

Product: **Prescription Drug**

Group Name: **City of Newark**

Group Number: **89504**

**8946-15**

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## INTRODUCTION

This Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) Prescription Drug Program gives you and your covered Dependents broad protection to help meet the cost of Prescription Drugs.

In this Booklet, you'll find the important features of your group's Prescription Drug 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.

Horizon BCBSNJ certifies that insurance is provided according to the Group Policy for each insured Employee. 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 insert 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.

**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:** An amount determined by Horizon BCBSNJ as the least of the following amounts: (a) the actual charge made by the provider for the service or supply; or (b) in the case of In-Network Providers, the amount that the provider has agreed to accept for the service or supply; or (c) in the case of Out-of-Network Providers, the amount determined for the service or supply based on the Resource Based Relative Value System promulgated by the Centers for Medicare and Medicaid Services; or (d) in the case of Out-of-Network Providers, an amount determined for the service or supply based on: (i) profiles compiled by Horizon BCBSNJ based on the usual and prevailing payments made to providers for similar services or supplies in specific geographical areas; or (ii) similar profiles compiled by outside vendors.

**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.

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

**Booklet:** A detailed summary of benefits covered.

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

**Calendar Year:** A year starting January 1.

**Child Dependent:** A person who: has not attained the age of 26; is unmarried; and is:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- a. Furnished or ordered by a Provider; and
- b. For Preventive Care, or Medically Necessary and Appropriate to diagnose or treat an Illness (including Biologically-based and Non-Biologically-based Mental Illnesses) or Injury.

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

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

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

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

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

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

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

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

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

- b. There must be sufficient proof, published in peer-reviewed scientific literature, that confirms the effectiveness of the Technology. That proof must consist of well-designed and well-documented investigations. But, if such proof is not sufficient or is questionable, Horizon BCBSNJ may consider opinions about and evaluations of the Technology from appropriate specialty advisory committees and/or specialty consultants.
- c. The Technology must result in measurable improvement in health outcomes, and the therapeutic benefits must outweigh the risks, as shown in scientific studies. "Improvement" means progress toward a normal or functional state of health.
- d. The Technology must be as safe and effective as any established modality. (If an alternative to the Technology is not available, Horizon BCBSNJ may, to determine the

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

- e. The Technology must demonstrate effectiveness when applied outside of the investigative research setting.
- f. Services and supplies that are furnished for or in connection with an Experimental or Investigational Technology are not Covered Services and Supplies under this Program, even if they would otherwise be deemed Covered Services and Supplies. But, this does not apply to: (a) services and supplies needed to treat a patient suffering from complications secondary to the Experimental or Investigational Technology; or (b) Medically Necessary and Appropriate services and supplies that are needed by the patient apart from such a Technology.

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

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

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

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

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

**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.

**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.

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

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

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

**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.

**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 an In-Network Provider provides the service or supply.

**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.

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

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

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

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

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

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

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

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

**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.

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

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

**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.

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

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

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

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

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

**Prescription Drug Maximum:** With respect to Prescription Drugs, the total benefits that will be provided under this Coverage for Covered Charges for them during a Benefit Period.

**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:** A 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.

**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.

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

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

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

**Specialty Pharmaceutical Provider:** A vendor that has contracted with Horizon BCBSNJ to provide Specialty Pharmaceuticals on an In-Network basis.

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

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

and sex. The Covered Person who is Totally Disabled must be under the regular care of a Practitioner.

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

**We, Us and Our:** Horizon BCBSNJ.

**You, Your:** An Employee.

## SCHEDULE OF COVERED SERVICES AND SUPPLIES

### COVERED CHARGES

Subject to the other applicable terms and conditions of this Program, this Program provides coverage for Prescription Drugs that: (a) are purchased from a Pharmacy for Out-of-Hospital use; (b) are (except for insulin) dispensed under a Prescription Order or Prescription Mail Order; and (c) in the usual course of medical practice are self-administered.

However, Covered Charges will not include charges made for more than:

- (a) for maintenance drugs, a 90-day supply for each Prescription Order;
- (b) for insulin in strengths for which federal law does not require a prescription, and
- (c) for other Prescription Drugs, a 90-day supply for each Prescription Order.

Note that to ensure timely receipt of drugs prescribed for acute Illnesses, they should be obtained through retail Pharmacies, rather than Mail-Order Pharmacies.

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

### 1. IN-NETWORK

#### **Copayments for Prescription Drugs (including Specialty Pharmaceuticals) other than Prescription Drugs dispensed by a Mail-Order Pharmacy:**

- a. A **\$5.00** Copayment is required for Generic Prescription Drugs.
- b. A **\$10.00** Copayment is required for Brand Name Prescription Drugs.

For Prescription Orders which are not dispensed by a Mail Order Pharmacy, one Copayment will apply for each 34 day supply. For orders which exceed 100 units, Copayments shall be based upon the day supply as follows:

1 to 34 day supply - one Copayment

35 to 60 day supply - two Copayments

61 to 90 day supply - three Copayments

Refills, as authorized under a Prescription Order, will be subject to the same requirements as for original Prescription Orders.

#### **Copayments for Prescription Drugs dispensed by a Mail-Order Pharmacy:**

- a. A **\$0.00** Copayment is required for Generic Prescription Drugs.

- b. A **\$0.00** Copayment is required for Brand Name Prescription Drugs.

For Prescription Mail Orders, one Copayment will be applied to each Prescription Mail Order. Refills, as authorized under a Prescription Order, will be subject to the same limitations.

