
Horizon®
Horizon Blue Cross Blue Shield of New Jersey

Product:	**OMNIA**
Group Name:	**AIR GROUP, LLC** **ONE PRINCE ROAD** **WHIPPANY, NJ 07981**
Group Number:	**00851H6-052**
Effective Date:	**June 1, 2019**

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Horizon Blue Cross Blue Shield of New Jersey

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

Dear Valued Customer:

Thank you for choosing Horizon Blue Cross Blue Shield of New Jersey for your health insurance coverage. You're enrolled in a great plan! We are here to help you understand your benefits and take charge of your health.

The enclosed information will help you better understand your benefits and the additional programs and resources available to you as a Horizon BCBSNJ member.

It is important to register for Member Online Services at **HorizonBlue.com**. Through Member Online Services, you can:

- View your benefits.
- Check your claims status and payments.
- View authorizations and referrals, if applicable.
- Print a duplicate member ID card or display your member ID card.
- Tell us if you have other health insurance coverage.
- Change your doctor or dentist, if applicable.
- Manage your Member Online Services account and preferences.

Important Tips to Follow

- Keep your Horizon BCBSNJ member ID card with your at all times. It is the key to accessing your health care benefits. Please present your member ID card whenever you need medical care or services. You can also sign in to Member Online Services at **HorizonBlue.com** to view and print your member ID card.
- Visit **HorizonBlue.com/doctorfinder** to find in-network doctors, hospitals or health care professionals. If you would like a printed copy of the directory, please call Member Services at **1-800-355-BLUE (2583)**.

Call our Interactive Voice Response (IVR) system for information at your convenience.
Through our IVR system, you can get answers to your questions 24 hours a day (usually including weekends/holidays).

Be prepared if a medical emergency arises. If you or a covered dependent experiences a medical emergency, we suggest you follow these steps:
- Call **911** or go directly to the nearest Emergency Room.
- Call your Primary Care Physician (PCP) or personal doctor as soon as reasonably possible so that he/she may coordinate your follow up care. You do not need to call Member Services in a medical emergency.

Have a question about your benefits?
If you have questions about your Horizon BCBSNJ coverage, you can sign in to Member Online Services at **HorizonBlue.com** to chat with a Member Services Representative or send a secure email using My Messages. You can also call **1-800-355-BLUE (2583)**, Monday through Wednesday and Friday from 8 a.m. to 6 p.m., Eastern Time (ET) and Thursday, from 9 a.m. to 6 p.m., ET, to speak with a representative.

We look forward to continuing to serve your health insurance needs.

Sincerely,

Christopher M. Lepre
Executive Vice President,
Commercial Business
Horizon Healthcare Services, Inc.

Horizon Blue Cross Blue Shield of New Jersey

If you need help understanding this Horizon Blue Cross Blue Shield of New Jersey information, you have the right to get help in your language at no cost to you. To talk to an interpreter, please call **1-800-355-BLUE (2583)** during normal business hours.

Spanish (Español): Si necesita ayuda para comprender esta información de Horizon Blue Cross Blue Shield of New Jersey, usted tiene el derecho de obtener ayuda en su idioma sin costo alguno. Para hablar con un intérprete, sírvase llamar al **1-855-477-AZUL (2985)** durante el horario normal de trabajo.

Chinese (中文)：如果您需要幫助來理解這份新澤西州地平線藍十字藍盾 (Horizon Blue Cross Blue Shield of New Jersey)資料，您有權免費獲得以您的語言提供的協助。欲聯絡翻譯人員，請於上班時間致電 **1-800-355-BLUE (2583)**。

Korean (한국어): 가입자는 Horizon Blue Cross Blue Shield of New Jersey에 관한 정보를 이해하기 위해 주로 사용하는 언어로 무료로 도움을 받을 권리가 있습니다. 통역사의 도움을 받으려면 정상 업무 시간 동안에 **1-800-355-BLUE (2583)**로 전화해 주십시오.

Portuguese (Português): Se precisar de ajuda para entender estas informações da Horizon Blue Cross Blue Shield of New Jersey, você tem o direito de receber gratuitamente assistência no seu idioma. Para falar com um intérprete, ligue para: **1-800-355-BLUE (2583)** no horário normal de trabalho.

Gujarati (ગુજરાતી): જો તમને આ ન્યુ જર્સી માહિતીનાં હોરાઈઝન્સ બ્લૂ ક્રોસ બ્લૂ શીલ્ડને સમજવા મદદની જરૂર હોય તો, તમને તમારી ભાષામાં કોઈ પણ ખર્ચ વગર મદદ મેળવવાનો અધિકાર છે. કોઈ દુભાષિયા સાથે વાત કરવા, કૃપા કરીને સામાન્ય બિઝનેસ કલાકો દરમિયાન **1-800-355-BLUE (2583)** પર ફોન કરો .

Polish (Polski): Jeżeli potrzebujesz pomocy, aby zrozumieć informacje planu Horizon Blue Cross Blue Shield of New Jersey, masz prawo poprosić o bezpłatną pomoc w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer **1-800-355-BLUE (2583)** podczas normalnych godzin pracy.

Italian (Italiano): Se vi serve aiuto per capire queste informazioni della Horizon Blue Cross Blue Shield of New Jersey, avete diritto ad assistenza gratis nella vostra lingua. Per parlare con un interprete, siete pregati di telefonare al numero **1-800-355-BLUE (2583)** durante le normali ore d'ufficio.

Tagalog (Tagalog): Kung kailangan mo ng tulong sa pag-unawa nitong impormasyon ng Horizon Blue Cross Blue Shield of New Jersey, may karapatan kang humingi ng tulong sa iyong wika nang walang gastos sa iyo. Upang makipag-usap sa isang taga-interpret, mangyaring tumawag sa **1-800-355-BLUE (2583)** sa loob ng karaniwang mga oras ng negosyo.

Russian (Русский язык): Если вам необходима помощь в разъяснении этой информации, предоставленной компанией Horizon Blue Cross Blue Shield of New Jersey, у вас есть право на получение помощи на вашем родном языке бесплатно. Для связи с переводчиком звоните по номеру телефона **1-800-355-BLUE (2583)** в обычные рабочие часы.

Haitian Creole (Kreyòl ayisyen): Si ou bezwen èd pou konprann enfòmasyon sou Horizon Blue Cross Blue Shield of New Jersey, ou gen dwa pou jwenn èd nan lang natifnatal ou gratis. Pou pale avèk yon entèprèt, tanpri rele nimewo **1-800-355-BLUE (2583)** pandan lè nòmal biznis.

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

Vietnamese (Tiếng Việt): Nếu cần được giúp đỡ để hiểu rõ thông tin này của Horizon Blue Cross Blue Shield of New Jersey, quý vị có quyền được giúp đỡ bằng ngôn ngữ của mình miễn phí. Xin gọi số **1-800-355-BLUE (2583)** trong giờ làm việc để nói chuyện với người thông dịch.

French (Français): Si vous avez besoin d'assistance pour comprendre ces informations au sujet de Horizon Blue Cross Blue Shield of New Jersey, vous avez le droit d'obtenir de l'aide dans votre langue, sans aucun frais. Pour parler avec un interprète, veuillez appeler le **1-800-355-BLUE (2583)** pendant les heures normales de bureau.

Navajo (Diné): Díí New Jersey bił hahoodzo Horizon Blue Cross Blue Shield, t'áá ninizaad k'ehjí baa hane'íí bik'i diitįįh bee shiká' a'doowoł nínízingo éí bee ná'ahoot'i' dóó doo bąąh ílíní da. Ata' halne'é ła' bich'į' hadeesdzih nínízingo t'áá shǫǫdí **1-800-355-BLUE (2583)**jį' nida'anishgo oolkiłíí bik'ehgo hodíílnih.

Arabic (عربي): إذا كنت بحاجة إلى المساعدة في فهم معلومات Horizon Blue Cross Blue Shield of New Jersey، لديك الحق في الحصول على المساعدة بلغتك دون تحملك أية تكلفة. للتكلم مع مترجم، يرجى الاتصال خلال ساعات العمل العادية بالرقم **1-800-355-BLUE (2583)**.

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

Horizon Blue Cross Blue Shield of New Jersey

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

Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon BCBSNJ provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information written in other languages.

Contacting Member Services
Please call Member Services at **1-800-355-BLUE (2583)** (TTY/TDD **711**) **or the phone number on the back of your member ID card**, if you need the free aids and services noted above and for **all other Member Services issues, including:**

- **Claim, benefits or enrollment inquiries**
- **Lost/stolen ID cards**
- **Address changes**
- **Any other inquiry related to your benefits or health plan**

Filing a Section 1557 Grievance
If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin, age or disability you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address:

Horizon BCBSNJ — Civil Rights Coordinator
PO Box 820
Newark, NJ 07101

If you are not a Horizon BCBSNJ member, you may contact Horizon BCBSNJ's Civil Rights Coordinator by calling **1-866-660-6528** (TTY/TDD **711**) or by writing to Horizon BCBSNJ's Civil Rights Coordinator at the above-referenced address.You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

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

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

Disclosures to Covered Persons Regarding Out-of-Network Treatment

THIS SUMMARY ONLY PROVIDES AN OVERVIEW OF HOW A COVERED PERSON'S HEALTH BENEFITS PLAN COVERS OUT-OF-NETWORK TREATMENT. IT IS ONLY GUIDANCE TO HELP A COVERED PERSON UNDERSTAND THEIR OUT-OF-NETWORK BENEFITS. THIS SUMMARY DOES NOT ALTER YOUR COVERAGE IN ANY WAY.

THE COVERED PERSON SHOULD REFER TO THEIR INDIVIDUAL POLICY, GROUP POLICY, CERTIFICATE OR EVIDENCE OF COVERAGE (IF EMPLOYER GROUP PLAN), OR SUMMARY OF BENEFITS AND COVERAGES FOR MORE INFORMATION ABOUT YOUR OUT-OF-NETWORK BENEFITS AND ABOUT COVERAGES AND COSTS FOR IN-NETWORK TREATMENT.

FOR ADDITIONAL INFORMATION – INCLUDING WHETHER A HEALTH CARE PROFESSIONAL OR FACILITY IS IN-NETWORK OR OUT-OF-NETWORK, EXAMPLES OF OUT-OF-NETWORK COSTS AND ESTIMATES FOR SPECIFIC SERVICES - PLEASE CONTACT US AT:

1-800-355-BLUE (2583)
Monday, Tuesday, Wednesday and Friday, between 8 a.m. and 6 p.m., Eastern Time (ET), and Thursday, between 9 a.m. and 6 p.m., ET
1-833-876-3825
Monday, Tuesday, Wednesday and Friday, between 6 p.m. to 12 a.m., Eastern Time (ET). and from 6 p.m. to 1 a.m. ET, on Thursday,

OR VISIT OUR WEBSITE AT:
https://www.horizonblue.com/members/education-center/understanding-your-coverage/out-of-network-payments

<table>
<tr><th>Your Policy Covers:</th><th>What this Means:</th><th>How Am I Protected by NJ law?</th></tr>
<tr><td rowspan="3">Medically Necessary Treatment on an Emergency or Urgent Basis by Out-Of-Network Health Care Professionals/Facilities</td><td rowspan="3">Emergency - You are covered for out-of-network treatment for 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 Disorder 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 unborn child in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. This includes any further medical examination and such treatment as may be required to stabilize the medical condition. This also includes if there is inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery or such transfer may pose a threat to the health or safety of the woman or unborn child.

Urgent – You are covered for out-of-network treatment of a non-life-threatening condition that requires care by a health care professional within 24 hours.</td><td>Except as discussed below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost-sharing") applicable to the same services when received in-network. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: www.state.nj.us/dobi/consumer.htm.</td></tr>
<tr><td>Your carrier and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the emergent/urgent medical services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of-pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled.</td></tr>
<tr><td>If an agreement cannot be reached, your carrier or the out-of-network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the medical services. The</td></tr>
</table>

		amount awarded by the arbitrator may exceed what the carrier has already paid to the out-of-network health care professional/facility; however, any additional amount paid by the carrier pursuant to the arbitration award will not increase your cost-sharing liability above the amount indicated as your responsibility on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total allowed charge/amount for the service(s).

Your Policy Covers:	**What this Means:**	**How Am I Protected by NJ law?**
Inadvertent out-of-network services	You are covered for treatment by an out-of-network health care professional for covered services when you use an in-network health care facility (e.g. hospital, ambulatory surgery center, etc.) and, for any reason, in-network health care services are unavailable or provided by an out-of-network health care professional in that in-network facility. This includes laboratory testing ordered by an in-network health care professional and performed by an out-of-network bio-analytical laboratory (e.g., imaging, x-rays, blood tests, and anesthesia).	Except as provided below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost-sharing") applicable to the same services when received in-network. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: https://www.state.nj.us/dobi/consumer.htm
		Your carrier and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the inadvertent out-of-network services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of-pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled.
		If an agreement cannot be reached, your carrier or the out-of-network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the inadvertent out-of-network services. The amount awarded by the arbitrator may exceed what the carrier has already paid to an out-of-network health care professional/facility; however, any additional amount paid by the carrier pursuant to the arbitration award will not increase your cost-sharing liability above the amount indicated as your responsibility

		on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total allowed charge/amount for the service(s).

Your Policy Covers:	What this Means:	How Am I Protected by NJ law?
Treatment from out-of-network health care professionals/ facilities if in-network health care professionals/facilities are unavailable.	Plans are required to have adequate networks to provide you with access to professionals/facilities within certain time/distance requirements so you can obtain medically necessary treatment of all illnesses or injuries covered by your plan.	You can request treatment from an out-of-network health care professional/facility when an in-network health care professional/facility is unavailable through an appeal, often called a request for an "in-plan exception." Please see the Department of Banking and Insurance's guide at: https://nj.gov/dobi/appeal/.

Your Policy DOES NOT Cover:	What this Means:	How Am I Protected by NJ law?
Voluntary out-of-network services	You are not covered for treatment by an out-of-network health care professional/facility when you knowingly, voluntarily and specifically select an out-of-network professional/facility for treatment when you have the opportunity to be serviced by an in-network healthcare professional/facility.	As discussed above, you can request treatment from an out-of-network health care professional/facility when an in-network health care professional/facility is unavailable through an appeal, called a request for "in-plan exception."

TABLE OF CONTENTS

INTRODUCTION

This Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) **OMNIA** Program 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 benefits provided by Horizon BCBSNJ. You should keep this Booklet in a safe place and read it carefully so that you become familiar with the benefits that are available to you and your family. This Booklet replaces any booklets and/or certificates you may previously have received.

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

Benefits and Amounts:

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

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

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

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

3 Penn Plaza East
Newark, New Jersey 07105-2200

HORIZON HEALTHCARE SERVICES, INC

CERTIFICATE OF COVERAGE

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

Allowance: Means the dollar amount Determined between Horizon BCBSNJ and a Provider as acceptable for the Covered Services and Supplies, unless otherwise required by law.

Alternate Payee:

a. A custodial parent, who is not an Employee under the terms of the Program, of a Child Dependent; or

b. The Division of Medical Assistance and Health Services in the New Jersey Department of Human Services which administers the State Medicaid Program.

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

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

a. It must:

    1. be staffed by Practitioners and Nurses under the supervision of a physician;

    2. have permanent operating and recovery rooms;

    3. be staffed and equipped to give Medical Emergency care; and

    4. have written back-up arrangements with a local Hospital for Medical Emergency care.

b. Horizon BCBSNJ will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

    1. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or

    2. approved for its stated purpose by Medicare.

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

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

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

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

Benefit Day: Each of the following:

a. Each midnight the Covered Person is registered as an Inpatient; or

b. Each day when Inpatient Admission and discharge occur on the same calendar day or

c. Two Inpatient days in a Skilled Nursing Facility.

Benefit Period: The twelve-month period starting on January 1 and ending on December 31. 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: a Facility, which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-time delivery, and the immediate post-partum period.

a. It must:

    1. provide full-time Skilled Nursing Care by or under the supervision of Nurses;

    2. be staffed and equipped to give Medical Emergency care; and

    3. have written back-up arrangements with a local Hospital for Medical Emergency care.

b. Horizon BCBSNJ will recognize it if:

    1. it carries out its stated purpose under all relevant state and local laws; or

    2. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or

    3. it is approved for its stated purposes by Medicare.

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

BlueCard Provider: A Provider, not in New Jersey, which has a written agreement with another Blue Cross Blue Shield plan to provide care to both that plan's subscribers and other Blue Cross Blue Shield plans' subscribers. For purposes of this Program, a BlueCard Provider is a Tier 2 In-Network Provider.

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: A year starting January 1.

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

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

Child Dependent: A person who: has not attained the age of **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.

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

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

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

Clean Claim: A claim for benefits that meets these tests: (a) it is an eligible claim for a Covered Service or Supply provided by an eligible Provider; (b) the person receiving the Covered Service or Supply was a Covered Person on the date the Covered Service or Supply was provided; (c) the claim is submitted with all of the information asked for by Horizon BCBSNJ on the claim form or in other instructions that were distributed in advance to the Provider or Covered Person in accordance with the requirements of law; and (d) Horizon BCBSNJ has no reason to believe that the claim has been submitted fraudulently.

Coinsurance: The percent applied to Covered Charges (not including Deductibles) for certain Covered Services or Supplies in order to calculate benefits under the Program. These are shown in the Schedule of Covered Services and Supplies. The term does not include Copayments. For example, if Horizon BCBSNJ's Coinsurance for an item of expense is **100%**, then the Covered Person's Coinsurance for that item is **0%.** Unless the context indicates otherwise, the Coinsurance percents shown in this Booklet are the percents that Horizon BCBSNJ will pay.

