered Person may also be eligible for Medicare by reason of disability or End-Stage Renal Disease (ESRD).
- c. Under the rules for coordination of benefits and services described earlier, a "Primary Plan" pays benefits for a Covered Person's Covered Charges first, ignoring what the Covered Person's "Secondary Plan(s)" pays. The "Secondary Plan(s)" then pays the remaining unpaid Allowable Expenses in accordance with the provisions of the Covered Person's secondary health plan.

The following rules explain how this Program's group health benefits interact with the benefits available under Medicare as Secondary Payer rules. A Covered Person may be eligible for Medicare by reason of age, disability or ESRD. Different rules apply to each type of Medicare eligibility as explained below:

In all cases where a person is eligible for Medicare and this Program is the secondary plan, the Allowable Expenses under this Program and for the purposes of the Coordination of Benefits and Services rules, will be reduced by what Medicare would have paid if the Covered Person had enrolled for full Medicare coverage. But this will not apply, however, if; (a) the Covered Person is eligible for, but not covered, under Part A of Medicare; and (b) he/she could become covered under Part A only by enrolling and paying the required premium for it.

Medicare Eligibility by Reason of Age (Generally for Employers with at least 20 Employees.)

This part applies to a Covered Person who:

- a. is the Employee or covered Spouse; and

- b. is eligible for Medicare by reason of age; and
- c. has coverage under this Program due to the current employment status of the Employee.

Under this part, such a Covered Person is referred to as a "Medicare eligible".

This part does **not** apply to:

- a. a Covered Person, other than an Employee or covered Spouse;
- b. a Covered Person who is under age 65; or
- c. a Covered Person who is eligible for Medicare solely on the basis of ESRD.

When a Covered Person becomes eligible for Medicare by reason of age, he/she must choose one of these options:

Option (A) - Choose this Program as the primary health plan.

When (a) a Medicare eligible person chooses this Program as the primary health plan; and (b) Incurs a Covered Charge for which benefits are payable under this Program and Medicare, this Program is deemed primary. This Program pays first, ignoring Medicare. Medicare is deemed the secondary health plan.

Option (B) - Choose Medicare as the primary health plan.

When a Medicare eligible person chooses Medicare as the primary health plan, he/she will no longer be covered by this Program, as required by Medicare's rules. Coverage under this Program will end on the date the Covered Person elects Medicare as his/her primary health plan.

If the Medicare eligible person fails to choose either option when becoming eligible for Medicare by reason of age, Horizon BCBSNJ will pay benefits as if he/she had chosen Option (A).

If the Medicare eligible person chooses Option (B), he/she can subsequently change the election and choose Option (A), subject to the Policyholder's requirements for enrolling in this Program.

Medicare Eligibility by Reason of Disability (Generally for Employers with at least 100 Employees.)

This part applies to a Covered Person who:

- a. is under age 65;
- b. is eligible for Medicare by reason of disability; and
- c. has coverage under this Program due to the current employment status of the Employee.

This part does **not** apply to:

- a. a Covered Person who is eligible for Medicare by reason of age; or
- b. a Covered Person who is eligible for Medicare solely on the basis of ESRD.

When a Covered Person becomes eligible for Medicare by reason of disability, this Program is the primary plan; Medicare is the secondary plan.

Medicare Eligibility by Reason of End Stage Renal Disease (Applies to all Employers.)

This part applies to a Covered Person who is eligible for Medicare solely on the basis of ESRD.

This part does **not** apply to a Covered Person who is:

- a. eligible for Medicare by reason of age ; or
- b. eligible for Medicare by reason of disability.

When (a) a Covered Person becomes eligible for Medicare solely on the basis of ESRD; and (b) Incurs a charge for the treatment of ESRD for which benefits are payable under both this Program and Medicare, this Program is deemed the Primary Plan for a specified time, referred to as the “coordination period”. This Program pays first, ignoring Medicare. Medicare is the Secondary Plan. The coordination period is 30 consecutive months.

The coordination period starts on the earlier of:

- a. the first month of a Covered Person’s Medicare Part A entitlement based on ESRD; or
- b. the first month in which he/she could become entitled to Medicare if he/she filed a timely application.

After the 30-month period described above ends, if an ESRD Medicare eligible person Incurs a charge for which benefits are payable under both this Program and Medicare, Medicare is the Primary Plan and this Program is the Secondary Plan.

Dual Medicare Eligibility

This part applies to a Covered Person who is eligible for Medicare on the basis of ESRD and either age or disability.