**PAYMENT:**

- a. **Payment for Covered Charges for Prescription Drugs (including Specialty Pharmaceuticals) other than Prescription Drugs dispensed by a Mail-Order Pharmacy:**

- 1. A Pharmacy will not charge a Covered Person an amount exceeding the Copayment, if applicable, for Covered Charges for Prescription Drugs.

- b. **Payment for Covered Charges for Prescription Drugs dispensed by a Mail-Order Pharmacy:**

- 1. A Pharmacy will not charge a Covered Person an amount exceeding the Copayment, if applicable, for Covered Charges for Prescription Drugs.

Under certain circumstances, a Pharmacy may not be able to determine at the point of transaction whether a Prescription Drug is covered. For example, the information on the Prescription Order may not be sufficient to determine Medical Necessity and Appropriateness. In those circumstances, a Covered Person may elect to receive a 96-hour supply of the Prescription Drug, as a covered benefit, until the determination is made. Alternatively, the Covered Person may decide to purchase the Prescription Drug and submit a claim for benefits. If the claim is denied, no charge in excess of the charge for the 96-hour supply will be a Covered Charge for that Prescription Drug or any refill(s) of it.

**2. OUT-OF-NETWORK:**

**Copayments:**

- a. A **\$5.00** Copayment is required for Generic Prescription Drugs.
- b. A **\$10.00** Copayment is required for Brand Name Prescription Drugs.

For Prescription Orders which are not dispensed by a Mail Order Pharmacy, one Copayment will apply for each 34 day supply .For orders which exceed 100 unit, Copayments shall be based upon the day supply as follows:

1 to 34 day supply - one Copayment

35 to 60 day supply - two Copayments

61 to 90 day supply - three Copayments

Refills, as authorized under a Prescription Order, will be subject to the same requirements as for original Prescription Orders.

**PAYMENT:**

**Payment for Covered Charges for Prescription Drugs:**

1. The Covered Person must pay for the Prescription Drug and submit a written notice of claim to Horizon BCBSNJ or its designee.
2. After any applicable Copayment has been met, Horizon BCBSNJ's payment will be **100%** of the remaining Allowance for the Prescription Drug.

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

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

**Enrollment of Dependents**

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

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

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

- Provide such information to the custodial parent as may be needed for the Child Dependent to obtain benefits through this Program;
- Permit the custodial parent, or the Provider, with the authorization of the custodial parent, to submit claims for the Child Dependent for Covered Services and Supplies, without your approval; and
- Make payments on such claims directly to: (a) the custodial parent; (b) the Provider; or (c) the Division of Medical Assistance and Health Services in the Department of Human Services, which administers Medicaid, as appropriate.

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

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

agency, in the Department of Human Services, to enroll the Child Dependent in this Program, if the parent who is the Covered Person fails to enroll the Child Dependent; and

- Not terminate coverage of the Child Dependent unless the parent who is the Covered Person provides Horizon BCBSNJ with satisfactory written proof that:
  - the court or administrative order is no longer in effect; or
  - the Child Dependent is or will be enrolled in a comparable health benefits plan which will be effective on the date coverage under this Program ends.

### **Special Enrollment Periods**

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

### **Individual Losing Other Coverage**

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

- a. The person was covered under a group or other health plan at the time coverage under this Program was previously offered.
- b. You stated in writing that coverage under the other plan was the reason for declining enrollment when it was offered.
- c. The other health coverage:
  - (i) was under a COBRA (or other state mandated) continuation provision and the COBRA or other coverage is exhausted; or
  - (ii) was not under such a provision and either: (a) coverage was terminated as a result of: loss of eligibility for the coverage (including as a result of legal separation; divorce; death; termination of employment; or reduction in the number of hours of employment); or (b) employer contributions toward such coverage ended.
- d. Enrollment is requested within 31 days after: (a) the date of exhaustion of the coverage described in item (c)(i) above; or (b) termination of the coverage or employer contributions as described in item (c)(ii) above.

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

### **New Dependents**

If the following conditions are met, Horizon BCBSNJ will provide a Dependent Special

Enrollment Period during which the Dependent (or, if not otherwise enrolled, you) may enroll or be enrolled:

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

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

### **Special Enrollment Due to Marriage**

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

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

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

### **Special Enrollment Due to Newborn/Adopted Children**

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

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

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

### **Multiple Employment**

If you work for both the Policyholder and an Affiliated Company, or for more than one Affiliated Company, Horizon BCBSNJ will treat you as if employed only by one Employer. You

will not have multiple coverage.

### **Eligible Dependents**

Your eligible Dependents are your Spouse and your Child Dependents.

Your Child Dependent is a person who: has not attained the age of **26**; is unmarried; and is:

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

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

Coverage for a Child Dependent ends at the first to occur of the following: (a) the last day of the Benefit Month in which the Child Dependent marries; (b) the end of day on the Birthday in which the Child Dependent reaches age **26**; or (c) the date on which the Child Dependent becomes employed and eligible for health coverage due to that employment.

Coverage will continue for a Child Dependent beyond the age of **26** if, immediately prior to reaching that age, he/she was enrolled under this Program and is incapable of self-sustaining employment by reason of mental retardation or physical handicap. For your handicapped Child Dependent to remain covered, you must submit proof of his/her inability to engage in self-sustaining employment by reason of mental retardation or physical handicap within 31 days of the child's attainment of age **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 Benefit Month in which the first of these occurs: (a) the end of your coverage; (b) the failure of your Child Dependent to meet the definition of Child Dependent for any reason other than age; or (c) the end of your Child Dependent's inability to engage in self-sustaining employment by reason of mental retardation or physical handicap.