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

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

a. Surgery to correct the result of an Injury;

b. Surgery to treat a condition, including a birth defect, which impairs the function of a body organ;

c. Surgery to reconstruct a breast after a mastectomy is performed.

d. Treatment of newborns to correct congenital defects and abnormalities.

e. Treatment of cleft lip.

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

a. Surgery to correct gynecomastia;

b. Breast augmentation procedures,

c. Reversal of breast augmentation procedures for asymptomatic women who had reconstructive Surgery or who previously had breast implants for cosmetic purposes;

d. Rhinoplasty, except when performed to treat an Injury;

e. Lipectomy;

f. Ear or other body piercing.

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

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

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

Covered Services and/or Supplies: The types of services and supplies described in the Covered Services and Supplies section of this Booklet. Network benefits are shown as OMNIA Tier 1 and Tier 2. Except as otherwise provided in this Booklet, the services and supplies must be:

a. Furnished or ordered by a Provider; and

b. For Preventive Care, or Medically Necessary and Appropriate to diagnose or treat an Illness (including Mental or Nervous Disorders) or Injury.

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

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

Custodial Care includes, but is not limited to: help in walking or getting into or out of bed; help in bathing, dressing and eating; help in other functions of daily living of a similar nature; administration of or help in using or applying creams and ointments; routine administration of medical gasses after a regimen of therapy has been set up; routine care of a patient, including functions such as changes of dressings, diapers and protective sheets and periodic turning and positioning in bed; routine care and

maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags and indwelling catheters; routine tracheostomy care; general supervision of exercise programs, including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled services.

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

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

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

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

a. is attributable to a mental or physical impairment, or a combination of them;

b. for the purposes solely of the provision of this Program entitled "Diagnosis and Treatment of Autism and Other Developmental Disabilities", is manifest before age 22;

c. is likely to continue indefinitely;

d. results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; the capacity for independent living or economic self-sufficiency; and

e. reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are: (i) of lifelong or extended duration; and (ii) individually planned or coordinated.

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

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

a. radiology, ultrasound and nuclear medicine;

b. lab and pathology; and

c. EKG's, EEG's and other electronic diagnostic tests.

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

a. It is designed for and able to withstand repeated use;

b. It is primarily and customarily used to serve a medical purpose;

c. It is generally not useful to a person in the absence of an Illness or Injury; and

d. It is suitable for use in the home.

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

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

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

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

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

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

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

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

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

b. There must be sufficient proof, published in peer-reviewed scientific literature, that confirms the effectiveness of the Technology. That proof must consist of well-designed and well-documented investigations. But, if such proof is not sufficient or is questionable, Horizon BCBSNJ may consider opinions about and evaluations of the Technology from appropriate specialty advisory committees and/or specialty consultants.

c. The Technology must result in measurable improvement in health outcomes, and the therapeutic benefits must outweigh the risks, as shown in scientific studies. "Improvement" means progress toward a normal or functional state of health.

d. The Technology must be as safe and effective as any established modality. (If an alternative to the Technology is not available, Horizon BCBSNJ may, to determine the safety and effectiveness of a

Technology, consider opinions about and evaluations of the Technology from appropriate specialty advisory committees and/or specialty consultants.)

e. The Technology must demonstrate effectiveness when applied outside of the investigative research setting.

Services and supplies that are furnished for or in connection with an Experimental or Investigational Technology are not Covered Services and Supplies under this Program, even if they would otherwise be deemed Covered Services and Supplies. But, this does not apply to: (a) services and supplies needed to treat a patient suffering from complications secondary to the Experimental or Investigational Technology; or (b) Medically Necessary and Appropriate services and supplies that are needed by the patient apart from such a Technology.

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

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

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

Also, regardless of anything above, this Program will provide benefits for services and supplies furnished to a Covered Person for medical care and treatment associated with: (i) an approved cancer clinical trial (Phase I, II, III and/or IV); or (ii) an approved Phase I, II, III and/or IV clinical trial for another life threatening condition. This coverage will be provided if: (a) the Covered Person's Practitioner is involved in the clinical trial; and (b) he/she has concluded that the Covered Person's participation would be appropriate. It can also be provided if the Covered Person gives medical or scientific information proving that such participation would be appropriate.

This coverage for clinical trials includes, to the extent coverage would be provided other than for the clinical trial: (a) Practitioners' fees; (b) lab fees; (c) Hospital charges; (d) treating and evaluating the Covered Person during the course of treatment or regarding a complication of the underlying Illness; and (e) other routine costs related to the patient's care and treatment, to the extent that these services are consistent with usual and customary patterns and standards of care furnished whenever a Covered Person receives medical care associated with an approved clinical trial.

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

With respect to coverage for clinical trials, Horizon BCBSNJ will not:

- Deny a qualified Covered Person participation in an approved clinical trial;
- Deny or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with an approved clinical trial; or

- Discriminate against the Covered Person on the basis of his/her participation in such a trial.

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

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

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

FDA: The Food and Drug Administration.

Generic Prescription Drug: A copy that, as determined by the FDA, is the same as a Brand Name Prescription Drug in dosage, safety strength, how it is taken, quality, performance, and intended use.

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

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

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

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

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

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

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

c. The care is furnished under a physician's order and under a plan of care that: (a) is established by that physician and the Home Health Care Provider; (b) is established within 14 days after Home Health Care starts; and (c) is periodically reviewed and approved by the physician.

Home Health Care Services: Any of these services needed for the Home Health Care plan: nursing care; physical therapy; occupational therapy; medical social work; nutrition services; speech therapy; home health aide services; medical appliances and equipment, drugs and medicines, lab services and special meals, to the extent these would have been Covered Services and Supplies if the Covered

Person was a Hospital Inpatient; diagnostic and therapeutic services (including Surgical services) performed in a Hospital Outpatient department, a physician's office, or any other licensed health care Facility, to the extent these would have been Covered Services and Supplies under this Program if furnished during a Hospital Inpatient stay.

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

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

a. approved for its stated purpose by Medicare; or

b. accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

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

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

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

b. approved as a hospital by Medicare.

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

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

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

Illness: A sickness or disease suffered by a Covered Person. Illness includes Mental or Nervous Disorders 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.

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

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

In-Network Coverage: The level of coverage, shown in the Schedule of Covered Services and Supplies, which is provided if (a) an In-Network Provider provides the service or supply; (b) the PCP provides or coordinates care, treatment, services and supplies for the Covered Person; or (c) the PCP refers the Covered Person to another provider for such care, treatment, services and supplies.

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

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

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

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

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

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 entirely under direction of a physician.

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

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

a. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;

b. physician and health care Provider specialty society recommendations;

c. the views of physicians and health care Providers practicing in relevant clinical areas; and

d. any other relevant factor as determined by the New Jersey Commissioner of Banking and Insurance by regulation.

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

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

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

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

a. accredited for its stated purpose by the Joint Commission;

b. approved for its stated purpose by Medicare; or

c. accredited or licensed by the state in which it is located to provide mental health services.

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

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

(1) Conditions classified as Z-codes in the most current edition of the Manual. These include relational problems such as: parent-child conflicts; problems related to abuse or neglect when intervention is focused on the perpetrator; situations not attributable to a diagnostic disorder, including: bereavement, academic, occupational, religious, and spiritual problems.

(2) Conditions related to behavior problems or learning disabilities, except as may be required by law with respect to the treatment of biologically-based mental illness.

(3) Conditions that Horizon BCBSNJ determines to be due to developmental disorders. These include, but are not limited to: intellectual disability; academic skills disorders; or motor skills disorders. But, this does not apply: (i) to the treatment required by law of Mental or Nervous Disorders; or (ii) to the extent needed to provide newly born dependents with coverage for Injury or Illness, including the necessary care and treatment of medically diagnosed congenital defects and abnormalities.

(4) Conditions that Horizon BCBSNJ determines to lack a recognizable III-R classification in the most current edition of the Manual. This includes, but is not limited to, treatment for: adult children of alcoholic families; or co-dependency.

Mutually Exclusive Surgical Procedures: Surgical procedures that:

(a) differ in technique or approach, but lead to the same outcome;

(b) represent overlapping services or accomplish the same result;

(c) in combination, may be anatomically impossible.

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

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

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

a. is properly licensed or certified to provide medical care under the laws of the state where he/she practices; and

b. provides medical services which are: (a) within the scope of his/her license or certificate; and (b) are covered by this Program.

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

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

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

Outpatient: Either: (a) a Covered Person at a Hospital who is other than an Inpatient; or (b) the services and supplies provided to such a Covered Person, depending on the context in which the term is used.

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

Per Lifetime: During the lifetime of a person.

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

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

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

b. approved for its stated purpose by Medicare.

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

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

a. is properly licensed or certified to provide medical care under the laws of the state where he/she practices; and

b. provides medical services which are: (a) within the scope of the license or certificate; and (b) are covered by this Program.

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

Prescription Drugs: Drugs, biological and compound prescriptions which: (a) are dispensed only by prescription; and (b) are required to show on the manufacturer's label the words: "Caution-Federal Law Prohibits Dispensing Without A Prescription." The term includes: 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 Drug Cost Share Amount: The sum total of the following In-Network expenses Incurred by a Covered Person or covered family during a Benefit Period 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 Benefit Period).

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

Prescription Drug Network: The network of Pharmacies, identified as such by Horizon BCBSNJ, that provides Prescription Drugs under this Program at a negotiated rate.

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

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.

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

Primary Care 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.

Horizon BCBSNJ 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.

Some Practitioners are classified as OMNIA Tier 1 PCPs. The Copayment for selection of these designated PCPs is less than the standard PCP Copayment. In order to take advantage of the lower Copayment, it will be necessary to select a PCP that participates in the OMNIA Tier 1 Network.

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

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

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

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

Referral or Referred: A written recommendation by your PCP or Specialist Physician, as determined by Horizon BCBSNJ, for a Covered Person to receive services from another Provider.

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

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

Service Area: The geographic area defined by the Zip Codes in the State of New Jersey and certain bordering areas.

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

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

a. accredited for its stated purpose by the Joint Commission; or

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

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

a. intensive care units;

b. cardiac care units;

c. neonatal care units; and

d. burn units.

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

Special Referral: A Referral provided by a PCP in certain cases that will allow a Covered Person to obtain certain Specialist Physician services covered under this Program 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: Drugs/pharmaceuticals that are specialized due to their having most, but not necessarily all, of these characteristics:

1) They are produced through biotechnology or recombinant DNA technology mechanisms;

2) They are generally administered by injection;

3) They require specialized patient monitoring, special handling or unique education prior to use;

4) They have restricted distribution procedures.

Disease stated that are commonly treated by Specialty Pharmaceuticals are: acromegaly; adenosine deaminase deficiency; AIDS; allergic asthma; alpha-1 proteinase inhibitor deficiency; age related macular degeneration; antiarthritics; anticoagulants; antiemetrics; blood modifiers; (anemia, neutropenia); blepharospasm; strabismus; cervical dystonia; hyperhydrosis; cancer/oncology; carcinoid tumors; chronic granulomatous disease; cytomegalo virus; contraceptives; cystic fibrosis; Chrohn's disease; growth deficiencies; hemophilia; hepatitis; hereditary tyrosinemia; hyaluronic acids' hypercalcemia; immune globulins; infertility; prostate cancer; precocious puberty; uterine fibroids; endometreosis/ lysosomal storage disorder; multiple sclerosis; osteoporosis; psoriasis; pulmonary hypertension; Rh factor; respiratory synctial virus; thrombocytopenia; ulcerative colitis; vasoactive intestinal peptide tumors; venereal or genital warts; Von Willebrand.

When Specialty Pharmaceuticals, as prescribed by a physician, are required, such Prescription Drugs must be purchased through a Specialty Pharmaceutical Provider. The Specialty Pharmaceuticals themselves are identified as such in Horizon BCBSNJ's formulary. Both the disease states and the Specialty Pharmaceuticals can change, and such changes will be communicated to Covered Persons as appropriate.

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

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

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 include substance use withdrawal.

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

a. accredited for its stated purpose by the Joint Commission; or

b. approved for its stated purpose by Medicare.

Surgery/Surgical:

a. The performance of generally accepted operative and cutting procedures, including: surgical diagnostic procedures; specialized instrumentations; endoscopic exams; and other invasive procedures;

b. The correction of fractures and dislocations;

c. Pre-operative and post-operative care; or

d. Any of the procedures designated by C.P.T. codes as Surgery.

Telehealth Services: means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical healthcare, provider consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L.2017, c.117.

Telemedicine Network: Horizon BCBSNJ'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.

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

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

a. ordered by a Practitioner;

b. performed by a Provider;

c. Medically Necessary and Appropriate for the treatment of a Covered Person's Illness or Accidental Injury.

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

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

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

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

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

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

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

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

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

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

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

b. Speech therapy to develop or improve speech to correct a defect that both: (a) existed at birth; and (b) impaired or would have impaired the ability to speak.

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 Illness: (a) cannot perform any duty of any occupation for which he or she is, or may be, suited by education, training and experience; and (b) is not, in fact, engaged in any occupation for wage or profit. A Dependent is Totally Disabled if he or she cannot engage in the normal activities of a person in good health and/or of like age and sex. The Covered Person who is Totally Disabled must be under the regular care of a Practitioner.

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

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.

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

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

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

We, Us and Our: Horizon BCBSNJ.

You, Your: An Employee or Retiree.

SCHEDULE OF COVERED SERVICES AND SUPPLIES

POLICYHOLDER: AIR GROUP, LLC

GROUP POLICY NO.: 00851H6-052

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

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

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

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

IMPORTANT: Except in case of Emergency, all services and supplies must be provided by an OMNIA Tier 1 or Tier 2 In-Network Provider. Some services and supplies are available from In-Network providers for which there is no designation of OMNIA Tier 1 and Tier 2. For such services and supplies, refer to the OMNIA Tier 1 Column.

Services and supplies provided by an Out-of-Network Provider are generally not covered. However, a Covered Person's liability for involuntary services rendered during a Hospital Inpatient stay in an OMNIA Tier 1 In-Network Hospital including, but not limited to, anesthesia and radiology, where the admitting physician is an In-Network Provider and the Covered Person and/or Provider has complied with all required Prior Authorization or notice requirements, shall be limited to the Copayment, Deductible, and/or Coinsurance applicable to OMNIA Tier 1 In-Network services.

Services and supplies provided by an Out-of-Network Provider are generally not covered. However, a Covered Person's liability for involuntary services rendered during a Hospital Inpatient stay in a Tier 2 In-Network Hospital including, but not limited to, anesthesia and radiology, where the admitting physician is an In-Network Provider and the Covered Person and/or Provider has complied with all required Prior Authorization or notice requirements, shall be limited to the Copayment, Deductible and/or Coinsurance applicable to Tier 2 In-Network services.

Furthermore, a Covered Person's liability for involuntary services rendered during a Hospital Inpatient stay in an OMNIA Tier 1 In-Network Hospital, including but not limited to anesthesia and radiology, where the admitting physician is an Out-of-Network provider, shall be limited to the Copayment, Deductible and/or Coinsurance applicable to OMNIA Tier 1 In-Network Services.

Additionally, a Covered Person's liability for involuntary services rendered during a Hospital Inpatient stay in a Tier 2 In-Network Hospital, including but not limited to anesthesia and radiology, where the admitting physician is an Out-of-Network provider, shall be limited to the Copayment, Deductible and/or Coinsurance applicable to Tier 2 In-Network Services.

Services and supplies provided by an Out-of-Network Provider are generally not covered. However, a Covered Person's liability for involuntary services rendered during a Hospital Inpatient stay in an In-Network Hospital, including, but not limited to, anesthesia and radiology, where the admitting physician

is an In-Network Provider and the Covered Person and/or Provider has complied with all required Prior Authorization or notice requirements, shall be limited to the Copayment, Deductible and/or Coinsurance applicable to In-Network services.

Furthermore, a Covered Person's liability for involuntary services rendered during a Hospital Inpatient stay in an In-Network Hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is an Out-of-Network Provider, shall be limited to the Copayment, Deductible and/or Coinsurance applicable to In-Network services.

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

Different In-Network Providers have agreed to be paid in different ways. Your Provider may be paid: (a) each time he/she treats you (fee-for-service); or (b) a set fee each month for each Covered Person that the Provider treats, whether or not the Covered Person actually receives services (capitation). These payment methods may also include financial incentive agreements whereby some Providers are paid more (bonuses) or less (withholds), based on many factors. Some of these factors are: member satisfaction; quality of care; control of costs; and use of services. If you want more information about how Our Providers in our Network are paid, please call us at 1-800-355-2583 or write Horizon BCBSNJ, 3 Penn Plaza East, Newark, NJ 07105.

	OMNIA Tier 1	**Tier 2**
Coinsurance	**90**% of Covered Basic Charges.	**70**% of Covered Basic Charges.
	90% of Covered Supplemental Charges.	**70**% of Covered Supplemental Charges.
	Preventive Care is always payable at 100%.	**Preventive Care is always payable at 100%.**
	OMNIA Tier 1	**Tier 2**
Out-of-Pocket Maximum	After **$3,000**/Covered Person, **$6,000**/Family, we provide 100%.	After **$6,000**/Covered Person, **$12,000**/Family, we provide 100%.
	OMNIA Tier 1	**Tier 2**
Deductible	**$1,500**/Covered Person.	**$2,500**/Covered Person.
	$3,000/Family.	**$5,000**/Family.

	Deductible does not apply to Preventive Care.	Deductible does not apply to Preventive Care.
	OMNIA Tier 1	**Tier 2**
Professional Office Care	PCP- **$15** Copayment. Specialist- **$25** Copayment.	PCP- **$30** Copayment. Specialist- **$50** Copayment.
Professional Care (Outpatient)	PCP- **90%** Coinsurance. Specialist- **90%** Coinsurance.	PCP- **70%** Coinsurance. Specialist- **70%** Coinsurance.

