Product: **HOSPITAL PLUS/MEDICAL-SURGICAL/ MAJOR MEDICAL**

Company Name: **CITY OF NEWARK**

Group Number: **89560**

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Introduction

Your health care program gives you broad protection to help meet the costs of Illnesses and Accidental Injuries.

In this booklet you'll find the important features of your group's health care benefits provided by Horizon Blue Cross Blue Shield of New Jersey.

You should read this booklet carefully so that you know the health care benefits available to you and your family.

This booklet replaces any booklets or certificates you may previously have received.

Definitions

This section defines certain important words used in this booklet. The meaning of each defined word, whenever it appears in this booklet, is governed by its definition as listed in this section.

We, Us, and Our – Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ.)

Accidental Injury – medical care for the treatment of traumatic bodily injuries resulting from an accident.

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

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

Acupuncture – the practice of piercing specific sites with needles to induce surgical anesthesia. Acupuncture is also used as a therapeutic agent for relief of pain.

Alcoholism – the abuse of or addiction to alcohol.

Allowance – actual charges of a Provider or a dollar amount set by Horizon BCBSNJ, unless otherwise required by law.

Ambulatory Surgical Center – an ambulatory care facility licensed as such by the State of New Jersey to provide same-day surgical services or one which meets the same standards if located in another state.

Approved Hemophilia Treatment Center – a health care facility licensed by the State of New Jersey for the treatment of hemophilia or one which meets the same standards if located in another state.

Benefit Month – means the one-month period beginning on the Effective Date of this Policy and each succeeding monthly period.

Benefit Period – the twelve-month period starting on January 1st and ending on December 31st. The first and/or last Benefit Period may be less than a calendar year. The first Benefit Period begins on your coverage date. The last Benefit Period ends when you are no longer covered.

Benefit Year – the period which begins on the date shown on the Covered Person's identification card. It ends 12 months after it began. The first Benefit Year may begin on or after the effective date of coverage.

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

a. It must:

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

b. Horizon BCBSNJ will recognize it if:

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

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

Blue Card Provider – a Provider not in New Jersey which has a written agreement with another Blue Cross and Blue Shield company to provide care to both that company's Subscribers and other Blue Cross and Blue Shield companies' Subscribers.

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

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

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 (CMA INDEM (11/96)) at the end of the Policy for information about Civil Unions.

Clean Claim – (1) the claim is an eligible claim for service rendered by an eligible Practitioner; (2) it has no material defect or impropriety (including, but not limited to, miscoding or missing documentation); (3) there is no dispute over the claim; (4) Horizon BCBSNJ has no reason to believe that the claim was submitted fraudulently; and (5) there is no need for special treatment such as might prevent timely payment.

Coinsurance – the percentage applied to the allowance for certain covered services and supplies in order to calculate benefits under this program.

Cosmetic Services – services rendered to refine or reshape body structures or surfaces that are not functionally impaired. They are to improve appearance or self-esteem, or for other psychological, psychiatric or emotional reasons.

Covered Person – you and your dependents who are enrolled under this program.

Covered Services and Supplies – the types of services and supplies described in the Covered Services and Supplies section of this booklet. The services and supplies must be:

a. furnished or ordered by a Provider; and

b. Medically Necessary and Appropriate to diagnose or treat an Illness, Accidental Injury or Mental or Nervous Disorders.

Creditable Coverage – With respect to a Member, prior coverage of the Member 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 Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a State health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plans as set forth in regulation by the Commissioner of Banking and Insurance.

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

Deductible – the amount of covered medical expenses that you must incur and pay for before you are eligible to receive benefits under your program.

Detoxification Facility – a health care facility licensed by the State of New Jersey as a Detoxification Facility for the treatment of alcoholism, or one which meets the same standards if located in another state.

Durable Medical Equipment – equipment which Horizon BCBSNJ determines to be:

a. designed and able to withstand repeated use;

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

c. generally not useful to you in the absence of an Illness or injury; and

d. suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, hearing aids, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Enrollment Date – the effective date of your coverage 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 satisfy the following criteria:

a. With respect to items requiring government approval (e.g., drugs, biological products and devices), the technology must have final approval from the appropriate government regulatory bodies for commercial distribution for use in the treatment of the condition under review. However, this program will not exclude as Experimental/Investigational a Prescription Drug for a treatment for which it has not been approved by the Food and Drug administration; and will provide coverage for such to the same extent as other Prescription Drugs if the drug is recognized as being Medically Necessary and Appropriate for the specific treatment for which it has been prescribed in one of the following compendia:

    1. the American Medical Association Drug Evaluations;
    2. the American Hospital Formulary Service Drug Information;
    3. the United States Pharmacopeia Drug Information; or
    4. it is recommended by a clinical study or review article in a major-peer reviewed professional journal;

Note: No coverage will be provided for Prescription Drugs for any Experimental or Investigational drug or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed;

b. With respect to items not requiring governmental approval, scientific evidence, including peer literature, must exist which demonstrates, as determined by Horizon BCBSNJ, that the technology improves net health outcomes; and

c. The technology must be as beneficial as any established alternatives; and

d. The improvement in net health outcome must be attainable under the usual conditions of medical practice.

Eye Examination - a comprehensive medical examination of the eye performed by a practitioner, including a diagnostic ophthalmic examination, with or without definitive refraction as medically indicated, with medical diagnosis and initiation of diagnostic and treatment programs, prescription of medication and lenses, post cycloplegic visit if required and verification of lenses if prescribed.

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

Family or Medical Leave of Absence – a period of time of predetermined length, approved by the employer, during which the employee does not work, but after which the employee is expected to return to active service. Any employee who has been granted an approved leave of absence in accordance with the Family and Medical Leave Act of 1993 shall be considered to be active for purposes of eligibility for Covered Services and Supplies under your group's program.

Government Hospital – a Hospital which is operated by a government or any of its subdivisions or agencies. This includes any federal, military, state, county or city Hospital.

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

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

Home Health Agency – a Provider which mainly provides Skilled Nursing Care for an ill or injured person in his home under a home health care program designed to eliminate Hospital stays. Horizon BCBSNJ will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice – a Provider which mainly provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. Horizon BCBSNJ will recognize a Hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. approved for its stated purpose by Medicare; or

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

Hospital – a Facility which mainly provides inpatient care for Ill or Injured people. Horizon BCBSNJ will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited as a Hospital by the Joint Commission or

b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, infirmary, Hospice, Substance Abuse Center or a Facility, or part of it, which mainly provides domiciliary or Custodial Care, educational care, non-medical or non-covered charges or rehabilitative care. A Facility for the aged is also not a Hospital.

Horizon BCBSNJ will pay benefits for covered medical expenses incurred at hospitals operated by the United States government only if services are for treatment on an emergency basis; or services are provided in a hospital located outside of the United States and Puerto Rico.

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

Illness – a sickness or disease suffered by you.

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 with Horizon BCBSNJ to furnish Covered Services or Supplies.