If your child was enrolled as a handicapped Child Dependent under prior coverage with Horizon

BCBSNJ and there has been no interruption in coverage, the child may be covered as a Child Dependent under this Program, regardless of age.

### **When Coverage Ends**

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

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

Coverage for a Dependent ends:

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

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

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

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

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

### **Benefits After Termination**

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

### **If You Leave Your Group Due To Total Disability**

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

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

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

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

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

### **Extension Of Coverage Due To Termination of the Group Policy**

This applies if you or a covered Dependent are Totally Disabled on the date coverage under this Program ends due to termination of the Group Policy. In this event, benefits will continue to be available for that person for Covered Services and Supplies needed due to the Illness or Injury that caused the disability. Benefits will continue to be paid during the uninterrupted period of the disability, but not for more than 90 days from the date the coverage ends.

### **Continued Coverage Under The Federal Family And Medical Leave Act**

If you take a leave that qualifies under the Federal Family and Medical Leave Act (FMLA) (e. g.,

to care for a sick family member, or after the birth or adoption of a Child Dependent), you may continue coverage under this Program. You may also continue coverage for your Dependents.

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

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

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

Consult your benefits representative for application forms and further details.

### **Continued Coverage For Surviving Dependents**

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

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

Consult your benefits representative for further details.

### **Continuation of Coverage under COBRA**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Uniformed services: The following:

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

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

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

### **Continued Coverage for Over-Age Dependents**

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

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

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

#### If a Dependent Is Over the Limiting Age for Dependent Coverage

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

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

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

#### Conditions for Election

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

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

#### Election of Continuation

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

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

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

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

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

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

#### Payment of Premiums

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

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

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

#### Grace Period for the Payment of Premiums

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

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

#### Scope of Continued Coverage

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

### Single Coverage for Over-Age Dependents

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

### When Continuation Ends

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

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

### Inapplicability of Other Continuation Provisions

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

### **Continued Coverage Pursuant to Michelle's Law**

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

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

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

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

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

### **Conversion Coverage**

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

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

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

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

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

### **Continuation of Care**

Horizon BCBSNJ will provide written notice to each Covered Person at least 30 business days prior to the termination or withdrawal from Horizon BCBSNJ’s Network of a Covered Person’s

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

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

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

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

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

### **Medical Necessity And Appropriateness**

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

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

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

## **MEDICAL EXPENSE.**

### **Cost Containment**

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

### **Managed Care Provisions**

#### **Member Services**

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

#### **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 PRESCRIPTION DRUG PROGRAM**

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

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

### **BENEFIT PROVISIONS**

#### **Payment Limits**

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

#### **Benefits From Other Plans**

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

## 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.

### COVERED BASIC SERVICES AND SUPPLIES

#### Diabetes Benefits

This Program covers dialysis services that: (a) are given Prior Authorization; and (b) 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 dietitian registered by a nationally recognized professional association of dietitians;
  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.

### **Fertility Services**

Your group's policy provides coverage for medications related to infertility.

### **Inherited Metabolic Disease**

This Program provides benefits for the therapeutic treatment of inherited metabolic diseases. This coverage includes 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.

### **Prescription Drug Benefits**

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

Prescription Drugs are covered under the following circumstances:

1. when prescribed for an FDA-approved treatment;
2. 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:
  - a. The American Medical Association Drug Evaluations;
  - b. The American Hospital Formulary Service Drug Information; or
  - c. 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.

Benefits, to the extent practicable, are available under this Policy in the form of service. Payment by or behalf of Horizon BCBSNJ discharges the obligations of Horizon BCBSNJ in the form of service. Horizon BCBSNJ reserves the right to indemnify the Covered Person directly from any

eligible benefits not provided in the form of service. Any payment to the Covered Person will not be more than Horizon BCBSNJ would have paid an In-Network Pharmacy.

### **Conditions under Which Service Will be Provided**

The Employee's identification card should be presented to the In-Network Pharmacy other than a Mail-Order Pharmacy when the Covered Person requests benefits.

Horizon BCBSNJ will not be responsible for any claim, injury or judgment based on tort or other grounds, including warranty of merchantability, arising out of or in connection with the sale, compounding, manufacturing or use of any Prescription Drug or insulin whether or not covered under this Policy.

### **Limitations**

A Pharmacy need not fill a Prescription Order, which, in the Pharmacist's professional judgment, should not be filled.

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

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

For Prescription Mail Orders, the quantity dispensed will be limited to a supply of no less than 90 consecutive days. One Copayment will be applied to each Prescription Mail Order. Refills, as authorized under a Prescription Order, will be subject to the same limitations.

If applicable, no Covered Person shall be required to use a Mail-Order Pharmacy. However, in the event a Covered Person chooses to use a Mail-Order Pharmacy, the Prescription Drug Copayment shall not differ between a Mail-Order and retail pharmacy if a) the drugs are of the same strength, quality and days' supply; and b) the retail pharmacy agrees to the same terms, conditions, price and services applicable to the Mail-Order Pharmacy. No Copayment, fee, or other condition shall be imposed upon a Covered Person selecting a participating pharmacist or pharmacy that is not also equally imposed upon all Covered Persons selecting a participating pharmacist or pharmacy.

### **Retail vs. Mail-Order Pharmacies**

No Covered Person shall be required to use a Mail-Order Pharmacy.

