
Horizon

Product:	**Advantage EPO**
Group Name:	**ASSOCIATION MEMBER TRUST**
Plan:	**DIRECT ACCESS 80% DESIGN (83)**

NOTICE

THE SELF-FUNDED MULTIPLE EMPLOYER WELFARE ARRANGEMENT IS NOT AN INSURANCE COMPANY AND DOES NOT PARTICIPATE IN ANY OF THE GUARANTEE FUNDS CREATED BY NEW JERSEY LAW. THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF A SELF-FUNDED MULTIPLE EMPLOYER WELFARE ARRANGEMENT BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.

THE HEALTH CARE BENEFITS THAT YOU HAVE PURCHASED OR ARE APPLYING TO PURCHASE ARE BEING ISSUED BY A SELF-FUNDED MULTIPLE EMPLOYER WELFARE ARRANGEMENT. THE SELF-FUNDED MULTIPLE EMPLOYER WELFARE ARRANGEMENT IS REQUIRED TO MAINTAIN SUFFICIENT RESERVES TO PAY FOR ALL INCURRED LOSSES INCLUDING UNPAID CLAIMS. IT IS IMPORTANT THAT YOU CHECK WITH YOUR EMPLOYER TO DETERMINE WHICH, IF ANY, STATE MANDATED HEALTH CARE BENEFITS MAY BE COVERED BY YOUR ARRANGEMENT.

FOR ADDITIONAL INFORMATION ABOUT THE MULTIPLE EMPLOYER WELFARE ARRANGEMENT, YOU SHOULD ASK QUESTIONS OF YOUR TRUST ADMINISTRATOR AT 1-800-631-7945

.

TABLE OF CONTENTS

Page

INTRODUCTION

This Plan gives you and your covered Dependents broad protection to help meet the cost of Illnesses and Injuries.

In this Booklet, you'll find the important features of your group's Exclusive Provider Organization 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.

The Plan has contracted with Horizon BCBSNJ for the purposes of providing claims administration services and for access to certain networks provided by and administered by Horizon BCBSNJ. The Plan Administrator maintains discretionary authority over administration of the Plan and interpretation of the Plan terms. However, to the extent the Plan Administrator has determined that it is in the best interests of the Plan to utilize Horizon BCBSNJ as a service provider, it adopts the standards and practices of Horizon BCBSNJ where the Plan Administrator has deemed those standards and practices to be consistent with the Plan terms. Any reference in this document to Horizon BCBSNJ is intended to reflect the Plan's adoption of those standards and practices through the contractual relationship between the Plan and Horizon BCBSNJ.

CONFORMITY WITH LAW

Any provision of this Policy that conflicts with the requirements of an applicable law or regulation of the State of New Jersey or the federal government is automatically changed to conform with the minimum requirements of that law or regulation.

DEFINITIONS

The words shown below have special meanings when used in the Plan and this Booklet. Please read these definitions carefully.

Accredited School means a school accredited by a nationally recognized accrediting association, such as one of the following regional accrediting agencies: Middle States Association of Colleges and Schools, New England Association of Schools and Colleges, North Central Association of Colleges and Schools, Northwest Association of Schools and Colleges, Southern Association of Colleges and Schools, or Western Association of Schools and Colleges. An accredited school also includes a proprietary institution approved by an agency responsible for issuing certificates or licenses to graduates of such an institution.

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

Actively at Work or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Planholder's place of business, or at any other place that the Planholder's business requires the Employee to go.

Acupuncture: The practice of piercing specific sites with needles to induce Surgical anesthesia.

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 means a company as defined in subsections (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986. All entities that meet the criteria set forth in the Internal Revenue Code shall be treated as one employer.

Alternate Payee:

a. A custodial parent, who is not an Employee 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 Plan.

Ambulance means a certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by state and local law.

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:

a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have permanent operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

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 Accreditation Association for Ambulatory Care; or
b) 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.

Anniversary Date The twelve-month period starting on **January 1st and ending on December 31st**.

Approved Cancer Clinical Trial means a scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer in human beings that meets the following requirements:

a) The treatment or intervention is provided pursuant to an approved cancer clinical trial that has been authorized or approved by one of the following: 1) The National Institutes of Health (Phase I, II and III); (2) the United States Food and Drug Administration, in the form of an investigational new drug (IND) exemption (Phase I, II and III); 3) The United States Department of Defense; or 4) The United States Department of Veteran Affairs.
b) The proposed therapy has been reviewed and approved by the applicable qualified Institutional Review Board.
c) The available clinical or pre-clinical data to indicate that the treatment or intervention provided pursuant to the Approved Cancer Clinical Trial will be at least as effective as standard therapy, if such therapy exists, and is expected to constitute an improvement in effectiveness for treatment, prevention and palliation of cancer.
d) The Facility and personnel providing the treatment are capable of doing so by virtue of their experience and training.
e) The trial consists of a scientific plan of treatment that includes specified goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of quantitative measures for determining treatment response and methods for documenting and treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval by one of the federal entities identified in item a. A cost-benefit analysis of clinical trials will be performed when such an evaluation can be included with a reasonable expectation of sound assessment.

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.

Association shall mean any of the individual associations or organizations who subscribe to the Plan.

Behavioral Health Provider: An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for Mental Health Conditions and Substance Use Disorders under the laws of the jurisdiction where the individual practices. See "Mental Health Conditions and Substance Use Disorders" definition.

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; or

c. Two Inpatient days in a Skilled Nursing Facility.

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

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

The Plan will recognize it if:

a) it carries out its stated purpose under all relevant state and local laws; or
b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) it is approved for its stated purpose by Medicare.

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

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

Booklet: A detailed summary of benefits covered.

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

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

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

Church Plan has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974"

Claims Administrator means any entity, insurance company, or service provider retained by the Plan to administer claims submission, adjudication, processing and/or payment on behalf of the Plan.

Coinsurance means the percentage of a Covered Charge that must be paid by a Covered Person. Coinsurance does **not** include Cash Deductibles, Copayments or Non-Covered Charges.

Complex Imaging Services means any of the following services:

a) Computed Tomography (CT),
b) Computed Tomography Angiography (CTA),
c) Magnetic Resonance Imaging (MRI),
d) Magnetic Resonance Angiogram (MRA),
e) Magnetic Resonance Spectroscopy (MRS),
f) Positron Emission Tomography (PET),
g) Nuclear Medicine including Nuclear Cardiology.

Copayment means a specified dollar amount a Covered Person must pay for specified Covered Charges. **Note**: The Emergency Room Copayment, if applicable, must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.

Cosmetic Procedures - 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 Option means any of the variety of coverage levels provided by the Plan. Coverage options may vary based on deductible amounts, co-payment amounts, contribution requirements

or benefit levels.

Covered Charges are Allowed Charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Plan. The services and supplies must be:

a) furnished or ordered by a recognized health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Plan, Horizon BCBSNJ pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by the Plan. Read the entire Certificate to find out what Horizon BCBSNJ limits or excludes.

Covered Person means an eligible Employee or a Dependent who is covered under the Plan.

Creditable Coverage – Your prior coverage under any of the following: a group health plan; a group or individual health benefits plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for Members and certain former Members of the uniformed services and their Dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth in regulation by the Commissioner of Banking and Insurance.

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

Current Procedural Terminology (C.P.T.) means 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 that 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.

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 means an Employee's:

a) Legal spouse where spouse shall include a Domestic Partner pursuant to P.L. 2003, c. 246;

b) Dependent child who is under age 26; and

c) A Dependent is not a person who is on active duty in the armed forces of any country.

Under certain circumstances, an incapacitated child is also a Dependent. See the Dependent coverage section of this Plan.

An Employee's "Dependent child" includes:

a) his or her legally adopted children,

b) his or her step-child,

c) the child of his or her Domestic Partner, and

d) children under a court appointed guardianship.

The Plan treats a child as legally adopted from the time the child is placed in the home for the purpose of adoption. The Plan treats such a child this way whether or not a final adoption order is ever issued.

Dependent's Eligibility Date means the later of:

a) the Employee's Eligibility Date; or

b) the date the person first becomes a Dependent.

Developmental Disability or **Developmentally Disabled** means a severe, chronic disability that:

a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;

b) is manifested before the Covered Person attains age 22 for purposes of the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision;

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; capacity for independent living; economic self-sufficiency;

e) reflects the Covered Person's need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of services, individualized support, and other forms of assistance that are lifelong or of extended duration and are individually planned and 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 means 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) laboratory and pathology; and

c) EKGs, EEGs and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services are not covered under the Plan if the procedures are ordered as part of a routine or periodic physical examination or screening examination.

Discretion / Determination / Determine means the Plan's sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Domestic Partner - an individual with whom the Employee certifies to be in a Domestic Partnership.

Domestic Partners: Persons who meet these criteria:

a. Both persons have a common residence and are otherwise jointly responsible for each other's common welfare, as evidenced by joint financial arrangements or joint ownership of real property, which shall be demonstrated by at least one of the following:

    1. A joint deed, mortgage agreement or lease;
    2. A joint bank account;
    3. Designation of one of the persons as a primary beneficiary in the other's will;
    4. Designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or

5. Joint ownership of a motor vehicle;

b. Both persons agree to be jointly responsible for each other's basic living expenses during the Domestic Partnership;

c. Neither person is in a marriage recognized by New Jersey law or a member of another Domestic Partnership;

d. Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;

e. Both persons have chosen to share each other's lives in a committed relationship of mutual caring;

f. Both persons are at least 18 years of age.

Domestic Partnership A relationship between the Employee and another person of the same sex as the Employee, including opposite sex couples age 62 and over, that meets the requirements set forth under this Program. Proof that such a relationship exists, as determined by The Plan, must be given to The Plan when requested. The Plan has the right to determine eligibility for coverage under this Program.

Durable Medical Equipment is equipment which is:

a) designed and able to withstand repeated use;

b) primarily and customarily used to serve a medical purpose;

c) generally not useful to a Covered Person in the absence of an Illness or Injury; and

d) suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors as well as hearing aids which are covered through age 15.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, 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.

Effective Date means the date on which coverage begins under the Plan for the Planholder, or the date coverage begins under the Plan for an Employee or Dependent, as the context in which the term is used suggests.

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.

Eligible Employees: Subject to the conditions of Eligibility and to all of the other conditions of the Plan, all of the Policyholder's Employees who are in an eligible class will be eligible if the

Employees are Actively at work, or Full Time Employees except those who are absent due to disability or a health status factor.

Eligible Retirees means someone who is no longer actively at work for a participating employer, who has ceased full time employment and who otherwise satisfies the conditions of eligibility as an Eligible Retiree as set forth in the General information section of the Plan.

Emergency means 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 Use Disorders such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn child.

Employee means a Full-Time bona fide Employee (25 hours per week) of the Planholder. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of the Plan. Pursuant to 26 USC 4980H, partners, proprietors and independent contractors are **not** employees of the Planholder.

Employee Open Enrollment Period means the 30-day period each year designated by the Planholder during which:

a) Employees and Dependents who are eligible under the Plan but who are Late Enrollees may enroll for coverage under the Plan; and

b) Employees and Dependents who are covered under the Plan may elect coverage under a different Plan, if any, offered by the Planholder.

Employee's Eligibility Date means the later of:

a) the date of employment; or

b) the day after any applicable Waiting Period ends.

Employer is any entity that is an active member participating in the Association and that maintains Employees on a regular basis.

Employer Open Enrollment Period means the period from November 15 through December 15 each year beginning in 2014.

Enrollment Date means, with respect to a Covered Person, the Effective Date or, if earlier, the first day of any applicable Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

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 disorders 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 means Horizon BCBSNJ determines a service or supply is:

a) not of proven benefit for the particular diagnosis or treatment of a particular condition; or

b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or

c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for treatment for which the drug has not been approved by the United States Food and Drug Administration (FDA), the Plan will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

The Plan will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

Horizon BCBSNJ will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

    1. The American Hospital Formulary Service Drug Information; or
    2. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.

d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable and

e. Proof as reflected in the published peer reviewed medical literature must exist that the improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means 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, an "Extended Care Center" may be called a "Skilled Nursing Facility."

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 means a place Horizon BCBSNJ is required by law to recognize which:

a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

b) provides health care services which are within the scope of its license, certificate or accreditation.

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.

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

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

Government Hospital means 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.

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, not explicitly excluded from the definition of a Health Benefits Plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health

Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

Health Status-Related Factor means any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

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

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. The Plan will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

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

a. The care must be given on a part-time or intermittent basis, except if full-time or 24-hour services are Medically Necessary and Appropriate on a short-term basis.

b. Continuing Inpatient stay in a Hospital would be needed in the absence of Home Health Care.

c. The care is furnished under a physician's order and under a plan of care that: (a) is established by 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 means a Provider which 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) it is 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 means 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 a convalescent home, rest or nursing Facility, or a Facility, or part of it which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance Use Disorders is also not a Hospital.

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 or Ill means a sickness or disease suffered by a Member. Illness includes Mental Health Conditions and Substance Use Disorders.

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.

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

Initial Dependent means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.

Injury or Injured means all damage to a Covered Person's body and all complications arising from that damage, or a description of a Covered Person suffering from such damage.

In-Network – A Provider, or the Covered Services and Supplies provided by a Provider, who has an agreement with Your Plan to furnish Covered Services or Supplies within the Horizon BCBSNJ Managed Care Network.