Late Enrollee – a Covered Person who requests enrollment under this program more than **31** days after first becoming eligible. However, you will not be considered a Late Enrollee under certain circumstances. See the General Information section of this booklet for additional information.

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

Medical Emergency – a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of Substance Abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention could reasonably be expected to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, a Medical Emergency exists where: there is inadequate time to effect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child. Examples of a Medical Emergency include but are not limited to heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning and loss of consciousness.

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

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

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

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

Member – an Employee or Dependent who is enrolled under your group's Program.

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

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

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

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

(c) Conditions that Horizon BCBSNJ Determines to be due to developmental disorders. These include, but are not limited to: mental retardation; academic skills disorders; or motor skills disorders. But, this does not apply: (i) to the treatment required by law of biologically-based mental illness; or (ii) to the extent needed to provide newly born dependents with coverage for Injury or Illness, including the necessary care and treatment of medically diagnosed congenital defects and abnormalities.

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

Network – the Horizon Hospital Network/Horizon Traditional Physicians Provider Network.

Out-of-Network – a Provider, or the services and supplies provided by a Provider, who does not have an agreement with Horizon BCBSNJ to provide Covered Services or Supplies.

Pharmacy – means a Facility which is registered as a pharmacy with the appropriate state licensing agency and in which prescription drugs are dispensed by a pharmacist.

Physician – a doctor who is licensed to practice medicine and surgery. Physician also includes the following when they are performing services within the scope of their license: Chiropodist, Chiropractor, Dentist (D.D.S.), Optometrist, Podiatrist (D.P.M.), Psychologist, Registered Physical Therapist, Audiologist, Speech-Language Pathologist, Registered Nurse, Certified Nurse-Midwife, Physician Anesthesiologist, or New Jersey bioanalytical laboratory directors.

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 HMO. 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).

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

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

b. approved for its stated purpose by Medicare.

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

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

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

Special 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 coverage under this program.

Substance Abuse – the abuse or addiction to drugs or controlled substances, not including alcohol.

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

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

b. approved for its stated purpose by Medicare.

Therapeutic Manipulation – the treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the

impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydro-therapy or other treatment of a similar nature.

Therapy Services – the following services and supplies when they are:

a. ordered by a practitioner;

b. performed by a provider;

c. for a Covered Person who is a Hospital inpatient or outpatient or a recipient of covered Home Health Agency;

d. Medically Necessary and Appropriate for the treatment of your Illness or Accidental Injury.

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

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

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

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

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

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

Physical Therapy – treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Accidental Injury or loss of limb.

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

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

Speech Therapy – treatment for the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

Total Disability or Totally Disabled means, except as otherwise specified in this Policy, a condition wherein an Employee, due to Illness or Injury, cannot perform any duty of any occupation for which he is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is Totally Disabled if he cannot engage in the normal activities of a person in good health and or like age and sex. The Covered Person who is Totally Disabled must be under the regular care of a practitioner.

Urgent Care - Outpatient or Out-of-Hospital medical care which, as Determined by Horizon BCBSNJ or an entity designated by Horizon BCBSNJ, is required by an unexpected Illness or Injury or other condition that is not life threatening, but should be treated by a provider within 24 hours.

Waiting Period – the period of time between enrollment in the program and the date when you become eligible for benefits.

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

Schedule of Covered Services and Supplies

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

NOTE: OUR BENEFITS WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION MANAGEMENT PROVISIONS CONTAINED IN YOUR GROUP'S PROGRAM.

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

Horizon BCBSNJ will provide the coverage listed in this Schedule of Covered Services and Supplies, subject to the terms, conditions, limitations and exclusions stated within this booklet.

HOSPITAL BENEFITS

Payment for covered Hospital benefits is as follows:

a. Network Hospital

1. For Inpatient or Outpatient services provided by a Network Hospital, Horizon BCBSNJ's payment to the Hospital plus any Deductible payment the Covered Person must make will be accepted by the Hospital as payment in full. Horizon BCBSNJ will pay **100%** of its Allowance for Inpatient services.

2. For Inpatient services provided by a Network Hospital, Horizon BCBSNJ's payment to the Hospital plus any Deductible payment the Covered Person must make will be accepted by the Hospital as payment in full. Horizon BCBSNJ will pay **100%** of its Allowance for Inpatient services.

b. Out-of-Network Hospital

Horizon BCBSNJ will pay **100%** of its Allowance up to **$30** per day for Inpatient or Outpatient services. However, any Inpatient Deductible required will be subtracted from any payment otherwise eligible.

c. Blue Card Hospital

1. For Inpatient Services, Horizon BCBSNJ's payment to the Hospital plus any Deductible payment the Covered Person must make will be accepted by the Hospital as payment in full.

2. For Outpatient Services, Horizon BCBSNJ's will pay up to **$30.00** per day toward the Hospital's reasonable charges.

d. Out-of-Network Government Hospital

1. Horizon BCBSNJ will pay Hospitals operated by the United States government only if services are for treatment on an emergency basis or are provided in a Hospital located outside of the United States and Puerto Rico. These limitations do not apply to military retirees, their dependents, and the dependents of active-duty military personnel who have both military health coverage and coverage with Horizon BCBSNJ, and receive care in Facilities run by the Department of Defense or Veteran's Administration.

2. Horizon BCBSNJ will pay the average daily amount being collected by the Facility from all patients, but not less than $6 nor more than $30 per day. If the actual charges for the eligible services provided are less than $6, Horizon BCBSNJ will pay the actual charges.

e. Out-of-Area Hospitals which are not Blue Card Hospitals

For Inpatient services or Outpatient services, Horizon BCBSNJ will pay **100%** of its Allowance up to **$30** per day.

Benefit Period

120 Days of Inpatient and Outpatient Care per Benefit Period.

Your outpatient days are part of your available inpatient days. Each day of outpatient care reduces by one day your available inpatient days.

There are **245** part benefit days available to be Covered Person as Inpatient or Outpatient days. These days pay **$5** per day after the first **120** days have been exhausted.

20 benefit days in the following governmental hospitals: In-Network Facility located outside of New Jersey, Out-of-Network Facility, New Jersey State. This does not apply to retired Military Personnel.

Renewal Interval

Benefit days will be renewed on the date a new Benefit Year begins, provided that, for related conditions, **90** days or more have passed from the date on which inpatient or home care services were last received.

COVERED SERVICES

Inpatient Benefits Subject to **100%** Coinsurance.

Horizon BCBSNJ will pay only for a Semi-Private Room. If the Covered Person occupies a Private Room, he will be responsible to pay the difference between the Private Room and the average Semi-Private Room rate.

Outpatient Benefits Subject to **100%** Coinsurance.

Outpatient days count toward the Covered Person's total Benefit Days.

Ambulatory Surgical Center Benefits Subject to **100%** Coinsurance.