If a Covered Person chooses to use a retail Pharmacy, any Prescription Drug Deductible, Copayment and/or Coinsurance described above shall not differ between a Mail-Order Pharmacy and the retail Pharmacy if (a) the Prescription Drugs purchased are of the same strength, quality

and days' supply; and (b) the retail Pharmacy has agreed to the same terms, conditions, price and services applicable to the Mail-Order Pharmacy.

No Copayment, fee, or other condition shall be imposed upon a Covered Person selecting a participating pharmacist or pharmacy that is not also equally imposed upon all Covered Persons selecting a participating pharmacist or Pharmacy.

### **Audits**

Pharmacies and pharmacists shall be audited yearly. Once Pharmacies have been selected for audit, Covered Persons utilizing these Pharmacies may receive a letter indicating the drugs that they received during the audit period; Covered Persons are asked to confirm the accuracy of this printout and return the information to our auditor. Pharmacies and Covered Persons are randomly chosen. Pharmacies are notified approximately two (2) weeks before the audit is scheduled to occur. The notification shall include the date of the audit and informs the pharmacist he/she may contact us if he/she has any questions or needs to reschedule the audit. All audits shall take place at a time mutually agreeable to the Pharmacy or pharmacist and the auditor. All audits shall be conducted by a licensed pharmacist on behalf of Horizon BCBSNJ. Upon conclusion of the audit, the auditor shall provide the pharmacist with a preliminary report and review the report with the pharmacist. Problems and remedies shall be discussed. Pursuant to N.J.A.C. §13.39-5.6(i), pharmacists shall be given three (3) business days to locate any missing documents and present them to our auditor. No audit shall include a review of any document relating to any person or prescription plan other than those reimbursable by Horizon BCBSNJ.

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

### **Specialty Pharmaceuticals**

When Specialty Pharmaceuticals as prescribed by a physician are required, such Prescription Drugs must be purchased through a Specialty Pharmaceutical Provider.

### **Drug Utilization, Cost Management and Rebates**

Horizon BCBSNJ conducts various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, Covered Persons 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 us 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 our 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 Copayment, Coinsurance or Deductibles applicable under the Prescription Drug Program.

**Obtaining Benefits for Out-of-Network Drugs**

If Prescription Drugs are purchased from Out-of-Network Pharmacies, Covered Persons will need to file a claim for benefits. See "Claim Procedures" in this Policy for information about this process.

## 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:**

Any part of a charge to the extent it exceeds the Allowance.

Drugs connected with sex transformation and treatment for gender identity disorders.

Drugs dispensed in unit-dose packaging when bulk packaging is available.

Drugs for weight reduction or control, special foods; food supplements; liquid diets; diet plans; or any related products.

Drugs for which a Covered Person is not legally obligated to pay.

Drugs for which the Covered Person would not have been charged if he/she did not have this Coverage.

Drugs needed for an 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 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.

Drugs 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 condition, unless coverage for the services is otherwise required by law.

Drugs purchased in connection with Cosmetic Services.

Drugs purchased for court ordered treatment that is not Medically Necessary and Appropriate.

Drugs purchased prior to the Covered Person's Coverage Date or after his/her coverage under this Program ends, except as otherwise stated in this Booklet.

Drugs that are eligible to be paid for 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 the coverage or payments for the drugs.

Drugs that are infused or administered by a Practitioner who is not a pharmacist; drugs that need to be administered with medical assistance.

Drugs that are needed due to condition 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.

Drugs that are not dispensed by a Pharmacist or a Pharmacy; services rendered by a Pharmacist that are beyond the scope of his/her practice.

Drugs that are not Medically Necessary and Appropriate.

Drugs that are obtained from a State or local public health agency.

Drugs that are prescribed or dispensed for cosmetic purposes and are not Medically Necessary and Appropriate (e.g., those prescribed or dispensed for hair growth or removing wrinkles.)

Drugs to replace those that may have been lost or stolen.

Drugs 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.

Drugs 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.

Drugs 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.

Drugs used for methodone maintenance.

Experimental or Investigational drugs.

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

Non-Prescription Drugs or supplies, except as otherwise provided above.

Prescription Drugs for which an exact drug is available without a Prescription.

Refills that: (a) are not authorized by a Prescription Order; or (b) are obtained beyond one year from the original Prescription Order date; or (c) are dispensed before 75% of the prior Prescription Order or refill would be used or consumed when used or taken as directed.

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.

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

Drugs to enhance normal functions, such as: steroids to improve athletic performance; drugs to improve memory; or growth drugs.

Drugs to treat sexual arousal dysfunction in excess of four units per month

## **BENEFITS PAYABLE FOR AUTOMOBILE RELATED INJURIES**

This section applies when expenses are Incurred by a Covered Person due to an Automobile Related Injury.

### **Definitions**

**"Automobile Related Injury"**: Bodily injury of a Covered Person due to an accident while occupying, entering into, alighting from or using an auto; or if the Covered Person was a pedestrian, caused by an auto or by an object propelled by or from an auto.

**"Allowable Expense"**: A Medically Necessary and Appropriate, reasonable and customary item of expense that is at least in part a Covered Charge under this Program or PIP.

**"Eligible Expense"**: That portion of expense Incurred for treatment of an Injury which is covered under this Program without application of Deductibles or Copayments, if any.

**"Out-of-State Automobile Insurance Coverage" or "OSAIC"**: Any coverage for medical expenses under an auto insurance contract other than PIP. This includes auto insurance contracts issued in another state or jurisdiction.

**"PIP"**: Personal injury protection coverage (i.e., medical expense coverage) that is part of an auto insurance contract issued in New Jersey.