A. COVERED BASIC SERVICES AND SUPPLIES

ACUPUNCTURE

OMNIA Tier 1	**Tier 2**
Subject to Deductible and **$25** Copayment.	Subject to Deductible and **$50** Copayment.

ALLERGY TESTING AND TREATMENT

OMNIA Tier 1	**Tier 2**
Subject to Deductible and **$25** Copayment.	Subject to Deductible and **$50** Copayment.

AMBULATORY SURGICAL CENTERS

OMNIA Tier 1	**Tier 2**
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

ANESTHESIA

OMNIA Tier 1	**Tier 2**
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

AUDIOLOGY SERVICES

OMNIA Tier 1	**Tier 2**
Subject to Deductible and **$25** Copayment.	Subject to Deductible and **$50** Copayment.

DENTAL CARE AND TREATMENT

OMNIA Tier 1	Tier 2
Subject to Deductible and **$25** Copayment.	Subject to Deductible and **$50** Copayment.

DIAGNOSTIC X-RAY AND LAB

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

DIALYSIS CENTER CHARGES

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

EMERGENCY ROOM

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance. Subject to **$100** Copayment (credited toward Inpatient Admission if Admission occurs within 24 hours as the result of the Medical Emergency).	Subject to Deductible and **90%** Coinsurance. Subject to **$100** Copayment (credited toward Inpatient Admission if Admission occurs within 24 hours as the result of the Medical Emergency).

FACILITY CHARGES* **365 days Inpatient Hospital care.**
***Excludes Mental or Nervous Disorders (including Group Therapy) and Substance Use Disorder**

	OMNIA Tier 1	Tier 2
a. Hospital Inpatient	Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.
Outpatient	Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

OMNIA Tier 1	Tier 2

b. Non-Hospital Facilities Inpatient	Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.
Outpatient* *Includes Urgent Care	Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.
	OMNIA Tier 1	**Tier 2**
c. Hospice Care	Subject to Deductible and **90%** Coinsurance. Respite care provided under this Hospice Care Benefit is subject to a 10 day maximum per Benefit Period combined OMNIA Tier 1 and Tier 2.	Subject to Deductible and **70%** Coinsurance. Respite care provided under this Hospice Care Benefit is subject to a 10 day maximum per Benefit Period combined OMNIA Tier 1 and Tier 2.

FERTILITY SERVICES

OMNIA Tier 1	**Tier 2**
Subject to Deductible and **$25** Copayment.	Subject to Deductible and **$50** Copayment.

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

OMNIA Tier 1	**Tier 2**
<u>For Child Dependents 15 years of age or younger:</u>	<u>For Child Dependents 15 years of age or younger:</u>
For the purchase of a hearing aid, benefits subject to Deductible and **90%** Coinsurance per hearing aid, for each hearing-impaired ear, during any period of 24 consecutive months.	For the purchase of a hearing aid, benefits subject to Deductible and **70%** Coinsurance per hearing aid, for each hearing-impaired ear, during any period of 24 consecutive months.
For other covered related services, benefits payable the same as for an office visit to a PCP/Practitioner who is a doctor specializing in: family practice; general practice; internal medicine; pediatrics.	For other covered related services, benefits payable the same as for an office visit to a PCP/Practitioner who is a doctor specializing in: family practice; general practice; internal medicine; pediatrics.
OMNIA Tier 1	**Tier 2**

For Other Covered Persons:	For Other Covered Persons:
No benefit.	No benefit.

HOME HEALTH CARE

OMNIA Tier 1	**Tier 2**
Subject to Deductible and **$15** Copayment	Subject to **Deductible and $30** Copayment

INPATIENT PHYSICIAN SERVICES

OMNIA Tier 1	**Tier 2**
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

MATERNITY/OBSTETRICAL CARE

OMNIA Tier 1	**Tier 2**
Subject to Deductible and **$25** Copayment for the initial visit.	Subject to Deductible and **$50** Copayment for the initial visit.

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

	OMNIA Tier 1	**Tier 2**
Inpatient	Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.
Outpatient	Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.
Out of Hospital	Subject to Deductible and **$25** Copayment.	Subject to Deductible and **$50** Copayment.

NUTRITIONAL COUNSELING

OMNIA Tier 1	**Tier 2**
Subject to Deductible and **$25** Copayment.	Subject to Deductible and **$50** Copayment.

ORALLY ADMINISTERED ANTI-CANCER DRUGS

Coverage provided at **100%**.

ORTHOTIC DEVICES

OMNIA Tier 1	Tier 2
Benefits payable are the same as for an office Visit to a OMNIA Tier 1 Provider specializing in family practice, general practice, internal medicine, or pediatrics.	Benefits payable are the same as for an office Visit to a OMNIA Tier 1 Provider specializing in family practice, general practice, internal medicine, or pediatrics.

PRACTITIONER'S CHARGES FOR SURGERY

OMNIA Tier 1	Tier 2
Subject to Deductible and **$25** Copayment.	Subject to Deductible and **$50** Copayment.

PRE-ADMISSION TESTING CHARGES

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

PREVENTIVE CARE/HEALTH WELLNESS

Subject to **100%** Coinsurance.

a. COLORECTAL CANCER SCREENING

Subject to **100%** Coinsurance.

b. GYNECOLOGICAL EXAMINATIONS

Subject to **100%** Coinsurance.

c. MAMMOGRAPHY

Subject to **100%** Coinsurance.

d. PAP SMEARS

Subject to **100%** Coinsurance.

e. ROUTINE PROSTATE CANCER SCREENING

Subject to **100%** Coinsurance.

f. ROUTINE ADULT PHYSICALS

Subject to **100%** Coinsurance.

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

Subject to **100%** Coinsurance.

h. WELL-CHILD CARE

Subject to **100%** Coinsurance.

PROSTHETIC DEVICES

OMNIA Tier 1	Tier 2
Benefits payable are the same as for an office Visit to a OMNIA Tier 1 Provider specializing in family practice, general practice, internal medicine, or pediatrics.	Benefits payable are the same as for an office Visit to a OMNIA Tier 1 Provider specializing in family practice, general practice, internal medicine, or pediatrics.

SECOND OPINION CHARGES

OMNIA Tier 1	Tier 2
Subject to Deductible and **$25** Copayment.	Subject to Deductible and **$50** Copayment.

SKILLED NURSING FACILITY CHARGES

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.
Benefits subject to a **100** day limit per Benefit Period, combined OMNIA Tier 1 and Tier 2.	Benefits subject to a **100** day limit per Benefit Period, combined OMNIA Tier 1 and Tier 2.

SPECIALIST SERVICES

OMNIA Tier 1	Tier 2
	Subject to Deductible and **$50** Copayment.

Subject to Deductible and **$25** Copayment.

SURGICAL SERVICES

	OMNIA Tier 1	Tier 2
Inpatient	Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.
Outpatient	Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

TELEMEDICINE SERVICES, PROVIDED BY HORIZON CAREONLINE

OMNIA Tier 1	Tier 2
Subject to Deductible and **$5** Copayment.	Subject to Deductible and **$5** Copayment.

THERAPEUTIC MANIPULATIONS

OMNIA Tier 1	Tier 2
Subject to Deductible and **$25** Copayment.	Subject to Deductible and **$30** Copayment.

THERAPY SERVICES

a. CHELATION THERAPY

OMNIA Tier 1	Tier 2
Subject to **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

b. CHEMOTHERAPY

OMNIA Tier 1	Tier 2
Subject to **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

c. COGNITIVE REHABILITATION THERAPY

OMNIA Tier 1	Tier 2
Subject to Deductible and **$15** Copayment.	Subject to Deductible and **$30** Copayment.

d. DIALYSIS TREATMENT

OMNIA Tier 1	Tier 2
Subject to **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

e. INFUSION THERAPY

OMNIA Tier 1	Tier 2
Subject to **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

f. OCCUPATIONAL THERAPY

OMNIA Tier 1	Tier 2
Subject to Deductible and **$15** Copayment.	Subject to Deductible and **$30** Copayment.
Benefits subject to a **30** Visit maximum per Benefit Period, combined OMNIA Tier 1 and Tier 2. The 30 Visit maximum does not apply to the treatment of autism.	Benefits subject to a **30** Visit maximum per Benefit Period, combined OMNIA Tier 1 and Tier 2. The 30 Visit maximum does not apply to the treatment of autism.

g. PHYSICAL THERAPY

OMNIA Tier 1	Tier 2
Subject to Deductible and **$15** Copayment.	Subject to Deductible and **$30** Copayment.
Benefits subject to a **30** Visit maximum per Benefit Period, combined OMNIA Tier 1 and Tier 2. The 30 Visit maximum does not apply to the treatment of autism.	Benefits subject to a **30** Visit maximum per Benefit Period, combined OMNIA Tier 1 and Tier 2. The 30 Visit maximum does not apply to the treatment of autism.

h. RADIATION TREATMENT

OMNIA Tier 1	Tier 2
Subject to **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

i. RESPIRATION THERAPY

OMNIA Tier 1	Tier 2
Subject to Deductible and **$15** Copayment.	Subject to Deductible and **$30** Copayment.
Benefits subject to a **30** Visit maximum per Benefit Period, combined OMNIA Tier 1 and Tier 2.	Benefits subject to a **30** Visit maximum per Benefit Period, combined OMNIA Tier 1 and Tier 2.

j. SPEECH THERAPY

OMNIA Tier 1	Tier 2
Subject to Deductible and **$15** Copayment.	Subject to Deductible and **$30** Copayment.
Benefits subject to a **30** Visit maximum per Benefit Period, combined OMNIA Tier 1 and Tier 2. The 30 Visit maximum does not apply to the treatment of autism.	Benefits subject to a **30** Visit maximum per Benefit Period, combined OMNIA Tier 1 and Tier 2. The 30 Visit maximum does not apply to the treatment of autism.

TRANSPLANT BENEFITS

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

VISION CARE

OMNIA Tier 1	Tier 2
For Child Dependents under age 19 Subject to Deductible and **$25** Copayment. Limited to Eye Exam and one Vision Survey per Benefit Period, combined OMNIA Tier 1 and Tier 2.	For Child Dependents under age 19 Subject to Deductible and **$50** Copayment. Limited to Eye Exam and one Vision Survey per Benefit Period, combined OMNIA Tier 1 and Tier 2.

OMNIA Tier 1	Tier 2
For Other Covered Persons No benefit.	For Other Covered Persons No benefit.

WILM'S TUMOR

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

B. COVERED SUPPLEMENTAL SERVICES AND SUPPLIES

AMBULANCE SERVICES

OMNIA Tier 1	Tier 2
Subject to Deductible and **100%** Coinsurance.	Subject to Deductible and **100%** Coinsurance.

BLOOD

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

DIABETES BENEFITS

OMNIA Tier 1	Tier 2
Subject to Deductible and **$25** Copayment.	Subject to Deductible and **$50** Copayment.

DURABLE MEDICAL EQUIPMENT

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

HOME INFUSION THERAPY

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

INHERITED METABOLIC DISEASE

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

OXYGEN AND ADMINISTRATION

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

PHYSICAL REHABILITATION CENTER

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

PRESCRIPTION DRUGS

Retail	Subject to Deductible and **70%** Coinsurance.
Mail Order	Subject to Deductible and **70%** Coinsurance.

PRIVATE DUTY NURSING

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.
This Program covers 240 hours per Benefit Period, combined OMNIA Tier 1 and Tier 2.	This Program covers 240 hours per Benefit Period, combined OMNIA Tier 1 and Tier 2.

SPECIALIZED NON-STANDARD INFANT FORMULAS

OMNIA Tier 1	Tier 2
Subject to Deductible and **90%** Coinsurance.	Subject to Deductible and **70%** Coinsurance.

WIGS

Subject to Deductible and **90%** Coinsurance.

GENERAL INFORMATION

How To Enroll

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

Your Identification (ID) Card

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

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

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

Types Of Coverage Available

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

- **Single** - provides coverage for you only.
- **Family** - provides coverage for you, your Spouse and your Child Dependents.
- **Husband and Wife/Two Adults** - provides coverage for you and your Spouse only.
- **Parent and Child(ren)** - provides coverage for you and your Child Dependents, but not your Spouse.

Change In Type Of Coverage

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

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

For example:

- If you are enrolled in Family or Parent Child(ren) type coverage, your adopted child is automatically included. However, if you are enrolled for Family or Parent Child(ren) coverage, you must still submit an enrollment form to notify us of the addition within 31 days of the completed adoption and contribute any required additional premium. If you are enrolled for Single coverage, you must enroll your child and contribute any required additional premium within 31 days of the completed adoption in order to continue the child's coverage beyond that point.

- The following example applies as of 1/16/2018 for subscribers of new groups effective on or after 1/16/2018 or, upon renewal as of 1/16/2018 and after for subscribers of groups effective prior to 1/16/2018. If you are enrolled for Family or Parent Child(ren) type coverage, your newly born child is automatically covered for the initial 60 days after birth. However, if you are enrolled for Family or Parent Child(ren) coverage, you must still submit an enrollment form to notify us of the addition within 60 days of the birth in order to consinue the child's coverage beyond that point. If you are enrolled for Single coverage, your newly born child is automatically covered for the initial 60 days after birth. However, you must enroll your child and contribute any required additional premium within 60 days of the birth in order to continue the child's coverage beyond that point.

- If you have Single coverage and marry , your new Spouse or Civil Union Partner will be covered from the date you marry or meet the rules for covering Civil Unions if you apply for Husband and Wife/Civil Union coverage within 31 Days

Except as provided below, anyone who does not enroll within a required time will be considered a Late Enrollee.

Late Enrollee may enroll only during the next Open Enrollment Month(s). Coverage for them will be effective as of the Open Enrollment Effective Date.

Enrollment of Dependents

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

- The Child Dependent was born out of wedlock;

- The Child Dependent is not claimed as a dependent on your federal tax return; or

- The Child Dependent does not reside with you or in the Service Area.

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

- Provide such information to the custodial parent as may be needed for the Child Dependent to obtain benefits through this Program;

- Permit the custodial parent, or the Provider, with the authorization of the custodial parent, to submit claims for the Child Dependent for Covered Services and Supplies, without your approval; and

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

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

- Permit you to enroll your Child Dependent, without any enrollment restrictions;

- Permit: (a) the Child Dependent's other parent; (b) the Division of Medical Assistance and Health Services; or (c) the Division of Family Development as the State IV D agency, in the Department of Human Services, to enroll the Child Dependent in this Program, if the parent who is the Covered Person fails to enroll the Child Dependent; and

- Not terminate coverage of the Child Dependent unless the parent who is the Covered Person provides Horizon BCBSNJ with satisfactory written proof that:

  - the court or administrative order is no longer in effect: or

  - the Child Dependent is or will be enrolled in a comparable health benefits plan which will be effective on the date coverage under this Program ends.

Special Enrollment Periods

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

Individual Losing Other Coverage

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

a. The person was covered under a group or other health plan at the time coverage under this Program was previously offered.

b. You stated in writing that coverage under the other plan was the reason for declining enrollment when it was offered.

c. The other health coverage:

   (i) was under a COBRA (or other state mandated) continuation provision and the COBRA or other coverage is exhausted; or

   (ii) was not under such a provision and either: (a) coverage was terminated as a result of: loss of eligibility for the coverage (including as a result of legal separation; divorce; death; termination of employment; or reduction in the number of hours of employment); or (b) employer contributions toward such coverage ended.

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

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

New Dependents

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

a. You are covered under the Program (or have met any Waiting Period and are eligible to enroll but for a failure to enroll during a previous enrollment period).

b. The person becomes your dependent through marriage, birth, or adoption (or placement for adoption).

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

Special Enrollment Due to Marriage

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

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

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

Special Enrollment Due to Newborn

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 written request to enroll the child within 60 days; and
- contribute toward the premium amount for the coverage within 31 days after the date of birth.

If you do not make the request and the premium is not paid within 60 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 a dependent child coverage on the date the chiled 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 written request to enroll the child within 31 days; and
- contribute towards the premium for the coverage within 31 days from the date of completed ado ption.

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

Multiple Employment

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

Eligible Dependents

Your eligible Dependents are your Spouse and your Child Dependents.

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

Coverage for a Child Dependent ends at the last day of the Calendar Year in which the Child Dependent reaches age **26**.

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

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

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

When Coverage Ends

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

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

Coverage for a Dependent ends:

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

In addition to the above reasons for the termination of coverage under the Program, an act or omission by a Covered Person which, as determined by Horizon BCBSNJ shows intent to defraud Horizon BCBSNJ (such as: (a) the intentional and/or repeated misuse of Horizon BCBSNJ's services; or (b) the omission or misrepresentation of a material fact on a Covered Person's application for enrollment, health statement or similar document)), upon 30 days prior written notice, will result in the cessation of the Covered Person's coverage under this Program. Such an act includes, but is not limited to:

- The submission of any claim and/or statement with materially false information.
- Any information which conceals for the purpose of misleading.
- Any act which could constitute a fraudulent insurance act.

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

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

Benefits After Termination

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

If You Leave Your Group Due To Total Disability

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

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

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

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

Coverage under this Program is also available to you (and any eligible Dependents), subject to the above requirements, if you are a Totally Disabled former Employee whose group health coverage for you

and those Dependents under your Employer's plan provided by another carrier was continued without interruption pursuant to state law.

Extension Of Coverage Due To Termination of the Group Policy

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

Continued Coverage Under The Federal Family And Medical Leave Act

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

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

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

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

Consult your benefits representative for application forms and further details.