For an Out-of-Network Ambulatory Surgical Center, Horizon BCBSNJ will pay up to $30 per day toward the Facility's reasonable charges.

Outpatient days count toward the Covered Person's total Benefit Days.

Skilled Nursing Facility Charges Subject to **100%** Coinsurance. and a **30** day Benefit Year maximum.

If the Covered Person occupies a Private Room, he will be responsible to pay the difference between the Private Room and the average Semi-Private Room rate.

No benefits are available for services from an Out-of-Network Skilled Nursing Facility.

These days are eligible only as part of the days available to the Covered Person for general conditions and must follow an eligible hospital stay of three days.

Home Health Agency Care Benefits Subject to **100%** Coinsurance.

Subject to a **60** visit maximum in the **120** day period following hospital discharge.

No benefits are available for services from an Out-of-Network Home Health Agency.

These days are eligible only as part of the benefit days available to the Covered Person for general conditions and must follow an eligible hospital stay of three days**.**

Accidental Injury Benefits Subject to **100%** Coinsurance.

Medical Emergency Benefits Subject to **100%** Coinsurance**.**

Mental or Nervous Disorders or Substance Abuse	Subject to **100%** Coinsurance.
Hospice Care Benefits	Subject to **100%** Coinsurance.
Transplant Benefits	Subject to **100%** Coinsurance.

MEDICAL-SURGICAL BENEFITS

The following are conditions to payment:

a. Use of In-Network or Blue Card Practitioners:

A Covered Person is entitled to receive In-Network benefits for services covered under the Medical-Surgical portion of this program if the Covered Person goes to an In-Network or a Blue Card Practitioner who has agreed to accept Our Allowance as payment in full for Covered Services.

b. Conditions for Benefits

To qualify for In-Network benefits a service must be performed by an In-Network Practitioner or Blue Card Practitioner. Payment for Covered Services will be limited to the Allowance as Determined by Horizon BCBSNJ. An In-Network Practitioner or Blue Card Practitioner may not collect more than the Allowance for a Covered Service.

c. Use of Out-of-Network Practitioners

If the services are performed by an Out-of-Network Practitioner or Out-of Area Practitioner who is not a Blue Card Practitioner and the Out-of-Network Practitioner's or Out-of Area Practitioner who is not a Blue Card Practitioner's fee for Covered Services is higher than the Allowance for the services as Determined by Horizon BCBSNJ, the Covered Person will be liable for the difference. If the Out-of-Network Practitioner's or Out-of-Area Practitioner who is not a Blue Card Practitioner's fee is less than the Allowance, Horizon BCBSNJ will not pay more than the amount of the Out-of-Network Practitioner's or Out-of Area Practitioner who is not a Blue Card Practitioner's fee.

d. Limits Set By The Allowances

To be eligible for payment, services must be personally performed by a Practitioner. Horizon BCBSNJ is not liable to pay more than the Allowance as determined by Horizon BCBSNJ for any service.

e. Benefits To Be Paid Under Our Rules And Regulations

Benefits for any service will be paid in accordance with Horizon BCBSNJ's administrative policies, rules and regulations in effect at the time the service is performed.

f. More Than One Service During One Hospital Confinement

During any Hospital Confinement, only one of the following services is eligible for coverage: surgical service, dental surgical service, In-Hospital medical service, or obstetrical service. This is true even when Covered Services are given by more than one Practitioner during the same Hospital confinement. Horizon BCBSNJ can waive this rule, but the decision to waive it is entirely up to Us.

g. Determination of Services

If the nature or extent of a given service must be Determined, this Determination is entirely up to Horizon BCBSNJ. This includes Determining whether services are emergency in nature, and whether they are needed to treat an accidental injury from an external cause; and determining whether a Practitioner gave services.

h. Limits on In-Hospital or Facility Days

The number of days covered for In-Hospital medical services are limited in accordance with the following rules:

1. In counting the number of days in a Hospital Stay, each calendar day or portion of a day counts as one day.

2. Each calendar day when an eligible Inpatient receives In-Hospital medical service counts as one day of this service.

3. When Hospital or Skilled Nursing Facility Stays are close together, they can count as one confinement whether or not they are at the same Hospital or Skilled Nursing Facility. Only when an Admission is at least **90** days after the Covered Person's last covered day of Hospital or Skilled Nursing Facility confinement, does the new stay count as a new confinement.

Benefit Period — **365** days of Inpatient medical care per admission. Coverage is limited to services of only one physician per day. Horizon BCBSNJ can waive this rule, but it is entirely up to Horizon BCBSNJ.

Renewal Interval — Benefit Period is renewed when **90** days without care in a Hospital have elapsed and/or a new Benefit Year begins.

COVERED SERVICES

Surgical Services — Subject to **100%** Coinsurance.

In-Hospital Medical Service — Subject to **100%** Coinsurance.

Outpatient Medical Services — Subject to **100%** Coinsurance.

Skilled Nursing Facility Care — Subject to **100%** Coinsurance.

The Covered Person is entitled to benefits for doctor's Visits during the first **30** days in the Skilled Nursing Facility subject to the following maximums:

During the first week in the Skilled Nursing Facility, one Visit by a physician per day is covered. During the second week, one Visit by a physician every other day is covered. After the second week, one Visit by a physician every third day is covered. Post-operative care is not covered in a Skilled Nursing Facility. The benefits available for a stay in a Skilled Nursing Facility depend on the number of remaining eligible In-Hospital medical days.

Home Health Agency Care — Subject to **100%** Coinsurance.

Subject to a one visit per week, maximum up to **16** Visits in **120** days Benefit Year maximum. These benefits are available only as part of the eligible In-Hospital medical Visits that began during the Hospital confinement.

Shock Therapy — Subject to **100%** Coinsurance.

Subject to a **12** Shock Treatment Benefit Year maximum.

Mental or Nervous Disorders or Substance Abuse — Subject to **100%** Coinsurance.

Transplant Benefits — Subject to **100%** Coinsurance.

Joint Hospital And Medical-Surgical Additional Benefits

- **Diagnostic X-ray and Radioactive Isotope Studies** — Subject to **$400** Benefit Year maximum.
- **Radium, Radioactive Isotope (Sealed Sources), Radon Therapy or X-ray Therapy** — Subject to **$560** Benefit Year maximum.
- **Physical Therapy Services** — Subject to $**50** Benefit Year maximum.

MAJOR MEDICAL BENEFITS

Coinsurance	**80%** of Covered Charges.
Deductible	**$250**/Covered Person.

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

Fourth Quarter Deductible Carry-over – Covered Services and Supplies incurred within the last **3** months of a Benefit Period which were applied against the Deductible but did not satisfy the Deductible may be carried over and applied against the Deductible for the following Benefit Period.

Prior Carrier Deductible Carry-over – Charges for Covered Services and Supplies which satisfied any portion of a Deductible required for the final Benefit Period under the Employer's prior Major Medical contract will be applied to satisfy all or any portion of the initial Deductible required under this program.