### **Application of this Provision**

When expenses are Incurred as a result of an Automobile Related Injury, and the injured person has coverage under PIP or OSAIC, this provision will be used to determine whether this Program provides coverage that is primary to such coverage or secondary to such coverage.

### **Determination of Primary or Secondary Coverage**

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

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

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

### **Benefits This Program Will Pay if it is Primary to PIP or OSAIC**

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

**Benefits This Program Will Pay if it is Secondary to PIP**

If this Program is secondary to PIP, the actual coverage will be the lesser of:

- a. the Allowable Expenses left uncovered after PIP has provided coverage (minus this Program's Deductibles, Copayments, and/or Coinsurance); or
- b. the actual benefits that this Program would have paid if it provided its coverage primary to PIP.

**Medicare**

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

## THE EFFECT OF MEDICARE ON BENEFITS

### IMPORTANT NOTICE

For the purposes of this Booklet's "Coordination of Benefits and Services" provision, the benefits for a Covered Person may be affected by whether he/she is eligible for Medicare and whether the "Medicare as Secondary Payer" rules apply to the Program. This section, on "Medicare as Secondary Payer", or parts of it, may not apply to this Program. The Employee must contact the Policyholder to find out if the Policyholder is subject to Medicare as Secondary Payer rules.

For the purpose of this section:

- a. "Medicare" means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
- b. A Covered Person is deemed to be eligible for Medicare by reason of age from the first day of the month during which he/she reaches age 65. But, if the Covered Person is born on the first day of a month, he/she is deemed to be eligible for Medicare from the first day of the month that is immediately prior to his/her 65th birthday. A Covered Person may also be eligible for Medicare by reason of disability or End-Stage Renal Disease (ESRD).
- c. Under the rules for coordination of benefits and services described earlier, a "Primary Plan" pays benefits for a Covered Person's Covered Charges first, ignoring what the Covered Person's "Secondary Plan(s)" pays. The "Secondary Plan(s)" then pays the remaining unpaid Allowable Expenses in accordance with the provisions of the Covered Person's secondary health plan.

The following rules explain how this Program's group health benefits interact with the benefits available under Medicare as Secondary Payer rules. A Covered Person may be eligible for Medicare by reason of age, disability or ESRD. Different rules apply to each type of Medicare eligibility as explained below:

In all cases where a person is eligible for Medicare and this Program is the secondary plan, the Allowable Expenses under this Program and for the purposes of the Coordination of Benefits and Services rules, will be reduced by what Medicare would have paid if the Covered Person had enrolled for full Medicare coverage. But this will not apply, however, if; (a) the Covered Person is eligible for, but not covered, under Part A of Medicare; and (b) he/she could become covered under Part A only by enrolling and paying the required premium for it.

### **Medicare Eligibility by Reason of Age (Generally for Employers with at least 20 Employees.)**

This part applies to a Covered Person who:

- a. is the Employee or covered Spouse; and
- b. is eligible for Medicare by reason of age; and
- c. has coverage under this Program due to the current employment status of the Employee.

Under this part, such a Covered Person is referred to as a "Medicare eligible".

This part does **not** apply to:

- a. a Covered Person, other than an Employee or covered Spouse;
- b. a Covered Person who is under age 65; or
- c. a Covered Person who is eligible for Medicare solely on the basis of ESRD.

When a Covered Person becomes eligible for Medicare by reason of age, he/she must choose one of these options:

**Option (A)** - Choose this Program as the primary health plan.

When (a) a Medicare eligible person chooses this Program as the primary health plan; and (b) Incurs a Covered Charge for which benefits are payable under this Program and Medicare, this Program is deemed primary. This Program pays first, ignoring Medicare. Medicare is deemed the secondary health plan.

**Option (B)** - Choose Medicare as the primary health plan.

When a Medicare eligible person chooses Medicare as the primary health plan, he/she will no longer be covered by this Program, as required by Medicare's rules. Coverage under this Program will end on the date the Covered Person elects Medicare as his/her primary health plan.

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

If the Medicare eligible person chooses Option (B), he/she can subsequently change the election and choose Option (A), subject to the Policyholder's requirements for enrolling in this Program.

**Medicare Eligibility by Reason of Disability (Generally for Employers with at least 100 Employees.)**

This part applies to a Covered Person who:

- a. is under age 65;
- b. is eligible for Medicare by reason of disability; and
- c. has coverage under this Program due to the current employment status of the Employee.

This part does **not** apply to:

- a. a Covered Person who is eligible for Medicare by reason of age; or
- b. a Covered Person who is eligible for Medicare solely on the basis of ESRD.

When a Covered Person becomes eligible for Medicare by reason of disability, this Program is the primary plan; Medicare is the secondary plan.

### **Medicare Eligibility by Reason of End Stage Renal Disease (Applies to all Employers.)**

This part applies to a Covered Person who is eligible for Medicare solely on the basis of ESRD.

This part does **not** apply to a Covered Person who is:

- a. eligible for Medicare by reason of age ; or
- b. eligible for Medicare by reason of disability.

When (a) a Covered Person becomes eligible for Medicare solely on the basis of ESRD; and (b) Incurs a charge for the treatment of ESRD for which benefits are payable under both this Program and Medicare, this Program is deemed the Primary Plan for a specified time, referred to as the “coordination period”. This Program pays first, ignoring Medicare. Medicare is the Secondary Plan. The coordination period is 30 consecutive months.

The coordination period starts on the earlier of:

- a. the first month of a Covered Person’s Medicare Part A entitlement based on ESRD; or
- b. the first month in which he/she could become entitled to Medicare if he/she filed a timely application.

