

Product: **Horizon Direct Access-County Employees**

Company Name: **County of Monmouth**

Group Number: **86260**

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Horizon Blue Cross Blue Shield of New Jersey

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

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



Horizon Blue Cross Blue Shield of New Jersey



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

- Qualified sign language interpreters
- Information written in other languages

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

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

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

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

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

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

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INTRODUCTION

This Plan gives you and your covered Dependents broad protection to help meet the cost of Illnesses and Injuries. This Plan offers the highest level of benefits when services are obtained from a Hospital or other Provider designated as a Horizon Direct Access 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 Horizon Direct Access benefits provided by the Plan. 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.

Your benefits are self-insured through your Employer. Therefore, while Horizon BCBSNJ will initially review claims, all final claims decisions will be made by the Plan Administrator named by your Employer.

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.

Acupuncture: The practice of piercing specific sites with needles to induce Surgical anesthesia. Acupuncture is also used as a therapeutic agent for relief of pain.

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

Adverse Benefit Determination: An adverse benefit determination is any denial, reduction or termination of, or failure to provide or make payment for (in whole or in part), a benefit, including one based on a determination of eligibility, as well as one based on the application of any utilization review criteria, including determinations that an item or service for which benefits are otherwise provided are not covered because they are deemed to be experimental/investigational or not medically necessary or appropriate.

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

Allowance: Subject to the exceptions below, an amount determined by the Plan as the least of the following amounts:

- (a) the actual charge made by the Provider for the service or supply;
- (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, the amount determined as **150%** of the amount that would be reimbursed for the service or supply under Medicare:

Exceptions:

- (1) With respect to (i) a Medical Emergency; or (ii) Covered Services and Supplies provided in an In-Network Hospital, the Allowance determined in accordance with (c), above, for any Covered Services and Supplies provided by Out-of-Network Providers shall be increased as needed to ensure that the Covered Person has no greater liability than he/she would have if they were provided by In-Network Providers. But this (ii) shall not apply if the Covered Person: (a) had or was given the opportunity to select In-Network Providers to provide the Covered Services and Supplies; and (b) elected the services of Out-of-Network Providers.

- (2) In a case where a Covered Person's Primary Care Practitioner refers him/her to an Out-of-Network Provider, the Allowance for the Out-of-Network Provider's services will be the amount determined in accordance with (a), above.
- (3) With respect to (c), above, if Medicare does not prescribe a reimbursement rate for a Covered Service or Supply, the Allowance for the Covered Service or Supply will be determined based on profiles compiled by Horizon BCBSNJ based on usual and prevailing payments made to Providers for similar services or supplies in specific geographical areas, or similar profiles compiled by outside vendors.

Alternate Payee:

- a. A custodial parent, who is not an Employee or Retiree under the terms of the Plan, 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. The Plan 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.

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

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.

Behavioral Interventions Based on Applied Behavioral Analysis (ABA): Interventions or strategies, based on learning theory, that are intended to improve a person's socially important behavior. This is achieved by using instructional and environmental modifications that have been evaluated through scientific research using reliable and objective measurements. These include the empirical identification of functional relations between behavior and environmental factors.

Such intervention strategies include, but are not limited to: chaining; functional analysis; functional assessment; functional communication training; modeling (including video modeling); procedures designed to reduce challenging and dangerous behaviors; prompting; reinforcement systems, including differential reinforcement, shaping and strategies to promote generalization.

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.

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

Benefit Period: The twelve-month period starting on **October 1st and ending on September 30th**. The first and/or last Benefit Period may be less than a calendar year. The first Benefit Period begins on the Employee's or Retiree's Coverage Date. The last Benefit Period ends when the Employee or Retiree 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. The Plan 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.

The Plan does not recognize a Facility as a Birthing Center if it is part of a Hospital.

BlueCard 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 Plan, a BlueCard Provider is an In-Network Provider.

Booklet: A detailed summary of benefits covered.

Calendar Year: A year starting January 1.

Care Manager: A person or entity designated by the Plan or 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 26; and is:

- The natural born child or stepchild of you, your Spouse;
- A child who is: (a) legally adopted by you, your Spouse; or (b) placed with you for adoption. But, proof of such adoption or placement satisfactory to the Plan must be furnished to us when we ask;
- You, your Spouse's legal ward. But, proof of guardianship satisfactory to the Plan 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.

Coinsurance: The percent applied to Covered Charges (not including Deductibles) for certain Covered Services or Supplies in order to calculate benefits under the Plan. These are shown in the Schedule of Covered Services and Supplies. The term does not include Copayments. For example, if the Plan'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 the Plan will pay.

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 Plan 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 Plan, the Plan provides coverage for Covered Services or Supplies Incurred by a Covered Person while the person is covered by this Plan.

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

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.

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, the Plan does not cover care if it is custodial in nature.

Day Programs: Outpatient personalized or packaged programs that: (a) are designed primarily for patients who are medically stable enough to live at home, but who may require certain therapies; (b) offer multiple therapies in a day setting; and (c) are usually scheduled for three to five days a week and five to nine and a half hours per day. Some examples of the therapies offered are: cognitive therapy; recreation therapy; work hardening programs; vocational therapy; group cognitive/interpersonal therapy; remedial treatments; and treatments to improve interpersonal communication and social skills. “Day Programs” do not include outpatient programs for the treatment of mental illnesses.

Deductible: The amount of Covered Charges that a Covered Person must pay before this Plan 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, Civil Union Partner or Child Dependent whom the Employee or Retiree enrolls for coverage under this Plan, as described in the General Information section of this Booklet.

Developmental Disability(ies): A person’s severe chronic disability which:

- (a) is attributable to a mental or physical impairment, or a combination of them;
- (b) for the purposes solely of the provision of this Program entitled “Diagnosis and Treatment of Autism and Other Developmental Disabilities”, is manifest before age 22;
- (c) is likely to continue indefinitely;

- (d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; the capacity for independent living or economic self-sufficiency; and
- (e) reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are: (i) of lifelong or extended duration; and (ii) individually planned or coordinated.

Developmental Disability includes, but is not limited to, severe disabilities attributable to: intellectual disability; autism; cerebral palsy; epilepsy; spina-bifida; and other neurological impairments where the above criteria are met.

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.

Durable Medical Equipment: Medically Necessary and Appropriate equipment which the Plan 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; heat appliances; improvements made to the home or place of business; waterbeds; whirlpool baths; and exercise and massage equipment.

Elective Surgical Procedure: Non-emergency Surgery that may be scheduled for a day of the patient's choice without risking the patient's life or causing serious harm to the patient's bodily functions.

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

Employer: Collectively, all employers included under the Plan.

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

Essential Health Benefits: This has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act, and as further defined by the Secretary of the U.S. Department of Health and Human Services. The term includes: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); rehabilitative and habilitative services and devices; lab services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).

Experimental or Investigational: Any: treatment; procedure; Facility; equipment; drug; device; or supply (collectively, "Technology") which, as determined by The Plan, 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; or (b) proven to The Plan'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 The Plan 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, The Plan 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, The Plan 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.

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, The Plan 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, The Plan will still deem it to be Medically Necessary and Appropriate if supportive clinical evidence for the particular use of the drug is given in a clinical study or published in a major peer-reviewed medical journal. 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 Plan will provide benefits for services and supplies furnished to a Covered Person for medical care and treatment associated with: (i) an approved cancer clinical trial (Phase I, II, III and/or IV); or (ii) an approved Phase I, II, III and/or IV clinical trial for another life threatening condition. This coverage will be provided if: (a) the Covered Person's Practitioner is involved in the clinical trial; and (b) he/she has concluded that the Covered Person's participation would be appropriate. It can also be provided if the Covered Person gives medical or scientific information proving that such participation would be appropriate.

This coverage for clinical trials includes, to the extent coverage would be provided other than for the 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 clinical trial.

This coverage for clinical trials 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.

With respect to coverage for clinical trials, The Plan will not:

- Deny a qualified Covered Person participation in an approved clinical trial;

- Deny or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with an approved clinical trial; or
- Discriminate against the Covered Person on the basis of his/her participation in such a trial.

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 the Plan either: (i) is required by law to recognize; or (ii) determines in its sole discretion to be eligible under the Plan.

Family or Medical Leave of Absence: A period of time of predetermined length, approved by the Employer, 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 Plan.

FDA: The Food and Drug Administration.

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. The Plan 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:

- 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.
- 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 Plan 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. The Plan 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. The Plan 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.