BENEFIT PERIOD MAXIMUM	**Unlimited Benefit Period Maximum.**
LIFETIME MAXIMUM	**Unlimited Lifetime Maximum.**

Payment of Benefits

a. For Out-of-Network Providers, any difference between payment for Covered Services or Supplies and a Provider's charge shall be the responsibility of the Covered Person.

b. Horizon BCBSNJ will have no liability to pay any percentage of the amount of medical expenses incurred before the Covered Person is covered under this program.

COVERED SERVICES

Acupuncture	Subject to Deductible and **80%** Coinsurance**.**
Allergy Testing And Treatment	Subject to Deductible and **80%** Coinsurance.
Ambulance Services	Subject to Deductible and **80%** Coinsurance.
Diabetes Benefits	Subject to Deductible and **80%** Coinsurance.
Durable Medical Equipment	Subject to Deductible and **80%** Coinsurance.

Facility Charges Subject to Deductible and **80%** Coinsurance.

Health Wellness

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

Subject to **100%** Coinsurance.

b. For all Covered Persons 35 years of age or older, a glaucoma eye test every 5 years.

Subject to **100%** Coinsurance.

c. For all Covered Persons 40 years of age or older, an annual stool examination for presence of blood;

Subject to **100%** Coinsurance.

d. For all Covered Persons 45 years of age or older, a left sided colon examination of 35 to 60 centimeters every 5 years;

Subject to **100%** Coinsurance.

e. For all adult Covered Persons recommended immunizations;

Subject to **100%** Coinsurance.

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

Subject to **100%** Coinsurance.

g. Mammography

Subject to **100%** Coinsurance.

h. Gynecological Examination

Subject to **100%** Coinsurance. Limited to one exam per Benefit Period.

i. Pap Smear

Subject to **100%** Coinsurance.

j. Prostate Cancer Screening

Subject to **100%** Coinsurance.

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

Subject to **100%** Coinsurance. The Deductible does not apply to immunizations and lead poisoning screening and treatment covered pursuant to P.L. 1995, Ch. 316.

l. Well-Child Care

Subject to **100%** Coinsurance.

m. Newborn Hearing Screening

Subject to **100%** Coinsurance.

n. Colorectal Cancer Screening

Subject to **100%** Coinsurance.

Hearing Aids and Related Services (Not applicable to hearing screening and monitoring for newborns, covered elsewhere)

For Child Dependents 15 years of age or younger:

For the purchase of a hearing aid, benefits subject to Deductible and **80%** Coinsurance, up to a maximum benefit of **$1,000** per hearing aid, for each hearing-impaired ear, during any period of 24 consecutive months.

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

For other Covered Persons:

No benefit.

Infertility Services Subject to Deductible and **80%** Coinsurance.

Inherited Metabolic Disease Subject to Deductible and **80%** Coinsurance.

Inpatient Medical Services	Subject to Deductible and **80%** Coinsurance.
Medical Emergency	Subject to Deductible and **80%** Coinsurance.
Mental or Nervous Disorders or Substance Abuse	Subject to Deductible and **80%** Coinsurance.
Prescription Drugs	Subject to Deductible and **80%** Coinsurance. Note: This is applicable to Copayment Only.

Prosthetic or Orthotic Devices

For devices charged for by a Hospital, benefits are determined the same as for other Hospital charges.

For devices charged for by a Practitioner, benefits are determined the same as for an office Visit to a Practitioner who is a doctor specializing in family practice, general practice, internal medicine or pediatrics.

Second Opinion Charges	Subject to **100%** Coinsurance.
Skilled Nursing Facility Care	Subject to Deductible and **80%** Coinsurance.

If the Covered Person occupies a Private Room, he will be responsible to pay the difference between the Private Room and the average Semi-Private Room rate.

Specialized Non-Standard Infant Formula

	Subject to Deductible and **80%** Coinsurance.
Therapeutic Manipulations	Subject to Deductible and **80%** Coinsurance.
Therapy Services	Subject to Deductible and **80%** Coinsurance.
Wigs Benefit	Subject to Deductible and **80%** Coinsurance. Subject to a **$500** Benefit Period Maximum.

General Information

How To Enroll

You may enroll in this program by completing an enrollment card. If you enroll your dependents, their coverage will become effective on the same date as your own.

Your Identification Card

You will receive an identification card to show to the Hospital, Physician or provider when you receive services or supplies. Your identification card shows the group through which you are enrolled, your type of coverage, your identification number and the effective date when you can start to use your benefits. All of your eligible dependents share your identification number as well.

Always carry this card and use your identification number when you receive covered services or supplies. If you lose your card, you can still use your coverage if you know your identification number. The inside back cover of this booklet has space to record your identification number along with other information you will need when making inquiries about your benefits. You should, however, contact your enrollment official immediately to replace the lost card.

You cannot let anyone not named in your coverage use your card or your coverage.

When Your Coverage Begins

Your Coverage begins on the effective date shown on your identification card.

Types of Coverage Available

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

- **Single –** provides coverage for yourself only;
- **Parent and Child(ren) –** provides coverage for you and your eligible children but not your spouse;
- **Family –** provides coverage for you, your spouse and your eligible children.

Change In Type of Coverage

If you want to change your type of coverage, see your enrollment official. If you marry, you should arrange for enrollment changes within **60** days before or after your marriage.

If you gain or lose a member of your family or whenever 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: for example, through the birth or adoption of a child, or the divorce or death of a spouse.

- If you already are enrolled under Family or Parent and Child(ren) coverage, your newborn infant is automatically included;
- If you have Single coverage, your newborn will be eligible from the date of birth if you apply for Family or Parent and Child(ren) coverage within **60** days of birth.

Anyone who does not enroll within these periods will be considered a Late Enrollee. Late Enrollees may enroll only during the next re-enrollment month. Coverage will be effective on the first day of the calendar month one month after the end of that enrollment month.

Enrollment of Dependents

Horizon BCBSNJ cannot deny coverage for your child dependents 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 Horizon BCBSNJ's 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 necessary for the child dependent to obtain benefits through this program;
- Permit the custodial parent, or the health care provider with the authorization of the custodial parent, to submit claims for covered services without your approval; and
- Make payments on claims submitted as specified above directly to the custodial parent, the health care provider, or the Division of Medical Assistance and Health Services in the Department of Human Services which administers the State Medicaid program, as appropriate.

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

- Permit you to enroll your child as a child dependent, without any enrollment season restrictions:
- Permit the child's other parent or the Division of Medical Assistance and Health Services as the State Medicaid agency or the Division of Family Development as the State IV-D agency, in the Department of Human Services, to enroll the child dependent under your group's program if the parent who is the subscriber fails to enroll the child dependent; and
- Not terminate coverage of the child dependent unless the parent who is the subscriber provides Horizon BCBSNJ with satisfactory written evidence 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 whose coverage will be effective on the date of the termination of coverage.