When a Covered Person who is eligible for Medicare due to either age or disability (other than ESRD) has this Program as the primary payer, then becomes eligible for Medicare based on ESRD, this Program continues to be the primary payer for the first 30 months of dual eligibility. After the 30-month period, Medicare becomes the primary payer (as long as Medicare dual eligibility still exists).

When a Covered Person who is eligible for Medicare due to either age or disability (other than ESRD) has this Program as the secondary payer, then becomes eligible for Medicare based on ESRD, this Program continues to be the secondary payer.

When a Covered Person who is eligible for Medicare based on ESRD also becomes eligible for Medicare based on age or disability (other than ESRD), this Program continues to be the primary payer for 30 months after the date of Medicare eligibility based on ESRD.

How To File A Claim If You Are Eligible For Medicare

Follow the procedure that applies to you or the Covered Person from the categories listed below when filing a claim.

New Jersey Providers:

- The Covered Person should give the Practitioner or other Provider his/her identification number. This number is shown on the Medicare Request for Payment (claim form) under “Other Health Insurance”;
- The Provider will then submit the Medicare Request for Payment to the Medicare Part B carrier;
- After Medicare has taken action, the Covered Person will receive an Explanation of Benefits form from Medicare;
- If the remarks section of the Explanation of Benefits contains this statement, no further action is needed: “This information has been forwarded to Horizon Blue Cross Blue Shield of New Jersey for their consideration in processing supplementary coverage benefits;”
- If the above statement does not appear on the Explanation of Benefits, the Covered Person should include his/her Identification number and the name and address of the Provider in the remarks section of the Explanation of Benefits and send it to us.

Out-of-State Providers:

- The request for Medicare payment should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information;
- Upon receipt of the Explanation of Benefits, show the Identification Card number and the name and address of the Provider in the remarks section and send the Explanation of Benefits to us for processing.

CLAIMS PROCEDURES

Claim forms and instructions for filing claims will be provided to Covered Persons by the Employer. Completed claim forms and any other required materials must be submitted to Horizon BCBSNJ or its designees for processing. Covered Persons do not need to file claims for In-Network Covered Services and Supplies. For Out-of-Network Covered Services and Supplies, Covered Persons will generally have to file a claim for benefits, unless a state law requires Providers to file claims on behalf of Covered Persons. In this case, however, a Covered Person still has the option to file claims on his/her own behalf.

If Horizon BCBSNJ fails to furnish claim forms to the Employer for delivery to Covered Persons, or if the Covered Person fails to receive them from the Employer within 15 days after requesting them, the Covered Person making a claim will be deemed to have met the requirements for giving proofs of loss (see item b. under "Submission of Claims", below) if he or she submits written proof of loss covering the occurrence, character and extent of the loss within the time limit for submitting such proof.

Submission of Claims

These procedures apply to the filing of claims. All notices from Horizon BCBSNJ will be in writing.

- a. If a Deductible applies under the Program, we recommend that it should be met before a claim is filed. Once the first claim is filed, we recommend that you send later claims: (a) when you or a covered Dependent Incurs \$100.00 or more in Covered Charges; or (b) whenever a lesser amount has been Incurred and four months have passed from the time you submitted your first claim.
- b. Claim forms must be filed no later than 18 months after the date the services were Incurred.
- c. Itemized bills must accompany each claim form. A separate claim form is needed for each claim filed. In general, the bills must contain enough data to identify: the patient; the Provider; the type of service and the charge for each service and the Provider's license number.

Bills for Prescription Drugs must contain: the prescription number; and the name, strength and quantity of the drug dispensed.

Bills for Private Duty Nursing must state that the Nurse is a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) and must contain the Nurse's license number.
- d. Horizon BCBSNJ will pay all Clean Claims no later than 30 calendar days of receipt. If the claim is not a Clean Claim, we will pay any part of it that is complete and proper according to these time limits.

- e. If a claim is disputed or denied due to missing information or documentation, Horizon BCBSNJ will pay the claim within 30 calendar days after receipt of the missing information or documentation.
- f. If a claim is denied or disputed, in whole or in part, Horizon BCBSNJ will notify the claimant (or his/her agent or designee) of it within 30 calendar days after receipt of the claim.