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 means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such settings.

Joint Commission means the Joint Commission on the Accreditation of Health Care Organizations.

Large Employer - is defined as a business entity that employs more than fifty (50) eligible employees in the prior calendar year. Large employers may define a "full-time employee" for coverage eligibility purposes as a full-time employee working 30 hours or more each week.

Late Enrollee means an eligible Employee or Dependent who requests enrollment under the Plan more than 30 days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the General Information section of this Booklet for more details.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person managing the property and rights of a minor child.

Legend Drug means any drug which must be labeled "Caution – Federal Law prohibits dispensing without a prescription."

Low Protein Modified Food Product: A food product that is: (a) specially formulated to have less than one gram of protein per serving; and (b) intended to be used under the direction of a physician for the dietary treatment of an Inherited Metabolic Disease. The term does not include a natural food that is naturally low in protein**.**

Mail-Order Pharmacy: A Pharmacy which, during the course of its daily business, dispenses Prescription Drugs primarily by mail. For the purposes of this Prescription Drug Expense

Coverage, "Mail-Order Pharmacy", as used below, shall also be deemed to include any retail Pharmacy that has agreed to the same terms, conditions, price and services that apply to the Mail-Order Pharmacy.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from:

a) a Participating Mail Order Pharmacy by ordering the drugs through the mail; or

b) a Participating Pharmacy that has agreed to accept the same terms, conditions, price and services as a Participating Mail Order Pharmacy.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

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 Use Disorders) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in: (a) placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of a bodily organ or part.

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

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

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

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and the Plan determines at its Discretion, that it is:

a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;

b) provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;

c) in accordance with generally accepted medical practice;

d) not for the convenience of a Covered Person;

e) the most appropriate level of medical care the Covered Person needs; and

f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

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

Medicare means Parts 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.

Mental Health Center means a Facility which mainly provides treatment for people with Mental Illness. The Plan will recognize such a place 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;

b) approved for its stated purpose by Medicare; or

c) accredited or licensed by the state of New Jersey to provide mental health services.

Mental Health Condition means a condition which is referenced by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth edition, and any subsequent editions.

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.

Network – The Horizon BCBSNJ Managed Care Network.

Network Maximum Out-of-Pocket (MOOP): Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar year.

Newly Acquired Dependent means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

Nicotine Dependence Treatment means "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

Non-Covered Charges are charges which do not meet the Plan's definition of Covered Charges or which exceed any of the benefit limits shown in the Plan, or which are specifically identified as Non-Covered Charges or are otherwise not covered by the Plan.

Non-Preferred Drug means a drug that has not been designated as a Preferred Drug.

Nurse means a registered nurse or licensed practical nurse, including 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 or she practices; and

b) provides medical services which are within the scope of his or her license or certificate and 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.

Orientation Period means a period of no longer than one month during which the employer and employee determine whether the employment situation is satisfactory for each party and any necessary orientation and training processes commence. As used in this definition, one month is determined by adding one calendar month and subtracting one calendar day, measured from an Employee's start date in a position that is otherwise eligible for coverage. Ref to 26 C.F.R. 54.9815-2708 (C) (iii).

Orthotic Appliance means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

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

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

Out-of-Network Benefits: The coverage shown in the Schedule of Covered Services and Supplies which is provided if an Out-of-Network Provider provides a Covered Service or Supply or the Care Manager does not authorize or coordinate the care, treatment, services and supplies.

Outpatient means a Covered Person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such Outpatient settings.

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

Participant – an Employee or Dependent who is enrolled under your group's Plan.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by Prime Therapeutics, LLC or with whom Horizon BCBSNJ has signed a pharmacy service agreement, that is:

a) equipped to provide Prescription Drugs through the mail; or

b) is a Participating Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement.

Participating Pharmacy means 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 and (c) with whom Horizon BCBSNJ has signed a pharmacy services agreement.

Per Lifetime: During the lifetime of a person.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. The Plan determines if the cause(s) of the confinements are the same or related.

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 **Association Member Trust** Medical Plan.

Plan Sponsor has the meaning given that term under Title I, section 3 of Pub.L.93-406, the ERISA (29 U.S.C. §1002(16)(B)). That is:

a) the Small Employer in the case of an employee benefit plan established or maintained by a single employer;

b) the employee organization in the case of a plan established or maintained by an employee organization; or

c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

Plan Year: The twelve-month period starting on **January 1st and ending on December 31st**.

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

Practitioner means a person 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 or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

Pre-Approval or Pre-Approved means the Horizon BCBSNJ approval using paper or electronic means for specified services and supplies prior to the date charges are incurred. Horizon BCBSNJ may reduce benefits with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by Horizon BCBSNJ provided that benefits would otherwise be payable under the Plan.

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.

Preferred Drug means a Prescription Drug that; a) has been designated as such by either Us, or a third party with which Horizon BCBSNJ contracts, as a Preferred Drug; b) is a drug that has been approved under the Federal Food, Drug and Cosmetic Act; and c) is included in the list of Preferred Drugs distributed to Preferred Providers and made available to Covered Persons, upon request.

The list of Preferred Drugs will be revised, as appropriate.

Prescription Drug Cost Share Amount: The sum total of the following In-Network expenses Incurred by a Covered Person or covered family during a Calendar Year under a self-insured stand-alone group prescription drug plan or an insured stand-alone group prescription drug plan provided by Horizon BCBSNJ or another carrier:

(a) Expenses that are applied toward the prescription drug plan's deductible, if any (excluding any such expenses, including any fourth quarter deductible carry over as defined in the prescription drug plan, that were carried over from the preceding Calendar Year).

(b) Amounts paid or payable by the Covered Person as copayments and/or coinsurance under the prescription drug plan.

Prescription Drugs: Drugs, biological and compound prescriptions which: (a) are dispensed only by prescription; and (b) are required to show on the manufacturer's label the words: "Caution-Federal Law Prohibits Dispensing Without A Prescription." The term includes: insulin and may include other drugs and devices (e.g., syringes; glucometers; over-the-counter drugs mandated by law), as determined by Horizon BCBSNJ.

Prescription Mail Order – a Covered Person's request that a Prescription Order for drugs be filled and mailed to him or her by a licensed mail order Pharmacy.

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

Preventive Care. As used in the Plan preventive care means:

a) Evidence based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services task Force with respect to the Covered Person;

b) Immunizations for routine use for Covered Persons of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Covered Person;

c) Evidence–informed preventive care and screenings for Covered Persons who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;

d) Evidence–informed preventive care and screenings for female Covered Persons as included in the comprehensive guidelines supported by the Health Resources and Services Administration except for contraceptive services and supplies; and

e) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, and Nicotine Dependence Treatment.

Primary Care Practitioner (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 who meet the requirements of N.J.A.C. 11:24-6.2(c) 1 through 3.

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 /www.horizonblue.com/doctorfinder. A paper provider directory/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.

Private Duty Nursing means Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

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

Prosthetic Appliance means any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of the Plan.

Referral means specific direction or instructions from a Covered Person's Primary Care Physician or care manager in conformance with Horizon BCBSNJ's policies and procedures that direct a Covered Person to a Facility or Practitioner for health care.

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

a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

b) approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

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.

Routine Foot Care means 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, deratomas, keratosis, onychauxis, onychocryptosis tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, and supportive devices for the foot.

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

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered nurse or licensed practical nurse, and require the technical skills and professional training of a registered nurse or licensed practical nurse.

Same Terms and Conditions means, with respect to the treatment of Mental Health Conditions and Substance Use Disorders, Horizon BCBSNJ cannot apply more restrictive non-quantitative limitations or more restrictive quantitative limitations to Mental Health Conditions and

Substance Use Disorder, than Horizon BCBSNJ applies to substantially all other medical or surgical benefits.

Skilled Nursing Facility (see Extended Care Center.)

Small Employer means:

a) in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least one but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least one eligible Employee on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.; OR

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

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

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

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

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

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

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

Special Care Unit means 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 it must have 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.

Special Referral: A Referral provided by a PCP in certain cases that will allow a Covered Person to obtain certain Specialist services covered under this Plan directly through an In-Network Provider, without the need for further Referrals from the PCP. A Special Referral may be limited in scope, e.g. as to: duration; diagnosis; condition; and other factors, as determined by Horizon BCBSNJ.

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.

Specialty Pharmaceuticals are oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These Prescription Drugs must be exclusively dispensed through a designated Specialty Pharmaceutical Provider and are not available from Mail-Order Pharmacies.

Examples of Prescription Drugs that are considered Specialty Pharmaceuticals include some orally administered anti-cancer Prescription Drugs and those used to treat the following

conditions: Crohn's Disease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; and Gaucher's Disease. A list of these drugs is available on Horizon BCBSNJ's website.

Specialty Pharmaceutical Provider: Prime Specialty Pharmacy, a vendor that has contracted with Horizon BCBSNJ to exclusively dispense Specialty Pharmaceuticals on an In-Network basis.

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

Subscription Agreement means the agreement whereby an Employer agrees to participate in the Association Member Trust and agrees to be bound by the terms, conditions and provisions of the Plan.

Substance Use Disorders: As defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and any subsequent editions. Substance Use Disorders includes substance use withdrawal.

Substance Use Disorders Centers: Facilities that mainly provide treatment for people with Substance U**se** Disorder problems. The Plan will recognize such a place 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 means**:**

a) the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
b) the correction of fractures and dislocations;
c) reasonable and customary preoperative and post-operative care; or
d) any of the procedures designated by Current Procedural Terminology codes as Surgery.

Telemedicine Network: Horizon's designated provider American Well provides a network of U.S. board certified, licensed and credentialed physicians throughout the country for members to consult with a licensed doctor via live interactive audio and video.

Telemedicine Services: means the delivery of health care services including diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection. Telemedicine is not available to anyone on Medicare.

Therapeutic Manipulation means 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 are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool, hydro therapy or other treatment of 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 accidental injury.

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

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

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

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

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

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

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

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

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

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

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

Triggering Event means the following dates:

a) The date an Employee or Dependent loses eligibility for minimum essential coverage including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.

b) The date an Employee acquires a Dependent or becomes a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.

c) The date an Employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation or inaction by the federal government.

d) The date an Employee or eligible Dependent demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

e) The date the Employee or Dependent gains access to new qualified health plans as a result of a permanent move.

f) The date the Employee or Dependent loses eligibility for Medicaid or NJ FamilyCare.

g) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ FamilyCare plan.

Trust Document means that document that created the Plan and designates the legal ability of the Plan to operate.

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 means the period of time between the date of hire with your sponsoring employer and the date when you become eligible for coverage. The sponsoring employer has determined the appropriate Waiting Period for its eligible employees to be the first of the month following 0, 30, or 60 days of continuous employment. The Waiting Period cannot exceed 90 days.

We, Us and Our: The Plan.

You, Your, Yours: An Employee.

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: OUR 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 Out-of-Network Provider are generally not covered.

However, this does not apply to: Medical Emergencies; Urgent Care; or 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 an In-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.

Coinsurance

In-Network	**80%** of Covered Basic Charges.
	80% of Covered Supplemental Charges.
Out-of-Network	No Benefit.

Preventive Care is always payable at 100%.

Out-of-Pocket Maximum

In-Network	After **$4,500**/Covered Person, **$9,000** /family, we pay at **100%.**
Out-of-Network	No Benefit.

Note: The Out-of-Pocket Maximum cannot be met with Non-Covered Charges.

Deductible

In-Network	**$1,500**/Covered Person**, $3,000**/family (aggregate)**.**
Out-of-Network	No Benefit.
Per Admission Copayment	**$500** Per day for up to five days per admission. The maximum Copayment is 2 admissions per Covered Person in any one Benefit Period.

***Note:** The Per Admission Copayment applies to all In-Network Inpatient Facility charges.

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

Prior Carrier Deductible Carry-Over - Charges for Covered Services and Supplies which met any portion of a Deductible required for the final Benefit Period under the Employer's prior group health benefits contract will be applied to meet all or any portion of the initial Deductible under this Plan.

Professional Office Care

PCP	Subject to **$35.00** Copayment and **100%** Coinsurance.
Non-PCP	Subject to **$50.00** Copayment and **100%** Coinsurance.

Professional Care (Outpatient)

PCP	Subject to Deductible, and **80%** Coinsurance.
Non-PCP	Subject to Deductible, and **80%** Coinsurance.

BENEFIT PERIOD MAXIMUM

In-Network	**Unlimited.** Applies to all Covered Services and Supplies.
Out-of-Network	No Benefit**.**

PER LIFETIME MAXIMUM

In-Network	**Unlimited.** Applies to all Covered Services and Supplies.
Out-of-Network	No Benefit.

A. COVERED BASIC SERVICES AND SUPPLIES

ACUPUNCTURE

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

Out-of-Network No Benefit.

ALLERGY TESTING AND TREATMENT

In-Network Subject to **$50.00** Copayment and **100%** Coinsurance. The **$50** Copayment and **100%** Coinsurance apply only if an office visit is charged. Other services are subject to the Deductible, and **80%** Coinsurance.

Out-of-Network No Benefit.

AMBULATORY SURGICAL CENTERS

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

Out-of-Network No Benefit.

ANESTHESIA

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

Out-of-Network No Benefit.

APPROVED CANCER CLINICAL TRIAL

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

Out-of-Network No Benefit

AUDIOLOGY SERVICES

In-Network Subject to **$50.00** Copayment and **100%** Coinsurance.