Special Enrollment Periods

If you enroll during a Special Enrollment Period, you are not considered a Late Enrollee.

Individual losing other coverage

If you are eligible for coverage, but not enrolled, you must be permitted to enroll if each of the following conditions is met:

a. the individual was covered under a group health plan or had health insurance coverage at the time coverage was previously offered;

b. the Employee stated in writing that coverage under a group health plan or health insurance coverage was the reason for declining enrollment when it was first offered;

c. the Employee or Dependent coverage described in the first bullet above:

   (i) was under a COBRA "(or other state mandated)" continuation provision and the COBRA coverage was exhausted; or
   (ii) was not under such a provision and either 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 Employer contributions toward such coverage were terminated;

d. the Employee requests enrollment not later than 31 days after the date of exhaustion of coverage described in (i) above or termination of coverage or Employer contribution described in (ii) above.

Coverage must be effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

New Dependents

If the following conditions are met, a Dependent Special Enrollment Period will be provided, during which the Dependent (or, if not otherwise enrolled, the Employee) may be enrolled as a Dependent of the Employee:

a. the Employee is covered under the Program (or has met any Employer-imposed waiting period applicable to becoming covered under the Program and is eligible to be enrolled under the Program but for a failure to enroll during a previous enrollment period), and

b. a Member becomes a Dependent of the covered Employee through marriage, birth, or adoption (or placement for adoption).

Dependent Special Enrollment Period – The Dependent Special Enrollment Period is a Period of no less than 31 days and shall begin on the later of the date Dependent coverage is made available or the date of the marriage, birth, or adoption/placement.

Special Enrollment Due to Marriage

You may enroll a new Spouse under your group's 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 of marriage.

The coverage becomes effective not later than the first day of the month after the completed request is received.

Special Enrollment Due to Newborn/Adopted Children

You may enroll a newly born or newly adopted Dependent Child.

A Spouse can be enrolled separately when a Child Dependent is born or adopted/placed.

If you are eligible, but previously declined coverage, you are also eligible to enroll at the same time that your Dependent is enrolled.

You must request enrollment of the new Dependent within 31 days of the birth or adoption/placement.

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

Multiple Employment

If you work for both the Employer and an Affiliated Company, or for more than one Affiliated Company, Horizon BCBSNJ will treat you as if employed only by one Employer; and you will not have multiple coverage. But, if your group's program uses the amount of an Employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, your earnings will be calculated as the sum of your earnings from the Employer and its Affiliated Companies.

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 or your legal spouse, regardless of where or with whom the child resides.
- A child legally adopted by you or your legal spouse, regardless of where or with whom such child resides, provided proof of adoption satisfactory to Horizon BCBSNJ in its sole discretion is submitted to us when requested;
- You or your legal spouse's legal ward who resides with you in a regular parent-child relationship and who is principally dependent upon you for support and maintenance, provided proof of guardianship satisfactory to Horizon BCBSNJ in its sole discretion is submitted to us when requested.

Coverage for your spouse will end on the date of your spouse's death, at the end of the benefit month in which you divorce, or at the end of the benefit month in which you notify us to delete your spouse from coverage following marital separation.

Coverage for a child dependent ends upon the earliest of the following: the last day of the benefit month in which the child dependent marries, the date in which the child reaches age **26**, or the date on which the child dependent becomes employed and eligible for health insurance coverage available as a result of that employment.

Coverage will continue for a child dependent beyond the age of **26** provided that prior to age **26** he or 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 to remain covered, you must submit proof of the child's 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 which meets our approval. Such proof must be resubmitted every two (2) years within **31** days before or after the child's birth date.

Coverage for a handicapped child dependent will end on the last day of the benefit month in which the earliest of the following occurs: the termination of your coverage, the failure of your child dependent to satisfy the definition of child dependent for any reason other than age and the termination of your child dependent's inability to engage in self-sustaining employment by reason of mental retardation or physical handicap.

If your child was enrolled as a handicapped dependent under previous coverage with Horizon Blue Cross Blue Shield of New Jersey and there has been no interruption in coverage, the child may be covered as an eligible dependent under this program, regardless of age.

When Your Coverage Ends

Your coverage ends on the last day of the benefit month in which your enrollment in this program ends, or on the last day of the benefit month for which premiums have been paid by your group.

Coverage for a dependent will end when your coverage ends; or on the date in which the dependent fails to meet the definition of a dependent; or the date on which your child dependent becomes employed and eligible for health care insurance available as a result of that employment.

Termination for Fraud

Immediate cancellation of your group's Policy will occur if the Policyholder commits fraudulent acts or makes misrepresentations with respect to the coverage of Covered Persons. Any act or omission by a Covered Person which indicates intent to defraud Horizon BCBSNJ, such as the intentional and/or repetitive misuse of Horizon BCBSNJ's services or the omission or misrepresentation of a material fact on a Covered Person's application for enrollment, health statement or similar document, will result, as Determined by Horizon BCBSNJ, in the immediate termination of the Covered Person's coverage under the Policy. The above includes, but is not limited to the submission of any claim and/or statement containing any materially false information, any information which conceals for the purpose of misleading, and/or any act which could constitute a fraudulent insurance act. The termination will be retroactive to the coverage date. Horizon BCBSNJ retains the right to recoup from any individual all payments made and to retain all charges.

Benefits After Termination

If you or any of your dependents are confined as an inpatient in an eligible facility on the date your coverage ends, benefits will be available for eligible services provided during the uninterrupted continuation of that stay, but only to the extent they would otherwise be available.

If You Leave Your Group Due To Total Disability

If you can no longer be employed due to a total disability, you can arrange to continue coverage through your group (including coverage for dependents) if:

- You were continuously enrolled under the group program for the three months immediately prior to your loss of employment;
- You notify your employer in writing that you want to continue your group coverage (within **31** days of the date your coverage would normally end);
- You pay to your employer any contribution required toward the group rate for continuation of coverage.

However, continued coverage under this program for you and your eligible dependents will end at the first to occur of the following:

- Failure by you to make timely payment of any contribution required by your employer. If this happens, coverage will end at the end of the period for which contributions were made;
- The date you become employed and eligible for benefits under another employer's health plan or, in the case of an eligible dependent, the date the dependent becomes employed and eligible for such benefits;
- The date this program ends.

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

Totally disabled means that due to Accidental Injury or Illness, as determined by us:

- You are unable to engage in your regular occupation and are not, in fact, engaged in any employment for wage or profit; or
- Your dependent is unable to engage in the normal activities of a person of like age and sex in good health.

Extension of Coverage Due To Group Termination

If you or any of your dependents are totally disabled on the date your group's coverage under this program ends, benefits will continue to be available for that person for covered medical expenses resulting from the sickness or Accidental Injury that caused the disability during the uninterrupted continuation of the disability. However, benefits will not be extended beyond (1) the date the disability ends, (2) for Hospital and Medical-Surgical benefits, **90** days from the date group coverage ends; for Major Medical expenses, **12** months from the date the group coverage ends; or (3) the extent that benefits remain when the program ends, whichever comes first.