Continued Coverage For Surviving Dependents

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

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

Consult your benefits representative for further details.

Continuation of Coverage under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you and your enrolled Dependents, and any newborn or newly adopted child may have the opportunity to continue group health care coverage which would otherwise end, if any of these events occur:

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

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

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

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

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

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

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

- Up to 18 months in the event of the end of your employment or a reduction in your hours. Further, if you or a covered Dependent are determined to be disabled, according to the Social Security Act, at the time you became eligible for COBRA coverage, or during the first 60 days of the continued coverage, that person and any other person then entitled to the continued coverage may elect to extend this 18-month period for up to an extra 11 months. To elect this extra 11 months, the person must give the Employer written proof of Social Security's determination before the first to occur of: (a) the end of the 18 month continuation period; or (b) 60 days after the date the person is determined to be disabled.
- Up to 36 months for your Dependent(s) in the event of: your death; your divorce or legal separation; your entitlement to Medicare; or your child ceasing to qualify as a Child Dependent.

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

- This Program ends for the class you belong to.

- The person fails to make required payments for the coverage.
- The person becomes covered under any other group health plan. But, coverage will not end due to this rule until the end of any period for which benefits for them are limited, under the other plan.
- The person becomes entitled to Medicare benefits.

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

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

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

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

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

- The end of the 24-month period starting on the date the Employee was first absent from work due to the service.
- The date on which the Employee fails to return to work after completing service in the uniformed services, or fails to apply for reemployment after completing service in the uniformed services.
- The date on which this Policy ends.

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

a) If the Employee's service in the uniformed services is less than 31 days, his/her contribution for the coverage will be the same as if there were no absence from work.

b) If the service extends for 31 or more days, the Employee's contribution for the coverage can be up to 102% of the full premium for it.

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

Uniformed services: The following:

1. The Armed Services.
2. The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty.

3. The commissioned corps of the Public Health Service.

4. Any other category of persons designated by the President in time of war or national emergency.

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

1. Active duty.

2. Active and inactive duty for training.

3. National Guard duty under federal statute.

4. A period for which a person is absent from employment: (a) for an exam to determine the fitness of the person to perform any such duty; or (b) to perform funeral honors duty authorized by law.

5. Service as: (a) an intermittent disaster-response appointee upon activation of the National Disaster Medical System (NDMS); or (b) a participant in an authorized training program in support of the mission of the NDMS.

Continued Coverage for Over-Age Dependents

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

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

- is 30 years of age or younger;

- is not married, or in a Civil Union;

- has no dependents of his/her own;

- is either a New Jersey resident or enrolled as a full-time student at an accredited school;

- is not covered under any other group or individual health benefits plan; group health plan; church plan; or health benefits plan; and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

If a Dependent Is Over the Limiting Age for Dependent Coverage

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

(a) the Dependent's group health benefits are ending or have ended due to his/her attainment of that age; or

(b) the Dependent has proof of receipt of benefits,

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

Conditions for Election

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

- The Over-Age Dependent must provide receipt of benefits under: a group or individual health benefits plan; group health plan; church plan; health benefits plan; or Medicare. Such prior coverage must have been in effect at some time prior to making an election for this Over-Age Dependent coverage.

- Unless a parent of an Over-Age Dependent has no other Dependents eligible for coverage under this Policy, or has a Spouse or Civil Union who is covered elsewhere, the parent must be enrolled for Dependents coverage under this Policy at the time the Over-Age Dependent elects continued coverage.

Election of Continuation

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

- The date the Over-Age Dependent gives written notice to Horizon BCBSNJ.

- The date the Over-Age Dependent pays the first premium for it.

- The date the Over-Age Dependent would otherwise lose coverage due to attainment of the limiting age.

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

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

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

Payment of Premiums

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

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

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

Grace Period for the Payment of Premiums

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

- With respect to the first due payment, if it is made within 30 days after the election for continued coverage;

- With respect to later payments, if they are made within 30 days of the date they become due.

Scope of Continued Coverage

The continued coverage will be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an Employee under this Policy and will be evidenced by a separate Booklet and ID card being issued to the Over-Age Dependent. Subject to the following subsection, if this Policy's coverage for other dependents who are Covered Persons is modified, the coverage for Over-Age Dependents will be modified in like manner. Evidence of insurability is not required for the continued coverage.

Single Coverage for Over-Age Dependents

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

When Continuation Ends

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

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

Inapplicability of Other Continuation Provisions

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

Conversion Coverage

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

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

The coverage will be at least equal to the basic benefits under contracts then being issued by Horizon BCBSNJ to new non-group applicants of the same age and family status. This coverage is called

"conversion coverage." The conversion coverage, if provided, may be different than the coverage provided by this Program. We will provide details of this conversion coverage upon request.

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

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

Continuation of Care

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

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

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

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

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

Medical Necessity And Appropriateness

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

- Services are performed or prescribed by your attending physician;
- Services, in our judgment, are provided at the proper level of care (Inpatient; Outpatient; Out-of-Hospital; etc.);

- Services or supplies are Medically Necessary and Appropriate for the diagnosis and treatment of an Illness or Injury.

THE FACT THAT YOUR ATTENDING PHYSICIAN MAY PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE OR SUPPLY DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY AND APPROPRIATE FOR THE DIAGNOSIS AND TREATMENT OF AN ILLNESS OR INJURY OR MAKE IT AN ELIGIBLE MEDICAL EXPENSE.

Cost Containment

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

Managed Care Provisions

Member Services

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

Referral Forms

A Covered Person can be Referred for Specialist Physician services by his/her PCP through the use of a Referral form to receive In Network Benefits. This form is valid only for the specific number of Visits and/or types of service shown on it by the PCP.

A Covered Person may take the referral form with him/her and present it when obtaining specialty care.

Miscellaneous Provisions

a. This Program is intended to pay for Covered Services and Supplies as described in this booklet. Horizon BCBSNJ does not provide the services or supplies themselves, which may, or may not, be available.

b. Horizon BCBSNJ is only required to provide its Allowance for Covered Services and Supplies, to the extent stated in the Group Policy. Horizon BCBSNJ has no other liability.

c. Benefits are to be provided in the most cost-effective manner practicable. If Horizon BCBSNJ determines that a more cost-effective manner exists, Horizon BCBSNJ reserves the right to require that care be rendered in an alternate setting as a condition of providing payment for benefits.

Your Horizon Program

Your Horizon BCBSNJ Program is a tiered network plan that encourages you to get care from OMNIA Tier 1 designated doctors, hospitals and other health care professionals. Your plan also covers care provided or arranged by Tier 2 doctors and other health care professionals participating as an In-Network Provider in the Horizon network of plans. In order to receive benefits under this Program, You must use In-Network Providers. Generally, no benefits will be provided for the services of Out-of-Network Providers.

Under this Program, you are not required to choose a Primary Care Practitioner (PCP.) but when you pre-select an In-Network PCP, he or she can help You obtain the most appropriate services and treatment in the proper setting.

Some of the In-Network Providers are classified as OMNIA Tier 1 or Tier 2. The cost sharing (Copayment, Deductible and/or Coinsurance) is lower for use of OMNIA Tier 1 In-Network Providers than for Tier 2 In-Network Providers within Our Service Area. In order to take advantage of the lower e cost sharing for the use of a OMNIA Tier 1 Hospital it will be necessary to select an In-Network Provider who has admitting privileges at the OMNIA Tier 1 Hospital when hospitalization becomes necessary. Where there are no OMNIA Tier 1 In- Network Providers available within the geographic accessibility standards established under N.J.A.C 11:24-6.1 et seq., Horizon BCBSNJ will provide an in-plan exception to make Tier 2 In-Network Providers available at the OMNIA Tier 1 cost-share.

This section explains what you pay, and how Deductible, Coinsurance and Copayments work together.

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

BENEFIT PROVISIONS

OMNIA Tier 1 and Tier 2 Deductible

This program has 2 separate Deductibles. The OMNIA Tier 1 Deductible is for treatment , services or supplies given by a OMNIA Tier 1 In-Network Provider.The Tier 2 Deductible is for treatment, services or supplies given by a Tier 2 In-Network Provider as well as for treatement, services or supplies given Tier 1 In-Network Provider. Preventive care Services are not subject to a Deductible.Where there is a OMNIA Tier 1 Deductible, any cost sharing such as Copayment, Deductible and/or Coinsurance expended in connection with a OMNIA Tier 1 Covered Charge will also be credited to the Tier 2 Deductible. Cost-sharing for Tier 2 Covered Charges are not credited to the OMNIA Tier 1 Deductible.

Each Deductible is shown in the Schedule of Covered Services and Supplies.

OMNIA Tier 1 Single Deductible Limit

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a OMNIA Tier 1 In-Network Provider that exceed the OMNIA Tier 1 Deductible before Horizon BCBSNJ pays benefits for OMNIA Tier 1 Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a OMNIA Tier 1 In-Network Provider, while insured under this Program, can be used to meet this OMNIA Tier 1 Deductible. Once the OMNIA Tier 1 Deductible is met, Horizon BCBSNJ pays benefits for other such OMNIA Tier 1 Covered Charges above the Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. Additionally, Horizon BCBSNJ pays benefits for OMNIA Tier 1 Covered Charges once the Tier 2 Deductible is met, less any applicable Coinsurance or Copayments, for the rest of the Calendar Year.

Tier 2 Single Deductible Limit

Each Calendar Year, the sum of the Covered Charges for each Covered Person for treatment, services or supplies from a Tier 2 In-Network Provider and those from a OMNIA Tier 1 In-Network Provider must exceed the Tier 2 Deductible before Horizon BCBSNJ pays for Tier 2 Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from OMNIA Tier 1 or a Tier 2 In-Network Provider, while insured by this Policy, can be used to meet this Deductible. Once the Tier 2 Deductible is met, Horizon BCBSNJ pays benefits for other such Covered Charges above both the OMNIA Tier 1 and Tier 2 Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

The OMNIA Tier 1 and the Tier 2 Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured under this Program can be used to meet the Deductible. What Horizon BCBSNJ pays is based on all the terms of this Program.

Family Deductible Limit

The Family Deductible is a cumulative Deductible for all family members for each Calendar Year.

Each Deductible is shown in the Schedule of Covered Services and Supplies.

OMNIA Tier 1 Family Aggregate Deductible Limit

When the Covered Person and each covered Dependent incurs Covered Charges that apply towards the OMNIA Tier 1 Individual Deductible, these Covered Charges will also count toward the OMNIA Tier 1 Family Deductible Limit. The OMNIA Tier 1 Family Deductible Limit can be met by a combination of family members. Once this OMNIA Tier 1 Family Deductible is met in a Calendar Year, Horizon BCBSNJ provides coverage for all OMNIA Tier 1 Covered Charges for all Covered Persons who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of the Calendar Year.

Tier 2 Family Aggregate Deductible Limit

When the Covered Person and each covered Dependent incurs Covered Charges that apply towards the OMNIA Tier 1 and Tier 2 Individual Deductibles, these Covered Charges will also count toward the Tier 2 Family Deductible Limit. The Tier 2 Family Deductible Limit can be met by a combination of family members. Once this Tier 2 Family Deductible is met in a Benefit Period/ Calendar Year, Horizon BCBSNJ provides coverage for all OMNIA Tier 1 and Tier 2 Covered Charges for all Covered Persons who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of the Calendar Year.

OMNIA Tier 1 Individual Out-of-Pocket Maximum

OMNIA Tier 1 Out-of-Pocket Maximum means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all OMNIA Tier 1 Covered Services and Supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance for OMNIA Tier 1 Covered Services and Supplies shall count toward the OMNIA Tier 1 Out- of-Pocket Maximum. Once the OMNIA Tier 1 Out-of-Pocket Maximum has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for OMNIA Tier 1 Covered Services and Supplies for the remainder of the Calendar Year.

OMNIA Tier 1 Family Out-of-Pocket Maximum

Once a Covered Person who is a member of a covered family individually meets the amount equal to the OMNIA Tier 1 Individual Out-of-Pocket Maximum, That person will : (1) no longer have an obligation to the OMNIA Tier 1 Individual Out-of-Pocket Maximum, and (2) will have no further obligation to pay any amounts as OMNIA Tier 1 Deductible, Copayment, or Coinsurance for Covered Services or Supplies for the remainder of the Calendar Year. Once the covered family collectively Incurs during a Calendar Year, an amount equal to the OMNIA Tier 1 Out-of-Pocket Maximum, the covered family has no further obligation to pay any amounts as OMNIA Tier 1 Deductible, Copayment, or Coinsurance for Covered Services or Supplies for the remainder of the Calendar Year.

Tier 2 Individual Out-of-Pocket Maximum

Tier 2 Out-of-Pocket Maximum means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all OMNIA Tier 1 and Tier 2 Covered Services and Supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance, regardless of whether the services are OMNIA Tier 1 or Tier 2 shall count toward the Tier 2 Out-of-Pocket Maximum. Once the Tier 2 Out-of-Pocket Maximum has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for OMNIA Tier 1 or Tier 2 Covered Services and Supplies for the remainder of the Calendar Year.

Tier 2 Family Out-of-Pocket Maximum

Once a Covered Person who is a member of a covered family individually meets the amount equal to the Tier 2 Individual Out-of-Pocket Maximum, That person will : (1) no longer have an obligation to the OMNIA Tier 1 and Tier 2 Individual Out-of-Pocket Maximum, and (2) will have no further obligation to pay any amounts as OMNIA Tier 1 and Tier 2 Deductible, Copayment, or Coinsurance for Covered Services or Supplies for the remainder of the Calendar Year. Once the covered family collectively Incurs during a Calendar Year, an amount equal to the Tier 2 Out-of-Pocket Maximum, the covered family has no further obligation to pay any amounts as OMNIA Tier 1 and Tier 2 Deductible, Copayment, or Coinsurance for Covered Services or Supplies for the remainder of the Calendar Year.

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

Benefits From Other Plans

The benefits Horizon BCBSNJ will provide may also be affected by benefits from Medicare and other health benefit plans. Read The Effect of Medicare on Benefits and Coordination of Benefits and Services sections of this Booklet for an explanation of how this works.

If This Plan Replaces Another Plan

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

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

a. they were Incurred during the Calendar Year in which this Program starts;

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

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

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

SUMMARY OF COVERED SERVICES AND SUPPLIES

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

A. COVERED BASIC SERVICES AND SUPPLIES

Acupuncture

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

Allergy Testing and Treatment

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

Ambulatory Surgery

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

Anesthesia

This Program covers anesthetics and their administration.

Audiology Services

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

Birthing Centers

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

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

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

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

Contraceptives

The Policy covers Prescription female contraceptives which require a Practitioner's prescription and which are approved by the Food and Drug Administration for that purpose. Prescription female contraceptives are covered as Preventive Care which means they are covered without application of any Copayment, Deductible, or Coinsurance, as applicable.

As used in this provision, Prescription female contraceptive means any drug or device used for contraception by a female. Examples include but are not limited to birth control and diaphragms.

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, 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.

Dental Care and Treatment

This Program covers:

a. the diagnosis and treatment of oral tumors and cysts; and

b. the surgical removal of bony impacted teeth; and

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

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

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

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

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

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

Diagnosis and Treatment of Autism and Other Developmental Disabilities

This Program 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, and regardless of anything in the Program to the contrary, the Program provides coverage for the following Medically Necessary and Appropriate Therapy Services, as prescribed in a treatment plan:

a. Occupational Therapy needed to develop the Covered Person's ability to perform the ordinary tasks of daily living;

b. Physical Therapy needed to develop the Covered Person's physical functions; and

c. Speech Therapy needed to treat the Covered Person's speech impairment.

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

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

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

Any treatment plan referred to above must: (a) be in writing; (b) be signed by the treating Practitioner; and (c) include: (i) a diagnosis; (ii) proposed treatment by type, frequency and duration; (iii) the anticipated outcomes stated as goals; and (iv) the frequency by which the treatment plan will be updated. With respect to the covered behavioral interventions and programs mentioned above, the term "Practitioner" shall also include a person who is credentialed by the national Analyst Certification Board as either: (a) a Board Certified Behavior Analyst-Doctoral; or (b) a Board Certified Behavior Analyst.

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

If a Covered Person:

a. is eligible for early intervention services through the New Jersey Early Intervention System;

b. has been diagnosed with autism or other Developmental Disability; and

c. receives Physical Therapy; Occupational Therapy; Speech Therapy; ABA; or Related Structured Behavioral Programs;

the portion of the family cost share attributable to such services is a Covered Charge under the Program. Any Deductible, Coinsurance or Copayment that applies under the Program to a non-specialist Practitioner Visit for treatment of an Illness or Injury will apply to the family cost share.

Therapy Services a Covered Person received through New Jersey Early Intervention will not reduce the Therapy Services otherwise available to the Covered Person under this provision.

Diagnostic X-rays and Lab Tests

This Program covers diagnostic X-ray and lab tests.

Donated Breast Milk

The Policy covers pasteurized donated human breast milk for Covered Persons under the age of six months subject to the following conditions:

a) The Covered Person is medically or physically unable to receive maternal breast milk or participate in breast feeding, or the Covered Person's mother is medically or physically unable to produce breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; and

b) The Covered Person's Practitioner issued an order for the donated human breast milk

The Policy also cover pasteurized donated human breast milk as ordered by the Covered Person's Practitioner for Covered Persons under the age of six months if the Covered Person meets any of the following conditions:

1. A body weight below healthy levels determined by the Covered Person's Practitioner;
2. A congenital or acquired condition that places the Covered Person at a high risk for development of necrotizing enterocolitis; or
3. A congenital or acquired condition that may benefit from the use of donor breast milk as determined by the New Jersey Department of Health.