Out-of-Network No Benefit.

BIRTHING CENTERS

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

Out-of-Network No Benefit

BREASTFEEDING SUPPORT

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

Out-of-Network No Benefit

CONTRACEPTIVES

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

Out-of-Network No Benefit

DENTAL CARE AND TREATMENT

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

Out-of-Network No Benefit.

DIAGNOSIS AND TREATMENT OF AUTISM AND OTHER DEVELOPMENTAL DISABILITES

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

Out-of-Network No Benefit

DIAGNOSTIC X-RAY AND LAB

In-Network

Professional Office Care Subject to Deductible, and **80%** Coinsurance.

Professional Care (Outpatient) Subject to Deductible, and **80%** Coinsurance.

Out-of-Network No Benefit.

DIALYSIS CENTER CHARGES

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

Out-of-Network No Benefit.

EMERGENCY ROOM

In-Network Subject to **$150.00** Copayment and **80%** Coinsurance.

Emergency services Out- of- Network are covered at the In-Network level for true emergency diagnosis.

Out-of-Network No Benefit (non emergency diagnosis).

FACILITY CHARGES

In-Network

Inpatient Subject to Preapproval, Per Admission Copayment, Deductible, and **80%** Coinsurance.

Outpatient Subject to Deductible, and **80%** Coinsurance.

Out-of-Network No Benefit.

FERTILITY SERVICES

In-Network

Professional Office Care Subject to **$50.00** Copayment and **100%** Coinsurance.

Professional Care (Outpatient) Subject to Deductible, and **80%** Coinsurance.

Out-of-Network No Benefit.

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

In-Network For the purchase of a hearing aid, benefits subject Deductible, and **80%** Coinsurance.

Hearing aids for Covered Persons are subject to a maximum of one hearing aid for each hearing-impaired ear every 24 months

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

Out-of-Network No Benefit.

HOME HEALTH AGENCY CARE

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

Out-of-Network No Benefit.

HOSPICE CARE

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

Out-of-Network No Benefit.

INPATIENT PHYSICIAN SERVICES

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

Out-of-Network No Benefit.

MASTECTOMY BENEFITS

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

Out-of-Network No Benefit

MATERNITY/OBSTETRICAL CARE

In-Network

Professional Office Care Subject to **$35.00** Copayment and **100%** Coinsurance. The Copayment applies to the initial visit only. All other In-Network services are reimbursed at **80%** Coinsurance, subject to the Deductible.

Professional Care (Outpatient) Subject to Deductible, and **80%** Coinsurance.

Out-of-Network No Benefit.

MATERNITY CARE FOR CHILD DEPENDENTS

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

Out-of-Network No Benefit

MEDICAL EMERGENCY AND MEDICAL SCREENING EXAMINATIONS

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

Out-of-Network No Benefit

MENTAL HEALTH CONDITIONS

a. INPATIENT

In-Network Subject to Preapproval, Per Admission Copayment, Deductible, and **80%** Coinsurance.

Out-of-Network No Benefit.

b. OUTPATIENT AND OUT-OF-HOSPITAL

In-Network Subject to **$50.00** Copayment and **100%** Coinsurance.

Out-of-Network No Benefit.

c. PARTIAL HOSPITALIZATION

In-Network **2** partial days = **1** inpatient day. Subject to Deductible, and **80%** Coinsurance.

Out-of-Network No Benefit.

d. INPATIENT MEDICAL VISITS

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

Out-of-Network No Benefit.

e. GROUP THERAPY

In-Network Subject to **$50.00** Copayment and **100%** Coinsurance.

3 Sessions equals **1** Outpatient visit.

Out-of-Network No Benefit.

NUTRITIONAL COUNSELING

In-Network

Professional Office Care	Subject to **$50.00** Copayment and **100%** Coinsurance.
Professional Care (Outpatient)	Subject to Deductible, and **80%** Coinsurance.

Benefits subject to a **3** Visit maximum per Benefit Period.

Out-of-Network	No Benefit.

ORALLY ADMINISTERED ANTI-CANCER PRESCRIPTION DRUGS

In-Network	Subject to Deductible, and **80%** Coinsurance
Out-of-Network	No Benefit

PRACTITIONER'S CHARGES FOR SURGERY

In-Network

Professional Office Care	Subject to **$50.00** Copayment and **100%** Coinsurance.
Professional Care (Outpatient)	Subject to Deductible, and **80%** Coinsurance.

Out-of-Network	No Benefit.

PRE-ADMISSION TESTING

In-Network	Subject to Deductible, and **80%** Coinsurance.
Out-of-Network	No Benefit.

PREVENTIVE CARE

In-Network	Subject to **100%** Coinsurance.
Out-of-Network	No Benefit.

a. GYNECOLOGICAL CARE AND EXAMINATIONS

One per year, no referral needed.

b. MAMMOGRAPHY

One per year, no referral needed.

c. PAP SMEARS

One per year, no referral needed.

d. ROUTINE PHYSICALS AND IMMUNIZATIONS

e. WELL-CHILD CARE

f. WELL-CHILD IMMUNIZATIONS AND LEAD POISONING SCREENING AND TREATMENT

g. PROSTATE CANCER SCREENING

One per calendar year.

h. COLORECTAL CANCER SCREENING

i. NEWBORN HEARING SCREENING

In addition to the preventive benefits described above, the Plan shall cover the following preventive services:

j. Evidenced based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

k. 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 individuals involved;

l. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

m. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Plan shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services**.**

PROSTHETIC OR ORTHOTICS APPLIANCES

In-Network	Benefits payable are the same as for an office Visit to a Provider who is a doctor specializing in: family practice, general practice, internal medicine, or pediatrics.
Out-of-Network	No Benefit**.**

SECOND OPINION CHARGES

In-Network	Subject to **$50.00** Copayment and **100%** Coinsurance.
Out-of-Network	No Benefit.

SKILLED NURSING FACILITY CHARGES

In-Network	Subject to Deductible, and **80%** Coinsurance.
Out-of-Network	No Benefit.

SPECIALIST SERVICES

In-Network

Professional Office Care	Subject to **$50.00** Copayment and **100%** Coinsurance.
Professional Care (Outpatient)	Subject to Deductible, and **80%** Coinsurance.

Out-of-Network	No Benefit.

TELEMEDICINE BEHAVIORAL HEALTH SERVICES, PROVIDED BY HORIZON CAREONLINE

In-Network	Subject to **$10.00** Copayment.
Out-of-Network	No Benefit.

TELEMEDICINE MEDICAL SERVICES, PROVIDED BY HORIZON CAREONLINE

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

Out-of-Network No Benefit.

THERAPEUTIC MANIPULATIONS

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

The Plan does not cover more than **30** Visits per Benefit Period.

Out-of-Network No Benefit.

THERAPY SERVICES

a. CHELATION THERAPY

In-Network

Professional Office Care

PCP Subject to Deductible, and **80%** Coinsurance.

Specialist Subject to Deductible, and **80%** Coinsurance.

Professional Care (Outpatient) Subject to Deductible, and **80%** Coinsurance.

Out-of-Network No Benefit.

b. CHEMOTHERAPY

In-Network

Professional Office Care

PCP Subject to Deductible, and **80%** Coinsurance.

Specialist Subject to Deductible, and **80%** Coinsurance.

Professional Care (Outpatient) Subject to Deductible, and **80%** Coinsurance.

Out-of-Network No Benefit.

c. COGNITIVE REHABILITATION THERAPY

In-Network

Professional Office Care

PCP	Subject to Deductible, and **80%** Coinsurance.
Specialist	Subject to Deductible, and **80%** Coinsurance.
Professional Care (Outpatient)	Subject to Deductible, and **80%** Coinsurance.

Benefits subject to a **60** visit maximum per Benefit Period.

Out-of-Network	No Benefit.

d. DIALYSIS TREATMENT

In-Network

Professional Office Care

PCP	Subject to Deductible, and **80%** Coinsurance.
Specialist	Subject to Deductible, and **80%** Coinsurance.
Professional Care (Outpatient)	Subject to Deductible, and **80%** Coinsurance.

Out-of-Network	No Benefit.

e. INFUSION THERAPY

In-Network

Professional Office Care

PCP	Subject to Deductible, and **80%** Coinsurance.
Specialist	Subject to Deductible, and **80%** Coinsurance.
Professional Care (Outpatient)	Subject to Deductible, and **80%** Coinsurance.

Out-of-Network	No Benefit.

f. OCCUPATIONAL THERAPY

In-Network

Professional Office Care

PCP	Subject to Deductible, and **80%** Coinsurance.
Specialist	Subject to Deductible, and **80%** Coinsurance.
Professional Care (Outpatient)	Subject to Deductible, and **80%** Coinsurance.

Benefits subject to a **60** visit maximum per Benefit Period. The 60 Visit maximum does not apply to certain mental health diagnosis, including the treatment of autism.

Out-of-Network No Benefit.

g. PHYSICAL THERAPY

In-Network

Professional Office Care

PCP	Subject to Deductible, and **80%** Coinsurance.
Specialist	Subject to Deductible, and **80%** Coinsurance.
Professional Care (Outpatient)	Subject to Deductible, and **80%** Coinsurance.

Benefits subject to a **60** visit maximum per Benefit Period. The 60 Visit maximum does not apply to certain mental health diagnosis, including the treatment of autism.

Out-of-Network No Benefit.

h. RADIATION TREATMENT

In-Network

Professional Office Care

PCP	Subject to Deductible, and **80%** Coinsurance.
Specialist	Subject to Deductible, and **80%** Coinsurance.
Professional Care (Outpatient)	Subject to Deductible, and **80%** Coinsurance.

Out-of-Network No Benefit.

i. RESPIRATION THERAPY

In-Network

Professional Office Care

PCP	Subject to Deductible, and **80%** Coinsurance.
Specialist	Subject to Deductible, and **80%** Coinsurance.
Professional Care (Outpatient)	Subject to Deductible, and **80%** Coinsurance.

Benefits subject to a **30** Visit maximum per Benefit Period.

Out-of-Network No Benefit.

j. SPEECH THERAPY

In-Network

Professional Office Care

PCP	Subject to Deductible, and **80%** Coinsurance.
Specialist	Subject to Deductible, and **80%** Coinsurance.
Professional Care (Outpatient)	Subject to Deductible, and **80%** Coinsurance.

Benefits subject to a **60** visit maximum per Benefit Period. The 60 Visit maximum does not apply to certain mental health diagnosis, including the treatment of autism.

Out-of-Network No Benefit.

TRANSPLANT BENEFITS

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

Out-of-Network No Benefit.

VISION CARE

In-Network Subject to **$50.00** Copayment and **100%** Coinsurance.

Limited to one Eye Examination and one Vision Survey per Benefit Period.

Hardware coverage limited to **$50.00** in a two year Benefit Period.

Out-of-Network No Benefit.

WILM'S TUMOR

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

Out-of-Network No Benefit.

B. COVERED SUPPLEMENTAL SERVICES AND SUPPLIES

AMBULANCE SERVICES

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

Out-of-Network No Benefit.

BLOOD

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

Out-of-Network No Benefit.

CHARGES FOR THE TREATMENT OF HEMOPHILIA

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

Out-of-Network No Benefit

DIABETES BENEFITS

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

Out-of-Network No Benefit.

DURABLE MEDICAL EQUIPMENT

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

Out-of-Network No Benefit.

HOME INFUSION THERAPY

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

Out-of-Network No Benefit.

INHERITED METABOLIC DISEASE

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

Out-of-Network No Benefit.

NON-PRESCRIPTION SUPPLIES

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

Out-of-Network No Benefit

OXYGEN AND ADMINISTRATION

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

Out-of-Network No Benefit.

PHYSICAL REHABILITATION CENTER

In-Network

Inpatient Subject to Deductible, and **80%** Coinsurance.

Out-of-Network No Benefit.

PRIVATE DUTY NURSING

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

Subject to a **30** visits per Benefit Period.

Out-of-Network No Benefit.

SPECIALIZED NON-STANDARD INFANT FORMULAS

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

Out-of-Network No Benefit.

WIGS

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

Subject to a **$500** maximum per Benefit Period.

Out-of-Network No Benefit.

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 card. If you enroll your eligible Dependents at the same time, their coverage will become effective on the same date as your own. Except as otherwise provided below, if you or an eligible Dependent is not enrolled within 31 days after becoming eligible for the coverage under this Plan, that person is deemed a Late Enrollee.

Your Identification (ID) Card

You will receive an ID card, digitally or hardcopy, 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.

If you receive a hardcopy, always carry this card and use your ID number when you or a Dependent receive(s) 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.

When Employee Coverage Starts

An Employee must be working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her.

The Employee must elect to enroll and agree to make the required payments, if any, within 30 days of the Employee's Eligibility Date. If he or she does this within 30 days of the Employee's Eligibility Date, his coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the Effective Date of an Employee's coverage.

If the Employee does this more than 30 days after the Employee's Eligibility Date, Association Member Trust will consider the Employee a Late Enrollee.

Eligible Employees

Subject to the conditions of Eligibility and to all of the other conditions of the Plan, all of the Policyholder’s Employees who are in an eligible class will be eligible if the Employees are Actively at work, or Full Time Employees except those who are absent due to disability or a health status factor.