The Plan 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 the Plan 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.

Incidental Surgical Procedure: One that: (a) is performed at the same time as a more complex primary procedure; and (b) is clinically integral to the successful outcome of the primary procedure.

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

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 Plan.

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, (b) the PCP provides or coordinates care, treatment, services and supplies for the Covered Person; or (c) the PCP refers the Covered Person to another provider for such care, treatment, services and supplies.

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 Plan 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.

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.

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.

Mental Health Center: A Facility, which mainly provides treatment for people with mental health problems. The Plan 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, the Plan 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 with respect to the treatment of Mental or Nervous Disorders or Developmental Disabilities.
- (3) Conditions that the Plan 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 extent required by law for the treatment of Mental or Nervous Disorders or Developmental Disabilities; 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 the Plan 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.

Mutually Exclusive Surgical Procedures: Surgical procedures that:

- (a) differ in technique or approach, but lead to the same outcome;
- (b) represent overlapping services or accomplish the same result;
- (c) in combination, may be anatomically impossible.

Negotiation Arrangement (a.k.a., Negotiated National Account Arrangement): An agreement negotiated between a control/home licensee and one or more par/host licensees for any national account that is not delivered through the BlueCard Program.

Non-Covered Charges: Charges for services and supplies which: (a) do not meet this Plan'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 Plan.

Optical Services: The following services when provided for lenses, including contact lenses, and frames:

- a. Facial measurements;
- b. Help in the selection of frames;
- c. Acquiring proper lenses and frames;
- d. Fitting and adjustment;
- e. After-care for verification of fitting and lens adjustment, and for maintenance of comfort and efficiency.

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 (a) an Out-of-Network Provider provides the service or supply; or (b) the PCP does not authorize or coordinate the care, treatment, services and supplies.

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; or chemical dependency; 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. The Plan 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.

Plan: The **County of Monmouth** Medical Plan

Plan Year: The twelve-month period starting on October 1st and ending on September 30th.

Post-Service Claim: Any claim for a benefit under a group health Plan that is not a Pre-Service claim.

Practitioner: A person that the Plan 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 Plan.

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.

Pre-Service Claim: Any claim for a benefit under a group health plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

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.

Primary Care Provider (PCP): An In-Network physician or other health care professional who: (a) is licensed or otherwise authorized to provide health care services in the state or jurisdiction in which the services are furnished; and (b) supervises, coordinates and maintains continuity of care for Covered Persons. PCPs include: nurse practitioners/clinical nurse specialists; physician assistants; and certified nurse midwives.

The Plan allows the designation of a PCP. A Covered Person has the right to choose any In-Network PCP who is available to accept the Covered Person as a patient. In the case of a Child Dependent, the parent may designate a pediatrician as the Child Dependent's PCP.

Also, a Covered Person does not need Prior Authorization from Horizon BCBSNJ or from any other person (including a PCP) to access obstetrical or gynecological care from an In-Network health care Practitioner who specializes in obstetrics or gynecology. But the Practitioner may need to comply with certain procedures, including: obtaining Prior Authorization for certain services; following a pre-approved treatment plan; or procedures for making referrals.

For information on how to select a PCP, and for a list of In-Network PCPs or Practitioners who specialize in obstetrics or gynecology, access Horizon BCBSNJ's website at www.horizonblue.com/doctorfinder. A paper version of Horizon's Doctor & Hospital Finder is also available upon request.

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 Plan.

Related Structured Behavioral Programs: Services given by a qualified Practitioner that are comprised of multiple intervention strategies, i.e., behavioral intervention packages, based on the principles of ABA. These include, but are not limited to: activity schedules; discrete trial instruction; incidental teaching; natural environment training; picture exchange communication system; pivotal response treatment; script and script-fading procedures; and self-management,

Retiree: A person who has met the requirements for Retirement from his/her employment with the Employer.

Retirement: The voluntary termination of employment with the Employer after having met the age and service requirements set by the Employer.

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. The Plan 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 Plan.

Specialist: A health care Practitioner who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Specialist Physician: A fully licensed physician who:

- (a) is a diplomat of a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association; or
- (b) is a fellow of the appropriate American specialty college or a member of an osteopathic specialty college; or
- (c) is currently admissible to take the exam administered by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association; or has evidence of completion of an appropriate qualifying

residency approved by the American Medical Association or American Osteopathic Association; or

- (d) holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or
- (e) is recognized in the community as a specialist by his or her peers.

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

Substance Abuse: The abuse or addiction to drugs or controlled substances, including alcohol.

Substance Abuse Centers: Facilities that mainly provide treatment for people with Substance Abuse problems. The Plan 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. Medically Necessary and Appropriate for the treatment of a Covered Person's Illness or

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 provided by a qualified speech therapist and is described in a., b. or c:

- 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.
- c. Regardless of anything in a. or b. above to the contrary, speech therapy needed to treat a speech impairment of a Covered Person diagnosed with a Developmental Disability.

Urgent Care: Outpatient and Out-of-Hospital medical care which, as determined by the Plan or an entity designated by the Plan, 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.

Urgent Care Claim: An Urgent Care Claim is any claim for medical care which, if denied, in the opinion of the Covered Person or his/her Provider, will cause serious medical consequences in the near future, or subject the Covered Person to severe pain that cannot be managed without the medical services that have been denied.

Value-Based Program: An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

Vision Survey: A survey and analysis performed by a Practitioner acting within the scope of his/her license, including, but not limited to: a case history; complete refraction; coordination measurements and tests; visual field charting; and prescription of lenses, as needed.

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, if any, between enrollment in the Plan and the date when a person becomes eligible for benefits.

War: Includes, but is not limited to, declared war, and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization.

We, Us and Our: The Plan.

You, Your: An Employee or Retiree.

SCHEDULE OF COVERED SERVICES AND SUPPLIES

BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS PLAN 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 THE ALLOWANCE, UNLESS OTHERWISE STATED.

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

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

The Plan 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. 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 Plan'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 the Allowance, when services are rendered by an Out-of-Network Provider.

Coinsurance **100%** of Covered Basic Charges.

In-Network **100%** of Covered Supplemental Charges.

Coinsurance **70%** of Covered Basic Charges.

Out-of-Network **70%** of Covered Supplemental Charges.

Out-of-Pocket Maximum

**In-Network
& Supplemental** After **\$5,000/Covered Person, \$10,000/family**, the Plan provides **100%** of Covered Allowance

Out-of-Network & Supplemental After **\$5,000**/Covered Person, **\$10,000**/family, the Plan, the Plan provides **100%** of Covered Allowance

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

- Non-Covered Charges

Deductible
In-Network \$0/Single
\$0/Family

Out-of-Network \$400/Single
\$800/Family (**Note:** May be aggregately met by 2 or more covered family members.)

Applies to Basic/Supplemental Services.

Deductible does not apply to Preventive Care.

BENEFIT PERIOD MAXIMUM

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

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

PER LIFETIME MAXIMUM

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

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

A. COVERED BASIC SERVICES AND SUPPLIES

ACUPUNCTURE

In-Network Subject to **\$10.00** Copayment and **100%** Coinsurance.

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

Subject to a **20** visit maximum per benefit Period, combined In-Network and Out-of-Network.

ALLERGY TESTING AND TREATMENT

In-Network Subject to **\$10.00** 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 **\$10.00** 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 **\$100.00** Copayment and **100%** Coinsurance.

FACILITY CHARGES 365 days Inpatient Hospital Care.

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

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

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

Out-of-Network

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

FERTILITY SERVICES

In-Network Subject to **\$10.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance. Out-of-network benefits are limited to the diagnosis and treatment of the underlying cause of infertility.

Limited to **6** attempts per lifetime, combined In-Network and Out-of-Network.

HOME HEALTH CARE

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

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

Subject to **120** visits per Benefit Period, combined In-Network and Out-of-Network.

HOSPICE CARE

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

Out-of-Network Subject to 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 Subject to **\$10.00** Copayment for the initial Visit, and **100%** Coinsurance.

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

MENTAL OR NERVOUS DISORDERS (INCLUDING GROUP THERAPY) AND SUBSTANCE ABUSE

Inpatient

In-Network and Out-of-Network Pursuant to federal law, benefits for these conditions must be provided on the same basis as for other conditions under the Plan.

**Outpatient and
Out-of-Hospital**

**In-Network and
Out-of-Network**

Pursuant to federal law, benefits for these conditions must be provided on the same basis as for other conditions under the Plan.