As used in this provision, pasteurized donated human breast milk means milk obtained from a human milk bank that meets the quality guidelines established by the New Jersey Department of Health. If there is no supply of human breast milk that meets such guidelines there will be no coverage under this provision.

The pasteurized donated human breast milk may include human milk fortifiers if indicated by the Covered Person's Practitioner.

Emergency Room

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

Facility Charges

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

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

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

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

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

Fertility Services

This Program covers services relating to Infertility (defined below), including, but not limited to, the following services and procedures recognized by the American Society for Reproductive medicine or the American College of Obstetricians and Gynecologists:

a. Assisted hatching;

b. Diagnosis and diagnostic tests;

c. Completed egg retrievals Per Lifetime of the Covered Person;

d. Gamete intrafallopian transfer (requires Prior Authorization);

e. Medications, including injectable infertility medications;

f. Ovulation induction;

g. Surgery, including microsurgical sperm aspiration;

h. Artificial insemination;

i. In vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate (requires Prior Authorization);

j. Fresh and frozen embryo transfer;

k. Zygote intrafallopian transfer (requires Prior Authorization);

l. Intracytoplasmic sperm injections.

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

1. Services for in vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer shall be limited to a Covered Person who:

   (i) has used all reasonable, less expensive, and medically appropriate treatments for infertility

3. Coverage of Prescription Drugs is not included if Infertility medication benefits are provided under another group health insurance policy or contract issued to the Policyholder.

4. To be covered, the services described in this section must be provided at a Facility that conforms to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

5. The following services are not covered:

   a. Medical services given to a surrogate, for purposes of childbearing, if the surrogate is not a Covered Person.

b. Medical costs of a live donor used in egg retrieval after the donor has been released by the reproductive endocrinologist.

c. Non-medical costs of an egg or sperm donor.

d. Ovulation kits and sperm testing kits and supplies.

e. Reversal of voluntary sterilization.

f. The cryopreservation and storage of sperm, eggs and embryos.

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

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

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

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

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

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

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

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

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

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

Fertilization: The penetration of the egg by the sperm.

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

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

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

Infertility: A disease or condition that results in the abnormal function of the reproductive system such that:

A) a determination of infertility is made pursuant to American Society for Reproductive Medicine practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology; or

B) the Covered Person meets one of the following conditions:

(i) a male is unable to impregnate a female;

(ii) a female with a male partner and under 35 years of age is unable to conceive after twelve months of unprotected sexual intercourse;

(iii) a female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;

(iv) a female without a male partner and under 35 years of age who is unable to conceive after twelve failed attempts of intrauterine insemination under medical supervision;

(v) a female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;

(vi) partners are unable to conceive as a result of involuntary medical sterility;

(vii) the Covered Person is unable to carry a pregnancy to live birth; or

(viii) a previous determination of Infertility.

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

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

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

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

Oocyte: The female egg or ovum.

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

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

Surrogate: A woman who carries an embryo that was formed from her own egg inseminated by the sperm of a designated sperm donor.

Zygote: A fertilized egg before cell division begins.

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

Hearing Aids and Related Services

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

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

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

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

Home Health Care

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

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

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

This Policy does not cover:

a. services furnished to family members, other than the patient; or

b. services and supplies not included in the Home Health Care plan; or

c. services that are mainly Custodial Care.

Inpatient Physician Services

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

Mastectomy Benefits

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

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

Maternity/Obstetrical Care

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

(a) at the time of delivery; or

(b) in the case of multiple births, at the time of the last delivery; or

(c) if the delivery occurs out of the Hospital, at the time the mother or newborn is admitted to the Hospital.

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

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

Maternity/Obstetrical Care for Child Dependents

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

Medical Emergency and Medical Screening Examinations

This Policy provides coverage for Medical Emergencies, including diagnostic X-ray and lab and Urgent Care for medical conditions and mental or nervous disorders, on a 24-hour, 7-day-a-week basis. This Policy provides coverage for eligible services and supplies provided by an In-Network Provider as stated in this Policy 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 Practitioner. 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.

See the Schedule of Covered Services and Supplies for additional limitations and benefit levels.

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

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

For the purposes of this section, "Plan Year" means the year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

Except as stated below for the treatment of Substance Use Disorders, Horizon BCBSNJ pays benefits for the Covered Charges a Covered Person incurs for the treatment of mental or Nervous Disorders or Substance Use Disorders the same way Horizon BCBSNJ would for any other Illness, if such treatment is prescribed by a Practitioner.

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

a. the prospective determination of the 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. Prior authorization is 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 Hospitalization services during each Plan Year but retrospective review may be required for the balance of the Plan Year; and

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.

The first 180 days per Plan Year assumes 180 inpatient days whether consecutive or intermittent. Extended Outpatient services such as a 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.

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

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

Nutritional Counseling

This program 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 treatment 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 Drug

This Policy covers expenses Incurred for Orally Administered Anti-Cancer Drugs.

Regardless of any other provisions of this Policy describing coverage for Prescription Drugs, benefits for Covered Charges for these Orally Administered Anti-Cancer Drugs are not subject to any Deductible, Copayment or Coinsurance.

For the purpose of this subsection, "Orally Administered Anti-Cancer Drugs" are Prescription Drugs that: (a) are used to slow or kill the growth of cancerous cells; and (b) are administered orally. Such drugs do not include:

- Those that are prescribed to maintain red or white cell counts;
- Those that treat nausea; or
- Those that are prescribed to support anti-cancer Prescription Drugs.

Orthotic Devices

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

Practitioner's Charges for Non-Surgical Care and Treatment

This Program covers Practitioner's charges for the non-Surgical care and treatment of an Illness, Injury, Mental or Nervous Disorders or Substance 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 Program covers Practitioners' charges for Surgery. This Program does not cover Cosmetic Surgery. Surgical procedures include: (a) those after a mastectomy on one or both breasts; (b) reconstructive breast Surgery; and (c) Surgery to achieve symmetry between both breasts.

Pre-Admission Testing Charges

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

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

Preventive Care/Health Wellness

This Program provides benefits for certain Covered Services and Supplies relating to Preventive Care including: related diagnostic X rays and lab tests; and screening tests. Coverage may be limited each Benefit Period as shown in the Schedule of Covered Services and Supplies.

The covered Preventive Care is as follows:

a. For all Covered Persons 20 years of age and older, annual tests to determine blood, hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density lipoprotein (LDL) level and high-density lipoprotein (HDL) level.

b. For all Covered Persons 35 years of age or older, a glaucoma eye test every five years.

c. For all Covered Persons 40 years of age or older, a yearly stool exam for presence of blood.

d. For all Covered Persons 45 years of age or older, a left-sided colon exam of 35 to 60 centimeters every five years.

e. For all adult Covered Persons recommended immunizations; and

f. For all Covered Persons 20 years of age and older, a yearly consultation with a Provider to discuss lifestyle behaviors that promote health and well-being, including but not limited to: smoking control; nutrition and diet recommendations; exercise plans; lower back protection; weight control; immunization practices; breast self-exam; testicular self-exam; and seat belt usage in motor vehicles.

g. For all female Covered Persons 20 years of age or older, a Pap smear. The term "Pap smear" means: an initial Pap smear; any confirmatory test when Medically Necessary and Appropriately and ordered by a Covered Person's physician; and all lab costs related to the initial Pap Smear and any such confirmatory test.

h. For all female Covered Persons 40 years of age or older, a yearly mammogram exam.

i. **Gynecological Examinations**

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

j. **Mammography**

The 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 thisProgram, and these rules:

Horizon BCBSNJ will cover charges for:

1. 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.

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

3. One mammogram exam each year for Covered Persons age 40 and over.

4. 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:
   - The mammogram exam demonstrates extremely dense breast tissue;
   - The mammogram is abnormal within any degree of breast density, including not dense; moderately dense; heterogeneously dense; or extremely dense breast tissue; or
   - 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.

5. Digital Tomosynthesis Charges

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

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

k. **Pap Smears**

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

l. **Prostate Cancer Screening**

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

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

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

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

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

n. **Colorectal Cancer Screening**

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

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

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

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

o. **Newborn Hearing Screening**

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

For the purposes of this part:

a. "newborn" means a child up to 28 days old;

b. "infant" means a child between the ages of 29 days and 36 months;

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

p. **Well Child Care**

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

q. **Additional Preventive Services**

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

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person;

3. For infants and children (if coverage under the Policy is provided for them) and adolescents who are Covered Persons, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. With respect to female Covered Persons, such additional preventive care and screenings, not described in part 1, above, as are provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Horizon BCBSNJ shall administratively update new recommendations to the preventive services listed above at the schedule established by the Secretary of Health and Human Services.

Prosthetic Devices

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

Second Opinion Charges

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

a. are board certified and qualified, by reason of his/her specialty, to give an opinion on the proposed Surgery or Hospital Admission;

b. are not a business associate of the Practitioner who recommended the Surgery; and

c. does not perform or assist in the Surgery if it is needed.

Skilled Nursing Facility Charges

This Program covers bed and board (including diets, drugs, medicines and dressings and general nursing service) in a Skilled Nursing Facility.

Specialist Services

This Program covers services rendered by a Network Provider who is not a PCP and who provides services within his/her specialty to Covered Persons In-Network Specialist Physician services require a referral from a Covered Person's PCP. 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.

Speech-Language Pathology Services

Speech-language pathology services rendered by a Physician or a licensed speech-language pathologist, where such services are determined to be Medically Necessary and Appropriate and when performed within the scope of practice.

Surgical Services

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

a. Horizon BCBSNJ 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:

    (a) Horizon BCBSNJ will cover the primary procedure, plus 50% of what Horizon BCBSNJ would have paid for each of the other procedures, up to five, had those procedures been performed alone.

(b) If more than five surgical procedures are performed, each of the procedures beyond the fifth will be reviewed. The amount that Horizon BCBSNJ will pay for each such procedure will then be based on the circumstances of the particular case.

Exception: Horizon BCBSNJ 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 Policy 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 HorizonCare Online

This Policy covers Telehealth and Telemedicine Services using the Telemedicine Network of Horizon BCBSNJ's designated telemedicine vendor American Well.

The Telemedicine Services program allows you to visit with a Primary Care Practitioner (PCP) via telecommunication using a computer, tablet or smart phone. The Telemedicine Services program does not provide additional covered services (or benefits under your health benefit plan. Telemedicine Services are a covered benefit only when provided through Horizon BCBSNJ's designated Telemedicine Services provider, The Telemedicine Services program is not available to Covered Persons who are eligible for Medicare when Medicare is primary to this Plan.

Members can enroll online or may call 1-855-818-3627 to enroll by phone. For information on how to connect with a Telemedicine Services Provider, access https://www.americanwell.com/doctors-available-24-hours. Members may access telemedicine providers online through Horizon BCBSNJ's member portal or may download the mobile application available for iPhone, android or tablet.

Therapeutic Manipulation

This Program provides benefits for Therapeutic Manipulations.

Therapy Services

This Program covers all Therapy Services.

Transplant Benefits

This Program covers services and supplies:

a. Cornea;

b. Kidney;

c. Lung;

d. Liver;

e. Heart;

f. Heart valve;

g. Pancreas;

h. Small bowel;

i. Chondrocycte (for a 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-myeloblative stem cell;

u. Tandem stem cell.

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

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

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

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

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

a. The search for a donor (benefits not to exceed $10,000 per transplant).

b. Typing (immunologic).

c. The harvesting of the organ tissue, and related services.

d. The processing of tissue.

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

Urgent Care

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

Wilm's Tumor

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

B. COVERED SUPPLEMENTAL SERVICES AND SUPPLIES

Ambulance Services

This Program covers charges for transporting a Covered Person to:

a. a local Hospital, if it can provide the needed care and treatment;

b. the nearest Hospital that can furnish the needed care and treatment, if: (a) a local Hospital cannot provide it; and (b) the person is admitted as an Inpatient; or

c. another Inpatient Facility when Medically Necessary and Appropriate.

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

Blood

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

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

This Program also covers expenses Incurred in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia. The home treatment program must be under the supervision of a State approved hemophilia treatment center. A home treatment program will not preclude further or additional treatment or care at an eligible Facility. But, the number of home treatments, according to a ratio of home treatments to

Benefit Days established by regulation by New Jersey's Commissioner of Insurance, cannot exceed the total number of Benefit Days allowed for any other Illness under this Program.

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

Diabetes Benefits

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

a. blood glucose monitors and blood glucose monitors for the legally blind;

b. test strips for glucose monitors and visual reading and urine testing strips;

c. insulin;

d. injection aids;

e. cartridges for the legally blind;

f. syringes;

g. insulin pumps and appurtenances to them;

h. insulin infusion devices; and

i. oral agents for controlling blood sugar.

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

a. Benefits for self-management education and education relating to diet shall be limited to Visits that are Medically Necessary and Appropriate upon:

    1. the diagnosis of diabetes;

    2. the diagnosis by a physician or nurse practitioner/clinical nurse specialist of a significant change in the Covered Person's symptoms or conditions which requires changes in the Covered Person's self-management; and

    3. determination of a physician or nurse practitioner/clinical nurse specialist that reeducation or refresher education is needed.

b. Diabetes self-management education is covered when rendered by:

1. a dietician registered by a nationally recognized professional association of dieticians;

2. a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators; or

3. a registered pharmacist in New Jersey qualified with regard to management education for diabetes by any institution recognized by the Board of Pharmacy of the State of New Jersey.

Durable Medical Equipment

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

a. replacements or repairs; or

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

Inherited Metabolic Disease

This Program provides benefits for the therapeutic treatment of Inherited Metabolic Diseases. This coverage includes the purchase of Medical Foods and Low Protein Modified Food Products that are determined to be Medically Necessary and Appropriate by the Covered Person's physician.

Oxygen and Its Administration

This Program covers oxygen and its administration.

Physical Rehabilitation

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

Supplemental Prescription Drugs Benefits

This Program covers Prescription Drugs for Out-of-Hospital use. They are covered:

a. when prescribed for an FDA-approved treatment; or

b. when prescribed for a non-FDA-approved treatment. In this case, the drug must be deemed Medically Necessary and Appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia:

    1. The American Hospital Formulary Service Drug Information; or

    2. The United States Pharmacopeia Drug Information;

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

A Prescription Drug identification card (ID card) will be issued to the Covered Person, who will be required to use it to obtain In-Network Prescription Drug benefits. Prescription Mail Orders are also covered.

When a Covered Person presents the ID card at an In-Network retail Pharmacy, the Covered Person will only be required to pay the applicable In-Network Coinsurance/Copayment (See the Schedule of Covered Services and Supplies). However, if an In-Network Deductible applies (see the Schedule of Covered Services and Supplies) and has not been met, the Covered Person will be required to pay the full discounted cost of the Prescription Drug. The amount of the charge will then be applied towards satisfaction of the Deductible.

If the Covered Person uses an Out-of-Network retail Pharmacy to purchase Prescription Drugs, or when the Covered Person does not present his/her ID card at an In-Network Pharmacy, he/she must pay the Pharmacy the full undiscounted cost of the Prescription Drug and then submit a claim form for any applicable reimbursement.

If a Mail-Order Pharmacy is used, the Mail-Order Pharmacy will charge the applicable Deductible, Copayment or Coinsurance (see the Schedule of Covered Services and Supplies) for each eligible Prescription Mail Order.

Covered Charges will not include charges made for more than:

(a) for maintenance drugs, a 90-day supply or 100 unit dose quantity, whichever is greater, for each Prescription Order;

(b) for insulin in strengths for which federal law does not require a prescription, four vials; and

(c) for other Prescription Drugs, a 90-day supply for each Prescription Order.

Refills, as authorized under a Prescription Order, will be subject to the same requirements as described above.

Note: Covered Prescription Drugs that are for Preventive Care/Health Wellness are not subject to any Deductible, Copayment or Coinsurance.

Benefits of Using an In-Network Pharmacy:

To maximize your Prescription Drug benefits, you should use In-Network Pharmacies. When you use an In-Network Pharmacy, you pay less for your Prescription Drugs because the Coinsurance amount that you pay is based on a discounted price rather than the actual retail price.

To take advantage of these benefits, simply present your ID card at the In-Network Pharmacy. You do not have to fill out a claim form when you use an In-Network Pharmacy.

Please note that if you do not present your ID card, you will have to pay the pharmacist the actual retail cost of the Prescription Drug, as described below.

Synchronization of Prescription Drugs

This Program provides for synchronization of covered Prescription Drugs on at least one occasion per year for each Covered Person. For the purposes of this section "synchronized" and "synchronization" refers to the process by which a Covered Person refills his or her multiple Prescription Drugs at the same time and from the same Pharmacy.

Prescription Drugs may be dispensed by an In-Network Pharmacy in an amount equal to less than a 30-day supply in order to reduce the Copayment or Coinsurance, as applicable. Copayments and/or Coinsurance for Prescription Drugs dispensed for supplies of less than 30-days will be prorated on a daily basis and will only be provided when:

(a) the Covered Person's Practitioner has determined that a reduced supply of Prescription Drugs is Medically Necessary and Appropriate; or

(b) for purposes of synchronizing a Covered Person's Maintenance Prescription Drugs

A Covered Person may also have his or her Maintenance Prescription Drugs synchronized pursuant to a written treatment plan developed by the Covered Person, the Provider, and the pharmacist showing the Provider's recommended synchronization of the Covered Person's Maintenance Prescription Drugs.

However, synchronization will not be provided for Prescription Drugs or Maintenance Prescription Drugs that are opioid analgesics, which is defined as a drug class prescribed to treat moderate to severe pain or other conditions, whether in immediate release or extended release form, and whether or not combined with other drug substances to form a single drug product or dosage form.