After the 30-month period described above ends, if an ESRD Medicare eligible person Incurs a charge for which benefits are payable under both this Program and Medicare, Medicare is the Primary Plan and this Program is the Secondary Plan.

### **Dual Medicare Eligibility**

This part applies to a Covered Person who is eligible for Medicare on the basis of ESRD and either age or disability.

When a Covered Person who is eligible for Medicare due to either age or disability (other than ESRD) has this Program as the primary payer, then becomes eligible for Medicare based on ESRD, this Program continues to be the primary payer for the first 30 months of dual eligibility. After the 30-month period, Medicare becomes the primary payer (as long as Medicare dual eligibility still exists).

When a Covered Person who is eligible for Medicare due to either age or disability (other than ESRD) has this Program as the secondary payer, then becomes eligible for Medicare based on ESRD, this Program continues to be the secondary payer.

When a Covered Person who is eligible for Medicare based on ESRD also becomes eligible for Medicare based on age or disability (other than ESRD), this Program continues to be the primary payer for 30 months after the date of Medicare eligibility based on ESRD.

### **How To File A Claim If You Are Eligible For Medicare**

Follow the procedure that applies to you or the Covered Person from the categories listed below when filing a claim.

#### **New Jersey Providers:**

- The Covered Person should give the Practitioner or other Provider his/her identification number. This number is shown on the Medicare Request for Payment (claim form) under “Other Health Insurance”;
- The Provider will then submit the Medicare Request for Payment to the Medicare Part B carrier;
- After Medicare has taken action, the Covered Person will receive an Explanation of Benefits form from Medicare;
- If the remarks section of the Explanation of Benefits contains this statement, no further action is needed: “This information has been forwarded to Horizon Blue Cross Blue Shield of New Jersey for their consideration in processing supplementary coverage benefits;”
- If the above statement does not appear on the Explanation of Benefits, the Covered Person should include his/her Identification number and the name and address of the Provider in the remarks section of the Explanation of Benefits and send it to us.

#### **Out-of-State Providers:**

- The request for Medicare payment should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information;
- Upon receipt of the Explanation of Benefits, show the Identification Card number and the name and address of the Provider in the remarks section and send the Explanation of Benefits to us for processing.

## **CLAIMS PROCEDURES**

Claim forms and instructions for filing claims will be provided to Covered Persons by the Employer. Completed claim forms and any other required materials must be submitted to Horizon BCBSNJ or its designees for processing. Covered Persons do not need to file claims for In-Network Covered Services and Supplies. For Out-of-Network Covered Services and Supplies, Covered Persons will generally have to file a claim for benefits, unless a state law requires Providers to file claims on behalf of Covered Persons. In this case, however, a Covered Person still has the option to file claims on his/her own behalf.

If Horizon BCBSNJ fails to furnish claim forms to the Employer for delivery to Covered Persons, or if the Covered Person fails to receive them from the Employer within 15 days after requesting them, the Covered Person making a claim will be deemed to have met the requirements for giving proofs of loss (see item b. under "Submission of Claims", below) if he or she submits written proof of loss covering the occurrence, character and extent of the loss within the time limit for submitting such proof.

### **Submission of Claims**

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

- a. If a Deductible applies under the Program, we recommend that it should be met before a claim is filed. Once the first claim is filed, we recommend that you send later claims: (a) when you or a covered Dependent Incurs \$100.00 or more in Covered Charges; or (b) whenever a lesser amount has been Incurred and four months have passed from the time you submitted your first claim.
- b. Claim forms must be filed no later than 18 months after the date the services were Incurred.
- c. Itemized bills must accompany each claim form. A separate claim form is needed for each claim filed. In general, the bills must contain enough data to identify: the patient; the Provider; the type of service and the charge for each service and the Provider's license number.

Bills for Prescription Drugs must contain: the prescription number; and the name, strength and quantity of the drug dispensed.

Bills for Private Duty Nursing must state that the Nurse is a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) and must contain the Nurse's license number.

- d. Horizon BCBSNJ will pay all Clean Claims no later than 30 calendar days of receipt. If the claim is not a Clean Claim, we will pay any part of it that is complete and proper according to these time limits.

- e. If a claim is disputed or denied due to missing information or documentation, Horizon BCBSNJ will pay the claim within 30 calendar days after receipt of the missing information or documentation.
- f. If a claim is denied or disputed, in whole or in part, Horizon BCBSNJ will notify the claimant (or his/her agent or designee) of it within 30 calendar days after receipt of the claim.

The denial notice will set forth:

1. the reason(s) the claim is denied;
  2. specific references to the main Program provision(s) on which the denial is based;
  3. a specific description of any further material or information needed to complete the claim, and why it is needed;
  4. a statement that the claim is disputed, if this is so. If the dispute is about the amount of the claim, we will explain why and also explain any change of coding that we make;
  5. a statement of the special needs to which the claim is subject, if this is the case;
  6. an explanation of the Program's claim review procedure, including any rights to pursue civil action;
  7. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either the specific rule or a statement that such a rule was relied upon in making the decision, and that a copy of such rule will be provided free of charge upon request;
  8. if the decision is based on Medical Necessity and Appropriateness or an Experimental or Investigational (or similar) exclusion or limitation, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Program to the medical circumstances, or a statement that such explanation will be provided free of charge upon request;
  9. if the decision involves a Medical Emergency or Urgent Care, a description of the expedited review process applicable to such claims; and
  10. the toll free number that the Covered Person or his/her Provider can call to discuss the claim.
- g. If Horizon BCBSNJ does not process claims within the time frames described above, we will pay interest on the claims as and to the extent required by law.