NUTRITIONAL COUNSELING

In-Network Subject to **\$10.00** Copayment, and **100%** Coinsurance.

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

PHYSICAL REHABILITATION CENTER

Inpatient

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

Inpatient

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

PRACTITIONER'S CHARGES FOR NON-SURGICAL CARE AND TREATMENT

In-Network Subject to **\$10.00** 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.

PREVENTIVE CARE

a. GYNECOLOGICAL EXAMINATIONS

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

Out-of-Network No Benefit.

Limited to one exam per Benefit Period.

b. MAMMOGRAPHY

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

Out-of-Network No Benefit.

Limited to 1 per Benefit Period for women age 40 and over

c. PAP SMEARS

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

Out-of-Network No Benefit.

d. ROUTINE PROSTATE CANCER SCREENING

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

Out-of-Network No Benefit.

e. ROUTINE ADULT PHYSICALS AND IMMUNIZATIONS

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

Out-of-Network No Benefit.

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

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

Out-of-Network No Benefit.

g. WELL-CHILD CARE

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

Out-of-Network No benefit.

h. NEWBORN HEARING SCREENING

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

Out-of-Network No benefit.

PRIMARY CARE PHYSICIAN

In-Network Subject to **\$10.00** Copayment and **100%** Coinsurance.

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

SECOND OPINION CHARGES

In-Network Subject to **\$10.00** Copayment and **100%** Coinsurance.

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

SKILLED NURSING FACILITY CHARGES

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

Out-of-Network Subject to Deductible and **70%** Coinsurance. Subject to a **60** day Benefit Period maximum.

SPECIALIST SERVICES

In-Network Subject to **\$10.00** Copayment, and **100%** Coinsurance.

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

SURGICAL SERVICES

In-Network

Inpatient Subject to **100%** Coinsurance.

Out-of-Network

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

In-Network

Outpatient Subject to **100%** Coinsurance.

Out-of-Network

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

THERAPEUTIC MANIPULATIONS

In-Network Subject to **\$10.00** Copayment, and **100%** Coinsurance.

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

The Plan does not cover more than **20** 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. DIALYSIS TREATMENT

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

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

d. INFUSION THERAPY

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

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

e. COGNITIVE REHABILITATION THERAPY

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

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

Combined In-Network and Out-of-Network benefits subject to a **60** Visit maximum per Benefit Period.

f. OCCUPATIONAL THERAPY

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

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

Combined In-Network and Out-of-Network benefits subject to a **60** Visit maximum per Benefit Period. The **60** Visit maximum does not apply to the treatment of autism.

g. SPEECH THERAPY

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

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

Combined In-Network and Out-of-Network benefits subject to a **60** Visit maximum per Benefit Period. The **60** Visit maximum does not apply to the treatment of autism.

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.

Subject to a **60** visit per condition maximum per Benefit Period, combined In-Network and Out-of-Network.

j. PHYSICAL THERAPY

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

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

Combined In-Network and Out-of-Network benefits subject to a **60** Visit maximum per Benefit Period. The **60** Visit maximum does not apply to the treatment of autism.

TRANSPLANT BENEFITS

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

Out-of-Network No Benefit.

B. COVERED SUPPLEMENTAL SERVICES AND SUPPLIES

AMBULANCE SERVICES

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

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

BLOOD

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

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

DIABETES BENEFITS

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

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

DURABLE MEDICAL EQUIPMENT

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

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

HOME INFUSION THERAPY

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

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

OXYGEN AND ADMINISTRATION

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

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

PRIVATE DUTY NURSING

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

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

PROSTHETIC DEVICES

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

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

VISION CARE

In-Network Subject to **\$10.00** Copayment, and **100%** Coinsurance.

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

Limited to one Eye Examination and one Vision Survey per Contract Year. Hardware coverage limited to \$35.00 in a 24 month period.

WIGS

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

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

GENERAL INFORMATION

How To Enroll

If you meet your Employer's eligibility rules, including any Waiting Period established by the Employer, you may enroll by completing an enrollment form. 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 Plan, 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 receives 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 Civil Union Partner and your Child Dependents.
- **Husband and Wife/Two Adults** – provides coverage for you and your Spouse or Civil Union Partner only.
- **Parent and Child(ren)** – provides coverage for you and your Child Dependents, but not your Spouse or Civil Union Partner.

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 after your marriage.

If: (a) you gain or lose a member of your family; or (b) someone covered under this Plan 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 enrolled in Family or Parent Child(ren) type health coverage, your adopted child is automatically included. However, if you are enrolled for Family or Parent Child(ren) health coverage, you must still submit an enrollment form to notify us of the addition within 31 days of the completed adoption and contribute any required additional premium. If you are enrolled for Single health coverage, you must enroll your child and contribute any required additional premium within 31 days of the completed adoption in order to continue the child's health coverage beyond that point.
- If you are enrolled for Family or Parent Child(ren) type health coverage, your newly born child is automatically covered for the initial 60 days after birth. However, if you are enrolled for Family or Parent Child(ren) health coverage, you must still submit an enrollment form to notify us of the addition within 60 days of the birth in order to continue the child's health coverage beyond that point. If you are enrolled for Single health coverage, your newly born child is automatically covered for the initial 60 days after birth. However, you must enroll your child and contribute any required additional premium within 60 days of the birth in order to continue the child's health coverage beyond that point.
- If you have Single coverage and marry, your new Spouse or Civil Union Partner will be covered from the date you marry or meet the rules for covering Civil Unions if you apply for Husband and Wife/Civil Union 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 as of the open-enrollment date.

Enrollment of Dependents

The Plan 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, the Plan will:

- Provide such information to the custodial parent as may be needed for the Child Dependent to obtain benefits through this Plan;
- 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, the Plan 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 Plan, 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 or the Plan 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 Plan 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 Plan 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 Plan will be effective as of the date that the prior health coverage ended.

New Dependents

If the following conditions are met, the Plan 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 Plan (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 or Acquiring a Civil Union Partner

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

You must request enrollment of your Spouse or Civil Union Partner within 31 days after the marriage or acquiring the Civil Union Partner.

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

Special Enrollment Due to Newborn

You may enroll a newborn Child Dependent. If you are already enrolled, Horizon BCBSNJ will cover your newborn child for 60 days from the date of birth. Health benefits may be continued beyond such 60-day period by following the requirements stated below:

- (a) You are already enrolled in dependent child coverage on the date the child is born. Coverage automatically continues beyond the initial 60 days, provided the premium required for the coverage is still paid within the 60 days from the date of birth.

(b)If you are enrolled, but not covered for child coverage on the date the child is born, you must:

- make a written request to enroll the child within 60 days; and
- contribute toward the premium amount for the coverage within 60 days from the date of birth.

If you do not make the request and the premium is not paid within such 60-day period, the child will be a Late Enrollee

A Spouse can be enrolled separately, within 31 days, when a Child Dependent is born.

An Employee who is Eligible, but who previously declined coverage under the Contract, can use Special Enrollment due to Newborn. However, these new enrollees will have 31 days from the date of the Newborn birth to make written request to enroll themselves or their newborn dependent(s). The coverage must be effective on the date of birth. Coverage will automatically continue beyond the first 31 days, provided the premium required for the coverage is paid within 31 days from the date of birth.

Special Enrollment Due to Adoption

You may enroll a newly adopted Child Dependent.

Horizon BCBSNJ will cover your newly adopt child for 31 days from the date of completed adoption/placement. Health benefits may be continued beyond such 31-day period as stated below:

(a)If you are already enrolled in dependent child coverage on the date the child is adopted, coverage automatically continues beyond the initial 31 days, provided the premium required for the coverage is still paid within the 31 days from the date of adoption.

(b)If you are enrolled, but not covered for child coverage on the date the child is adopted, you must:

- make a written request to enroll the child within 31 days; and
- contribute toward the premium for the coverage within 31 days from the date of completed adoption.

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

A Spouse can be enrolled separately, within 31 days, when a Child Dependent is adopted/placed.

An Employee who is Eligible, but who previously declined coverage under the Contract, can utilize the Special Enrollment due to adoption. These new enrollees have 31 days from the date of the completed adoption/placement to enroll themselves or their newly adopted dependents.

The coverage must be effective on the date of adoption/placement.

Multiple Employment

If you work for both the Employer and an Affiliated Company, or for more than one Affiliated Company, the Plan 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 Civil Union Partner, your Child Dependents.