Continuing 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), you may continue to participate in your group's health benefit plan. Your dependents' coverage may also be continued. You will be subject to the same rules regarding deductibles, copayments and contributions as an active employee. However, your legal right to have your employer pay its share of the health benefits' plan premium, as it would for active employees, is conditioned on your eventual return to active employment. Consult your benefits representative for application forms and further information.

Continuing Coverage For Surviving Dependents

Eligible dependents of a deceased employee may have coverage continued under this program for at least **180** days after the employee's death. See your enrollment official for further details and to arrange to make any required premium payments through the group.

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

<u>If a Dependent Is Over the Limiting Age for Dependent Coverage</u>

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.

<u>Conditions for Election</u>

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 Partner who is covered elsewhere, the parent must be enrolled for Dependents coverage under this Policy at the time the Over-Age Dependent elects continued coverage.

Election of Continuation

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

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

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

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

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

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

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

Payment of Premiums

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

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

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

Grace Period for the Payment of Premiums

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

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

Scope of Continued Coverage

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

Single Coverage for Over-Age Dependents

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

When Continuation Ends

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

- The date on which the Over-Age Dependent fails to meet any one of the conditions to be an Over-Age Dependent.

- The end of a period during which a required premium payment for the continued coverage is not made when due, subject to the "Grace Period for the Payment of Premiums" subsection above.

- The date on which the Employee's coverage ends.

- The date on which this Policy's 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.

<u>Inapplicability of Other Continuation Provisions</u>

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.

Continuation of Coverage under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you, 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 the following events occur:

- Your death;
- Your hours of employment are reduced or your employment is terminated (except if your employment was terminated as a result of gross misconduct);
- Your divorce or legal separation;
- Your entitlement to Medicare;
- Your child no longer qualifies as a dependent.
- A proceeding under the United States Bankruptcy Code involving the employer from whom you have retired.

You or your dependent must notify your enrollment official of a divorce, legal separation or child no longer qualifying as a dependent. This notice must be given within **60** days of the date the event occurred. If notice is not given within this time, you and your dependents will not be allowed to continue coverage.

You must pay the required amount to maintain your coverage. If you and/or your dependents elect to continue coverage, it will be identical to the health care coverage for other members of your group; it will continue for a maximum of:

- Up to **18** months in the event of the termination of your employment or a reduction in your hours; further, if you were disabled, according to the Social Security Act, at the time you became eligible for COBRA coverage, or within the first **60** days of COBRA coverage, you may continue coverage for an additional **11** months (up to **29** months total if your disability continues during that period);
- Up to **36** months for your dependent(s) in the event of your death, your divorce or legal separation, if you become entitled to Medicare or if your child no longer qualifies as a dependent.
- If there is a proceeding under the United States Bankruptcy Code involving the employer from whom you have retired, your continuation coverage will end when you die, and continuation coverage for your dependents will end **36** months after the date of your death.

Continuation coverage will cease before the end of the maximum periods just described if one of these events occurs:

- this program terminates;
- you or your dependents fail to make required contributions;
- either you or your dependent become employed and covered under any other group health plan (except that coverage will not end under this provision if the new coverage contains an exclusion or limitation with respect to a pre-existing condition);
- you become entitled to Medicare benefits
- if your continuation coverage was extended past **18** months as a result of disability, continuation coverage will end on the first day of the month which is more than **30** days following a determination that you are no longer disabled.

Your employer is responsible for providing all notices required with respect to this provision.

If you are a divorced spouse of the employee you 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.

Conversion Coverage

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

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

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

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

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

Medical Necessity

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 or out-of-Hospital);
- Services or supplies are Medically Necessary for the treatment and diagnosis of an Illness or Accidental 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 FOR THE TREATMENT AND DIAGNOSIS OF AN ILLNESS OR ACCIDENTAL 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 service when performed in that setting.

Your Health Care Program

Your health care program provides you with the freedom to choose any Provider. Any balances or services not covered under the hospital or medical-surgical portion of your program may be submitted to major medical. Eligible major medical services are covered to our allowance, and are subject to deductible and coinsurance. If you receive care from physicians in the Horizon BCBSNJ Traditional Physician's Network, they will accept our payment as payment in full. Physicians who are not in the Horizon Traditional Physician's network may balance bill to charges.

Your major medical program shares the cost of your health care expenses with you. This section explains how Deductibles and Coinsurance work.

How The Program Works

Benefit Period

The benefit period is from January 1 to December 31 in each year while the coverage remains in effect.

Deductible

The Deductible amount that must be paid by a Covered Person before he or she will be eligible for major medical benefits is **$250**.

Please see the Schedule of Covered Services and Supplies for additional information.

Coinsurance and Maximum Benefits

After you have paid your Deductible, you share in paying the balance of covered medical expenses. This is called your Coinsurance. The coinsurance for outpatient and out-of-Hospital mental care may vary.

We will pay a percentage of our applicable allowance for covered medical expenses incurred by each Covered Person in excess of the Deductible. Our coinsurance amounts are shown in the Schedule of Covered Services and Supplies; you will be responsible for the remainder. For example, if our coinsurance is **80%**, the coinsurance you will be responsible for will be **20%**.

Summary of Covered Services and Supplies

This section lists the types of charges Horizon BCBSNJ will consider as Covered Services or Supplies up to its Allowance subject to all the terms of your group's policy including, but not limited to, Medical Necessity and Appropriateness, Utilization Management features, Schedule of Covered Services and Supplies, benefit limitations and exclusions.

A. ELIGIBLE HOSPITAL BENEFITS

The following will be considered Covered Services or Supplies only when billed for by and payable to a Hospital or other Facility as specifically stated in this section.

Ambulatory Surgical Center Benefits

a. Benefits will be provided for Covered Services performed at an Ambulatory Surgical Center only if the services would be considered Covered Services if performed in a Hospital as an Outpatient. Procedures related to obstetrical care are eligible only if the Covered Person is eligible for obstetrical benefits.

b. The Covered Person must be admitted and discharged within a 24-hour period.

Domestic Violence

Coverage shall not be denied for those Covered Services and Supplies incurred in the treatment of an Injury or Injuries sustained as the result of domestic violence.