- h. This applies if an Employee is the non-custodial parent of a Child Dependent. In this case, Horizon BCBSNJ will give the custodial parent the information needed for the Child Dependent to obtain benefits under the Program. We will also permit the custodial parent, or the Provider with the authorization of the custodial parent, to submit claims for Covered Services and Supplies without the Employee's approval.

**To Whom Payment Will Be Made**

- a. Payment for services of an In-Network Provider or a BlueCard Provider will be made directly to that Provider if the Provider bills Horizon BCBSNJ, as Horizon BCBSNJ determines. To receive In-Network coverage, a Covered Person must show his/her ID card when requesting Covered Services and Supplies from a Provider that has such an agreement.
- b. Payment for services of Out-of-Network Providers will be made to you.
- c. Except as stated above, in the event of a Covered Person's death or total incapacity, any payment or refund due will be made to his/her heirs, beneficiaries, trustees or estate.
- d. If an Employee is the non-custodial parent of a Child Dependent, Horizon BCBSNJ will pay claims filed as described in paragraph d of the section "Submission of Claims" directly to: the Provider or Custodial parent; or the Division of Medical Assistance and Health Services in the Department of Human Services which administers the State Medicaid program, as appropriate.

If Horizon BCBSNJ pays anyone who is not entitled to benefits under this Program, Horizon BCBSNJ has the right to recover those payments.

## APPEALS PROCESS

### PHARMACY APPEALS

A Covered Person (or a Provider acting on behalf of the Covered Person and with the Covered Person's consent) may appeal administrative and Utilization Review determinations, regarding the Pharmacy benefit program. Administrative determinations involve benefit issues. For example, if Horizon BCBSNJ decides not to cover the extra cost of a brand name Prescription Drug when there is a generic equivalent, and the Covered Person (or his/her Practitioner) believe that the brand name drug is needed, the Covered Person (or Practitioner) has the right to appeal the decision. Utilization Review determinations involve a denial, termination or other limitation of covered Pharmacy benefits, including Medical Necessity and Appropriateness determinations. No Covered Person or Provider who files an appeal will be subject to disenrollment, discrimination or penalty by Horizon Blue Cross Blue Shield of New Jersey.

The appeal process consists of an informal internal review by us, a formal internal review by us and a formal external review by the Independent Health Care Appeals Program in the Department of Banking and Insurance (DOBI). Nothing in our policies, procedures or Provider agreements shall prohibit a Covered Person (or Provider acting on behalf of the Covered Person and with the Covered Person's consent) from discussing or exercising the right to an appeal.

A Covered Person must follow the steps for filing the three levels of appeal as outlined in this Booklet. If these procedures are not followed, the Covered Person's appeal review may be delayed or the Covered Person may be prohibited from pursuing an external review. If we fail to comply with the appeals process or the Covered Person expressly waives their right to an internal review of any appeal, then the Covered Person (or Provider acting on behalf of the Covered Person and with the Covered Person's consent) may proceed directly to the formal external review.

#### **a. First Level Appeal**

A Covered Person (or a Provider acting on behalf of the Covered Person and with the Covered Person's consent) can file a First Level Appeal by calling or writing Horizon BCBSNJ at the telephone number and address on the Covered Person's ID card. At the First Level Appeal, a Covered Person may discuss any medical determination made by us directly with the physician who issued that determination or the medical director designated by us. All First Level Appeals must be made within 12 months from the date the Covered Person was notified by us of the original denial for coverage or payment.

To submit a First Level Appeal, the Covered Person must include the following information:

1. the name and address(es) of the Covered Person(s) or Provider(s) involved;
2. the Covered Person's ID number;
3. the date(s) of purchase or attempted purchase;

4. the details regarding the actions in question;
5. the nature and reason behind the appeal;
6. the remedy sought; and
7. the documentation to support the appeal.

The Covered Person will be notified of determinations of administrative First Level Appeals within 30 days from receipt of the required documentation. The Covered Person will be notified of determinations of Utilization Review First Level Appeals from Medical Emergency or Urgent Care decisions within 72 hours from receipt of the required documentation and within 5 business days of receipt of the required documentation for all others. We will provide the Covered Person and/or the Provider written notification of the outcome, the reasons for the determination and instructions for filing a Second Level Appeal.

**b. Second Level Appeal**

If a Covered Person (or a Provider acting on behalf of the Covered Person and with the Covered Person's consent) is not satisfied with Horizon BCBSNJ's First Level determination, the Covered Person or Provider can file a Second-Level Appeal before a panel of physicians and/or other health care professionals selected by us who have not been involved in the Utilization Review determination at issue. At the Covered Person's request, the health care Provider involved in the original medical determination may participate in the decision with the panel.

We will acknowledge Second Level Appeals in writing within 10 business days of receipt. Within 72 hours of receipt for Utilization Review appeals that, due to Medical Necessity and Appropriateness require review on an expedited basis, and within 20 business days of receipt for all other Utilization Review appeals, the Covered Person will receive written notification of the final determination of the appeal, the reasons for it and instructions for filing an External appeal with the necessary forms. In the case of Utilization Review determination appeals that are responded to within 20 business days of receipt, we may extend the review for up to an additional 20 business days where reasonable cause for the delay exists which is beyond our control. We will provide the Covered Person or Provider with a written progress report within 20 business days of receipt of the Second Level Appeal. The written progress report will comply with the applicable requirements promulgated by the DOBI.