Coverage for your Spouse or Civil Union Partner will end: (a) at the end of the month in which you divorce or the Civil Union dissolves; or (b) at the end of the month in which you tell us to delete your Spouse or Civil Union Partner from coverage following marital separation or the dissolution of the Civil Union.

Coverage for a Child Dependent ends the last day of the month in which the Child Dependent reaches age 26.

Coverage will continue for a Child Dependent beyond the age of 26 if, immediately prior to reaching that age, he/she was enrolled under this Plan 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 26. 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 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.

When Coverage Ends

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

- The end of the Benefit Month which you cease to be eligible due to termination of your employment or any other reason.
- The date on which the Plan 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 Plan 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 Plan, if a Covered Person,

- (1) performs an act, practice or omission that constitutes fraud; or
- (2) makes an intentional misrepresentation of material fact,

then the Plan has the right to rescind that Covered Person's coverage under the Plan. The Plan will provide a notice of rescission to the Covered Person at least 30 days in advance of the termination date.

The Plan retains the right to recoup from any involved person all payments made and/or benefits paid on his/her behalf.

Benefits After Termination

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

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 Plan. You may also continue coverage for your Dependents.

You will be subject to the same Plan rules as an Active Employee. But, your legal right to have your Employer pay its share of the required contribution, 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 Plan 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 Plan'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, not including a Dependent who is your Civil Union Partner 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 reason 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 Plan's rules.

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 Plan 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 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.

NOTE: Any right to continue the Plan'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.

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.

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 Plan (for himself/herself and the Employee's Dependents, if any, not including a Civil Union Partner). 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 Plan 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 total cost of coverage.

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.

Medical Necessity And Appropriateness

We will make payment for benefits under this Plan 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 it has been determined 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

Choosing a PCP

A Covered Person is encouraged to choose a PCP from the Horizon BCBSNJ Managed Care Doctor & Hospital Finder when he/she first obtains this coverage.

The choice of a PCP or other Practitioner is solely up to a Covered Person. However, the availability of a particular Practitioner cannot be guaranteed.

If the PCP chosen cannot accept more patients, the Covered Person will be notified and given a chance to make another PCP selection.

Changing a PCP

A Covered Person must contact Horizon BCBSNJ to select a new PCP from the Network.

Horizon BCBSNJ will process the form within 30 days. Horizon BCBSNJ will then send a Covered Person a letter that confirms the selection and indicates the date that the change is effective.

Until the Covered Person receives this letter, he/she must continue to use the current PCP. But, if the current PCP is no longer in the Network, the Covered Person may start to use the new PCP right away.

Member Services

The Member Services Representatives who staff Horizon BCBSNJ Member Services Departments are there to answer Covered Persons' questions about the Plan 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, 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 Plan is intended to pay for Covered Services and Supplies as described in this Booklet. The Plan does not provide the services or supplies themselves, which may, or may not, be available.
- b. The Plan is only required to provide its Allowance for Covered Services and Supplies, to the extent stated in the Plan. The Plan has no other liability.
- c. Benefits are to be provided in the most cost-effective manner practicable. If the Plan determines that a more cost-effective manner exists, the Plan reserves the right to require that care be rendered in an alternate setting as a condition of providing payment for

benefits.

24 Hour Nurse Line

County of Monmouth has selected a program for its members through Horizon BCBSNJ, that will provide you with answers to your health questions twenty four hours a day seven days a week, access to registered nurses and doctor approved information to guide your health care decisions.

Here is how the process works:

1. You may call a toll free number (1-888-624-3096) to speak with nurse. When you call, a registered nurse can help you:
 - Understand if the Emergency Room, a doctor visit or self-care is right for your needs.
 - Learn more about a diagnosis.
 - Explore the risks, benefits and possible outcomes of treatment options.
 - Get tips on nutrition and exercise to help you maintain a healthy weight.
 - Learn about health screenings and immunizations.
2. You may also access online resources to receive health advise:

You can access Live Chat, and have an individual, secure and confidential online discussion with a health care resource and get the health information you need.

YOUR HORIZON DIRECT ACCESS PROGRAM

Your Horizon Direct Access 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 Plan 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 Plan.

BENEFIT PROVISIONS

The Deductible

Each Benefit Period, each Covered Person must have Covered Charges that exceed the Deductible before the Plan provides coverage for that person. The Out-of-Network Deductible(s) 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 Plan can be used to meet this Deductible.

Once the Deductible is met, the Plan 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 Plan. Also, what coverage the Plan provides is based on all the terms of this Plan.

Family Aggregate Deductible

The total Deductible for a family in any one Benefit Period will not be more than **\$800** for Out-of-Network Services. This family Deductible can be met by any combination of Covered Charges Incurred by one, some, or all of the covered family members, except that no individual can contribute more than the individual Deductible amount. If a covered family member meets the individual Deductible, the Plan will cover that person's additional Covered Charges Incurred during that Benefit Period even if the Deductible for the entire family has not been met.

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 Plan equal to the Out-of-Pocket Maximum (see the Schedule of Covered Services and Supplies), the Plan 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.

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

An Out-of-Pocket Maximum cannot be met with Non-Covered Charges. But solely for the purposes of this subsection, a Covered Person's or covered family's Prescription Drug Cost Share Amount shall be applied towards the applicable In-Network Out-of-Pocket Expense Maximum under this Program.

Payment Limits

The Plan limits what it will pay for certain types of charges. See the Schedule of Covered Services and Supplies for these limits.

Benefits From Other Plans

The benefits the Plan 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.

SUMMARY OF COVERED SERVICES AND SUPPLIES

This section lists the types of services and supplies that the Plan will consider as Covered Services or Supplies, up to its Allowance and subject to all the terms of this Plan. 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

Acupuncture

Acupuncture services and supplies are covered when: (a) the Acupuncture is performed for therapeutic purposes for the relief of pain by a Practitioner; and (b) the services are given Prior Authorization by Horizon BCBSNJ as being Medically Necessary and Appropriate.

Allergy Testing and Treatment

This Plan covers allergy testing and treatment, including routine allergy injections.

Ambulatory Surgery

This Plan 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 Plan covers anesthetics and their administration.

Audiology Services

This Plan 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

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

in full. 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, the Plan will not provide payment to the Birthing Center.

Dental Care and Treatment

This Plan 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 Plan does not cover charges for orthodontia, crowns or bridgework. "Surgery", if needed, includes the pre-operative and post-operative care connected with it.

This Plan also covers charges for the treatment of 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.

Note: Oral surgery is only covered if related to an accident and/ or damage to perfect healthy teeth.

Diagnosis and Treatment of Autism

This Plan provides coverage for charges for the screening and diagnosis of autism.

If a Covered Person's primary diagnosis is autism, and regardless of anything in the Plan to the contrary, the Plan provides coverage when the services are for the following Medically Necessary and Appropriate Therapy Services, as prescribed in a treatment plan:

- (a) Occupational Therapy needed to develop the Covered Person's ability to perform the ordinary tasks of daily living;
- (b) Physical Therapy needed to develop the Covered Person's physical functions; and
- (c) Speech Therapy needed to treat the Covered Person's speech impairment.

Notwithstanding anything in the Plan to the contrary, the foregoing Therapy Services as prescribed in a treatment plan will not be subject to benefit Visit maximums.

Also, if a Covered Person's primary diagnosis is autism, in addition to coverage for certain Therapy Services, as described above, the Plan also covers Medically Necessary and Appropriate: (a) Behavioral Interventions Based on Applied Behavioral Analysis (ABA); and (b) Related Structured Behavioral Plans. Such interventions and programs must be prescribed in a

treatment plan.

Benefits for these services are payable on the same basis as for other conditions, and they are available under this provision whether or not the services are restorative. Benefits for the above Therapy Services available pursuant to this provision are payable separately from those payable for other conditions and will not operate to reduce the Therapy Services benefits available under the Plan for those other conditions.

Any treatment plan referred to above must: (a) be in writing; (b) be signed by the treating Practitioner; and (c) include: (i) a diagnosis; (ii) proposed treatment by type, frequency and duration; (iii) the anticipated outcomes stated as goals; and (iv) the frequency by which the treatment plan will be updated.

With respect to the covered behavioral interventions and programs mentioned above, the term “Practitioner” shall also include a person who is credentialed by the national Analyst Certification Board as either: (a) a Board Certified Behavior Analyst-Doctoral; or (b) a Board Certified Behavior Analyst.