The denial notice will set forth:

1. the reason(s) the claim is denied;
 2. specific references to the main Program provision(s) on which the denial is based;
 3. a specific description of any further material or information needed to complete the claim, and why it is needed;
 4. a statement that the claim is disputed, if this is so. If the dispute is about the amount of the claim, we will explain why and also explain any change of coding that we make;
 5. a statement of the special needs to which the claim is subject, if this is the case;
 6. an explanation of the Program's claim review procedure, including any rights to pursue civil action;
 7. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either the specific rule or a statement that such a rule was relied upon in making the decision, and that a copy of such rule will be provided free of charge upon request;
 8. if the decision is based on Medical Necessity and Appropriateness or an Experimental or Investigational (or similar) exclusion or limitation, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Program to the medical circumstances, or a statement that such explanation will be provided free of charge upon request;
 9. if the decision involves a Medical Emergency or Urgent Care, a description of the expedited review process applicable to such claims; and
 10. the toll free number that the Covered Person or his/her Provider can call to discuss the claim.
- g. If Horizon BCBSNJ does not process claims within the time frames described above, we will pay interest on the claims as and to the extent required by law.
 - h. This applies if an Employee is the non-custodial parent of a Child Dependent. In this case, Horizon BCBSNJ will give the custodial parent the information needed for the

Child Dependent to obtain benefits under the Program. We will also permit the custodial parent, or the Provider with the authorization of the custodial parent, to submit claims for Covered Services and Supplies without the Employee's approval.

To Whom Payment Will Be Made

- a. Payment for services of an In-Network Provider or a BlueCard Provider will be made directly to that Provider if the Provider bills Horizon BCBSNJ, as Horizon BCBSNJ determines. To receive In-Network coverage, a Covered Person must show his/her ID card when requesting Covered Services and Supplies from a Provider that has such an agreement.
- b. Payment for services of Out-of-Network Providers will be made to you.
- c. Except as stated above, in the event of a Covered Person's death or total incapacity, any payment or refund due will be made to his/her heirs, beneficiaries, trustees or estate.
- d. If an Employee is the non-custodial parent of a Child Dependent, Horizon BCBSNJ will pay claims filed as described in paragraph d of the section "Submission of Claims" directly to: the Provider or Custodial parent; or the Division of Medical Assistance and Health Services in the Department of Human Services which administers the State Medicaid program, as appropriate.

If Horizon BCBSNJ pays anyone who is not entitled to benefits under this Program, Horizon BCBSNJ has the right to recover those payments.

BlueCard Claims

When you obtain health care services through BlueCard outside the geographic area Horizon BCBSNJ serves, the amount you pay for covered services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over-or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the usual BlueCard method described in the first paragraph of this section or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

APPEALS PROCESS

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) may appeal Horizon BCBSNJ's administrative and Utilization Review (UR) decisions. Administrative decisions involve benefit issues. Utilization Review decisions involve a denial, termination or other limitation of covered health care services. No Covered Person or Provider who files an appeal will be subject to disenrollment, discrimination or penalty by Horizon BCBSNJ.

The appeal process consists of: (a) an informal internal review by Horizon BCBSNJ; (b) a formal internal review by Horizon BCBSNJ; and (c) a formal external review by an independent Utilization Review Organization (IURO). The external review by an IURO is only available for Utilization Review decisions. Nothing in Horizon BCBSNJ's policies, procedures or Provider contracts prevents a Covered Person (or Provider acting on behalf of the Covered Person and with the Covered Person's consent) from discussing or exercising the right to an appeal.

A Covered Person must follow the steps for filing the three levels of appeal. If these steps are not followed, the Covered Person's appeal review may be delayed. Also, in the case of a Utilization Review matter, the Covered Person may be prevented from pursuing an external review. If Horizon BCBSNJ fails to comply with the appeals process or expressly waives its rights to an internal review of any appeal, then the Covered Person (or Provider acting on behalf of the Covered Person and with the Covered Person's consent) may proceed directly to the formal external review.

a. First Level Appeal

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) can file a First Level Appeal by calling or writing Horizon BCBSNJ at the telephone number and address on the Covered Person's ID card. At the First Level Appeal, a Covered Person may discuss an adverse medical decision directly with the Horizon BCBSNJ physician who made it, or with the medical director designated by Horizon BCBSNJ. All First Level Appeals must be made within 12 months from the date that Horizon BCBSNJ informed the Covered Person of the denial of coverage or payment.

To submit a First Level Appeal, the Covered Person must include the following information:

- 1) the name(s) and address(es) of the Covered Person(s) or Provider(s) involved;
- 2) the Covered Person's ID number;
- 3) the date(s) of service;
- 4) the details regarding the actions in question;
- 5) the nature of and reason behind the appeal;
- 6) the remedy sought; and

7) the documentation to support the appeal.