General Inpatient Benefits

a. Bed and meals, including special dietary service in a Semi-Private room. If the Covered Person occupies a Private room in an In-Network Hospital, he must pay the difference between the Private Room rate and the average room rate for all Semi-Private rooms in the same area of service in the Hospital;

b. Routine Nursing Care;

c. Services of all Hospital employees, interns, residents, technicians and independent contractors when paid by the Hospital for providing Covered Services;

d. Use of the operating, recovery, treatment, delivery and emergency room equipment and Facilities;

e. Therapeutic solutions, all types of anesthetic agents, oxygen, sera (when used as other than blood substitutes or replacements), dressings, bandages, casts, surgically implanted cardiac pacemakers, including batteries, electrodes and their replacements;

f. All drugs and medicines used during the Covered Person's hospitalization which are approved by the Food and Drug Administration (FDA) for consumption by the general public. 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 if the drug has been recognized as medically appropriate for the specific treatment for which the drug 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 Pharmacopoeia Drug Information;

      or it is recommended by a clinical study or review article in a major peer-reviewed professional journal. However, coverage under this sub-paragraph shall not be required for any Experimental or Investigational drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

g. Therapy Services;

h. Breast prostheses following a mastectomy on one breast or both breasts;

i. Blood processing services provided by the Hospital or by a non-profit blood supplier for drawing, processing and distributing blood. The cost of blood is not covered;

j. Diagnostic X-ray examinations, radioactive isotope studies, laboratory and pathology services;

k. **Second Opinion Charges –** This Policy covers a consultative opinion given by a qualified specialist physician who has agreed to provide second surgical opinions, and directly related Diagnostic Services to confirm the need for elective surgery as first recommended by a physician. The consultation services must be performed before the Covered Person is admitted to the Hospital or Facility for the recommended Surgery. This Policy covers such charges if:

   a. the second opinion consultant must not be the physician who first recommended elective Surgery;

   b. elective Surgery is covered Surgery that may be deferred and is not an emergency;

c. use of a second opinion is at the Covered Person's option;

d. if the first opinion for elective Surgery and the second conflict, then a third opinion and directly related Diagnostic Services are Covered Services;

e. if consultant's opinion is against elective Surgery and the Covered Person decides to have the elective Surgery, the Surgery is a Covered Service;

f. Horizon BCBSNJ will not pay for a second opinion consultation for the following kinds of elective Surgery: cosmetic Surgery.

l. X-ray therapy, radium therapy, radon or radioactive isotope therapy;

m. Surgical services including, but not limited to, those following a mastectomy on one breast or both breasts, reconstructive breast surgery and surgery to achieve symmetry between the two breasts.

This program also covers a Hospital stay for at least 72 hours following a modified radical mastectomy and a Hospital stay for at least 48 hours following a simple mastectomy, unless the Covered Person, in consultation with the Covered Person's physician, determines that a shorter length of stay is medically appropriate. While there is no requirement that the Covered Person's Provider obtain Preapproval from BCBSNJ for prescribing 72 or 48 hours, as appropriate, of Inpatient care as set forth in this subsection, any notification requirements under this program remain in full force and effect;

If you are receiving benefits in connection with a mastectomy and elect to have breast reconstruction along with that mastectomy, your plan must provide in a manner determined in consultation with the attending physician and you, coverage for the following:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided to the same extent as for any other sickness under your group's policy.

n. All other approved Hospital Facilities and equipment not specifically excluded in this section.

Home Health Agency Care

This program covers Home Health Agency care services and supplies under a physician's supervision only if furnished by Providers on a part-time or intermittent basis, except when full-time or **24** hour service is needed on a short-term basis, and if the patient is receiving Hospital benefits for home health care through Horizon BCBSNJ or would be eligible for such benefits if enrolled for coverage with Horizon BCBSNJ.

The home health care plan must be established in writing by the Covered Person's Practitioner within **14** days after home health care starts and it must be reviewed by the Covered Person's Practitioner at least once every **60** days. In order for Home Health Agency charges to be considered Covered Charges the Covered Person's Admission to Home Health Agency care must occur within 14 days of an Inpatient Admission lasting 3 or more days.

When these conditions are met, the patient is entitled to benefits for physician's Visits for such home care. Home care is available only if the Covered Person would otherwise have to stay in a Hospital or Skilled Nursing Facility. Only Medically Necessary care is covered. Horizon BCBSNJ can require evidence that the home care is necessary, and that institutional care would otherwise be needed. Home medical service does not cover any of the following: post-operative care; care for mental, psychoneurotic and personality disorders.

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

This program does not cover:

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

b. services and supplies not included in the home health care plan.

Hospice Care Benefits

a. Hospice Care benefits will be provided for:

    1. part-time professional nursing services of an R.N., L.P.N. or L.V.N.;

    2. home health aide services provided under the supervision of a R.N.;

    3. medical care rendered by a Hospice Care Program Practitioner;

    4. Therapy Services;

    5. Diagnostic Services;

    6. medical and Surgical supplies and Durable Medical Equipment if Preapproved;

7. Prescription Drugs;
8. oxygen and its administration;
9. medical social services;
10. respite care;
11. psychological support services to the Terminally Ill or Injured patient;
12. family counseling related to the patient’s terminal condition;
13. dietitian services; and
14. Inpatient room, board and Routine Nursing Care.

b. No Hospice Care benefits will be provided for:

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

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

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

Inpatient Dental Care Benefits

a. Services received because of an accidental injury;

b. Extraction of impacted molars or impacted bicuspids, or treatment of a malignancy of the mouth, or oral surgery (except extractions of the teeth which are not impacted molars or impacted bicuspids);

c. Extraction of teeth that has been certified in writing by a physician to be Medically Necessary because of a non-dental condition;

d. Services given as part of treatment for an eligible non-dental condition to relieve the patient's discomfort during an eligible Hospital Stay.

This program also covers:

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

b. the surgical removal of bony impacted teeth; and

c. charges for Surgical and non-Surgical treatment of temporo-mandibular joint dysfunction syndrome (TMJ) in a Covered Person. However, this program does not cover any charges for orthodontia, crowns or bridgework.

This program also covers treatment of an Injury to natural teeth or the jaw, but only if:

a. the Injury occurs while the Covered Person is covered under this program; and

b. the Injury was not caused, directly or indirectly, by biting or chewing.

Treatment includes replacing natural teeth lost due to such Injury, in no event does it include orthodontic treatment.

For a Covered Person who is severely disabled or who is a Child Dependent under age 6, coverage shall be provided for the following:

a. general anesthesia and Hospitalization for dental services; or

b. dental services rendered by a dentist regardless of where the dental services are provided for medical conditions covered by this Contract which require Hospitalization of general anesthesia.

This coverage shall be subject to the same utilization requirements imposed upon all inpatient stays.

Inpatient Obstetrical Care Benefits

Hospital Stay related to pregnancy, childbirth, abortion, or miscarriage, including the Hospital delivery, is covered for at least 48 hours after a vaginal delivery or 96 hours after a cesarean section if the attending Practitioner determines that Inpatient care is Medically Necessary and Appropriate or if requested by the eligible mother notwithstanding Medical Necessity and Appropriateness.

Hospital care provided to a newborn Child during the initial eligible joint Hospital Stay of the eligible mother and her Child is covered in the Covered Person's obstetrical care benefits.

Maternity care benefits are extended to Child Dependents. For the newborn infant of a Child Dependent to be covered beyond the initial, joint Hospital Stay, the Child Dependent must apply for a change to a non-group Parent and Child contract. This change will be approved automatically if the application is submitted within **60** days of the newborn Child's birth. A newborn Child will be covered from birth if the application is submitted within **60** days of birth.