The Plan may request more information if it is needed to determine the coverage under the Plan. The Plan may also require the submission of an updated treatment plan once every six months, unless the Plan and the treating physician agree to more frequent updates.

Diagnostic X-rays and Lab Tests

This Plan covers diagnostic X-ray and lab tests.

Emergency Room

This Plan 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.

Coverage when traveling

If you require medical attention while you are traveling or your covered Dependent child requires care while away at school, the Plan will pay benefits as follows if an Out-of-Network provider is utilized.

Emergency care will be reimbursed at the network level. Emergency care includes conditions that require immediate treatment, such as bone fractures, wounds requiring sutures, poisoning and loss of consciousness.

Facility Charges

This Plan covers Hospital semi-private room and board and Routine Nursing Care provided by a Hospital on an Inpatient basis. The Plan 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 Plan covers the charges the same way it covers charges for any Illness.

This Plan 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 Plan ends, this Plan will continue to cover that Facility stay, subject to all other terms of this Plan.

Fertility Services

This Plan covers charges for artificial and surgical procedures designed to enhance fertility, including, but not limited to, artificial insemination, in-vitro fertilization, in-vitro fertilization, gamete-intra-fallopian-transfer (GIFT), Zygote Intra-fallopian-transfer (ZIFT), sperm, egg, and/or inseminated eggs procurement and processing and freezing, and storage and thawing of sperm and/or embryos. Storage is limited to 6 months.

In-network services include the following:

- a. artificial insemination subject to a lifetime maximum of 6 attempts;
- b. diagnostic, as well as, therapeutic surgery;
- c. coverage for ART is limited to:
 1. no more than 1 cycle per 24-month period for all ART services and treatment, including IVF, GIFT, and cryopreserved embryo transfer;
 2. charges associated with your care when participating in a donor IVF program, including fertilization and culture;
 3. charges associated with obtaining the partner's sperm for ART, when the partner is also covered under this plan.

Out-of-Network services include the following:

- a. coverage is limited to the diagnosis and treatment of the underlying cause of infertility and these services include the initial evaluation, history, physical examination and library studies performed at an appropriate participating laboratory;
- b. evaluation of ovulatory function;
- c. ultrasound of ovaries;

- d. postcoital test;
- e. hysterosalpingogram;
- f. endometrial biopsy;
- g. hysteroscopy.

Fertility prescription pharmacy medications are not covered under this plan.

Home Health Care

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

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.

This Plan 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.

"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.

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

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

Inpatient Physician Services

This Plan 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 Plan 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 for prescribing 72 or 48 hours, as appropriate, of Inpatient care. But, any rule of this Plan that that the patient or her Provider notify Horizon BSBSNJ 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 Plan.

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 Plan 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 Care for Child Dependents

This Plan covers a Child Dependent's obstetrical care, including any services incident to or resulting from her pregnancy. But, this Plan does not provide coverage for the newborn child of the Child Dependent.

Medical Emergency

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

When the Care Manager: manages; assesses; coordinates; directs; and authorizes a Covered Person's Inpatient treatment for a Mental or Nervous Disorder or Substance Abuse, coverage for that treatment will be provided at the In-Network level of benefits, unless, as part of this process, the Covered Person elects treatment from an Out-of-Network Provider. Coverage will always be provided at a reduced level if the Care Manager does not: manage; assess; coordinate; direct; and authorize a Covered Person's Inpatient treatment for a Mental or Nervous Disorder or Substance Abuse before expenses are Incurred. No benefits are payable with respect to any treatment that is not Medically Necessary and Appropriate.

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.

Nutritional Counseling

This Plan covers charges for nutritional counseling for the management of a medical condition that has a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner. This section does not apply to nutritional counseling related to "Diabetes Benefits".

Physical Rehabilitation

This Plan covers Inpatient treatment in a Physical Rehabilitation Center. Inpatient treatment will include the same services and supplies available to any other Facility Inpatient.

Practitioner's Charges for Non-Surgical Care and Treatment

This Plan covers Practitioner's charges for the non-Surgical care and treatment of an Illness, Injury, Mental or Nervous Disorder 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 Plan covers Practitioners' charges for Surgery. This Plan 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 Plan 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 Plan 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.

Preventive Care

This Program provides in-network benefits only for certain Covered Services and Supplies relating to Preventive Care including: related diagnostic X-rays and lab tests; and screening tests.

The covered Preventive Care is as follows:

a. Gynecological Examinations

This Plan 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.

b. Mammography

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

The Plan will cover charges for:

- (a) A mammogram exam at such age and intervals as deemed Medically Necessary and Appropriate by the Covered Person's Practitioner if they are under 40 years

of age and has a family history of breast cancer or other breast cancer risk factors.

- (b) A mammogram exam each year for Covered Persons age 40 and over.
- (c) An ultrasound evaluation; magnetic resonance imaging scan; three-dimensional mammography; or other additional testing of an entire breast or breasts after any baseline mammogram exam, if:
 - 1. The mammogram exam demonstrates extremely dense breast tissue;
 - 2. The mammogram is abnormal within any degree of breast density, including not dense; moderately dense; heterogeneously dense; or extremely dense breast tissue; or
 - 3. The patient has additional risk factors for breast cancer, including, but not limited to: (1) family history of breast cancer; (2) prior personal history of breast cancer; (3) positive genetic testing; (4) extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or (5) other indications, as determined by the patient's Practitioner.
- (d) Digital Tomosynthesis Charges

This Plan covers charges for digital tomosynthesis to detect or screen for breast cancer and for diagnostic purposes as follows:

- a) When used for the detection and screening for breast cancer in a Covered Person age 40 years and older, the Plan will cover charges for digital tomosynthesis as Preventive Care which means they are covered without application of any Copayment, Deductible and/or Coinsurance, as applicable.

c. **Prostate Cancer Screening**

This Plan 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 40 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.

d. **Routine Adult Physicals and Immunizations**

This Program covers routine adult physical exam(s) (including related X-rays and lab tests) and immunizations for you and your Spouse or Civil Union Partner, and Child Dependents over the age of 7.

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

This Plan 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..
- (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. Medical evaluation and any necessary follow-up and treatment for lead-poisoned children are also covered.

f. Newborn Hearing Screening

This Plan 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 similar procedure.

g. Well Child Care

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

h. Additional Preventive Services

In addition to any other Preventive Care benefits described above, the Plan shall cover the following preventive services and shall not impose any cost-sharing requirements, such as Deductibles, Copayments or Coinsurance, on any Covered Person receiving them:

- 1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- 2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person;

3. For infants and children (if coverage under the Plan are provided for them) and adolescents who are Covered Persons, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to female Covered Persons, such additional preventive care and screenings, not described in part 1, above, as are provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

New recommendations to the preventive services listed above at the schedule established by the Secretary of Health and Human Services shall be administratively updated.

Second Opinion Charges

If a covered Person is scheduled for an Elective Surgical Procedure, this Plan 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 Plan will cover a Practitioner's charges for a third opinion regarding the need for the Surgery. This Plan 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. do not perform or assist in the Surgery if it is needed.

Skilled Nursing Facility Charges

This Plan 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, for continuing medical care and treatment prescribed by a Practitioner.

Specialist Services

This Plan covers services rendered by a Network Provider who is not a PCP and who provides services within his/her specialty to Covered Persons. Such services must: (a) be determined to be Medically Necessary and Appropriate, and (b) be within the scope of the Practitioner's practice.

Surgical Services

Subject to all of the Plan's other terms and conditions, the Plan covers Surgery, subject also to the following requirements:

- a. The Plan will not make separate payment for pre- and post-operative care.

- b. Subject to the following exception, if more than one surgical procedure is performed: (i) on the same patient; (ii) by the same physician; and (iii) on the same day, the following rules apply:
1. The Plan will cover the primary procedure, plus 50% of what the Plan would have paid for each of the other procedures, up to five, had those procedures been performed alone.
 2. If more than five surgical procedures are performed, each of the procedures beyond the fifth will be reviewed. The amount that the Plan will pay for each such procedure will then be based on the circumstances of the particular case.

Exception: The Plan will not cover or make payment for any secondary procedure that, after review, is deemed to be a Mutually Exclusive Surgical Procedure or an Incidental Surgical Procedure.

As part of the coverage for Surgery, if a Covered Person is receiving benefits for a mastectomy, the Plan will also cover the following, as determined after consultation between the attending physician and the Covered Person:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Protheses and the treatment of physical complications at all stages of the mastectomy, including lymphodemas.