We will inform Covered Persons of decisions about administrative First Level Appeals within 30 calendar days after receipt of the required documentation. We will inform Covered Persons of decisions about Utilization Review First Level Appeals regarding Medical Emergency or Urgent Care issues within 72 hours from receipt of the required documentation (including all situations in which the Covered Person is confined as an Inpatient), and within five business days of receipt of the required documentation for all other Utilization Review issues. Horizon BCBSNJ will provide the Covered Person and/or the Provider with; (a) written notice of the outcome; (b) the reasons for the decision; and (c) instructions for filing a Second Level Appeal.

b. Second Level Appeal

If a Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) is not satisfied with Horizon BCBSNJ's First Level Appeal decision, the Covered Person or Provider can file a Second Level Appeal before a panel of physicians and/or other health care professionals selected by Horizon BCBSNJ who were not involved in the original and First Level Appeal decisions. At the Covered Person's request, the Provider involved in the original medical decision may take part in the process.

Horizon BCBSNJ will acknowledge Second Level Appeals in writing within ten business days of receipt. We will provide written notice of the final decision on the appeal: (a) within 72 hours after receipt (in the case of Utilization Review appeals that require review on an expedited basis due to a Medical Emergency, Urgent Care or a Medical Necessity and Appropriateness issue); and (b) within 20 business days of receipt in the case of all other Utilization Review appeals.

Horizon BCBSNJ may extend the review for up to an additional 20 business days when: (a) there is a reasonable cause for the delay that is beyond Horizon BCBSNJ's control; and (b) the explanation satisfies the New Jersey Department of Banking and Insurance (DOBI). Horizon BCBSNJ will provide the Covered Person or Provider with written notice of the delay within the original 20 day period.

If the Second Level Appeal is denied, Horizon BCBSNJ will provide the Covered Person and/or Provider with written notice of the reasons for the denial, together with a written notice of his/her right to proceed to an external appeal. Horizon BCBSNJ will include specific instructions as to how the Covered Person and/or Provider may arrange for an external appeal and will also include any forms needed to start the appeal.

c. External Appeal

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) who is dissatisfied with the results from Horizon BCBSNJ's internal appeal process can pursue an External Appeal with an IURO assigned by the Department of Banking and Insurance. The Covered Person's right to such an appeal depends on the Covered Person's full compliance with both stages of Horizon BCBSNJ's internal appeal process. However, if, at any time during that process, Horizon BCBSNJ fails to handle the appeal within the applicable time frame set forth in a. or b., the Covered Person or his/her designated Provider can proceed immediately to

pursue the External Appeal.

To start an External Appeal, the Covered Person or Provider must submit a written request within 60 business days from receipt of the written decision about the Second Level Appeal (or within 60 business days from the last date of the filing of an appeal regarding which Horizon BCBSNJ failed to meet the required time frame set forth in a. or b., above). The Covered Person or Provider must use the required forms and include both: (a) a **\$25.00** check made payable to "New Jersey Department of Banking and Insurance"; and (b) an executed release to enable the IURO to obtain all medical records pertinent to the appeal, to:

**Office of Managed Care
New Jersey Department of Banking and Insurance
P.O. Box 325
Trenton, New Jersey 08625-0325**

If the Covered Person cannot afford to pay the fee, the fee may be reduced to a **\$2.00** fee if the Covered Person can show proof of financial hardship. Proof of financial hardship can be demonstrated through evidence that one or more members of the household is receiving aid or benefits under: Pharmaceutical Assistance to the Aged and Disabled; Medicaid; General Assistance; Social Security Insurance; NJ KidCare; or the New Jersey Unemployment Assistance program.

Upon receipt of the appeal, together with the executed release and the appropriate fee, the DOBI shall immediately assign the appeal to an IURO to conduct a preliminary review and accept it for process. But, this will happen only if the DOBI finds that:

1. the person is or was a Covered Person of Horizon BCBSNJ;
2. the service or supply which is the subject of the appeal reasonably appears to be a Covered Service or Supply under the Covered Person's Program;
3. the Covered Person has fully complied with both levels of Horizon BCBSNJ's internal appeals system; (or, alternately, that Horizon BCBSNJ failed to meet the time frames in its internal appeals system); and
4. the Covered Person has furnished all information needed by the IURO and the DOBI to make the preliminary determination. This includes: the appeal form; a copy of any information furnished by Horizon BCBSNJ regarding its decision to deny, reduce or terminate the Covered Service or Supply; and the fully executed release.

Upon completion of this review, the IURO will immediately inform the Covered Person or Provider, in writing, as to whether or not the appeal has been accepted for review. If it is not accepted, the IURO will give the reasons. If the appeal is accepted, the IURO will complete its review and issue its recommended decision within 30 business days from receipt of all documentation needed to complete its review (or within 48 hours from such receipt, if the appeal involves emergency or urgent care).