Types Of Coverage Available

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

- **Single** – provides coverage for you only.
- **Family** – provides coverage for you, your Spouse or Domestic Partner and your Child Dependents.
- **Husband and Wife/Two Adults** – provides coverage for you and your Spouse or Domestic Partner only.
- **Parent and Child(ren)** – provides coverage for you and your Child Dependents, but not your Spouse or Domestic 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 before or 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 already are enrolled under Family or Parent and Child(ren) coverage, your newborn infant is automatically covered for the initial 60 days after birth. However, a new enrollment form must be completed and forwarded by your employer to the Association Member Trust within 60 days of birth;
- If you have Husband and Wife or Domestic Partners coverage, your newborn is automatically covered for sickness or injury for 60 days, but you must apply for Family coverage within 60 days of the birth for coverage to continue beyond the 60th day;
- If you have Single coverage, your newborn is automatically covered for sickness or injury for 60 days, but you must apply for Parent/Child(ren) coverage within 31 days of the birth for coverage to continue beyond the 60th day;
- If you have Single coverage and marry, or acquire a Domestic Partner, your new Spouse or Domestic Partner will be covered from the date you marry or meet the rules for covering Domestic Partners if you apply for Husband and Wife or Family coverage within 31 days.

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

Eligible Retirees

1. The participating Employer must have previously established a Retiree health benefit program.

2. The Retiree must have Medicare A & B and other available Medicare coverage.

3. The participating Employer establishes non-discriminatory contribution formula.

4. The participating Employer must remain eligible and be active in Association Member Trust.

5. The Retiree must have been employed by the participating Employer for at least seven (7) years.

6. The Retiree has participated in Employer's group plan for at least three (3) years prior to retirement.

7. The Retiree cannot re-enroll after terminating coverage.

8. If a Dependent of a Retiree is eligible to participate as an Employee, such person cannot enroll as a Dependent of a Retiree.

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, Horizon BCBSNJ will:

- Permit you to enroll your Child Dependent, without any enrollment restrictions;
- Permit: (a) the Child Dependent's other parent; (b) the Division of Medical Assistance and Health Services; or (c) the Division of Family Development as the State IV-D agency, in the Department of Human Services, to enroll the Child Dependent in this 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 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.

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).

Dependent Special Enrollment Period

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 Periods

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.

Special Enrollment Due to Marriage or Acquiring a Domestic Partner

You may enroll a new Spouse or Domestic 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 Domestic Partner is enrolled.

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

The coverage becomes effective on the first day of the month after the completed request is received.

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 adopted 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.

Employee Open Enrollment Period means the 30-day period each year designated by the Planholder during which:

a) Employees and Dependents who are eligible under the Plan but who are Late Enrollees may enroll for coverage under the Plan; and

b) Employees and Dependents who are covered under the Plan may elect coverage under a different Plan, if any, offered by the Planholder.

Benefit choices made during the Open Enrollment period will become effective based on the Plan's Renewal Date (January 1st) and remain in effect for the next twelve months unless there is a change in family status during the year (birth, death, marriage, divorce, adoption, or leave of absence) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one Plan to another Plan.

Benefit choices for Late Enrollees made during the Open Enrollment period will become effective based on the Plan's Renewal Date (January 1st).

A Plan participant who fails to make an election during Open Enrollment will automatically retain his or her present or comparable coverage if a Plan is eliminated.

Multiple Employment

If you work for both the Policyholder 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 as follows:

a) Legal spouse where spouse shall include a Domestic Partner pursuant to P.L. 2003, c. 246;

b) Dependent child who is under age 26; and

c) A Dependent is not a person who is on active duty in the armed forces of any country.

Under certain circumstances, an incapacitated child is also a Dependent. See the Dependent coverage section of this Plan.

An Employee's "Dependent child" includes:

a) his or her legally adopted children,

b) his or her step-child,

c) the child of his or her Domestic Partner, and

d) children under a court appointed guardianship.

The Plan treats a child as legally adopted from the time the child is placed in the home for the purpose of adoption. The Plan treats such a child this way whether or not a final adoption order is ever issued.

Coverage will continue for a Child Dependent beyond the age of **26** if, immediately prior to reaching that age: (1) the child is unmarried; and (2) he/she was enrolled under this Plan or another policy/contract and is incapable of self-sustaining employment by reason of intellectual disability 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 intellectual disability 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.

If your child was enrolled as a handicapped Dependent under previous coverage with your Plan and there has been no interruption in coverage, the child may be covered as an eligible Dependent under this Program, regardless of age.

When Coverage Ends

Your coverage ends on the last day of the benefit month in which your enrollment in this program ends, or on the last day of the benefit month for which required contributions have been paid by your employer or yourself, or the date this program ends.

Coverage for a Dependent will end when your coverage ends; or on the last day of the benefit month in which the Dependent fails to meet the definition of a Dependent; or the date this program ends.

Coverage for your spouse will end on the date of your spouse's death, at the end of the benefit month in which you divorce, at the end of the benefit month in which you notify us to delete your spouse from coverage, or failure by you or your employer to make timely payment of any required contributions.

Coverage for a Child Dependent ends upon the earliest of the following: the last day of the calendar month in which the child reaches age 26, or failure by you or your employer to make timely payment of any required contributions.

Coverage for a handicapped Child Dependent will end on the last day of the benefit month in which the earliest of the following occurs; the termination of your coverage, the failure of your Child Dependent to satisfy the definition of a Child Dependent for any reason other than age, and the termination of your Child Dependent's inability to engage in self-sustaining employment by reason of intellectual disability or physical handicap, or failure by you or your employer to make timely payment of any required contributions.

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, but only to the extent they would otherwise be available.

If You Leave Your Group Due To Total Disability

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

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

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

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

If you are a Totally Disabled former employee whose group coverage (including coverage for any eligible Dependents) has been continued without interruption in accordance with state law, through the employer's prior health carrier, you will also be eligible for coverage under this program. Such coverage will be continued until you no longer meet the eligibility requirements described above.

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

Extension Of Coverage Due To Employer Termination

If you or any of your Dependents are Totally Disabled on the date your employer's coverage under this program ends, benefits will continue to be available for that person for covered medical expenses resulting from the sickness or accidental injury that caused the disability during the uninterrupted continuation of the disability. However, benefits will not be extended beyond (1) the date the disability ends, (2) 12 months from the date the employer's coverage ends, or (3) the date the program ends, whichever comes first.

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 premium, as it does for Active Employees, is subject to your eventual return to Active work.

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

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

Consult your benefits representative for application forms and further details.

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). 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.

Continued Coverage For Surviving Dependents

Eligible Dependents of a deceased employee may have coverage continued under this program for at least 6 months after the employee's death or your eligibility for Medicare Benefits. See your enrollment official for further details and to arrange to make any required premium payments through the group.

Continuation of Care

Horizon BCBSNJ shall provide written notification to each Covered Person at least 30 business days prior to the termination or withdrawal from Horizon BCBSNJ's provider network of a Covered Person's personal care physician (PCP) and any other physician or Provider from which the Covered Person is currently receiving a course of treatment, as reported to Horizon BCBSNJ. The 30 day prior notice may be waived in cases of immediate termination of a health care professional based on breach of contract by the health care professional, a Determination of fraud, or where Horizon BCBSNJ's medical director is of the opinion that the health care professional is an imminent danger to the patient or the public health, safety or welfare.

Horizon BCBSNJ shall assure continued coverage of covered services at the contract price by a terminated health care professional for up to four (4) months in cases where it is Medically Necessary for the Covered Person to continue treatment with the terminated health care professional. In the case of pregnancy of a Covered Person, coverage of services by the terminated health care professional shall continue to the postpartum evaluation of the Covered Person, up to 6 weeks after the delivery. With respect to pregnancy, Medical Necessity shall be deemed to have been demonstrated. In the event that a Covered Person is receiving post-operative follow-up care, Horizon BCBSNJ shall continue to cover services rendered by the health care professional for the duration of the treatment for up to (not to exceed) 6 months.

In the event that a Covered Person is receiving oncological treatment or psychiatric treatment, Horizon BCBSNJ shall continue to cover services rendered by the health care professional for the duration of the treatment for up to (not to exceed) one year. In the event that the above services are provided in an acute care facility, Horizon BCBSNJ will continue to provide coverage for services rendered by the health care professional regardless of whether the acute care facility is under contract or agreement with Horizon BCBSNJ.

Services shall be provided to the same extent as provided while the health care professional was employed by or under contract with Horizon BCBSNJ. Reimbursement for services shall be pursuant to the same schedule used to reimburse the health care professional while the health care professional was employed by or under contract with Horizon BCBSNJ.

In the event a Covered Person is admitted to a health care facility on the date that this Plan is terminated, Horizon BCBSNJ shall continue to provide benefits for the Covered Person until the date of the Covered Person's discharge from the health care facility, or exhaustion of the Covered Person's benefits under this Plan, whichever occurs first.

Horizon BCBSNJ shall not provide continued services in those instances in which the health care professional has been terminated based upon the opinion of Horizon BCBSNJ's medical director that the health care professional is an imminent danger to a patient or to the public health, safety and welfare, a Determination of fraud, or a breach of contract by the health care professional. The Determination of Medical Necessity of a Covered Person's continued treatment with a health care professional shall be subject to the appeal procedures set forth in Section IV, Claims Procedure. Horizon BCBSNJ shall not be liable for any inappropriate treatment provided to a Covered Person by a health care professional who is no longer employed by or under contract with Horizon BCBSNJ.

If Horizon BCBSNJ refers a Covered Person Out-of-Network, the service or supply shall be covered as an In-Network service or supply such that Horizon BCBSNJ is fully responsible for payment to the health care professional and the Covered Person is only responsible for any applicable in-network copayment, coinsurance or deductible for the service or supply.

Continuation of Coverage under COBRA (For Employers with 20 or more employees)

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage?

COBRA continuation coverage is group health insurance coverage that certain employers must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who is a Qualified Beneficiary?

In general, a Qualified Beneficiary is:

(i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(iii) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provides that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(i) The death of a covered Employee.

(ii) The termination (other than by reason of the Employee’s gross misconduct), or reduction of hours, of a covered Employee’s employment.

(iii) The divorce or legal separation of a covered Employee from the Employee’s Spouse.

(iv) A covered Employee's enrollment in the Medicare program.

(v) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

(vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last?

An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

There may be other coverage options for the Employee, Spouse or a Dependent child of the covered Employee. Due to the enactment of the Patient Protection and Affordable Care Act, the Employee will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, the Employee could be eligible for a new kind of tax credit that lowers his or her monthly premiums right away, and the Employee can see what his or her premium, deductibles, and out-of-pocket costs will be before the Employee makes a decision to enroll. Being eligible for COBRA does not limit the Employee's eligibility for coverage for a tax credit through the

Marketplace. Additionally, the Employee may qualify for a special enrollment opportunity for another group health plan for which the Employee is eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if the Employee requests enrollment within 30 days.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

(i) A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.

(ii) The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage.

Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(i) The last day of the applicable maximum coverage period.

(ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(iii) The date upon which the Employer ceases to provide group health benefit coverage through AMT.

(iv) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(v) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or

(ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What is the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(ii) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.

(iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event.

How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.

Can a Plan require payment for COBRA continuation coverage?

Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage?

Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the 180- day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries

STATE MANDATED CONTINUATION OPTIONS

(For Employers with 2 - 19 Employees)

NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)

Important Notice

Except as stated below, under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:

a) a full-time covered Employee;

b) the spouse of a full-time covered Employee; or

c) the Dependent child of a full-time covered Employee.

Exception: A Newly Acquired Dependent, where birth, adoption, or marriage occurs after the Qualifying Event is also a "Qualified Continuee" for purposes of being included under the Employee's continuation coverage.

If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours to fewer than 25 hours per week, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated for cause. The Employee's spouse and Dependent children may elect to continue benefits even if the Employee does not elect continuation for himself or herself.

A Qualified Continuee may elect to continue coverage under NJGCR even if the Qualified Continuee:

a) is covered under another group plan on or before the date of the NJGCR election; or
b) is entitled to Medicare on or before the date of the NJGCR election.

The continuation:

a) may cover the Employee and/or any other Qualified Continuee; and
b) is subject to the "When Continuation Ends" section.

Extra Continuation for Disabled Qualified Continuees

If a former Employee who is a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the termination of employment or reduction of work hours to fewer than 25 hours per week or during the first 60 days of continuation coverage, he or she may elect to extend his or her 18-month continuation period for himself or herself and any Dependents who are Qualified Continuees for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee must give the Carrier written proof of Social Security's determination of his or her disability before the earlier of:

a) the end of the 18 month continuation period; and
b) 60 days after the date the Qualified Continuee is determined to be disabled.

If, during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Carrier within 31 days of such determination, and continuation will end, as explained in the "When Continuation Ends" section.

An additional 50% of the total premium charge also may be required from the Qualified Continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured

If an Employee dies while insured, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the "When Continuation Ends" section.

If An Employee's Marriage or Domestic Partnership Ends

If an Employee's marriage ends due to legal divorce or legal separation or termination of a Domestic Partnership, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the "When Continuation Ends" section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of Dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits for up to 36 months, subject to the "When Continuation Ends" section.

The Employer's Responsibilities

Upon loss of coverage due to termination of employment or reduction in work hours, the Employer must notify the former employee in writing, of:

a) his or her right to continue this Policy's group health benefits;

b) the monthly premium he or she must pay to continue such benefits; and

c) the times and manner in which such monthly payments must be made.