Also, see “Transplant Benefits”.

Surgical Treatment of Morbid Obesity

Covered expenses shall include charges for surgical treatment of morbid obesity for covered persons with health problems that are aggravated by or related to the morbid obesity. All services must be pre-certified.

Therapeutic Manipulation

This Plan provides benefits for Therapeutic Manipulations.

Therapy Services

This Plan covers all Therapy Services.

Transplant Benefits

This Plan covers services and supplies for the following types of transplants:

- 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-myeloablative stem cell;
- u. Tandem stem cell.

When organs/tissues are harvested from a cadaver, this Plan 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 Plan 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, the Plan will cover these services only if: (a) the recipient of the transplant is a Covered Person under this Plan; 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 Plan provides benefits for Covered Services and Supplies furnished for Urgent Care of a Covered Person.

B. COVERED SUPPLEMENTAL SERVICES AND SUPPLIES

Ambulance Services

This Plan 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 Plan does not cover chartered air flights. The Plan will not cover other travel or communication expenses of patients, Practitioners, Nurses or family members.

Blood

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

This Plan 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, cannot exceed the total number of benefit days allowed for any other Illness under this Plan.

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 Plan 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 Plan 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 to a professional described in b., below and 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 Plan covers charges for the rental of Durable Medical Equipment needed for therapeutic use. The Plan may decide to cover the purchase of such items when it is less costly and more practical than to rent them. This Plan 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 Plan 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 prolastin therapy.

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

Oxygen and Its Administration

This Plan covers oxygen and its administration.

Private Duty Nursing Care

This Plan 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 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.

Prosthetic Devices

This Plan limits coverage for prosthetic devices. This Plan covers only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. To be covered, such devices must: (a) take the place of a natural part of a Covered Person's body; or (b) be needed due to a functional birth defect in a covered Child Dependent; or (c) be needed for reconstructive breast Surgery. This Plan does not cover: repairs of prosthetic devices or dental prosthetics or devices.

Wigs Benefit

This Plan 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 PLAN DOES NOT COVER ANY INPATIENT ADMISSION, OR ANY OTHER SERVICE OR SUPPLY THAT IS NOT MEDICALLY NECESSARY AND APPROPRIATE.

This Plan 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 Plan.

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

This Plan 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 Plan 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.

This Plan has a Blue Distinction Centers feature. Under this feature, a Covered Person may obtain needed care and treatment from Providers with whom Horizon BCBSNJ has entered into agreements. See the Blue Distinction Centers Feature description for details.

UTILIZATION REVIEW-REQUIRED HOSPITAL STAY REVIEW

Notice of Hospital Admission Required

If a Covered Person plans to use an In-Network Facility, the Facility will usually make all needed arrangements for Pre-Admission Review. If a Covered Person plans to use an Out-of-Network Facility, 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, the Plan 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. Horizon BCBSNJ 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, Horizon BCBSNJ determines:
 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 the 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.

Your physician should obtain Pre-Certification for you. However, you are ultimately responsible for Pre-certification for all services regardless of network provider. Failure to Pre-Certify may result in \$200 Penalty.

Continued Stay Review

The Plan has the right to conduct a continued stay review of any Inpatient Facility 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 Facility 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 extended stay ;
- 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. Horizon BCBSNJ confirms 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 Plan, the Plan reduces what it otherwise pays for Covered Services and Supplies by **\$200** when:
 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 Plan.
- b. Penalties cannot be used to meet this Plan's:
 1. Deductible(s)
 2. Out-of-Pocket Limit(s)
 3. Copayment(s)

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 Plan.

"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 Disorder; or
- m. any other Illness or Injury determined to be catastrophic.

Alternate Treatment/Individual Case Management Plan

Horizon BCBSNJ will identify cases of Catastrophic Illness or Injury. Horizon BCBSNJ 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 Plan.

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 the Plan 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.

BLUE DISTINCTION CENTERS FEATURE

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

Definitions

"Blue Distinction Center": A Provider that has entered into an agreement with Horizon BCBSNJ and/or the Blue Cross and Blue Shield Association 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 Blue Distinction Center 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 Blue Distinction Center.

Covered Charges

In order for charges to be Covered Charges, the Blue Distinction Center 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 Blue Distinction Center will be subject to the terms and conditions of this Plan. The Utilization Review features described above will not apply.

SCHEDULE OF PROCEDURES, TREATMENT AND SUPPLIES REQUIRING PRIOR AUTHORIZATION

- Air Ambulance.
- All Admissions to a Skilled Nursing Facility or Subacute Facilities.
- All Possible Cosmetic or Plastic Services.
- All Surgical Procedures performed in an Out-of-Network Ambulatory Surgical Center.
- Cardiac Catheterization.
- Computed Tomography - CT Scans (Outpatient).
- Cochlear Implants.
- Durable Medical Equipment Rentals or Purchases over **\$500.00**.
- 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).
- Occupational Therapy, Physical Therapy, Speech and Cognitive Therapy.
- Pacemakers.
- Pain Management Services.
- 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.
- Varicose Vein Surgery.
- Zygote Intra Fallopian Transfer (ZIFT).

EXCLUSIONS

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

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

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

Ancillary charges connected with self-administered services such as: patient-controlled analgesia; related diagnostic testing; self-care; and self-help training.

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

An inpatient admission or any part of an inpatient admission primarily for:

- Physical Therapy, except as otherwise specified in this booklet; and/or
- rehabilitation therapy, except as otherwise specified in this booklet.

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.

Education or training while a Covered Person is confined in an institution that is primarily an institution for learning or training.

Expenses Incurred for Day Programs.

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, osseous Surgery and any other Surgery to the periodontium; except for the removal of malignant tumors (e) replacing missing teeth; (f) the removal and re-implantation of teeth (and related services); (g) any orthodontic treatment; and (h) dental implants and related services.

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.

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, except when used as the sole source of nutrition).

Herbal medicine.

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.

Hypnotism.

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 the Plan 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.

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; calluses; 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, and any appliances, including orthotics and their casting, 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,

Services for injuries resulting from a motor vehicle accident if such services are eligible for payment under the Personal Injury Protection or compulsory medical payments provisions of a motor vehicle insurance contract required by any federal or state no-fault motor vehicle insurance law. This exclusion applies whether or not a proper and timely claim for payment for these services is made under the motor vehicle insurance contract.

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 (b) 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 Plan 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 Civil Union 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; Exception: As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition;
- 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 coverage for the services is otherwise required by law;
- 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 Plan 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.

Smoking cessation aids of all kinds and the services of stop-smoking providers, except as otherwise stated in this Booklet.

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.

Surrogate motherhood.

Telephone consultations, except as Horizon BCBSNJ may request.

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 Plan as an Employee and by another plan as a Dependent of his or her Spouse. If he or she is, this provision allows the Plan to coordinate what the Plan 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.

The Plan 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 Plan is coordinating benefits with a plan that restricts coordination of benefits to a specific coverage, the Plan 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 Plan 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

The Plan 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 Plan or PIP.

"Eligible Expense": That portion of expense Incurred for treatment of an Injury, which is covered under this Plan 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 Plan will always provide secondary coverage to such coverage. Since this Plan 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 Plan's Deductibles, Copayments, and/or Coinsurance); or
- b. The actual benefits that this Plan would have paid if it provided its coverage primary to PIP.

If there are other plans that: (a) provided benefits to the Covered Person; and (b) are primary to auto insurance coverage, then this Plan's rules regarding the coordination of benefits will apply.

SUBROGATION AND REIMBURSEMENT

If another person or entity, through an act or omission, causes any participant, beneficiary, or any other covered person receiving benefits under this Plan, hereinafter individually and collectively referred to as “Covered Person”, to suffer an injury or illness, and in the event benefits were paid under the Plan for that injury or illness, a Covered Person must agree to the provisions listed below. Additionally, if a Covered Person is injured and no other person or entity is responsible but a Covered Person receives (or is entitled to) a recovery from another source, and if the Plan paid benefits for that injury, a Covered Person must refund the Plan all benefits paid and must also agree to the provisions listed below.