Using an Out-of-Network Pharmacy:

If you do not use an In-Network Pharmacy (or if you do not present your ID card at an In-Network Pharmacy), you will have to pay the actual retail price for your Prescription Drug. You will then need to complete and send in a claim form to receive any applicable reimbursement. If you need a claim form, you can get one by contacting Horizon BCBSNJ at 1-800-355-2583.

Mail Order Prescription Service

Under your Program, you can obtain your Prescription Drugs from a Mail-Order Pharmacy.

For Prescription Mail Orders (and refills of them), the quantity dispensed will be for 90 consecutive days.

The advantages of the mail order services are:

- you will pay less for your Prescription Drugs (see the Schedule of Covered Service and Supplies);
- you may purchase a supply of medication by mail;
- the medication is mailed directly to your home, eliminating the need to make repeated visits to your local In-Network Pharmacy for maintenance Prescription Drugs.

To use this service, simply mail your prescription to **PrimeMail** in the appropriate mail order envelope and include a completed mail order form. If you do not have a mail order envelope or form, you may request one by calling **PrimeMail** at **1-888-844-3828**.

No Covered Person shall be required to use a Mail-Order Pharmacy. But in the event a Covered Person chooses to use a Mail-Order Pharmacy, the Prescription Drug Coinsurance shall not differ between a Mail-Order Pharmacy and a retail Pharmacy if: (a) the Prescription Drugs are of the same strength, quality and days' supply; and (b) the retail Pharmacy agrees to the same terms, conditions, price and services that apply to the Mail-Order Pharmacy. No fee or other condition shall be imposed upon a Covered Person choosing an In-Network pharmacist or Pharmacy that is not also equally imposed upon all Covered Persons selecting an In-Network pharmacist or Pharmacy.

If you have any questions concerning your Mail Order Prescription Drug program, please call **PrimeMail** at: **1-888-844-3828**.

Specialty Pharmaceuticals:

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

Drug Utilization, Cost Management and Rebates:

Horizon BCBSNJ conducts various utilization management activities designed to: (a) ensure appropriate Prescription Drug usage; (b) avoid inappropriate usage; and (c) encourage the use of cost-effective Prescription Drugs. Through these efforts, you benefit by obtaining appropriate Prescription Drugs in a cost-effective manner.

Horizon BCBSNJ may, from time-to-time, also enter into agreements that result in its receiving rebates or other funds (collectively, "rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drug products across all of Horizon BCBSNJ's business and not solely on any one Covered Person's or one group's utilization of Prescription Drugs. Rebates will not change or reduce the amount of any cost-sharing requirement applicable under our Prescription Drug Program.

Limitations:

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

If you need help or have any questions concerning your Prescription Drug benefits, your Deductible, Copayment or Coinsurance, or any other matter relating to this Prescription Drug Program, please call **Horizon BCBSNJ** at:

1-800-355-2583

Private Duty Nursing Care

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

a. The care must be ordered by a physician.

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

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

Specialized Non-Standard Infant Formulas

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

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

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

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

Wigs Benefit

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

UTILIZATION REVIEW AND MANAGEMENT

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

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

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

a. is admitted as is scheduled to be admitted, as an Inpatient or Outpatient to a Hospital or other Facility; or

b. needs an extended length of stay; or

c. plans to obtain a service or supply to which the section "Medical Appropriateness Review Procedure", below, applies.

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

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

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

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

UTILIZATION REVIEW - REQUIRED HOSPITAL STAY REVIEW

Continued Stay Review

Except as explained below for certain admissions to treat Substance Use Disorders, Horizon BCBSNJ 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 initate 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 BCBSBNJ determines continued stay 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 noncompliance with the PreAdmission review features in this Program, Horizon BCBSNJ reduces what it otherwise pays for Covered Services and Supplies by 20% 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 Program.**

b. Penalties cannot be used to meet this Program's:

1. **Deductible(s)**

2. **Out-of-Pocket Limit(s)**

3. **Copayment(s)**

MEDICAL APPROPRIATENESS REVIEW PROCEDURE

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

The Covered Person or his/her Provider must request a required review from Horizon BCBSNJ at least five business days before the Covered Service or Supply is scheduled to be furnished, or as soon before as reasonably possible. If the treatment or procedure is being performed in a Hospital/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, We determine the Medical Necessity and Appropriateness of the treatment, procedure or supply, and either:

a. approve the request, or

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

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

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

ALTERNATE TREATMENT FEATURES/INDIVIDUAL CASE MANAGEMENT

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

Definitions

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

a. They are determined, in advance, by Horizon BCBSNJ to be Medically Necessary and Appropriate and cost-effective in meeting the longterm or intensive care needs of a Covered Person: (a) in connection with a Catastrophic Illness or Injury; or (b) in completing a course of care outside of the acute Hospital setting (for example, completing a course of IV antibiotics at home).

b. Benefits for charges Incurred for them would not otherwise be covered under this Program.

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

a. head injury requiring an Inpatient stay;

b. spinal cord injury;

c. severe burn over **20%** or more of the body;

d. multiple injuries due to an accident

e. premature birth;

f. CVA or stroke;

g. congenital defect which severely impairs a bodily function;

h. brain damage due to: an Injury; or cardiac arrest; or a Surgical procedure;

i. terminal Illness, with a prognosis of death within six months;

j. Acquired Immune Deficiency Syndrome (AIDS);

k. Substance Use Disorders;

l. a Mental or Nervous Disorders; or

m. any other Illness or Accidental Injury determined by Horizon BCBSNJ to be catastrophic.

Alternate Treatment/Individual Case Management Plan

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

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

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

    2. the Covered Person's attending Practitioner; and

    3. Horizon BCBSNJ or its designee.

b. The Alternate Treatment/Individual Case Management Plan includes:
    1. treatment plan objectives;

    2. a course of treatment to accomplish those objectives;

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

(a) Horizon BCBSNJ;

(b) the attending Practitioner;

(c) the Covered Person;

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

4. the estimated cost of the plan and savings.

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

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

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.

"PreTreatment Screening Evaluation": The review of past and present medical records and current Xray 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:

1. perform a pre-treatment screening evaluation; and

2. 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 Program. The Utilization Review features described above will not apply.

SCHEDULE OF PROCEDURES REQUIRING PRIOR AUTHORIZATION

- Air ambulance transportation.
- All Admissions to a Skilled Nursing Facility or Subacute Facilities.
- All medical Inpatient admissions, with the exception of those Inpatient admissions related to Substance Use Disorder.
- Any proposed Surgery or procedure that may meet this Booklet's definition of Cosmetic Services, including but not limited to septoplasty, rhinoplasty; blepharoplasty; mammaplasty; liposuction; abdominplasty; radial keratotomy; excision of excess skin/subcutaneous tissue (including lipectomy).
- Cardiac radiology services, when not provided in connection with Medical Emergency care or Urgent Care.
- Catheterization for hysterosonography.
- Diagnostic Services for radiology.
- Durable Medical Equipment Rentals, or Purchases over $500.00.
- Elective Inpatient Admissions, with the exception of those Inpatient admissions related to Substance Use Disorder.
- Fertility Services.
- Fetal biophysical profile.
- Gastric Bypass/Bariatric Procedures.
- Home Health Care.
- Home Infusion Therapy.
- Hospice Care, when provided at the home.
- Level II/III ultrasounds
- Mastectomy for gynecomastia.
- Nasal/Sinus Surgery/Endoscopy.
- Organ transplants and transplant services.
- Pain Management Services.
- Positron Emission Tomography Scans; single photon emission computed tomography scans (heart, brain, and breast).
- Private Duty Nursing.
- Radial keratotomy.

- Reconstructive Surgery.
- Septoplasty.
- Varicose Vein Surgery/Sclerotherapy.

EXCLUSIONS

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

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

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

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

Any part of a charge that exceeds the Allowance.

Any therapy not included in the definition of Therapy Services.

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

Broken appointments.

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

Completion of claim forms.

Consumable medical supplies.

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

Court ordered treatment that is not Medically Necessary and Appropriate.

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

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

Diversional/recreational therapy or activity.

Employment/career counseling.

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

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

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

Eye refractions.

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

Food products (including enterally administered food products, 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. "

Home Health Care Visits: connected with administration of dialysis.

Hospice Services, except as otherwise stated in this Booklet.

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

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

Immunizations, except as otherwise stated in this Booklet.

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

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

Maintenance therapy for:

- Physical Therapy;
- Manipulative Therapy;
- Occupational Therapy; and
- Speech Therapy.

Marriage, career or financial counseling; sex therapy.

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

Milieu Therapy:

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

This means that Horizon BCBSNJ has determined that:

1. the purpose of all or part of an Inpatient stay is chiefly to change or control a patient's environment; and

2. an Inpatient setting is not Medically Necessary and Appropriate for the treatment furnished, if any.

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

Pastoral counseling.

Personal comfort and convenience items.

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

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

Psychological testing for educational purposes.

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

Rest or convalescent cures.

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

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

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

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

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

Services performed by any of these:

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

b. Anyone who does not qualify as a Practitioner.

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

Services or supplies:

- eligible for payment under either federal or state programs (except Medicare and Medicaid when, by law, this Program is primary). This provision applies whether or not the Covered Person asserts his/her rights to obtain this coverage or payment for these services;

- for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;

- for which the Provider has not received a certificate of need or such other approvals as are required by law;

- for which the Covered Person would not have been charged if he/she did not have health care coverage;

- furnished by one of these members of the Covered Person's family, unless otherwise stated in this Booklet: Spouse, child, parent, in-law, brother or sister;

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

- needed due to an Injury or Illness to which a contributing cause was the Covered Person's commission of, or attempt to commit, a felony; or to which a contributing cause was the Covered Person's engagement in an illegal occupation; Exception: As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition;

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

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

- provided by a licensed pastoral counselor in the course of his/her normal duties as a pastor or minister;

- provided by a social worker, except as otherwise stated in this Booklet;

- provided during any part of a stay at a Facility, or during Home Health Care, chiefly for: bed rest; rest cure; convalescence; custodial or sanatorium care, diet therapy or occupational therapy;

- provided to treat an Injury or Illness suffered: (a) as a result of War or an Act of War, if the injury or Illness occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization; and (b) as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the Injury or Illness occurs while the Covered Person is serving in such forces and is outside the Home Area.

- provided to treat an Injury or Illness suffered: (a) as a result of War or an Act of War while the Covered Person is serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and (b) as a result of the special hazards incident to such service, provided the Injury or Illness occurs while; (i) the Covered Person is serving in such unit; and (ii) is outside the Home Area.

- provided to treat an Injury or Illness suffered as a result of War or an Act of War while the Covered Person is not in the military, naval or air forces of any country, combination of countries or international organization or in any civilian non-combatant unit supporting or accompanying such forces, if the Injury or Illness occurs outside the Home Area.

- rendered prior to the Covered Person's Coverage Date or after his/her coverage under this Program ends, except as otherwise stated in this Booklet;

- which are specifically limited or excluded elsewhere in this Booklet;

- which are not Medically Necessary and Appropriate; or

- for which a Covered Person is not legally obligated to pay.

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

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

Sterilization reversal.

Sunglasses, even if by prescription.

Telephone consultations, except as Horizon BCBSNJ may request.

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

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

Transplants, except as otherwise stated in this Booklet.

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

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

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

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

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

COORDINATION OF BENEFITS AND SERVICES

PURPOSE OF THIS PROVISION

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

DEFINITIONS

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

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

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

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

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

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

a. Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;

b. Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;

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

d. Group hospital indemnity benefit amounts that exceed $150.00 per day

e. Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

a. Individual or family insurance contracts or subscriber contracts;

b. Individual or family coverage through a Health Maintenance Organization HMO or under any other prepayment, group practice and individual practice plans;

c. Group or group-type coverage where the cost of coverage is paid solely by the Covered Person except when coverage is being continued pursuant to a Federal or State continuation law;

d. Group hospital indemnity benefit amounts of $150.00 per day or less;

e. School accident-type coverage;

f. A State plan under Medicaid

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

a. The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or

b. All Plans which cover the Covered Person use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the Plan determines its benefit first.

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

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

PRIMARY AND SECONDARY PLAN

Horizon BCBSNJ considers each Plan separately when coordinating payments.

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

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

the amount to pay is set forth below in the **Procedures to be Followed by the Secondary Plan to Calculate Benefits** section of this provision.

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

RULES FOR THE ORDER OF BENEFIT DETERMINATION

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

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

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

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

a. The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.

b. If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the Plan covering the parent for a shorter period of time

c. Birthday, as used above, refers only to month and day in a Calendar Year, not the year in which the parent was born.

d. If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

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

a. The benefits of the Plan of the parent with custody of the Child shall be determined first.

b. The benefits of the Plan of the spouse of the parent with custody shall be determined second.

c. The benefits of the Plan of the parent without custody shall be determined last.

d. If the terms of a court decree state that one of the parents is responsible for the health care expenses for the Child, and if the entity providing coverage under that Plan has knowledge of the terms of

the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

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

PROCEDURES TO BE FOLLOWED BY THE SECONDARY PLAN TO CALCULATE BENEFITS

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

a. The basis on which the Primary Plan and the Secondary Plan pay benefits; and

b. Whether the Provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

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

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a Provider, called an In- Network Provider, bills a charge, the Covered Person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Covered Person uses the services of an Out-of-Network Provider, the Plan will be treated as a Reasonable and Customary Charge Plan even though the Plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means that the carrier pays the Provider a fixed amount per member. The Covered Person is liable only for the applicable Deductible, Coinsurance and/or Copayment. In this section, a Plan that pays Providers based upon capitation is called a "Capitation Plan."

In the rules below, "Provider" refers to the provider who provides or arranges the services or supplies.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the Provider is an In-Network Provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a. The amount of any Deductible, Coinsurance and/or Copayment required by the Primary Plan; or
.
b. The amount the Secondary Plan would have paid if it had been the Primary Plan

The total amount the Provider receives from the Primary Plan, the Secondary Plan and the Covered Person shall not exceed the fee schedule of the Primary Plan. In no event shall the Covered Person be responsible for any payment in excess of the Copayment, Coinsurance and/or Deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Reasonable & Customary Plan

If the Provider is an In-Network Provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a. The amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or

b. The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Reasonable & Customary Plan or Fee Schedule Plan

If the Primary Plan is an HMO Plan that does not allow for the use of Out-of-Network Providers except in the event of Urgent Care or a Medical Emergency and the service or supply the Covered Person receives from an Out-of-Network Provider is not considered as Urgent Care or a Medical Emergency, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or Reasonable & Customary Plan

If the Covered Person receives services or supplies from a Provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

a. The amount of any Deductible, Coinsurance and/or Copayment required by the Primary Plan; or

b. The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or Reasonable & Customary Plan and Secondary Plan is Capitation Plan

If the Covered Person receives services or supplies from a Provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the Provider and shall not be liable to pay the Deductible, Coinsurance and/or Copayment imposed by the Primary Plan. The Covered Person shall not be liable to pay any Deductible, Coinsurance and/or Copayment of either the Primary Plan or the Secondary Plan

BENEFITS PAYABLE FOR AUTOMOBILE RELATED INJURIES

This section applies when expenses are Incurred by a Covered Person due to an Automobile Related Injury.

Definitions

"Automobile Related Injury": Bodily injury of a Covered Person due to an accident while occupying, entering into, alighting from or using an auto; or if the Covered Person was a pedestrian, caused by an auto or by an object propelled by or from an auto.

"Allowable Expense": A Medically Necessary and Appropriate, reasonable and customary item of expense that is at least in part a Covered Charge under this Program or PIP.

"Eligible Expense": That portion of expense Incurred for treatment of an Injury which is covered under this Program without application of Deductibles or Copayments, if any.

"Out-of-State Automobile Insurance Coverage" or "OSAIC": Any coverage for medical expenses under an auto insurance contract other than PIP. This includes auto insurance contracts issued in another state or jurisdiction.

"PIP": Personal injury protection coverage (i.e., medical expense coverage) that is part of an auto insurance contract issued in New Jersey.

Application of this Provision

When expenses are Incurred as a result of an Automobile Related Injury, and the injured person has coverage under PIP or OSAIC, this provision will be used to determine whether this Program provides coverage that is primary to such coverage or secondary to such coverage.

Determination of Primary or Secondary Coverage

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

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

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

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

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

Benefits This Program Will Pay if it is Secondary to PIP

If this Program is secondary to PIP, the actual coverage will be the lesser of:

a. the Allowable Expenses left uncovered after PIP has provided coverage (minus this Program's Deductibles, Copayments, and/or Coinsurance); or
b. the actual benefits that this Program would have paid if it provided its coverage primary to PIP.

Medicare

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

THE EFFECTS OF MEDICARE ON BENEFITS

IMPORTANT NOTICE

For the purposes of this Booklet's "Coordination of Benefits and Services" provision, the benefits for a Covered Person may be affected by whether he/she is eligible for Medicare and whether the "Medicare as Secondary Payer" rules apply to the Program. This section, on "Medicare as Secondary Payer", or parts of it, may not apply to this Program. The Employee must contact the Policyholder to find out if the Policyholder is subject to Medicare as Secondary Payer rules.

For the purpose of this section:

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

b. A Covered Person is deemed to be eligible for Medicare by reason of age from the first day of the month during which he/she reaches age 65. But, if the Covered Person is born on the first day of a month, he/she is deemed to be eligible for Medicare from the first day of the month that is immediately prior to his/her 65th birthday. A Covered Person may also be eligible for Medicare by reason of disability or End-Stage Renal Disease (ESRD).

c. Under the rules for coordination of benefits and services described earlier, a "Primary Plan" pays benefits for a Covered Person's Covered Charges first, ignoring what the Covered Person's "Secondary Plan(s)" pays. The "Secondary Plan(s)" then pays the remaining unpaid Allowable Expenses in accordance with the provisions of the Covered Person's secondary health plan.