The IURO may extend the period of review for a reasonable period of time, if it is needed due to circumstances beyond its control. But, in no event will it render its decision later than 90 calendar days following receipt of a completed application. In such an event, prior to the conclusion of the 30 business day review, the IURO will provide written notice to the Covered Person or Provider, the DOBI and Horizon BCBSNJ describing the status of its review and the specific reasons for the delay.

When the IURO completes its review, it will state its findings in writing and make a determination of whether our denial, reduction, or termination of benefits deprived the Covered Person of Medically Necessary and Appropriate treatment.

If the IURO determines that the denial, reduction, or termination of benefits deprived the Covered Person of Medically Necessary and Appropriate treatment, this will be conveyed to the Covered Person and Horizon BCBSNJ. The IURO will also describe the Medically Necessary and Appropriate services that should be received. This determination is binding upon us. If all or part of the IURO's decision is in favor of the Covered Person, Horizon BCBSNJ will provide coverage for those Covered Services and Supplies that are determined to be Medically Necessary and Appropriate. If the Covered Person and/or Provider do not agree with the IURO's decision, he/she may seek the desired health care services outside of the Program.

COVERED PERSONS' RIGHTS

A Covered Person has the right to:

- Formulate and have advance directives implemented in accordance with applicable law;
- Receive prompt written notice of benefit changes or the termination of benefits or services, no later than 30 days following the date of any such change or termination;
- File a complaint with New Jersey's Department of Banking and Insurance;

**New Jersey Department of Banking and Insurance
20 West State Street
(P.O. Box 325)
Trenton, NJ 08625-0325
(609) 292-5360**

- Access Covered Services and Supplies, and receive the Program's benefits for them, and have care available 24 hours a day, seven days a week, for Medical Emergencies and Urgent Care;
- Appeal a denial, reduction or termination of health care services or benefits pursuant to a utilization management decision by or on behalf of Horizon BCBSNJ;
- Be treated with courtesy, consideration, and with respect to his/her dignity and need for privacy;
- Be provided with information concerning our policies and procedures regarding products, services, providers, appeals procedures, and with other information about the organization and the care provided;
- Obtain a current directory of Network Providers upon request, including addresses and telephone numbers, and a listing of Providers who accept Covered Persons who speak languages other than English.

SERVICE CENTERS

If you have any questions about this Program, call your nearest Service Center.

Telephone personnel are available:

Monday, Tuesday, Wednesday and Friday from 8:00a.m. to 6:00p.m.

Thursday from 9:00 a.m. to 6:00pm (E.T.) Eastern Time

For questions and assistance with your Blue Card PPO benefits and services, please call us at:

**1-800-355-BLUE
(2583)**

When you are outside of New Jersey and need to locate a **nationwide Network PPO Provider**, please call:

**1-800-355-BLUE
(2583)**

For Mental Health and Substance Abuse, please call:

1-800-626-2212

For Pre-Admission Review and Individual Case Management, please call:

**1-800-664-BLUE
(2583)**

Always have your identification card handy when calling us. Your ID number helps us to get prompt answers to your questions about enrollment, benefits or claims.

Use this space for information you will need when asking about your coverage.

The company office or enrollment official to contact about coverage:

The identification number shown on my identification card:

The effective date when my coverage begins:

My group number is:

CIVIL UNION RIDER

I. The following terms shall have the meanings set forth below:

Civil Union: A union that is either established pursuant to New Jersey law or recognized by the State of New Jersey as a Civil Union.

Civil Union Partner: A person who has established and is in a Civil Union.

II. Pursuant to New Jersey law, your Booklet is changed in the following respects:

- (a) Except as otherwise provided in (c), below, all of the rights, benefits, obligations and privileges granted under the Policy to an Employee with respect to a Spouse and their Child Dependents shall also apply equally with respect to: (i) an Employee and a person with whom he/she has established a Civil Union; and (ii) the Child Dependents of the Employee and his/her Civil Union Partner.
- (b) Except as otherwise provided in (c) below, any provision of the Policy that affects a Spouse upon his/her divorce or legal separation from the Employee shall, subject to the Policy's terms and conditions, also equally affect an Employee's Civil Union Partner upon dissolution of the Civil Union. Such provisions include, but are not limited to, the following:
 - (i) Termination of the Civil Union Partner's coverage.
 - (ii) The right of the Civil Union Partner to convert to an individual health policy.
- (c) Regardless of anything above to the contrary, any right to continue the Policy's coverage that is granted to an Employee's Spouse pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, shall not apply with respect to an Employee's Civil Union Partner.