This Plan provides benefits to or on behalf of said Covered Person only on the following terms and conditions:

1. In the event that benefits are provided under this Plan, the Plan shall be subrogated to all of the Covered Person’s or the Covered Person’s representative’s (representative for this purpose includes, if applicable, heirs, administrators, legal representatives, parents (if a minor), successors, or assignees) rights of recovery against any person or organization to the extent of the benefits provided to the Covered Person. The Covered Person shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Covered Person shall do nothing after loss to prejudice such rights. The Covered Person hereby agrees to cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any injury, illness, or accident as the Plan or the Plan representatives deem necessary to fully investigate the incident.
2. The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan. The Plan is entitled under its right of recovery to be reimbursed for the full amount of the Plan’s benefit payments even if the Covered Person is not “made whole” for all of his or her damages in the recoveries that he or she receives.
3. The Plan’s right to reimbursement is, and shall be, prior and superior to the right of any other person or entity, including the Covered Person.
4. By accepting benefits hereunder, the Covered Person hereby grants an automatic lien against and assigns to the Plan, in an amount equal to the benefits paid by the Plan, any recovery, whether by settlement, judgment, or other payment intended for, payable to, or received by the Covered Person, or on behalf of the Covered Person. The Covered Person hereby consents to said lien and/or assignment and agrees to take whatever steps are necessary to help the Plan secure said lien and/or assignment. The Covered Person agrees that said lien and/or assignment shall constitute a charge upon

the proceeds of any recovery and the Plan shall be entitled to assert security interest thereon.

5. By the acceptance of benefits under the Plan, the Covered Person and his or her representatives agree to serve as a constructive trustee and to hold the proceeds of any settlement, judgment and/or other payment in constructive trust for the benefit of the Plan to the extent of 100% of all benefits paid on behalf of the Covered Person.
6. The subrogation and reimbursement rights and liens apply to any recoveries made by the Covered Person as a result of the injuries sustained, including but not limited to the following:
 - a. Payments made directly by the third party tortfeasor, or any insurance company on behalf of the third party tortfeasor, or any other payments on behalf of the third party tortfeasor.
 - b. Any payments or settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Covered Person or other person.
 - c. Any other payments from any source designed or intended to compensate a Covered Person for injuries sustained.
 - d. Any worker's compensation award or settlement.
 - e. Any recovery made pursuant to no-fault insurance.
 - f. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.
7. The Covered Person shall not take action that may prejudice the Plan's right of recovery, including but not limited to the assignment of any rights of recovery from any tortfeasor or other person or entity. No Covered Person shall make any settlement which specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Plan. The Plan will not reduce its share of any recovery unless, in the exercise of its discretion, the Plan agrees in writing.
8. The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Covered Person, which right shall not be defeated nor reduced by the application of any doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages. Accordingly, the Plan is entitled under its right of recovery to be reimbursed for its benefit payments even if the Covered Person is not "made whole" for all of his or her damages in the recoveries he or she receives; there shall be no application of the "made whole" doctrine, "rimes doctrine" or any such doctrine defeating the Plan's right of recovery.
9. No Covered Person hereunder shall incur any expenses on behalf of the Plan in

pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the prior express written consent of the Plan and the Plan's right of recovery is not subject to reduction of attorney's fees and costs under the "common fund" or any other doctrine.

10. In the event that a Covered Person shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including but not limited to attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future Plan benefits hereunder until the Covered Person has fully complied with his or her reimbursement obligations hereunder, regardless of how those future Plan benefits are incurred.
11. Any reference to state law in any other provision of this policy shall not be applicable to this provision, if the Plan is governed by ERISA. By acceptance of benefits under the Plan, the Covered Person agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

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 Plan. This section, on "Medicare as Secondary Payer", or parts of it, may not apply to this Plan. The Employee must contact the Employer to find out if the Employer 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 Plan'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 Plan is the secondary plan, the Allowable Expenses under this Plan 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.

This section applies to a Covered Person who is:

- a. The Employee or covered spouse;
- b. 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 Section, such a Covered Person is referred to as a "Medicare eligible".

This Section 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.

Employees who are still actively employed:

When a Covered Person becomes eligible for Medicare by reason of age and is still actively employed, he/she must choose one of the following options:

Option (A) - Choose the County of Monmouth as his primary health plan.

When a Medicare eligible person chooses this program as his primary health plan, if he Incurs a Covered Charge for which benefits are payable under this program and Medicare, this program is considered primary. This program pays first, ignoring Medicare. Medicare is considered 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. Coverage under this program will end on the date the Covered Person elects Medicare as his/her primary health plan.

Note: If the Medicare eligible person fails to choose either option when he becomes eligible for Medicare by reason of age, the Plan will pay benefits as if he/she had chosen Option (A).

Employees who are retired from County of Monmouth:

When a Covered Person becomes eligible for Medicare by reason of age, and is retired from the County of Monmouth, Medicare is primary.

Medicare Eligibility by Reason of Disability

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 Plan 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 Currently Employed Person or Spouse of a Currently Employed Person becomes eligible for Medicare by reason of disability, this Plan generally is the primary plan; Medicare is the secondary plan.

Medicare Eligibility by Reason of End Stage Renal Disease

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 Plan and Medicare, this Plan is deemed the Primary Plan for a specified time, referred to as the “coordination period”. This Plan pays first, ignoring Medicare. Medicare is the Secondary Plan. The coordination period is up to 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 Plan and Medicare, Medicare is the Primary Plan and this Plan 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 Plan as the primary payer, then becomes eligible for Medicare based on ESRD, this Plan 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 Plan as the secondary payer, then becomes eligible for Medicare based on

ESRD, this Plan 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 Plan 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 Horizon BCBSNJ.

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 Horizon BCBSNJ for processing.

CLAIMS PROCEDURES

Claim forms and instructions for filing claims will be provided to Covered Persons. 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.

Submission of Claims

These procedures apply to the filing of claims. All notices will be in writing.

- a. Claim forms must be filed no later than 18 months after the date the services were Incurred.
- b. 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 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.

- c. 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 Plan 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, Horizon BCBSNJ will explain why and also explain why any coding changes were made;
5. a statement of the special needs to which the claim is subject, if this is the case;
6. an explanation of the Plan'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 Plan 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.
- d. This applies if you are 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 Plan. Horizon BCBSNJ 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 your 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 you are the non-custodial parent of a Child Dependent, Horizon BCBSNJ will pay claims filed as described above under "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 Plan, Horizon BCBSNJ has the right to recover those payments on behalf of the Plan.

BLUECARD

Overview

Horizon BCBSNJ has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Arrangements.” These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever Covered Persons access healthcare services outside the geographic area we serve, the claims for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area we serve, Covered Persons obtain care from healthcare providers that have a contractual agreement (“BlueCard Providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Covered Persons may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement (“nonparticipating providers”) with the Host Blue. Horizon BCBSNJ remains responsible for fulfilling our contractual obligations to the Covered Person. Horizon BCBSNJ's payment practices in both instances are described below.

This disclosure describes how claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements.

Note that Dental Care Benefits that are not paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by Horizon BCBSNJ to provide the specific service or services, are not processed through Inter-Plan Arrangements.

BlueCard® Program

The BlueCard Program is an Inter-Plan Arrangement. Under this Inter-Plan Arrangement, when Covered Persons access Covered Services and Supplies within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its BlueCard Providers. The financial terms of the Inter-Plan Arrangements are described generally below.

Liability Calculation Method Per Claim – In General

Covered Person's Liability Calculation

Unless subject to a fixed dollar copayment, the calculation of the Covered Person's liability on claims for Covered Services and Supplies will be based on the lower of the BlueCard Provider's billed Covered Charges or the negotiated price made available to Horizon BCBSNJ by the Host Blue.

Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to us by the Host Blue may be represented by one of the following:

- (i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or
- (ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or
- (iii) An average price. An average price is a percentage of billed Covered Charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the Covered Person is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Horizon BCBSNJ in determining the group's premiums.

Covered Person's Liability Calculation.

Covered Person liability calculation will be based on the lower of either billed Covered Charges or negotiated price (refer to the description of negotiated price under "Claims Pricing" in the "Liability Calculation Method Per Claim – In General" provision above) made available to Horizon BCBSNJ by the Host Blue that allows the Covered Person access to negotiated participation agreement networks of specified participating healthcare providers outside of Horizon BCBSNJ's service area.

Special Cases: Value-Based Programs

Value-Based Programs Overview

The Covered Person may access Covered Services and Supplies from providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated National Account Arrangement(s).

Value-Based Programs under the BlueCard Program

Horizon BCBSNJ has included a factor for bulk distributions from Host Blues in a group's premium for Value-Based Programs when applicable under this Booklet.