The following rules explain how this Program's group health benefits interact with the benefits available under Medicare as Secondary Payer rules. A Covered Person may be eligible for Medicare by reason of age, disability or ESRD. Different rules apply to each type of Medicare eligibility as explained below:

In all cases where a person is eligible for Medicare and this Program is the secondary plan, the Allowable Expenses under this Program and for the purposes of the Coordination of Benefits and Services rules, will be reduced by what Medicare would have paid if the Covered Person had enrolled for full Medicare coverage. But this will not apply, however, if; (a) the Covered Person is eligible for, but not covered, under Part A of Medicare; and (b) he/she could become covered under Part A only by enrolling and paying the required premium for it.

Medicare Eligibility by Reason of Age

(Generally for Employers with at least 20 Employees.)

This part applies to a Covered Person who:

a. is the Employee or covered Spouse; and

b. is eligible for Medicare by reason of age; and

c. has coverage under this Program due to the current employment status of the Employee.

Under this part, such a Covered Person is referred to as a "Medicare eligible".

This part does not apply to:

a. a Covered Person, other than an Employee or covered Spouse;

b. a Covered Person who is under age 65; or

c. a Covered Person who is eligible for Medicare solely on the basis of ESRD.

When a Covered Person becomes eligible for Medicare by reason of age, he/she must choose one of these options:

Option (A) - Choose this Program as the primary health plan.

When (a) a Medicare eligible person chooses this Program as the primary health plan; and (b) Incurs a Covered Charge for which benefits are payable under this Program and Medicare, this Program is deemed primary. This Program pays first, ignoring Medicare. Medicare is deemed the secondary health plan.

Option (B) - Choose Medicare as the primary health plan.

When a Medicare eligible person chooses Medicare as the primary health plan, he/she will no longer be covered by this Program, as required by Medicare's rules. Coverage under this Program will end on the date the Covered Person elects Medicare as his/her primary health plan.

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

If the Medicare eligible person chooses Option (B), he/she can subsequently change the election and choose Option (A), subject to the Policyholder's requirements for enrolling in this Program.

Medicare Eligibility by Reason of Disability

(Generally for Employers with at least 100 Employees.)

This part applies to a Covered Person who:

a. is under age 65;

b. is eligible for Medicare by reason of disability; and

c. has coverage under this Program due to the current employment status of the Employee.

This part does **not** apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or

b. a Covered Person who is eligible for Medicare solely on the basis of ESRD.

When a Covered Person becomes eligible for Medicare by reason of disability, this Program is the primary plan; Medicare is the secondary plan.

Medicare Eligibility by Reason of End Stage Renal Disease

(Applies to all Employers.)

This part applies to a Covered Person who is eligible for Medicare solely on the basis of ESRD.

This part does not apply to a Covered Person who is:

a. eligible for Medicare by reason of age ; or

b. eligible for Medicare by reason of disability.

When (a) a Covered Person becomes eligible for Medicare solely on the basis of ESRD; and (b) Incurs a charge for the treatment of ESRD for which benefits are payable under both this Program and Medicare, this Program is deemed the Primary Plan for a specified time, referred to as the "coordination period". This Program pays first, ignoring Medicare. Medicare is the Secondary Plan. The coordination period is 30 consecutive months.

The coordination period starts on the earlier of:

a. the first month of a Covered Person's Medicare Part A entitlement based on ESRD; or

b. the first month in which he/she could become entitled to Medicare if he/she filed a timely application.

After the 30-month period described above ends, if an ESRD Medicare eligible person Incurs a charge for which benefits are payable under both this Program and Medicare, Medicare is the Primary Plan and this Program is the Secondary Plan.

Dual Medicare Eligibility

This part applies to a Covered Person who is eligible for Medicare on the basis of ESRD and either age or disability.

When a Covered Person who is eligible for Medicare due to either age or disability (other than ESRD) has this Program as the primary payer, then becomes eligible for Medicare based on ESRD, this Program continues to be the primary payer for the first 30 months of dual eligibility. After the 30-month period, Medicare becomes the primary payer (as long as Medicare dual eligibility still exists).

When a Covered Person who is eligible for Medicare due to either age or disability (other than ESRD) has this Program as the secondary payer, then becomes eligible for Medicare based on ESRD, this Program continues to be the secondary payer.

When a Covered Person who is eligible for Medicare based on ESRD also becomes eligible for Medicare based on age or disability (other than ESRD), this Program continues to be the primary payer for 30 months after the date of Medicare eligibility based on ESRD.

How To File A Claim If You Are Eligible For Medicare

Follow the procedure that applies to you or the Covered Person from the categories listed below when filing a claim.

New Jersey Providers:

- The Covered Person should give the Practitioner or other Provider his/her identification number. This number is shown on the Medicare Request for Payment (claim form) under "Other Health Insurance";
- The Provider will then submit the Medicare Request for Payment to the Medicare Part B carrier;
- After Medicare has taken action, the Covered Person will receive an Explanation of Benefits form from Medicare;

- If the remarks section of the Explanation of Benefits contains this statement, no further action is needed: "This information has been forwarded to Horizon Blue Cross Blue Shield of New Jersey for their consideration in processing supplementary coverage benefits;"

- If the above statement does not appear on the Explanation of Benefits, the Covered Person should include his/her Identification number and the name and address of the Provider in the remarks section of the Explanation of Benefits and send it to us.

Out-of-State Providers:

- The request for Medicare payment should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information;

- Upon receipt of the Explanation of Benefits, show the Identification Card number and the name and address of the Provider in the remarks section and send the Explanation of Benefits to us for processing.

CLAIMS PROCEDURES

Generally, since this Program 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. New Jersey requires Providers to file claims on behalf of Covered Persons, unless the Covered Person elects to file a claim on his/her own behalf.

To the extent they are needed, claim forms and instructions for filing claims will be provided to Covered Persons by the Employer. Completed claim forms and any other required materials must be submitted to Horizon BCBSNJ or its designees for processing.

If Horizon BCBSNJ fails to furnish claim forms to the Employer for delivery to Covered Persons, or if the Covered Person fails to receive them from the Employer within 15 days after requesting them, the Covered Person making a claim will be deemed to have met the requirements for giving proofs of loss (see item b. under "Submission of Claims", below) if he/she submits written proof of loss covering the occurrence, character and extent of the loss within the time limit for submitting such proof.

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. If a Deductible applies under the Program, we recommend that it should be met before a claim is filed. Once the first claim is filed, we recommend that you send later claims: (a) when you or a covered Dependent Incurs $100.00 or more in Covered Charges; or (b) whenever a lesser amount has been Incurred and four months have passed from the time you submitted your first claim.

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

c. Itemized bills must accompany each claim form. A separate claim form is needed for each claim filed. In general, the bills must contain enough data to identify: the patient; the Provider; the type of service and the charge for each service and the Provider's license number.

   Any bills for Prescription Drugs must contain: the prescription number; and the name, strength and quantity of the drug dispensed.

   Bills for Private Duty Nursing must state that the Nurse is a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) and must contain the Nurse's license number.

d. Horizon BCBSNJ will pay all Clean Claims no later than 30 calendar days of receipt. If the claim is not a Clean Claim, we will pay any part of it that is complete and proper according to these time limits.

e. If a claim is disputed or denied due to missing information or documentation, Horizon BCBSNJ will pay the claim within 30 calendar days after receipt of the missing information or documentation.

f. If a claim is denied or disputed, in whole or in part, Horizon BCBSNJ will notify the claimant (or his/her agent or designee) of it within the applicable time frame specified in the section "Appeals Process".

The denial notice will set forth:

1. the reason(s) the claim is denied;

2. specific references to the main Program provision(s) on which the denial is based;

3. a specific description of any further material or information needed to complete the claim, and why it is needed;

4. a statement that the claim is disputed, if this is so. If the dispute is about the amount of the claim, we will explain why and also explain any change of coding that we make;

5. a statement of the special needs to which the claim is subject, if this is the case;

6. an explanation of the Program's claim review procedure, including any rights to pursue civil action;
7. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either the specific rule or a statement that such a rule was relied upon in making the decision, and that a copy of such rule will be provided free of charge upon request;

8. if the decision is based on Medical Necessity and Appropriateness or an Experimental or Investigational (or similar) exclusion or limitation, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Program to the medical circumstances, or a statement that such explanation will be provided free of charge upon request;

9. if the decision involves a Medical Emergency or Urgent Care, a description of the expedited review process applicable to such claims; and

10. the toll free number that the Covered Person or his/her Provider can call to discuss the claim.

g. If Horizon BCBSNJ does not process claims within any applicable time frame, Horizon BCBSNJ will pay interest on the claims as and to the extent required by law.

h. This applies if an Employee is the non-custodial parent of a Child Dependent. In this case, Horizon BCBSNJ will give the custodial parent the information needed for the Child Dependent to obtain benefits under the Program. We will also permit the custodial parent, or the Provider with the authorization of the custodial parent, to submit claims for Covered Services and Supplies without the Employee's approval.

To Whom Payment Will Be Made

a. Payment for services of an In-Network Provider or a BlueCard Provider will be made directly to that Provider if the Provider bills Horizon BCBSNJ, as Horizon BCBSNJ determines.

b. Except for claims involving emergent or inadvertent services and/or unless you have assigned the benefits in accordance with the Assignment provision in this Booklet, payment for services of Out-of-Network Provider, Facility or Practitioner will be made to you. A Covered Person may direct Horizon BCBSNJ, in writing, to pay for claims to the Provider, Facility or Practitioner who provided the Covered Service or Supply for which benefits became payable. Horizon BCBSNJ will Determine to pay the Covered Person, Provider, Facility or Practitioner, as applicable. But, Horizon BCBSNJ will not assume responsibility for making sure that the assignment was prepared correctly and/or

that it correctly conveys the intention of the person who made it. We will not be held to know that one has been made unless it or a copy is filed with Horizon BCBSNJ. For more information about assignments under this Policy, please see the Assignment provision in the General Rules Section.

c. Except as stated above, in the event of a Covered Person's death or total incapacity, any payment or refund due will be made to his/her heirs, beneficiaries, trustees or estate.

d. If an Employee is the non custodial parent of a Child Dependent, Horizon BCBSNJ will pay claims filed as described in paragraph d of the section "Submission of Claims" directly to: the Provider or Custodial parent; or the Division of Medical Assistance and Health Services in the Department of Human Services which administers the State Medicaid program, as appropriate.

If Horizon BCBSNJ pays anyone who is not entitled to benefits under this Program, Horizon BCBSNJ has the right to recover those payments during the 18 months period starting with the date that the first payment on the claim was made. If Horizon BCBSNJ has made an overpayment, Horizon BCBSNJ will provide 45 days advance notice and a right of appeal prior to recovery. Horizon BCBSNJ will not offset against future claims prior to the later of: (a) 45 days from the date of notice; or (b) the exhaustion of any such appeal right.

OUT OF AREA SERVICES

Horizon BCBSNJ has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. These are referred to generally as "Inter-Plan Programs." When you obtain Covered Services and Supplies outside of Horizon BCBSNJ's Service Area, the claims for these services and supplies may be processed through one of these Inter-Plan Programs. These programs include the BlueCard Program, described below.

Typically, when you access medical care outside Horizon BCBSNJ's Service Area, you will obtain it from healthcare Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other area ("Host Blue"). But in some cases, you may obtain care from non-participating Providers. Horizon BCBSNJ's payment practices when you obtain out-of-area Covered Services and Supplies from such participating Providers are described generally below. Other parts of your Booklet describe what happens when you obtain Covered Services and Supplies from non-participating Providers.

A. BlueCard® Program

Under the BlueCard® Program, when you obtain Covered Services and Supplies within the geographic area served by a Host Blue, Horizon BCBSNJ will still fulfill its contractual obligations. But the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you obtain Covered Services and Supplies outside Horizon BCBSNJ's Service Area and the claim is processed through the BlueCard Program, the amount you pay, if not a flat Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Horizon BCBSNJ.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes it is an estimated price that takes into account a special

arrangement with that Provider or Provider group. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve: types of settlements; incentive payments; and/or other credits or charges.

Estimated and average pricing arrangements also take into account certain adjustments to their basic rates. These may be made to correct for an over- or underestimation of changes of the past pricing for the types of transactions noted above. But, such adjustments will not affect the price on the claim that Horizon BCBSNJ will use to determine the amount you pay.

Also, laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If any state law mandates other liability calculation methods, including a surcharge, Horizon BCBSNJ calculates a Covered Person's liability for any Covered Service or Supply according to applicable law.

B. Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program described above, a Covered Person's claims for Covered Services and Supplies may be processed through a negotiated national account arrangement with one or more Host Blues.

If Horizon BCBSNJ has arranged with one or more Host Blues to provide customized networks with respect to the Policy, then the terms of any such arrangement shall apply.

The amount you pay for Covered Services and Supplies under such an arrangement will be calculated based on the lower of either: (a) billed Covered Charges; or (b) the price that Horizon BCBSNJ has negotiated with the Host Blue under that arrangement. (Please refer to the description of negotiated price under section A. BlueCard Program.)

Determinations of Covered Healthcare Services

If Horizon BCBSNJ determines that healthcare services are covered under the Policy, coverage of those services cannot be denied based on the Host Blue's network protocols. Also, under the BlueCard Program, you cannot be denied coverage of healthcare services received outside of the geographic area served by Horizon BCBSNJ if those services: (a) are covered by the network protocols of the Host Blue; and (b) are not specifically limited or excluded by the Policy.

Summary

To summarize the above, the BlueCard Program is basically a means by which you can benefit from the discounts that another Blue Cross and Blue Shield Association Licensee has negotiated with Providers in its area of operation when you obtain Covered Services and Supplies outside of Horizon BCBSNJ's Service Area. The Program in no way affects the terms of the Policy with respect to your contractual liability for charges Incurred for a Covered Service or Supply. The calculation of that liability will be based on the lower of: (a) the billed charge for the Covered Service or Supply received in the other Licensee's area; or (b) a negotiated price that the Host Blue makes available to Horizon BCBSNJ. The calculation of your liability can also be affected by regulatory requirements of the state in which you obtain the Covered Service or Supply.

APPEALS PROCESS

For the purposes of this "Appeals Process" section, the following terms used below have these meanings:

Adverse Benefit Determination (ABD): A denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit. This includes such a denial, reduction, termination or failure that is due to: (a) eligibility; (b) a Rescission; (c) a policy exclusion or limitation that is not based on medical judgment or necessity; and/or (d) a decision involving the use of medical judgment.

Adverse Benefit Determination that is benefits based (ABD-Benefits): An ABD decision that: (a) is based on eligibility; (b) involves a Rescission; or (c) involves a policy exclusion or limitation that is not based on medical judgment.

Adverse Benefit Determination involving medical judgment (ABD-Medical): An ABD decision involving the use of medical judgment, e.g., that an item or service is deemed by the plan to be: not Medically Necessary or Appropriate; Experimental or Investigational; a Cosmetic Service; a dental item or service and therefore excluded.

Claim: A request by a Covered Person or Provider for payment relating to health care services or supplies.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination:

(a) that has been upheld by Horizon BCBSNJ at the completion of the internal review process;

(b) with respect to which Horizon BCBSNJ has waived its right to conduct an internal review;

(c) for which Horizon BCBSNJ did not fully comply with internal appeals process requirements within the regulations promulgated by the State of New Jersey; or

(d) for which the Covered Person or his/her Provider has applied for an expedited external review at the same time as applying for an expedited internal review.

Post-service Claim: Any Claim for a benefit that is not a Pre-service Claim.

Pre-service Claim: Any Claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on its approval in advance of obtaining medical care.

Rescission: A cancellation or discontinuance of coverage that has a retroactive effect. This does not include a loss of coverage due to a failure to timely pay: (a) required premiums; or (b) contributions to the cost of the coverage.

Urgent Care Claim: A Claim for medical care or treatment with respect to which application of the time periods for making a non-urgent determination:

(a) could, in the judgment of a prudent layperson possessing an average knowledge of health and medicine, seriously jeopardize the life or health of the Covered Person, or the ability of the Covered Person to regain maximum function; or

(b) would, in the opinion of a physician with knowledge of the Covered Person's medical condition, subject him/her to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Time Frame for Initial ABDs

A Covered Person shall be notified of Horizon BCBSNJ's initial Adverse Benefit Determination as quickly as possible based on the medical circumstances, but in no event later than:

(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); or

(c) 30 days from receipt of a Post-service Claim.

(d) 24 hours from the receipt of a Pre-services Claim relating to Substance Use Disorders.

Horizon BCBSNJ will provide written notice of the decision within two business days and will include an explanation of the applicable appeals process.

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) may appeal Horizon BCBSNJ's ABD, as described below. Requests for administrative and utilization management determinations may be made by the Covered Person or by the attending health care provider acting on behalf of the member. The attending health care providers in those instances are deemed as the Covered Person's authorized representative. No Covered Person or Provider who files an appeal will be subject to disenrollment, discrimination or penalty by Horizon BCBSNJ.

Appeals Process for ABD-Medical - Excluding those related to Substance Use Disorders

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) may appeal an ABD-Benefits. Such an appeal must be filed within 180 days from the date of the ABD.

The appeal process for a ABD-Benefits consists of: (a) an informal internal review by Horizon BCBSNJ; and (b) if the initial decision is upheld, a formal second level internal review by Horizon BCBSNJ.