**c. External Appeal**

After an internal appeal has been conducted and a Covered Person has received a final determination, he/she may request an external appeal in the event of a denial, reduction or termination of benefits. The appeal provides an independent Medical Necessity or Appropriateness of services review. A Covered Person may appeal to the Independent Health Care Appeals Program for a review of a decision to deny, reduce or terminate a benefit if: (a) Horizon BCBSNJ has failed to handle an appeal within the applicable time frame; or (b) the person has already completed Horizon BCBSNJ's internal appeal process and has contested the

final determination. The Covered Person must apply to the DOBI within 60 business days of the date the final determination was issued by Horizon, or from the last date of the filing of an appeal for which Horizon BCBSNJ failed to meet a required time frame. The Covered Person must provide the DOBI with:

1. The name and address of the carrier;
2. A brief description of the Covered Person's medical condition for which benefits were denied, reduced or terminated;
3. A copy of any information provided by the carrier regarding its decision to deny, reduce or terminate the benefit; and
4. A written consent to obtain any necessary medical records from the carrier and any other Out-of-Network physician the Covered Person may have consulted on the matter.

The Covered Person must pay the Department an application processing fee of **\$25.00** except that the Commissioner may reduce or waive the fee in the case of financial hardship.

## **COVERED PERSONS' RIGHTS**

A Covered Person has the right to:

- Formulate and have advance directives implemented in accordance with applicable law;
- Receive prompt written notice of benefit changes or the termination of benefits or services, no later than 30 days following the date of any such change or termination;
- File a complaint with New Jersey's Department of Banking and Insurance;

**New Jersey Department of Banking and Insurance  
20 West State Street  
(P.O. Box 325)  
Trenton, NJ 08625-0325  
(609) 292-5360**

- Access Covered Services and Supplies, and receive the Program's benefits for them, and have care available 24 hours a day, seven days a week, for Medical Emergencies and Urgent Care;
- Appeal a denial, reduction or termination of health care services or benefits pursuant to a utilization management decision by or on behalf of Horizon BCBSNJ;
- Be treated with courtesy, consideration, and with respect to his/her dignity and need for privacy;
- Be provided with information concerning our policies and procedures regarding products, services, providers, appeals procedures, and with other information about the organization and the care provided;
- Obtain a current directory of Network Providers upon request, including addresses and telephone numbers, and a listing of Providers who accept Covered Persons who speak languages other than English.

## SERVICE CENTER

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

**Telephone personnel are available twenty-four hours a day, seven days a week.**

**Please call Caremark Service Center at:**

**1-866-881-5603**

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:

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The identification number shown on my identification card:

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The effective date when my coverage begins:

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My group number is:

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## 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.

# **PATIENT PROTECTION AND AFFORDABLE CARE ACT RIDER**

The Policy/Booklet to which this Rider is attached is amended as described below.

## **Definitions**

The following term is defined in this rider as follows:

“Essential health benefits” 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 United States Department of Health and Human Services and 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; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

## **Dependent Coverage**

Any provision of the Policy/Booklet that indicates that a dependent child’s eligibility for coverage is based on any factor other than the relationship between the child and an individual covered under the Policy/Booklet for a child under the age of 26 is deleted. Any requirement that such a child be financially dependent on an individual covered under the Policy/Booklet, that the child share a residence with an individual covered under the Policy/Booklet, that the child meet certain student status requirements, that the child be unmarried or not in a Domestic or Civil Union Partnership, that the child not be eligible for other coverage or that the child not be employed, is deleted.

Any provision of the Policy/Booklet that indicates that the coverage of a dependent child under the age of 26 will terminate when the child marries or enters into a Domestic or Civil Union Partnership, ceases to be financially dependent on an individual covered under the Policy/Booklet, ceases to share a residence with an individual covered under the Policy/Booklet, ceases to be a full-time or part-time student, is eligible for other coverage becomes employed full-time or part-time, or reaches age under 26 is deleted.

Any dependent child limiting age of less than 26 in the Policy/Booklet is replaced with the age of 26.

## **Transitional Rules**

Any provision of the Policy/Booklet that defines or describes which children are eligible for coverage under the Policy/Booklet is revised to include a child who has not attained the child’s 26th birthday irrespective of the child’s:

- (1) Financial dependency on an individual covered under the Policy/Booklet;
- (2) Marital or Civil Union/Domestic Partner status;

- (3) Residency with an individual covered under the Policy/Booklet;
- (4) Student status;
- (5) Employment;
- (6) Eligibility for other coverage; or
- (7) Satisfaction of any combination of the above factors.

The Policy/Booklet is amended to provide coverage from the first day of the first policy year occurring on or after September 23, 2010, if a child meets all three of the following:

1. The child was terminated from coverage previously due to failure to satisfy the child definition of the Policy/Booklet or the child was prohibited from enrolling under the Policy/Booklet due to failure to meet the child definition in the Policy/Booklet;
2. The child is eligible for coverage based on the terms of this Rider; and
3. The child enrolls during the first 30 days of the first policy year occurring on or after September 23, 2010.

### **Rescissions**

Any provision of the Policy/Booklet that describes the right of Horizon BCBSNJ to rescind or void the Policy/Booklet or to rescind the coverage of an individual under the Policy/Booklet is amended to permit Horizon BCBSNJ to rescind or void the entire Policy/Booklet or the coverage of an individual only if (1) the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud; or (2) the individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

Any provision of the Policy/Booklet that describes notice of rescission of coverage and that provides less than 30-days advance written notice of rescission is amended to provide 30-days advance written notice of any rescission of coverage.