Upon being advised of the death of the Employee, divorce, termination of Domestic Partnership or Dependent child's loss of eligibility, the Employer should notify the Qualified Continuee in writing, of:

a) his or her right to continue this Policy's group health benefits;

b) the monthly premium he or she must pay to continue such benefits; and

c) the times and manner in which such monthly payments must be made.

Election of Continuation

To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 30 days of the date coverage ends. The first month's premium must be paid within 30 days of the date the Qualified Continuee elects continued coverage.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the "Extra Continuation for Disabled Qualified Continuees" section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee does not give the Employer notice of his or her intent to continue coverage, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 30 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the date it is due.

The Continued Coverage

The continued coverage shall be identical to the coverage provided to similarly situated active Employees and their Dependents under the Employer's plan. If coverage is modified for any group of similarly situated active Employees and their Dependents, the coverage for Qualified Continuees shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends

A Qualified Continuee's continued group health benefits end on the first of the following:

a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability, the end of the 29 month period which starts on the date the group health benefits would otherwise end. However, if the Qualified Continuee is no longer disabled, coverage ends on the later of:

- the end of the 18-month period; or

- the first day of the month that begins more than 31 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation or termination of the Domestic Partnership or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

d) the date the Employer ceases to provide any health benefits plan to any active Employee or Qualified Continuee;

e) the end of the period for which the last premium payment is made; or

f) the date he or she first becomes entitled to Medicare.

Conversion Coverage

If health care coverage under this Program for your spouse ends due to divorce, the spouse may apply to Horizon BCBSNJ for individual non-group health care coverage if he/she meets the following condition.

He/she must apply to Horizon BCBSNJ in writing no later than 31 days after his/her coverage under this program ends.

The spouse does not need to prove he/she is in good health. However, any health exception, limitation or exclusion which applied to her/him under this Program will be carried over to the conversion coverage. The coverage available will be in accordance with Horizon BCBSNJ's underwriting requirements in effect on the day Horizon BCBSNJ receives the spouse's application. The coverage will be at least equal to the basic benefits provided in contracts then being issued by your Plan to new non-group applicants of the same age and family status.

The new coverage is called "conversion coverage." The conversion coverage, if provided, may be different than the coverage provided by this Program. Details of the conversion coverage available will be given upon your or your spouse's request.

If Horizon BCBSNJ determines the spouse is entitled to conversion coverage (according to the rules set forth above), it will go into effect on the day after the spouse's coverage under this Program ends, provided the application is submitted timely and the premium for the conversion coverage is paid when due.

OVER-AGE DEPENDENT COVERAGE

Eligible Dependents

An Employee's child by blood or law who:

a) has reached the limiting age of 26 but less than 30 years of age;

b) is not married;

c) has no Dependents of his or her own;

d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and

e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare.

Enrollment Requirement

To continue group health benefits, the Over-Age Dependent must make written election to Association Member Trust.

For a Dependent whose coverage has not yet terminated due to the attainment of age 26, as applicable, the written election must be made within 30 days prior to termination of coverage due to the attainment of age 26.

For a person who did not qualify as an Over-Age Dependent because he or she failed to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election must be made within 30 days after the person first subsequently meets all of the requirements for an Over-Age Dependent.

This election opportunity is explained in greater detail as follows:

a) If a person did not qualify because he or she was married, the notice must be given within 30 days of the date he or she is no longer married.

b) If a person did not qualify because he or she had a Dependent of his or her own, the election must be made within 30 days of the date he or she no longer has a Dependent.

c) If a person did not qualify because he or she either was not a resident of New Jersey or was not a full-time student at an Accredited school, the election must be made within 30 days of the date he or she becomes a resident of New Jersey, or becomes a full-time student at an accredited school.

d) If a person did not qualify because he or she was covered under any other group or individual health benefits plan, group health plans, church plan or health benefits plan, or was entitled to Medicare, the election must be made within 30 days of the date he or she is no longer covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or is no longer entitled to Medicare.

An Over-Age Dependent may make written election to continue coverage during a 30 day period beginning on each anniversary date of the date the Dependent lost coverage due to attaining the limiting age, provided he or she meets the definition of an “Over-Age Dependent” during that 30 day period.

A person who qualifies as an Over-Age Dependent as of May 12, 2006, having reached the limiting age under a group plan and lost coverage under such group plan prior to May 12, 2006, may give written notice of an election for continued coverage at any time beginning May 12, 2006 and continuing until May 11, 2007.

The effective date of the continued coverage will be the first of the month following the later of:

a) the date the Over-Age Dependent gives written notice to Association Member Trust or

b) the date the Over-Age Dependent pays the first premium; or

c) the date the Dependent would otherwise lose coverage due to attainment of the limiting age.

When Over-Age Dependent Coverage Ends

An Over-Age Dependent's continued group health benefits end on the first of the following:

a) The date the Over-Age Dependent:

    1. attains age 30;

    2. marries;

    3. acquires a Dependent;

    4. is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or

    5. becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare.

b) The end of the period for which premium has been paid for the Over-Age Dependent.

c) The date the Plan ceases to provide coverage to the Over-Age Dependent's parent who is the Employee under the Plan.

d) The date the Plan under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.

e) The date the Over-Age Dependent's parent who is covered as an Employee under the Plan waives Dependent coverage. Except, if the Employee has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Employee waiving Dependent coverage.

Coverage for an Over-Age Dependent is single coverage. Any Deductible, Coinsurance and/or Copayments paid by an Over-Age Dependent is independent of any Deductible, Coinsurance and/or Copayments paid by the Over-Age Dependents parents, or siblings. Any provision in the Group Plan allowing for a family deductible or a family Maximum Out of Pocket does not apply to the coverage for the Over-Age Dependent.

The following plan provisions do not apply to Over Age Dependents:

a) COBRA CONTINUATION RIGHTS,

b) NEW JERSEY GROUP CONTINUATION RIGHTS,

c) A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS,

d) AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE,

e) A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS,

f) CONVERSION RIGHTS FOR DIVORCED SPOUSES,

g) COORDINATION OF BENEFITS AND SERVICES.

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

Managed Care Provisions

Choosing a PCP

A Covered Person is encouraged, but not required, to choose a PCP from the Horizon BCBSNJ Managed Care Provider Directory 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.

Referral Forms

Referrals are not required by this plan.

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.

YOUR HORIZON PROGRAM

Your Plan shares the cost of your health care expenses with you. However, in order to receive benefits under this Plan, you must use In-Network Providers. Generally, no benefits will be provided for the services of Out-of-Network Providers.

Horizon EPO members have access to the BlueCard PPO network when they require medical care outside of New Jersey. Out-of-state providers that contract with their local Blue Cross and Blue Shield PPO network will be paid at the In-Network level of benefits.

When you enroll, you will be given the option of selecting a Primary Care Physician (PCP) to manage your health care needs. We encourage you to do so.

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/are 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 2 times the individual Deductible. This family Deductible can be met by any combination of Covered Charges Incurred by some of 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 the covered members of a family collectively Incur, during a Benefit Period, an amount of Covered Charges for which no benefits are paid or payable under the Plan 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 and for any other limits that may apply.

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.

If This Plan Replaces Another Plan

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

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

a. they were Incurred during the Benefit Period in which this Plan starts;

b. this Plan would have paid benefits for them, if this Plan had been in effect;

c. the Covered Person was covered by the prior plan when it ended and enrolled in this Plan on its Effective Date; and

d. this Plan starts right after the prior plan ends.

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

This Plan covers Covered Services and Supplies for Acupuncture when the services are given prior authorization by Horizon BCBSNJ, determined to be medically necessary and appropriate, performed for anesthetic purposes and prescribed and performed within the scope of a licensed Practitioner.

Allergy Testing and Treatment

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

Ambulatory Surgery

This 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.

Approved Cancer Clinical Trials

The coverage described in this provision applies to Covered Persons who are eligible to participate in an approved clinical trial, Phase I, II, III and/or IV according to the trial protocol with respect to the treatment of cancer or another life threatening condition. The Plan will provide coverage for the clinical trial if the Covered Person’s practitioner is participating in the clinical trial and has concluded that the Covered Person’s participation would be appropriate; or the Covered Person provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.

The Plan provides coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.

The Plan will not deny a qualified Covered Person participation in an approved clinical trial with

respect to the treatment of cancer or another life threatening disease or condition. The Plan will not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. The Plan will not discriminate against the Covered Person on the basis of the Covered Person's participation in the clinical trial.

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

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

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

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

The Birthing Center's services, including pre-natal, delivery and post-natal care, will be covered 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, we will not provide payment to the Birthing Center.

Breastfeeding Support

This Plan covers lactation support, counseling and consultation and the rental or purchase of breastfeeding equipment as described in this provision. Coverage is provided in conjunction with each birth and continues for the entire period of breastfeeding. Charges covered under this provision are not subject to the Deductible or Coinsurance or Copayment, if any.

This Plan covers breastfeeding equipment as follows:

a) Purchase of single user breast pump which can be a double electric breast pump, or if requested by the Covered Person a manual pump. Such coverage does not require a prescription for the equipment nor are pre-authorization or evidence of medical necessity required. We also cover necessary repairs or replacement of the pump.

b) Rental or purchase of a multi-user breast pump, as recommended by a Practitioner who is a licensed health care provider. We may require a letter of medical necessity from a Practitioner.

c) Purchase of two breast pump kits; appropriate size breast pump flanges and other lactation accessories as recommended by a Practitioner.

The Plan covers lactation counseling and lactation consultation without pre-authorization, referral or prescription as follows:

a) In person, one-on-one services at a hospital, office, home or any other location

b) Telephonic lactation assistance in addition to the services described in item a) above.

c) Group lactation counseling including educational classes and support groups, in addition to the services described in item a) above.

Contraceptives

This Plan covers prescription contraceptives which require a Practitioner's prescription and which are approved by the United States Food and Drug Administration for that purpose In addition, this Plan covers over-the-counter contraceptive drugs which are approved by the United States Food and Drug Administration for that purpose without a prescription.

a) This Plan covers the following services, drugs, devices and procedures when obtained from or provided by network providers:

    1. Contraceptive drugs, devices or products approved by the United States Food and Drug Administration; or

    2. Therapeutic equivalents of contraceptive drugs, devices or products that are approved by the United States Food and Drug Administration.

    3. The medical necessity for contraceptive drugs, devices or products shall be as determined by the Covered Person's Practitioner.

b) Voluntary sterilization of a Covered Person whether male or female;

c) Patient education and counseling on contraception for a Covered Person;

d) Services related to the administration and monitoring of drugs, devices, products and services covered under this Contraceptives provision, including, but not limited to:

    1. Management of side effects;

    2. Counseling for continued adherence to a prescribed regimen;

3. Device insertion and removal;

4. Coverage of alternative contraceptive drugs, devices or products the Covered Person's practitioner determines are medically necessary; and

5. Diagnosis and treatment services provided pursuant to or as a follow-up to services covered under this Contraceptive provision.

With respect to the first dispensing of a specific contraceptive, coverage is provided for a three-month period. For a subsequent dispensing of that same contraceptive, whether or not the first dispensing was covered under this Policy, coverage is provided for a six-month period, except as stated below.

Exception: If the six-month period would extend beyond December 31, coverage will be reduced such that the period ends as of December 31.

Coverage under this Contraceptives provision is provided without the application of any deductible, coinsurance or copayment.

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

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

a. general anesthesia and Hospital Admission for dental services; or

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

This coverage shall be subject to the same Utilization Review and Management rules imposed

upon all Inpatient stays.

Diagnosis and Treatment of Autism and Other Developmental Disabilities

The Plan provides coverage for charges for the screening and diagnosis of autism and other Developmental Disabilities.

If a Covered Person's primary diagnosis is autism or another Developmental Disability, the Plan provides coverage for the following Medically Necessary and Appropriate Therapy Services, as prescribed in a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function. The therapy services are

a) Occupational therapy where occupational therapy refers to treatment to develop a Covered Person's ability to perform the ordinary tasks of daily living:

b) Physical therapy where physical therapy refers to treatment to develop a Covered Person's physical function; and

c) Speech therapy where speech therapy refers to treatment of a Covered Person's speech impairment.

The therapy services covered under this provision do not reduce the available therapy visits available under the **Therapy Services** provision. The therapy services covered under this provision are not subject to Pre-Approval as may be required under the Therapy Services provision.

If a Covered Person's primary diagnosis is autism, in addition to coverage for the therapy services as described above, the Plan also covers medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan(s) referred to above must be in writing, signed by the treating physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. Horizon BCBSNJ may request additional information if necessary to determine the coverage under this Plan. Horizon BCBSNJ may require the submission of an updated treatment plan once every six months unless Horizon BCBSNJ and the treatment physician agree to more frequent updates.

If a Covered Person:

a) Is eligible for early intervention services through the New Jersey Early Intervention System; and
b) Has been diagnosed with autism or other Developmental Disability; and
c) Received physical therapy, occupational therapy, speech therapy, applied behavior
88 analysis or related structured behavior services

The portion of the family cost share attributable to such services is a Covered Charge under this Plan. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an illness or injury will apply to the family cost share.

The therapy services a Covered Person receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this **Diagnosis and Treatment of Autism and Other Disabilities** provision.

Diagnostic X-rays and Laboratory Tests

This program covers diagnostic x-rays and laboratory 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.

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.