Value-Based Programs under Negotiated National Account Arrangements

If Horizon BCBSNJ has entered into a Negotiated National Account Arrangement with a Host Blue to provide Value-Based Programs to Covered Persons, Horizon BCBSNJ will follow the same procedures for Value-Based Programs as noted above in the Liability Calculation Method Per Claim – In General section.

Return of Overpayments

Recoveries of overpayments from a Host Blue or its BlueCard Providers and nonparticipating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, Horizon BCBSNJ will include any such surcharge, tax or other fee in determining a group's premium.

Non-Participating Healthcare Providers Outside Horizon BCBSNJ's Service Area

Covered Person's Liability Calculation

In General

When Covered Services and Supplies are provided outside of Horizon BCBSNJ's service area by nonparticipating providers, the amount(s) a Covered Person pays for such services will be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Covered Person may be responsible for the difference between the amount that the nonparticipating provider bills and the payment Horizon BCBSNJ will make for the Covered Services and Supplies as set forth in this paragraph. Payments for out-of-network emergency services will be provided as if the care was provided by a participating healthcare provider with respect to application of the Covered Person's copayment, deductible or coinsurance.

Exceptions

In some exception cases, at the group's direction Horizon BCBSNJ may pay claims from nonparticipating healthcare providers outside of Horizon BCBSNJ's service area based on the provider's billed charge. This may occur in situations where a Covered Person did not have reasonable access to a BlueCard Provider, as Determined by Horizon BCBSNJ in Horizon BCBSNJ's sole and absolute discretion in accordance with this Booklet or by state and/or federal law, as applicable. Adverse Determinations can be reviewed by an independent

utilization review agency (IURO), court of law, arbitrator or any administrative agency having the appropriate jurisdiction.

In other exception cases, at the group's direction, Horizon BCBSNJ may pay such claims based on the payment Horizon BCBSNJ would make if Horizon BCBSNJ were paying a nonparticipating provider inside of Horizon BCBSNJ's service area, as described elsewhere in this Booklet. This may occur where the Host Blue's corresponding payment would be more than Horizon BCBSNJ's in-service area nonparticipating provider payment. Horizon BCBSNJ may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Covered Person may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment Horizon BCBSNJ will make for the Covered Services and Supplies as set forth in this paragraph.

BCBS Global Core Coverage TM

General Information. If Covered Persons are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of BCBS Global Core when accessing Covered Services and Supplies. The BCBS Global Core Coverage is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although BCBS Global Core assists Covered Persons with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Covered Persons receive care from providers outside the BlueCard service area, the Covered Persons will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if Covered Persons contacts the BCBS Global Core Service Center for assistance, hospitals will not require Covered Persons to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit Covered Persons' claims to the BCBS Global Core Service Center to initiate claims processing.

However, if Covered Persons paid in full at the time of service, the Covered Persons must submit a claim to obtain reimbursement for Covered Services and Supplies. Covered Persons must contact Horizon BCBSNJ to obtain precertification for non-emergency inpatient services.

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require Covered Persons to pay in full at the time of service. Covered Persons must submit a claim to obtain reimbursement for Covered Services and Supplies.

Submitting a BCBS Global Core Claim

When Covered Persons pay for Covered Services and Supplies outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Covered Persons should complete a BCBS Global Core claim form and send the claim form with the provider's itemized bill(s) to the BCBS Global Core Service Center address on the form to initiate claims processing. The claim form is available from Horizon BCBSNJ, BCBS Global Core Service Center, or online at www.bcbsglobalbasic.com. If Covered Persons need assistance with their claim submissions, they should call BCBS Global Core at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

APPEALS PROCESS

A Covered Person (or a Provider or authorized representative acting on behalf of the Covered Person and with his/her consent) may appeal Adverse Benefit Determinations. There are two types of Adverse Benefit Determinations, administrative and utilization management. "Administrative" determinations involve issues such as eligibility for coverage, benefit decisions, etc. "Utilization management" determinations are decisions that involve the use of medical judgment and/or deny or limit an admission, service, procedure or extension of stay based on the Plan's clinical and medical necessity criteria. The appeal processes for the two types differ and are described briefly below.

No Covered Person or Provider who files an appeal will be subject to disenrollment, discrimination or penalty. If there is a claim denial for either type of decision, you will receive information that includes the reason for the denial, a reference to the Plan provision on which it is based, and a description of any internal rule or protocol that affected the decision.

Appeals Process for Adverse Administrative Decisions

For this type of adverse claim decisions, you will be notified of a denial as quickly as possible, but not later than the following:

- For Urgent Care Claims, 72 hours from receipt of the claim;
- For Pre-Service Claims, 15 calendar days from receipt of the claim;
- For Post-Service Claims, 30 calendar days from receipt of the claim.

If you wish to appeal the decision, you have 180 days to do so. Your written request for a review of the decision should include the reason(s) why you feel the claim should not have been denied. It should also include any additional information (e.g., medical records) that you feel support your appeal.

The decision regarding your appeal will be reached as soon as possible, but not later than the following:

- For Urgent Care Claims, 72 hours from receipt of your appeal;
- For Pre-Service Claims, 30 calendar days from receipt of your appeal;
- For Post-Service Claims, 60 calendar days from receipt of your appeal.

If the initial decision on your claim is upheld upon review, you will also be informed of any additional appeal rights that you may have.

Appeals Process for Adverse Utilization Management Decisions

The process for this type of adverse decision is briefly described below. A denial notification will include a brochure that fully describes your appeal rights and how you go about exercising them.

If such a claim is denied, your treating Provider can discuss your case with a Horizon BCBSNJ Medical Director, who can be reached by telephone at the number provided in the brochure. If the initial denial is upheld, you or the Provider can further appeal the decision within one year after receiving the denial letter. The appeal can be in writing or can be initiated by telephone. The applicable address and telephone number will be provided in the brochure.

Your appeal must include the following information:

- The name(s) and address(es) of the Covered Person and/or the Provider(s);
- The Covered Person's identification number;
- The date(s) of service;
- The nature of and reason behind your appeal;
- The remedy sought; and
- Any documentation that supports your appeal.

Your appeal will be decided as soon as possible, but not later than the following:

- For Urgent Care Claims, within 72 hours from receipt of your appeal;
- For other claims, within 30 calendar days from receipt of your appeal.

External Appeal Rights

If (a) the initial denial relates to an adverse utilization management decision or a rescission of coverage under the plan, (b) it is upheld pursuant to the internal appeal process, and (c) you are still dissatisfied, you have the additional right to pursue an external appeal with an Independent Review Organization (IRO). To exercise this right, you must request an external appeal in writing within four months after receiving our final internal appeal decision. The brochure accompanying our initial denial and final internal appeal decision will provide full details regarding the process that must be followed to request and obtain an external review. Generally, you must complete the internal appeal process before your claim will be eligible for external review. A small filing fee may be required. If so, it will be noted in the brochure.

If the process for obtaining this review is successfully completed, and your claim is deemed eligible, you will be notified and your appeal will be assigned to an IRO. Once it is assigned, the IRO will notify you about any additional steps that must be taken to complete your appeal. Once all of these additional steps are completed, the IRO will review all of the information in your

case as if it were new. The IRO is not bound by any decisions or conclusions that were reached during the internal appeals process.

The IRO's decision will be communicated to you in writing within 45 calendar days after its receipt of the appeal, or, if your external appeal request was handled on an expedited basis due to your medical circumstances, within 72 hours. The written decision issued by the IRO will include complete information regarding your appeal and the rationale for the decision. The decision will also include a statement that the IRO's decision is binding except to the extent that other remedies may be available to you or the Plan pursuant to state or federal law. If the decision is favorable to you, the Plan must pay benefits without delay even if it intends to seek other judicial remedies. The decision will also advise you about other resources that may be available to you for additional assistance.

STATEMENT OF ERISA RIGHTS

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. Your rights as a Participant in the Plan are governed by the plan documents and applicable State law and regulations.

This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations.

SERVICE CENTERS

If you have any questions about this Plan, call the Service Center.

Telephone personnel are available:

Monday, Tuesday, Wednesday and Friday from 8:00a.m. to 8:00p.m.

Thursday from 9:00 a.m. to 8:00pm (E.T.) Eastern Time

For questions and assistance with your Horizon Direct Access benefits and services, 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. Your ID number helps to get prompt answers to your questions about enrollment, benefits or claims.