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) can appeal an ABD-Benefits by calling or writing Horizon BCBSNJ at the telephone number or address on the Covered Person's ID card. The Covered Person must include the following information:

1) the name(s) and address(es) of the Covered Person(s) or Provider(s) involved;

2) the Covered Person's ID number;

3) the date(s) of service;

4) the details regarding the actions in question;

5) the nature of and reason behind the appeal;

6) the remedy sought; and

7) the documentation to support the appeal.

Following the plan's review of the appeal, if the initial ABD-Benefits is upheld, the Covered Person, if still dissatisfied, can file an appeal for a formal second level review that will be decided by Horizon BCBSNJ professionals who were not involved in the prior decisions. All ABD-Benefits denials include

a written explanation of the appeals process with instructions on how to proceed to the next level of the appeals process.

The time frames for deciding appeals for ABD-Benefits are as follows:

(a) For ABD-Benefits involving: an Urgent Care Claim; an Inpatient admission; the availability of medical care; the continuation of an Inpatient Facility stay; or a Claim for medical services for a Covered Person who has received emergency care, but who has not been discharged from a Facility: 72 hours.

(b) For all other ABD-Benefits: 15 calendar days for Pre-service Claims; 30 calendar days for Post-service Claims. The same time frames apply for the formal second level internal review.

For each level of appeal, Horizon BCBSNJ will provide the Covered Person and/or the Provider with notice of the outcome, and if the ABD-Benefits is upheld, instructions for filing for the next level of review. If the initial ABD-Benefits is upheld through both levels of the internal review process, no further remedies are available from Horizon BCBSNJ. In this event, Horizon BCBSNJ will provide the Covered Person with information regarding the availability of and contact information for the consumer assistance program of the New Jersey Department of Banking and Insurance. The Department's address and phone number appear below in subsection d. of the following section.

Appeals Process for ABD-Medical

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) may appeal an ABD-Medical. The appeal process for Adverse Benefit Determinations involving medical judgment (ABD-Medical) consists of: (a) an informal Stage 1 internal review by Horizon BCBSNJ; (b) a formal Stage 2 internal review by Horizon BCBSNJ; and (c) a formal external review by an Independent Utilization Review Organization (IURO). The initial appeal must be filed within 180 days after Horizon BCBSNJ's initial ABD-Medical.

Any ABD-Medical will be culturally and linguistically appropriate and will include the following timely information:

1) Information identifying the claim involved, including: the date of service; the health care Provider; the claim amount (if applicable); and a statement about the availability, upon request, of the diagnosis and treatment codes, and their corresponding meaning.

2) The reason(s) for the denial, including: the denial code and its meaning; and a description of the standard used by Horizon BCBSNJ in the denial.

3) Information regarding the availability of, and contact information for, the consumer assistance program of the New Jersey Department of Banking and Insurance. (The Department's address and phone number appear below in subsection d.)

Also, Horizon BCBSNJ will timely provide to the Covered Person and/or the Provider acting on his/her behalf, free of charge, any new or additional evidence or rationale, however generated, that Horizon BCBSNJ will rely upon, consider or use in connection with an ABD-Medical.

Except as otherwise provided below, a Covered Person must follow the steps for filing the three levels of appeal. If these steps are not followed, the Covered Person's appeal review may be delayed or forfeited.

a. First Level Appeal - Stage 1

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) can file a First Level Stage 1 Appeal by calling or writing Horizon BCBSNJ at the telephone number and address on the Covered Person's ID card. At the First Level Appeal, a Covered Person may discuss the ABD-Medical directly with the Horizon BCBSNJ physician who made it, or with the medical director designated by Horizon BCBSNJ.

To submit a First Level Appeal, the Covered Person must include the following information:

1) the name(s) and address(es) of the Covered Person(s) or Provider(s) involved;

2) the Covered Person's ID number;

3) the date(s) of service;

4) the details regarding the actions in question;

5) the nature of and reason behind the appeal;

6) the remedy sought; and

7) the documentation to support the appeal.

Horizon BCBSNJ will decide First Level Appeals within 72 hours in the case of an ABD-Medical involving:

(a) an Urgent Care Claim or a Medical Emergency;

(b) an Inpatient admission;

(c) the availability of medical care;

(d) the continuation of an Inpatient Facility stay; or

(e) a Claim for medical services for a Covered Person who has received emergency care, but who has not been discharged from a Facility.

Horizon BCBSNJ will decide all other First Level Stage 1 ABD- Medical Appeals within ten calendar days of receipt of the required documentation. Horizon BCBSNJ will provide the Covered Person and/or the Provider with: (a) written notice of the outcome; (b) the reasons for the decision; and (c) if the initial ABD-Medical is upheld, instructions for filing a Second Level Stage 2 Appeal.

b. Second Level Appeal - Stage 2

If a Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) is not satisfied with Horizon BCBSNJ's First Level Appeal decision, the Covered Person or Provider can file for, orally or in writing, a Second Level Stage 2 Appeal of the ABD-Medical to be decided by a panel of physicians and/or other health care professionals selected by Horizon BCBSNJ who were not involved in the original and First Level Appeal decisions. The panel shall have access to consultant Practitioners who are trained or who practice in the same specialty that would typically manage the case at issue being appealed. Upon the Covered Person's or Provider's request, such Consultant Practitioners will participate in the Second Level Stage 2 Appeal.

Horizon BCBSNJ will acknowledge the filing of Second Level Appeals in writing within ten business days of receipt and include instructions regarding the scheduling and how to participate in the Second Level Stage 2 Appeal hearing. Following the hearing, Horizon BCBSNJ will then provide written notice of the final decision on the appeal within 72 hours in the case of an ABD-Medical involving:

(a) an Urgent Care Claim or a Medical Emergency;

(b) an Inpatient admission;

(c) the availability of medical care;

(d) the continuation of an Inpatient Facility stay; or

(e) a Claim for medical services for a Covered Person who has received emergency care, but who has not been discharged from a Facility

Horizon BCBSNJ will decide all other Second Level Stage 2 Appeals of ABD-Medical within 20 business days.

If the Second Level Appeal is denied, Horizon BCBSNJ will provide the Covered Person and/or Provider with written notice of the reasons for the denial, together with a written notice of his/her right to proceed to an external appeal. Horizon BCBSNJ will include: (a) specific instructions as to how the Covered Person and/or Provider may arrange for such an external appeal; and (b) any forms needed to start the appeal.

c. Right to Waive Horizon BCBSNJ's Internal Appeal Process

In certain circumstances, a Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) may not have to complete Horizon BCBSNJ's internal appeals process with respect to an ABD-Medical, and may proceed directly to the external appeal process described below, if:

(a) Horizon BCBSNJ does not meet a time frame described above for the First and Second Level Appeals;

(b) Horizon BCBSNJ waives its right to an internal review; or

(c) the Covered Person or his/her Provider has applied for an expedited external review at the same time as applying for an expedited internal review.

With respect to (a), above, this right to proceed to the external appeal without completing the internal appeals process will not apply if Horizon BCBSNJ can show that: (a) the violation did not cause, and is not likely to cause, prejudice or harm to the Covered Person and/or Provider; (b) the violation was for a good reason or due to matters beyond Horizon BCBSNJ's control; (c) the violation occurred in the context of an ongoing, good faith exchange of information between Horizon BCBSNJ and the Covered Person and/or Provider; and (d) the violation is not reflective of a pattern or practice of non-compliance by Horizon BCBSNJ.

If Horizon BCBSNJ claims this exception, the Covered Person or his/her Provider may ask for a written explanation of the violation from Horizon BCBSNJ. Horizon BCBSNJ must then provide the explanation within ten calendar days. It must include a description of the basis for the assertion that the violation should not cause the internal process to be waived. Questions regarding this exception shall be decided by an external reviewer.

If it is determined that Horizon BCBSNJ meets the standard for the exception to part (a), the Covered Person and/or his/her Provider may then resubmit and pursue the internal appeal. Horizon BCBSNJ will then, within ten calendar days after that determination, notify the Covered Person and/or his/her Provider of that right. The time frame for refiling the Claim will start upon the Covered Person's and/or Provider's receipt of the notice.

d. External Appeal

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) who is dissatisfied with the results of Horizon BCBSNJ's internal appeal process with respect to a ABD-Medical can pursue an external appeal with an IURO assigned by the State of New Jersey Department of Banking and Insurance (the DOBI). Except as otherwise described above under part (c), the Covered Person's right to such an appeal depends on the Covered Person's full compliance with both stages of Horizon BCBSNJ's internal appeal process.

To start an external appeal, the Covered Person or Provider must submit a written request within four months from receipt of Horizon BCBSNJ's Final Internal Adverse Benefit Determination (or within four months from the date of an occurrence described in (a), (b) or (c) under "Right to Waive Horizon BCBSNJ's Internal Appeals Process", above).

The Covered Person or Provider must use the required forms and include both: (a) a **$25.00** check made payable to "New Jersey Department of Banking and Insurance"; and (b) an executed release to enable the IURO to obtain all medical records pertinent to the appeal, to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
P.O. Box 329
Trenton, New Jersey 08625-0329
(888) 393-1062

The $25.00 fee will be refunded to the Covered Person or Provider if the IURO reverses Horizon BCBSNJ's ABD-Medical decision.

If the Covered Person cannot afford to pay the fee, the fee will be waived if the Covered Person can show proof of financial hardship. Proof of financial hardship can be demonstrated through evidence that one or more members of the household are receiving aid or benefits under: Pharmaceutical Assistance to the Aged and Disabled; Medicaid; General Assistance; Social Security Insurance; NJ FamilyCare; or the New Jersey Unemployment Assistance program. Annual filing fees for anyone Covered Person shall not exceed $75.00.

Upon receipt of the request for the appeal, together with the executed release and the appropriate fee, if any, the DOBI shall immediately assign the appeal to an IURO to conduct a preliminary review and accept it for processing. But this will happen only if the IURO finds that:

1. the person is or was a Covered Person of Horizon BCBSNJ;

2. the service or supply which is the subject of the appeal reasonably appears to be a Covered Service or Supply under the Covered Person's Program; and

3. the Covered Person has furnished all information needed by the IURO and the DOBI to make the preliminary determination. This includes: the appeal form; a copy of any information furnished

by Horizon BCBSNJ regarding its Final Adverse Benefit Determination; and the fully executed release.

Upon completion of this review, the IURO will immediately inform the Covered Person or Provider, in writing, as to whether or not the appeal has been accepted for review. If it is not accepted, the IURO will give the reasons.

If the appeal is accepted, the IURO will notify the Covered Person and/or his/her Provider of the right to submit in writing, within five business days, any further information to be considered in the review. The IURO will provide Horizon BCBSNJ with any such information within one business day after its receipt.

The IURO will complete its review and issue its decision in writing within 45 calendar days from its receipt of the request for the review. But that time frame will be reduced to 48 hours if the appeal involves any of the following:

(a) An Urgent Care Claim or a Medical Emergency.

(b) An Inpatient admission

(c) The availability of medical care.

(d) The continuation of an Inpatient Facility stay.

(e) A Claim for medical services for a Covered Person who has received emergency care, but who has not been discharged from a Facility.

(f) A medical condition for which the standard time frame would seriously jeopardize the life or health of the Covered Person or his/her ability to regain normal function.

When the IURO completes its review, it will state its findings in writing and make a determination of whether Horizon BCBSNJ's denial, reduction, or termination of benefits deprived the Covered Person of Medically Necessary and Appropriate treatment. If a decision made within 48 hours was not in writing, the IURO will provide a written confirmation within 48 hours after the verbal decision.

If the IURO determines that the denial, reduction, or termination of benefits deprived the Covered Person of Medically Necessary and Appropriate treatment, this will be conveyed to the Covered Person and/or Provider and Horizon BCBSNJ. The IURO will also describe the Medically Necessary and Appropriate services that should be received. This determination is binding upon Horizon BCBSNJ and the Covered Person, except to the extent that other remedies are available to either party under state or federal law.

If all or part of the IURO's decision is in favor of the Covered Person, Horizon BCBSNJ will provide coverage for those Covered Services and Supplies that are determined to be Medically Necessary and Appropriate. Unless there is a judicial decision stating otherwise, this will be done without delay even if Horizon BCBSNJ intends to seek a judicial review or other remedies.

And within ten business days of its receipt of a decision in favor of the Covered Person, (or sooner, if the medical facts of the case indicate a more rapid response), Horizon BCBSNJ will send a written report to: the IURO; the Covered Person and/or Provider; and the DOBI that describes how Horizon BCBSNJ will implement the IURO's determination.

Appeals Process for ABD- Medical - Exclusive to Substance Use Disorders

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) may appeal an ABD-Medical with respect to Substance Use Disorders.

The appeal process for Adverse Benefit Determinations involving medical judgment with respect to Substance Use Disorders consists of the following:

(a) an expedited internal review by Horizon BCBSNJ (a "Substance Use Disorders Stage One Appeal"); and a

(b) a formal expedited external review with the Independent Health Care Appeals Program at DOBI (a "Substance Use Disorders Stage 2 Appeal").

Substance Use Disorders Stage 1 Appeal

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) can file a Substance Use Disorders Stage 1 Appeal by calling or writing Horizon BCBSNJ at the telephone number and address on the Covered Person's ID card. At the Substance Use Disorders Stage 1 Appeal, a Covered Person may discuss the ABD-Medical directly with the Horizon BCBSNJ physician who made it, or with the medical director designated by Horizon BCBSNJ.

To submit a Substance Use Disorders Stage 1 Appeal, the Covered Person must include the following information:

1. the name(s) and address(es) of the Covered Person(s) or Provider(s) involved;

2. the Covered Person's ID number;

3. the date(s) of service;

4. the details regarding the actions in question;

5. the nature of and reason behind the appeal;

6. the remedy sought; and

7. the documentation to support the appeal.

Horizon BCBSNJ will decide Substance Use Disorders Stage 1 Appeals within 24 hours. Horizon BCBSNJ will provide the Covered Person and/or the Provider with: (a) written notice of the outcome; (b) the reasons for the decision; and (c) if the initial ABD-Medical is upheld, instructions for filing a Substance Use Disorders Stage 2 Appeal.

Substance Use Disorders Stage 2 Appeal

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) who is dissatisfied with the results of Horizon BCBSNJ's internal appeal process with respect to a ABD-Medical can pursue a Substance Use Disorders Stage 2 Appeal, an expedited external appeal with an IURO assigned by the DOBI. The procedures for filing a Substance Use Disorders Stage 2 Appeal are the same as in those set forth above in "External Appeal".

When the IURO completes its review, it will state its findings in writing and make a determination of whether Horizon BCBSNJ's denial, reduction, or termination of benefits deprived the Covered Person of Medically Necessary and Appropriate treatment. The IURO will provide its decision within 48 hours from its receipt of the request for the review.

COVERED PERSONS' RIGHTS

A Covered Person has the right to:

- Formulate and have advance directives implemented in accordance with applicable law;
- Receive prompt written notice of benefit changes or the termination of benefits or services, no later than 30 days following the date of any such change or termination;
- File a complaint with New Jersey's Department of Banking and Insurance;

New Jersey Department of Banking and Insurance
20 West State Street
(P.O. Box 325)
Trenton, NJ 08625-0325
(609) 292-5360

- Access Covered Services and Supplies, and receive the Program's benefits for them, and have care available 24 hours a day, seven days a week, for Medical Emergencies and Urgent Care;
- Appeal a denial, reduction or termination of health care services or benefits pursuant to a utilization management decision by or on behalf of Horizon BCBSNJ;
- Be treated with courtesy, consideration, and with respect to his/her dignity and need for privacy;
- Be provided with information concerning our policies and procedures regarding products, services, providers, appeals procedures, and with other information about the organization and the care provided;
- Obtain a current directory of Network Providers upon request, including addresses and telephone numbers, and a listing of Providers who accept Covered Persons who speak languages other than English.

STATEMENT OF ERISA RIGHTS

As a participant in **AIR GROUP, LLC**, 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 plan's 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 your 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.

SERVICE CENTERS

If you have any questions about this Program, call your nearest Service Center.

Telephone personnel are available:

Monday, Tuesday, Wednesday and Friday from 8:00a.m. to 6:00p.m.

Thursday from 9:00 a.m. to 6:00pm (E.T.) Eastern Time

For questions and assistance with your **OMNIA** benefits and services, please call us at:

1-800-355-BLUE
(2583)

When you are outside of New Jersey and need to locate a **nationwide Network PPO Provider,** please call:

1-800-810-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 us. Your ID number helps us to get prompt answers to your questions about enrollment, benefits or claims.

Use this space for information you will need when asking about your coverage.

The company office or enrollment official to contact about coverage:

_____

The identification number shown on my identification card:

_____

The effective date when my coverage begins:

_____

My group number is:

_____

CIVIL UNION RIDER

I. The following terms shall have the meanings set forth below:

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

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

II. Pursuant to New Jersey law, your Booklet is changed in the following respects:

(a) Except as otherwise provided in (c), below, all of the rights, benefits, obligations and privileges granted under the Policy to an Employee with respect to a Spouse and their Child Dependents shall also apply equally with respect to: (i) an Employee and a person with whom he/she has established a Civil Union; and (ii) the Child Dependents of the Employee and his/her Civil Union Partner.

(b) Except as otherwise provided in (c), below, any provision of the Policy that affects a Spouse upon his/her divorce or legal separation from the Employee shall, subject to the Policy's terms and conditions, also equally affect an Employee's Civil Union Partner upon dissolution of the Civil Union. Such provisions include, but are not limited to, the following:

(i) Termination of the Civil Union Partner's coverage.

(ii) The right of the Civil Union Partner to convert to an individual health policy.

(c) Regardless of anything above to the contrary, any right to continue the Policy's coverage that is granted to an Employee's Spouse pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, shall not apply with respect to an Employee's Civil Union Partner.