A Covered Person must pay a Per-Admission Deductible/Inpatient Copayment as shown in the Schedule of Covered Services and Supplies.

Fertility Services

This Plan covers charges for procedures designed to enhance fertility, including, artificial insemination. However, fertility enhancement treatments, such as in-vitro fertilization, in-vivo 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 are specifically excluded.

Hearing Aids, Cochlear Implants, and Related Services

This Program covers expenses Incurred for or in connection with the purchase of a hearing aid or hearing aids that have been prescribed or recommended by a Practitioner.

This Plan also covers charges for the cost of treatment related to cochlear implants, including procedures for the implantation of cochlear devices and costs for any parts, attachments, or accessories of the device, including replacement of obsolete external cochlear implant processors.

Such expenses include, but are not limited to, charges Incurred for the following:

- the purchase of the hearing aid;
- hearing tests;
- fittings;
- modifications; and
- repairs (but not battery replacement).
- Coochlear implants and services covered pursuant to P.L. 2023, c. 275. A4048.

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

Home Health Agency 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.

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

This 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.

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

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

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

Inpatient Physician Services

This 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 the patient or her Provider notify Horizon BCBSNJ about the stay remains in force.

Benefits for these services shall be subject to the same Deductible, Copayments and/or Coinsurance as for other Hospital services covered under this 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 Obstetrical Benefits for a Child Dependent. A female Child Dependent is covered under the Plan for any services incidental to or resulting from her pregnancy. However, this Plan does not provide coverage to a child of a Child Dependent.

Medical Emergency and Medical Screening Examinations

This Plan provides coverage for Medical Emergencies, including diagnostic X-ray and lab and Urgent Care for medical conditions and Mental Health Conditions, on a 24-hour, 7-day-a-week basis. This Plan provides coverage for eligible services and supplies provided by an In-Network Provider as stated in this Plan for the treatment of a Medical Emergency, whether or not the services or supplies were arranged for or provided by an In-Network Provider.

Horizon BCBSNJ will not cover services and supplies that are not provided for or arranged by Horizon BCBSNJ beyond the time when the patient's condition, in the judgment of the attending physician, is medically stable, no longer requires critical care and the Member can be safely transferred to another In-Network Facility or the care of his Primary Care Physician. Horizon BCBSNJ will Determine the most cost effective and medically beneficial place for follow-up care.

Coverage for Emergency and Urgent Care includes coverage of trauma at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgment of the attending physician, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another facility. Horizon BCBSNJ shall provide coverage for a medical screening examination provided upon a Covered Person’s arrival in a Hospital, as required to be performed by the hospital in accordance with federal law, but only as necessary to determine whether an Emergency Medical Condition exists.

In the event of a potentially life-threatening condition, the 911 emergency response system should be used. Further 911 information is available on your ID card.

Mental Health Conditions or Substance Use Disorder

Except as stated below for the treatment of Substance Use Disorder, the Plan pays benefits for Covered Charges a Covered Person incurs for the treatment of Mental Health Conditions or Substance Use Disorder subject to the Same Terms and Conditions as apply to other medical or surgical benefits, if such treatment is prescribed by a Practitioner.

Horizon BCBSNJ provides benefits for the treatment of Substance Use Disorder at Network Facilities subject to the following:

(a) the prospective determination of Medically Necessary and Appropriate is made by the Covered Person's Practitioner for the first 180 days of treatment during each Plan Year and for the balance of the Plan Year the determination of Medically Necessary and Appropriate is made by Horizon BCBSNJ;

(b) pre-authorization or Pre-Approval are not required for the first 180 days of Inpatient and/or Outpatient treatment during each Plan Year but may be required for Inpatient treatment for the balance of the Plan Year;

(c) concurrent and retrospective review are not required for the first 28 days of Inpatient treatment during each Plan Year but concurrent and retrospective review may be required for the balance of the Plan Year;

(d) retrospective review is not required for the first 28 days of intensive Outpatient and partial 93 hospitalization services during each Plan Year but retrospective review may be required for the balance of the Plan Year;

(e) retrospective review is not required for the first 180 days of Outpatient treatment including Outpatient Prescription Drugs, during each Plan Year but retrospective review may be required for the balance of the Plan Year ; and

(f) If no In-Network Facility is available to provide in-patient services Horizon BCBSNJ shall approve an in-plan exception and provide benefits for Inpatient services at an Out-of-Network Facility.

The first 180 days per Plan Year assumes 180 Inpatient days whether consecutive or intermittent. Extended Outpatient services such as partial hospitalization and intensive Outpatient are counted as Inpatient days. Any unused Inpatient days may be exchanged for two Outpatient visits.

Inpatient or day treatment may be furnished by any licensed, certified or State approved Facility, including but not limited to:

(a) a Hospital

(b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;

(c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of The Joint Commission;

(d) a Mental Health Center;

(e) a Substance Use Disorders Center; or

(f) a combination Mental Health Center and Substance Use Disorders Center.

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".

Nutritional Counseling treatments for specific eating disorder diagnoses related to mental health will not be subject to visit limitations, due to the treatment limitation restrictions imposed by the Mental Health Parity and Addiction Equity Act of 2008, and as amended by the Affordable Care Act.

Orally Administered Anti-Cancer Prescription Drugs

As used in this provision, orally administered anti-cancer prescription drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs does not include: (a) those that are prescribed to maintain red or white cell counts, (b) those that treat nausea, or (c) those that are prescribed to support the anti-cancer prescription drugs. Any such Prescription Drugs are covered under the Prescription Drugs provision of the Policy.

This Plan covers orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Network Services and Supplies if the Covered Person is receiving care and treatment from a Network Practitioner who writes the prescription for such Prescription Drugs. The Plan covers orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Non-Network Services and Supplies if the Covered Person is receiving care and treatment from a Non-Network Practitioner who writes the prescription for such Prescription Drugs.

Anti-cancer prescription drugs are covered subject to the terms of the **Prescription Drugs** provision of the Plan as stated above. The Covered Person must pay the Deductible and/or Coinsurance required for Prescription Drugs. Using the receipt from the Pharmacy, the Covered Person may then submit a claim for the anti-cancer prescription drug under this Orally Administered Anti-Cancer Prescription Drugs provision of the Plan.

Upon receipt of such a claim the Plan will compare the coverage for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision, to the coverage the

Plan would have provided if the Covered Person had received intravenously administered or injected anti-cancer medications from the Network or Non-Network Practitioner, as applicable, to determine which is more favorable to the Covered Person in terms of Copayment, Deductible and/or Coinsurance.

If the Plan provides different Copayment, Deductible or Coinsurance for different places of service, the comparison shall be to the location for which the Copayment, Deductible and Coinsurance is more favorable to the Covered Person. If a Covered Person paid a Deductible and/or Coinsurance under the Prescription Drug provision that exceeds the Copayment, Deductible and/or Coinsurance that would have applied for intravenously administered or injected anti-cancer medications, the Covered Person will be reimbursed for the difference.

Orthotic Appliances

This Plan covers an Orthotic Device that a Covered Person's physician has determined to be medically necessary. An Orthotic Device is a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

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 Health Conditions or Substance Use Disorders. 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 benefits for certain Covered Services and Supplies relating to Preventive Care. Examples of preventive care include, but are not limited to: routine physical examinations,

including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, and Nicotine Dependence Treatment.

Coverage is limited for each Benefit Period as described in the Schedule of Covered Services and Supplies. The covered Preventive Care benefits are as follows:

a. Gynecological Care and Examinations

This program covers routine gynecological care and examinations including 1 pap smear per Benefit Period as designated in the Schedule of Covered Services and Supplies.

b. Mammography

This program 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 your group's program, and the following limitations:

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) One baseline mammogram exam for Covered Persons who are 40 years of age.

(c) One mammogram exam each year for Covered Persons age 40 and over.

(d) 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.

(e) 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. Pap Smears

This program provides benefits for charges Incurred in conducting a Pap smear. This benefit, except as may be Medically Necessary and Appropriate for diagnostic purposes, shall be limited to one pap smear per Benefit Period.

d. Routine Physicals and Immunizations

This program covers routine physical examination(s) and immunizations for you and your Spouse and Dependent Children over the age of twelve as designated in the Schedule of Covered Services and Supplies.

e. Well-Child Care Benefits

Benefits are provided for well-child care for your enrolled Child Dependents through the end of the day before the child attains age thirteen.

f. Well-Child Immunizations and Lead Poisoning Screening and Treatment

Well-Child immunizations and lead poisoning screening and treatment are covered without age restriction. In order to be covered under this section:

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

b. screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing must be as specified by the Department of Health

pursuant to Section 7. of P.L. 1995, Ch 316. Medical evaluation and any necessary follow-up and treatment for lead-poisoned children are also covered.

g. Prostate Cancer Screening

This program covers 1 routine office visit per Benefit Period for adult Covered Persons, including a digital rectal examination and a prostate-specific antigen test for adult male Covered Persons over the age of 40.

h. Colorectal Cancer Screening

The Plan covers charges made for colorectal cancer screening provided to a Covered Person age 45 or over and to younger Covered Persons who are considered to be high risk for colorectal cancer. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the Covered Person's Practitioner in consultation with the Covered Person regarding methods to use, the Plan will cover charges for:

a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

The Plan will cover the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the Covered Person's practitioner in consultation with the Covered Person.

High risk for colorectal cancer means a Covered Person has:

a) A family history of: familial adenomatous polyposis, hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or
c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

i. **Newborn Hearing Screening** – Coverage is provided for: (a) screening, by appropriate electrophysiologic screening measures, of covered newborns for hearing loss; and (b) tests for the periodic monitoring of covered 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 old ; and

(c) "electrophysiologic screening measures" means the electrical result of the application of physiologic agents. This includes, but not limited to: (i) the procedures currently known as; Auditory Brainstem Response testing (ABR); and Otoacoustic Emissions testing (OAE); and (ii) any other procedure adopted by New Jersey's Commissioner of Health and Senior Services.

In addition to the preventive benefits described above, the Program shall cover the following preventive services:

a). Evidence based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services task Force with respect to the Covered Person;

b). Immunizations for routine use for Covered Persons of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Covered Person;

c). Evidence–informed preventive care and screenings for Covered Persons who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;

d). Evidence–informed preventive care and screenings for female Covered Persons as included in the comprehensive guidelines supported by the Health Resources and Services Administration except for contraceptive services and supplies; and

e). Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Prosthetic Appliances

The Plan covers a Prosthetic Device that a Covered Person's physician has determined to be medically necessary. Solely for the purposes of this subsection, a Prosthetic Device is any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

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. does 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. This includes coverage for speech-language pathology services rendered by a physician or a licensed speech-pathologist. 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.
- Prostheses and the treatment of physical complications at all stages of the mastectomy, including lymphodemas.

Also, see "Transplant Benefits".

Telemedicine Services, provided by Horizon CareOnline

Association Member Trust has selected an innovative Telemedicine Program, Horizon CareOnline, for its members through Horizon BCBSNJ, currently powered by American Well. Members can enroll online or may call 1-877-716-5657 to enroll by phone. For information on how to connect with a Telemedicine provider, access www.horizoncareonline.com.

This additional Program allows you to visit with an American Well Primary Care Physician (PCP)/general practitioner via telecommunication using a computer, tablet or smart phone. This Program also allows you to visit with American Well psychiatrists, psychologists, or social workers for treatment of Mental Health Conditions via telecommunication using a computer, tablet or smart phone.

The Program does not provide additional covered services (or benefits) under your health benefit plan. Telemedicine Services only cover primary care services at this time. Telemedicine is a covered benefit only when provided through Horizon BCBSNJ's designated telemedicine provider. Telemedicine is not available to anyone on Medicare.

Therapeutic Manipulation

This Plan provides benefits for Therapeutic Manipulations.

Therapy Services

This Plan covers all Therapy Services.

Therapy Services for certain mental health diagnosis may not be subject to visit limitations, pursuant to the Mental Health Parity and Addiction Equity Act of 2008, and as amended by the Affordable Care Act.

Transplant Benefits

This Plan covers services and supplies:

a. Cornea;

b. Kidney;

c. Lung;

d. Liver;

e. Heart;

f. Heart valve;

g. Pancreas;

h. Small bowel;

i. Chondrocyte (for knee);

j. Heart/Lung;

k. Kidney/Pancreas;

l. Liver/Pancreas;

m. Double lung;

n. Heart/Kidney;

o. Kidney/Liver;

p. Liver/Small Bowel;

q. Multi-visceral transplant (small bowel and liver with one or more of the following: stomach; duodenum; jejunum; ileum; pancreas; colon);

r. Allogeneic bone marrow;

s. Allogeneic stem cell;

t. Non-myeloablative stem cell;

u. Tandem stem cell.

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

a. by institutions approved by the National Cancer Institute; or

b. pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists. Such treatment will be covered to the same extent as for any other Illness.

When organs/tissues are harvested from a cadaver, this 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, 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.

Vision Care

This Plan covers Eye Exam, Vision Surveys and Optical Services.

Wilm's Tumor

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

B. COVERED SUPPLEMENTAL SERVICES AND SUPPLIES

Ambulance Services

This 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

Blood, blood products, blood transfusions and the cost of testing and processing blood are covered. This program does not pay for blood which has been donated or replaced on behalf of the Covered Person.

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

This program covers expenses Incurred in connection with the treatment of routine bleeding episodes associated with hemophilia for 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 when the home treatment program is under the supervision of a State approved hemophilia treatment center. Participation in a home treatment program shall not preclude further or additional treatment or care at any eligible Facility if the number of home treatments, in accordance with a ratio of home treatments to Benefit Days established by regulation by the Commissioner of Insurance, does not exceed the total number of Benefit Days provided for any other Illness under this program. As used in the paragraph, "blood product" includes but is not limited to Factor VIII, Factor IX and cryoprecipitate; and "blood infusion equipment" includes but is not limited to syringes and needles.

Charges for the Treatment of Hemophilia

Horizon BCBSNJ covers Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia including the purchase of blood products and blood infusion equipment.

Horizon BCBSNJ will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a Network Provider if the Covered Person's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for the Horizon BCBSNJ's network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by Horizon BCBSNJ's network clinical laboratory.

Horizon BCBSNJ will pay the Hospital's clinical laboratory for the laboratory services at the same rate Horizon BCBSNJ would pay a Network clinical laboratory for comparable services.

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 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 covers repairs and replacements only for mobility devices that Horizon BCBSNJ has approved or would have approved for purchase and when considered medically necessary pursuant to Horizon BCBSNJ's Medical Policy.

This Plan does not cover:

a. replacements or repairs determined to be not medically necessary under Horizon BCBSNJ's Medical Policy; 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.

Inherited Metabolic Disease

This Plan provides benefits for the therapeutic treatment of Inherited Metabolic Diseases. This

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

Non-Prescription Supplies

This Plan provides benefits for colostomy bags, belts and irrigators.

Oxygen and Its Administration

This Plan covers oxygen and its administration.

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. The Schedule of Covered Services and Supplies shows limits on this coverage.

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 accidental injury; and (ii) the patient is not in a Facility that provides nursing care.

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

Specialized Non-Standard Infant Formulas

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

a. The covered infant's physician has diagnosed him/her as having multiple food protein intolerance;

b. The physician has determined that the formula is Medically Necessary and Appropriate; and

c. The infant has not responded to trials of standard non-cow milk-based formulas, including soybean and goat milk.

Wigs Benefit

This 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.

UTILIZATION REVIEW-REQUIRED HOSPITAL STAY REVIEW

Pre-Admission Review (PAR)

Except as explained below for certain admissions to treat Substance Use Disorders, all non-Medical Emergency Hospital and other Facility Admissions, except maternity 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. Generally, an In-Network Hospital or other Facility will make all the needed arrangements for the Pre-Admission Review. 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 our review. If a review results in a denial, Horizon BCBSNJ confirms that outcome in writing.

b. If Horizon BCBSNJ authorizes a Hospital or other Facility Admission, the authorization is valid for:

1. the specified Provider;

2. the named attending Practitioner;

3. the specified Admission date;

4. the authorized length of stay; and

5. the diagnosis and treatment plan.

c. The authorization becomes invalid, and the Covered Person's Admission must be reviewed by Horizon BCBSNJ again, if:

1. he/she enters a Hospital/Facility other than the specified Hospital/Facility;

2. he/she changes attending Practitioners;

3. there is an alteration in condition or treatment plan.

Continued Stay Review

Except as explained below for certain admissions to treat Substance Use Disorders, the Plan has the right to conduct a continued stay review of any Inpatient Hospital/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 Hospital/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 Hospital/Facility by phone of the outcome of the review. Horizon BCBSNJ confirm in writing the outcome of a review that results in a denial. The notice always includes any newly authorized length of stay.

Admissions for the Treatment of Substance Use Disorders

This section applies during the first 180 days of treatment per Plan Year whether the treatment is Inpatient or Outpatient. Thereafter, Inpatient treatment of Substance Use Disorders is subject to the above provisions governing Hospital and other Facility Admissions.

If a Covered Person is admitted to a Facility for the treatment of Substance Use Disorders, whether for a scheduled Admission or for an emergency Admission, the Facility must notify Horizon BCBSNJ of the Admission and initial treatment plan within 48 hours of the Admission.

Horizon BCBSNJ will not initiate continued stay review, also known as concurrent review, with respect to the first 28 days of the inpatient stay. Continued stay review may be required for any subsequent days, but not more frequently than at two-week intervals. If Horizon BCBSNJ determines continued stay is no longer Medically Necessary, We shall provide written notice within 24 hours to the Covered Person and his or her Practitioner along with information regarding appeal rights.

Penalties for Non-Compliance

a. As a penalty for non-compliance with the PreAdmission review features in this Plan, the Plan reduces what it otherwise pays for Covered Services and Supplies by **20%** to a maximum of **$2,500** 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)

MEDICAL APPROPRIATENESS REVIEW PROCEDURE

This Plan requires a Covered Person or his/her Provider to obtain Prior Authorization for certain Covered Services and Supplies. When a Covered Person or his/her Provider does not comply with this rule, the Plan reduces benefits for Covered Charges Incurred with respect to that Covered service or Supply. If Horizon BCBSNJ does not give its Prior Authorization, benefits for the Covered Service or Supply will be reduced by **20%** to a maximum of **$2,500.**

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

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

a. approve the request, or

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

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

The treatments, procedures and supplies needing Prior Authorization are listed in the Schedule of Treatments, Procedures and Supplies Requiring Prior Authorization,

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 Use Disorders;

l. Mental Health Conditions; or

m. any other Illness or accidental injury determined to be catastrophic.

Alternate Treatment/Individual Case Management Plan

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

a. An Alternate Treatment/Individual Case Management Plan is a specific written document. It is developed by Horizon BCBSNJ through discussion and agreement with:

    1. the Covered Person, or his/her legal guardian if necessary;

    2. the Covered Person's attending Practitioner; and

    3. Horizon BCBSNJ or its designee.

b. The Alternate Treatment/Individual Case Management Plan includes:

    1. treatment plan objectives;

    2. a course of treatment to accomplish those objectives;

3. the responsibility of each of these parties in carrying out the plan:

   (a) Horizon BCBSNJ;

   (b) the attending Practitioner;

   (c) the Covered Person;

   (d) the Covered Person's family, if any; and

4. the estimated cost of the plan and savings.

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

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

Exclusion

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

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 REQUIRING PRIOR AUTHORIZATION

Certification is required prior to receiving services for any of the following:

- All inpatient or outpatient hospital activity except same day surgery and outpatient X-rays
- Maternity stays over 48 hours for vaginal deliveries and over 96 hours for C-Section deliveries
- Physical, Speech and Occupational Therapies
- Home Care
- IV Therapy and Chemotherapy
- Infertility Services
- Lab and Radiology services performed by a non-participating provider
- Plastic, Reconstructive or Cosmetic Surgery, regardless of place of service
- Durable Medical Equipment over $500
- Nutritional Counseling
- Pain Management

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:

Acupuncture except when used as a substitute for other forms of anesthesia.

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

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.

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.

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.

Care and or treatment by a **Christian Science** Practitioner.

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

Completion of claim forms.

Consumable medical supplies.

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

Court ordered treatment that is not Medically Necessary and Appropriate.

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

Dental care or treatment, except as otherwise stated in this Booklet. This includes, but is not limited to: (a) the restoration of tooth structure lost by decay, fracture, attrition, or erosion; (b) endodontic treatment of teeth; (c) Surgery and related services to treat periodontal disease; (d) osseous Surgery and any other Surgery to the periodontium; 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.

Care or treatment by means of **dose intensive chemotherapy**, except as otherwise stated in Plan.

Services or supplies, the primary purpose of which is **educational** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for occupation; or treatment for learning disabilities except as otherwise stated in the Plan.

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.

Fertility services or supplies furnished in connection with any procedures to enhance fertility which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures invitro fertilization; embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); donor sperm, surrogate motherhood and b) Prescription Drugs not eligible under the Prescription Drugs section of the Plan.

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

Hearing aids or fitting of hearing aids except as stated in the “Hearing Aids and Newborn Hearing Screening” provision, services or supplies related to hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them.

Herbal medicines services or supplies.

Home Health Care Visits connected with administration of dialysis.

Hospice Services, except as otherwise stated in this Booklet.

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

Hypnotism.

Illness or accidental injury which occurred on the job or which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law except that 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.

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.

Medical Emergency services, or supplies, when not rendered by a Practitioner.

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

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. But this does not apply to: (a) insulin: or (b) Orally Administered Anti-Cancer Drugs or any other drug for which coverage is required by law; or (c) specialty pharmaceuticals that are: (i) purchased from a specialty pharmaceutical vendor or other Pharmacy; and (ii) administered in a Practitioner’s office or a Facility.

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

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

Psychological testing for educational purposes.

Removal of abnormal skin outgrowths and other growths. This includes, but is not limited to, paring or chemical treatments to remove: corns; 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 examinations or preventive care, including related x-rays and laboratory test, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; premarital or similar examinations or tests not required to diagnose or treat Illness or Injury except as stated in the Preventive Care section of the Plan.

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

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

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

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: (a) 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 provided during a stay at a Facility which in whole or in part was for diagnostic studies, except as stated otherwise in this evidence of coverage. This exclusion applies when the services were provided for any of the following reasons: diagnosis, evaluation, confirmation (or to rule out), or to check the current status of a condition which was treated in the past.

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, child, parent, in-law, brother or sister;

- connected with any procedure or exam not needed for the diagnosis or treatment of an Injury or Illness for which a bona fide diagnosis has been made because of existing symptoms;

- needed due to an Injury or Illness to which a contributing cause was the Covered Person’s commission of, or attempt to commit, a felony; or to which a contributing cause was the Covered Person’s engagement in an illegal occupation;

- provided by a Practitioner if the Practitioner bills the Covered Person directly for the services or supplies, regardless of the existence of any financial or contractual arrangement between the Practitioner and the Provider;

- provided by or in a government Hospital, or provided by or in a Facility run by the Department of Defense or Veteran’s Administration for a service-related Illness or Injury, unless coverage for the services is otherwise required by law;

  NOTE: The above limitations do not apply to military retirees, their Dependents, and the Dependents of active duty military personnel who have both military health coverage and coverage under your group’s program, and receive care in Facilities run by the Department of Defense or Veteran’s Administration;

- 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;

- received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;

- 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 provided under Preventive Care.

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.

Telemedicine services to Covered Persons who are eligible for Medicare when Medicare is primary to this Plan.

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.

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

Association Member Trust Employee Health Care Plan

Uniform Amendment to Summary Plan Description
Privacy Practices for Protected Health Information ("PHI")

Association Member Trust is the plan administrator of the Association Member Employee Health Care Plan (the "Plan"). Association Member Trust and the Plan are committed to protecting confidential and Protected Health Information ("PHI") it collects from you or receives about you. Any insurance companies utilized by Association Member Trust or the Plan to maintain the Plan are required by law to maintain the privacy of your PHI, as are Association Member Trust, and the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Plan's uses and disclosures of PHI
- Your privacy rights with respect to PHI
- The Plan's duties with respect to PHI
- The person or offices to contact for further information about the Plan's privacy practices.

Protected Information

PHI is information that relates to an individual's health, healthcare, treatment, or payment for health care that identifies the individual. Identification may be by name, social security number or similar information that relates to a specific individual. Information relating to your past health, present health, treatment, diagnosis or conditions is considered to be PHI.

Uses and Disclosures

Uses for which consent is Not Required

The welfare Plans use and disclose PHI for the purposes of effecting payment of claims and health care operations. This means that this Plan may disclose PHI to the extent necessary to maintain the Plan and that are necessary for it to continue as a source of welfare benefits. Examples of such disclosures include the release of information for eligibility verification, disclosure of past claims information for the purposes of obtaining new or different coverage or stop-loss coverage, and disclosure of information when auditing claims and reviewing claims payment decisions when an appeal is filed.

The Plan may also disclose PHI when required by law. These disclosures include federal, state and other health oversight committees, public health activities and emergencies, judicial and administrative proceedings, to law enforcement officials with a warrant or subpoena, to provide information to coroners and medical examiners and disclosures for government health data systems as required by governmental entities.

In all instances of use or disclosure of PHI, Association Member Trust will make all reasonable efforts not to use or disclose any more than the minimum amount of PHI necessary to accomplish the intended purpose of the use or disclosure, taking into consideration practical and technological limitations.

Disclosures Requiring Written Consent

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversation with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

Disclosures Requiring You to Agree or Disagree to Release

Disclosure of PHI to family members, other relative and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and,

- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Individual Rights

As a participant in the Association Member Trust Employee Health Care Plan, you have certain rights with respect to you PHI.

- You have the right to access your own PHI as maintained by the Plan, including a right to inspect and copy that information.

- You have the right to request amendment or correction of PHI if that information is inaccurate or incomplete.

- You have the right to receive confidential communications of PHI should you request that information from the Plan.

- You have the right to receive an accounting of instances when PHI has been disclosed for purposes other than treatment, payment and health care operations.

- You have the right to obtain this Notice and a copy of the Privacy Policy from the Plan if you request them, including a paper copy of this notice if it was received electronically.

- You have the right to request that the Plan restrict uses and disclosures of PHI. However, the Plan is not required to agree with a requested restriction.

The Plan's Obligations

The Association Member Trust Employee Health Care Plan will take every reasonable step to ensure that that any subcontractors or agents who may receive PHI agree to the same restrictions as are placed on Association Member Trust or the Plan. Association Member Trust as the plan administrator shall report to the Plan instances of use or disclosure of PHI that is inconsistent with the privacy regulations.

The Plan shall make PHI available to individuals, and shall permit individuals to amend their PHI when requested. The Plan will also provide individuals with an accounting of any instances where the individuals' PHI has been disclosed by the Plan for any reason other than for payment of claims or operation of the Plan coverage.

Association Member Trust agrees to return to the Plans any PHI received when it is no longer needed, or such information shall be destroyed by Association Member Trust, if feasible. Association Member Trust shall also make sure that adequate separation has been established between the Plan and employees of Association Member Trust to prevent inadvertent disclosure of PHI. Association Member Trust further warrants that it will not use or disclose PHI for employment related actions.

This notice does not apply to information that has been de-identified. De-identified information is that information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the Plan may use or disclose "summary health information" to Association Member Trust, for obtaining premium bids or modifying, amending or terminating group health plans. Summary health information is that which summarizes the claims history or claims experience of the group that has been otherwise de-identified.

The Plan reserves the right to amend or change its privacy practices at any time and to apply the change to any PHI received prior to the date of amendment. If a privacy practice is changed, a revised version of this Notice will be provided to all participants and beneficiaries for who the Plan maintains PHI. Any revised version of this Notice will be issued within sixty (60) days of the effective date of any material change to the privacy practices.

Your Right to File A Complaint

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following officer:

Timothy Harbison
Privacy Official
Association Member Trust
PO Box 506
Short Hills, NJ 07078
(973) 379-1090

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, DC 20201.

The Plan will not retaliate against you for filing a complaint.

Whom to Contact for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the following officer:

Timothy Harbison
Privacy Official
Association Member Trust
PO Box 506
Short Hills, NJ 07078
(973) 379-1090

Statement with Regard to Insurance Certificates

The Association Member Trust utilizes the service of insurance companies to provide uniform certificates of insurance describing the rights, obligations and options for participants in the Plan. To the extent these certificates of insurance as provided by the insurance companies are missing this provision, or a similar provision regarding privacy of participant health information, this statement is intended as a supplement to the summary plan description and certificate of insurance of the Association Member Trust Employee Health Care Plan.

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, Horizon BCBSNJ will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A Calendar Year, or portion of a Calendar Year, during which a Covered Person is covered by this 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 provision will be used to determine whether this Plan provides coverage that is primary to such coverage or secondary to such coverage.

Determination of Primary or Secondary Coverage

This Plan provides secondary coverage to PIP unless this Plan's health coverage has been elected as primary by or for the Covered Person. This election is made by the named insured under a PIP contract. It applies to that person's family members who are not themselves named insured under other auto contracts. This Plan may be primary for one Covered Person, but not for another if the persons have separate auto contracts and have made different selections regarding the primary of health coverage.

This Plan is secondary to OSAIC. But, this does not apply if the OSAIC contains provisions that make it secondary or excess to the Covered Person's other health benefits. In that case, this Plan is primary.

If the above rules do not determine which health coverage is primary, or if there is a dispute as to whether this Plan is primary or secondary, this Plan will provide benefits for Covered Charges as if it were primary.

Benefits This Plan Will Pay if it is Primary to PIP or OSAIC

If this Plan is primary to PIP or OSAIC, it will pay benefits for Covered Charges in accordance with its terms. If there are other plans that: (a) provide benefits to the Covered Person; and (b) are primary to auto insurance coverage, then this Plan's rules regarding the coordination of benefits will apply.

Benefits This Plan Will Pay if it is Secondary to PIP

If 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.

Medicare

To the extent that this Plan provides coverage that supplements Medicare's, then this Plan can be primary to automobile insurance only insofar as Medicare is primary to auto insurance.

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 Policyholder to find out if the Policyholder is subject to Medicare as Secondary Payer rules.

For the purpose of this section:

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

b. A Covered Person is deemed to be eligible for Medicare by reason of age from the first day of the month during which he/she reaches age 65. But, if the Covered Person is born on the first day of a month, he/she is deemed to be eligible for Medicare from the first day of the month that is immediately prior to his/her 65th birthday. A Covered Person may also be eligible for Medicare by reason of disability or End-Stage Renal Disease (ESRD).

c. Under the rules for coordination of benefits and services described earlier, a "Primary Plan" pays benefits for a Covered Person's Covered Charges first, ignoring what the Covered Person's "Secondary Plan(s)" pays. The "Secondary Plan(s)" then pays the remaining unpaid Allowable Expenses in accordance with the provisions of the Covered Person's secondary health plan.

The following rules explain how this 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.

Medicare Eligibility by Reason of Age

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 End Stage Renal Disease.

When a Covered Person becomes eligible for Medicare by reason of age, this Plan permits the Covered Person to make a prospective election change that cancels coverage under this Plan and elects Medicare as the primary health plan.

If a Covered Person cancels coverage under this Plan, the Covered Person will no longer be covered by this Plan. Medicare will be the primary payer. Coverage under this plan will end on the last day of the month in which the Covered Person elects Medicare the primary health plan.

If a Covered Person does not make an election upon becoming eligible for Medicare by reason of age, this Plan will continue to be the primary health plan. This plan pays first, ignoring Medicare. Medicare will be considered the secondary health plan.

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 Covered Person becomes eligible for Medicare by reason of disability, this Plan 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 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 us.

Out-of-State Providers:

- The request for Medicare payment should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information;
- Upon receipt of the Explanation of Benefits, show the Identification Card number and the name and address of the Provider in the remarks section. DO NOT SEND TO HORIZON BCBS OF NJ.

CLAIMS PROCEDURES

Generally, since this Plan requires the use of In-Network Providers for most Covered Services and Supplies, Covered Persons will not need to file claims. But there are some services, e.g., treatment for a Medical Emergency by an Out-of-Network Provider, for which a claim will need to be filed.

To the extent they are needed, 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.

Alternatively, claim forms can be accessed at and downloaded from Horizon BCBSNJ's web site (www.horizonblue.com).

Submission of Claims

These procedures apply to the filing of claims, when necessary. All notices from Horizon BCBSNJ will be in writing.

a. Claim forms must be filed no later than 12 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. that the claim is incomplete, with a statement as to what material or information is needed to complete the claim and why it is needed;

   2. that the claim contains incorrect information, with a statement as to what information must be corrected;

   3. that all or part of the claimed amount is disputed with a statement as to the basis for the dispute;

   4. that Horizon BCBSNJ finds that there is a strong evidence of fraud and has started an investigation;

5. that the claim does not meet Plan requirements, with specific references to the Plan provisions on which the denial is based;

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.

b. Payment for any Covered Services and Supplies provided by 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 in paragraph d of the section "Submission of Claims" directly to: the Provider or Custodial parent; or the Division of Medical Assistance and Health Services in the Department of Human Services which administers the State Medicaid program, as appropriate.

If Horizon BCBSNJ pays anyone who is not entitled to benefits under this 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.

Negotiated (non-BlueCard Program) National Account Arrangements

With respect to one or more Host Plans, instead of using the BlueCard Program, Horizon BCBSNJ may process the Covered Person's claims for Covered Services and Supplies through Negotiated National Account Arrangements.

In addition, if Horizon BCBSNJ and the group have agreed that (a) Host Blue(s) shall make available (a) custom healthcare provider network(s) in connection with this agreement, then the terms and conditions set forth in Horizon BCBSNJ's Negotiated National Account Arrangement(s) with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of claims when Covered Persons access such network(s). In negotiating such Negotiated National Account Arrangements, Horizon BCBSNJ is not acting on behalf of or as an agent for the group or the group health plan.

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 decision, you will be notified of a denial as quickly as possible, but not later than the following:

(a) 72 hours from receipt of an Urgent Care Claim;

(b) 15 days from receipt of a Pre-service Claim (excluding claims made for Substance Use Disorders);

(c) 30 days from receipt of a Post-service Claim; or

(d) 24 hours from receipt of a Pre-service Claim relating to Substance Use Disorder.

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:

(a) For Urgent Care Claims, 72 hours from receipt of your appeal;

(b) For Pre-Service Claims, 30 calendar days from receipt of your appeal;

(c) For Post-Service Claims, 60 calendar days from receipt of your appeal;

(d) For Substance Use Disorders Claims, within 24 hours of the receipt of your appeal.

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:

(a) For Urgent Care Claims, within 72 hours from receipt of your appeal;

(b) For other claims, excluding Substance Use Disorders claims, within 30 calendar days from receipt of your appeal;

(c) For Substance Use Disorders claims, within 24 hours of 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.

The IRO will complete its review of the Substance Use Disorders appeal and issue its decision in writing within 48 hours from its receipt of the request for the review.

ERISA INFORMATION

The following information, together with the information contained in the rest of this Booklet, comprise the Summary Plan Description required by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Name of Plan: Association Member Trust

Plan Sponsor: Exclusive Provider Organization (EPO) Program administered by Horizon Blue Cross Blue Shield of New Jersey

Plan Administrator: Association Member Trust
P.O. Box 506
636 Morris Turnpike, Suite 2A
Short Hills, NJ 07078.

Employer Identification Number: 226315089

Plan Number: **501**

Classification and Funding

The Plan described in this Booklet is classified as a welfare benefits plan by the Department of Labor. It is funded by both the company and Employee contributions.

Type of Administration: Contract Administration. Benefits are provided in accordance with the provisions of the Plan Sponsor. Horizon Blue Cross Blue Shield of New Jersey provides administrative services only.

Claims Administrator: **Horizon Blue Cross Blue Shield of New Jersey, Inc.**

Agent for Service of Legal Process: Plan Administrator

The Plan Year begins on January 1 and ends on December 31.

Plan Administrator Authority and Powers:

The Plan Administrator shall have exclusive discretionary authority and power to determine eligibility for benefits and to construe the terms and provisions of this Plan, to determine questions of fact and law arising under this Plan, and to exercise all of the powers necessary for the operation of this Plan.

Plan Modification and Termination Information

Notwithstanding anything to the contrary in this Summary Plan Description, the Plan Sponsor/Administrator expressly reserves the right, at any time, for any reason and without limitation to terminate, modify or otherwise amend this Plan and any or all of the benefits

provided thereunder, either in whole or in part, whether to all persons covered thereby or one or more groups thereof. These rights include specifically, but are not limited to, (1) the right to terminate benefits under the Plan with respect to any participant therein; (2) the right to modify benefits under this Plan to all or any group of participants therein; (3) the right to require or increase contributions by any participants therein towards the cost of this Plan; and (4) the right to amend this Plan or any term or condition thereof; in each case, whether or not such rights are exercised with respect to any other participant or group of participants in this plan.

Not a Contract of Employment

No provision of the Plan described in this Booklet is to be considered a contract of employment. The Employer's rights with respect to disciplinary actions and termination of Employees are in no way changed by the provisions of the Plan.

If you have any questions about the Plan, contact the Plan Administrator.

STATEMENT OF ERISA RIGHTS

As a participant in **Association Member Trust** Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Receive information about your plan and benefits.

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to **$110.00** a day until you receive

the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plans' decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

ASSOCIATION MEMBER TRUST TRUSTEES
January 2024

Ken Alexander
Alexander Plumbing & Heating
PO Box 379
Dayton, NJ 08810

Betty Boros .
NJ Business & Industry Assn.
10 W. Lafayette St.
Trenton, NJ 08608

Alice Gens
NJ Business & Industry Assn.
10 W. Lafayette St.
Trenton, NJ 08608

Steve Dobossy
R & R Irrigation
283 Lincoln Avenue
Middlesex, NJ 08846

Bryan Didonato
Abner, Herman & Brock LLC
185 Hudson St.
Jersey City, NJ 07311

Barbara Guinta
NJ State Funeral Directors
PO Box L
Manasquan, NJ 08736-0642

Reva Brennan
NJ Dental Association
1 Dental Plaza
No. Brunswick, NJ 08902

George Kelder
NJ Funeral Directors Assn.
PO Box L
Manasquan, NJ 08736-0642

Charles Kreyer
Dykes Lumber Company
1901 Park Avenue
Weehawken, NJ 07087

Harris Kirsch Dr.
Harris Kirsch Associates
23 Taft Court
Livingston, NJ 07039

Brien McLaughlin
McLaughlin Group P & H
4B-B Foxwood Dr.
Morris Plains, NJ 08016

Dominic Paragano
D L Paragano Homes, Inc..
636 Morris Turnpike
Short Hills, NJ 07078

Eric Blomgren
NJ Gasoline C-Store Assn.
465 Boulevard
Eatontown, NJ 07724

James Simpson
Victory Worldwide Trans., Inc.
1045 Cranbury So. River Rd.
Jamesburg, NJ 08831

Bryan Jaeger
Jaeger Lumber & Supply Co
2322 Morris Ave.
Union, NJ 07083

Jared Stadlin
Linden Warehouse & Dist.
1300 Lower Road
Linden, NJ 07036

Steven Tepper
Animal Hlth. Care of Marlboro
299 Route 9 South
Englishtown, NJ 07726

Alexander E. Tullo
Tullo Truck Stop, LLC
61 Lincoln Hwy.
So. Kearny, NJ 07040

Gail Woolcott
NJ Landscape Assoc.
465 Boulevard
Elmwood Park, NJ 07407

Norm Woolley
Woolley Fuel
12 Burnett Ave.
Maplewood, NJ 07040

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

Please call:

1-800-355-BLUE

(2583)

For **Mental Health and Substance Use Disorders**, 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.