Inpatient or Outpatient Treatment of Alcoholism

a. Care in a health care Facility licensed pursuant to P.L. 1971, c. 136 (N.J.S.A. 26:2H-1 et seq.);

b. At a detoxification Facility licensed pursuant to Section 8 of P.L. 1975, C. 305 (N.J.S.A. 26:2B-14); or

c. As an Inpatient or Outpatient at a licensed, certified or State approved residential treatment Facility, under a program which meets minimum standards of care equivalent to those prescribed by the Joint Commission.

Treatment or confinement at any Facility shall not preclude further or additional treatment at any other eligible Facility, if the Benefit Days used do not exceed the total number of Benefit Days provided for any other Illness under your group's Program.

Treatment or confinement at any of the above types of Facilities are covered only when the Covered Services are billed for by and payable to the Hospital or Facility and consist of:

1. Bed and board in a Semi-Private Room (Inpatient only);

2. Routine Nursing Care;

3. Services of the staff (voluntary or paid employees of the Facility) including necessary trained professionals contracted or paid for by the Facility;

4. Biologicals, solutions, drugs, medicines and medications used while the patient is in the Facility and which, at the time prescribed are in commercial production and commercially available to the Facility;

5. Laboratory tests necessary for patient care;

6. Psychological testing by a licensed psychologist;

7. Individual and group therapy or counseling;

8. Family counseling; and

9. Occupational Therapy but not diversional/recreational therapy or activity.

Ambulatory services must be provided under a program approved by the New Jersey State Division of Alcoholism.

Mammography Benefits

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

Horizon BCBSNJ will cover charges for:

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

b. one mammogram each year for female Covered Persons age 40 and older.

Mental or Nervous Disorders and Substance Abuse

This part of the Program covers treatment for Mental or Nervous Disorders and Substance Abuse.

The benefits for the treatment of Mental or Nervous Disorders or Substance Abuse are provided

on the same basis and subject to the same terms and rules as for other conditions.

Outpatient Hospital Benefits

The Covered Person is eligible for the same services that would have been covered for an Inpatient except that Outpatient benefits do not include bed, meals, Radiation Therapy or Physical Therapy. The Covered Person is entitled to benefits when he uses the outpatient department under the following situations:

a. Hospital care required as a result of any accidental injury;

b. Surgery of a cutting or cauterizing nature other than chemical cauterization. Procedures related to obstetrical care are eligible only if the Covered Person is otherwise eligible for obstetrical care;

c. Surgical diagnostic procedures which Horizon BCBSNJ determines must be performed in the outpatient department;

d. Blood transfusions;

e. Application of casts;

f. Complete cardiac pacemaker follow-up examinations but not telephone check-ups;

g. Dental services specified under Hospital Inpatient benefits;

h. Dialysis treatment;

i. Removal of implanted orthopedic hardware (nails, screws, plates, etc.);

j. Treatment of poisoning;

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

l. This program covers the following Joint Hospital and Medical-Surgical Additional Benefits on an Outpatient or Out-of-Hospital basis:

    1. X-ray therapy for a proven malignancy, radioactive isotope therapy (non-sealed sources), and Chemotherapy for a proven malignancy.

    2. Diagnostic X-ray and radioactive isotope studies, pathology including laboratory examinations, electrocardiograms, electroencephalograms, and other tests of a non-experimental nature approved by Horizon BCBSNJ.

3. Radium, radioactive isotope (sealed sources) or radon therapy.

4. Physical Therapy Services.

Skilled Nursing Facility Charges

This Policy covers bed and board, including diets, drugs, medicines and dressings and general nursing service in a Skilled Nursing Facility. The Covered Person must be admitted to the Skilled Nursing Facility within 14 days of discharge from a Hospital, following an Inpatient stay of at least 3 days, for continuing medical care and treatment prescribed by a Practitioner.

Transplant Benefits

This program covers Pre-approved services and supplies for the following types of transplants:

a. Cornea

b. Kidney

c. Lung

d. Liver

e. Heart

f. Pancreas

g. Allogeneic bone marrow

h. This program provides benefits for the treatment of cancer by dose-intensive Chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants when performed by institutions approved by the National Cancer Institute or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists. Such treatment shall be provided to the same extent as for any other Illness.

i. Heart-valve

j. Heart-lung

Wilm's Tumor

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

B. ELIGIBLE MEDICAL-SURGICAL BENEFITS

The following will be considered Covered Services or Supplies when provided to an Inpatient or on an Outpatient basis in a Hospital or other Facility, as specifically stated in this section, or on an Out-of-Hospital basis only when specifically stated in a paragraph of this section.

Alcoholism

This program covers Inpatient or Outpatient treatment of Alcoholism as follows:

a. Care in a health care Facility licensed pursuant to P.L. 1971, c. 136 (N.J.S.A. 26:2H-1 et seq.);

b. At a detoxification Facility licensed pursuant to Section 8 of P.L. 1975, C. 305 (N.J.S.A. 26:2B-14); or

c. As an Inpatient or Outpatient at a licensed, certified or State approved residential treatment Facility, under a program which meets minimum standards of care equivalent to those prescribed by the Joint Commission.

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

Treatment or confinement at any of the above types of Facilities are covered only when the Covered Services are billed for by and payable to the Hospital or Facility and consist of:

a. Bed and board in a Semi-Private Room (Inpatient only);

b. Routine Nursing Care;

c. Services of the staff (voluntary or paid employees of the Facility) including necessary trained professionals contracted or paid for by the Facility;

d. Biologicals, solutions, drugs, medicines and medications used while the patient is in the Facility and which, at the time prescribed are in commercial production and commercially available to the Facility;

e. Laboratory tests necessary for patient care;

f. Psychological testing by a licensed psychologist;

g. Individual and group therapy or counseling;

h. Family counseling; and

i. Occupational Therapy but not diversional/recreational therapy or activity.

Ambulatory services must be provided under a program approved by the New Jersey State Division of Alcoholism.

Anesthesia

This program covers the administration of general anesthesia by a physician anesthesiologist, or by a Certified Registered Nurse Anesthetist (CNRA) employed by and personally supervised by a physician anesthesiologist. This includes spinal and rectal anesthesia, and the administration of other anesthetics by injection or inhalation, but it does not include local anesthesia. Examinations, consultations, and other necessary care an anesthesiologist gives before, during, and after the operation are all included in the payment for anesthesia service. Anesthesia is not covered when given by the surgeon or the assistant surgeon.

Breast Prostheses

This program covers breast prostheses when provided by and billed for by a physician following a mastectomy on one breast or both breasts.

Home Health Agency Care

This program covers Out-of-Hospital Home Health Agency care services and supplies under a physician's supervision only if furnished by Providers on a part-time or intermittent basis, except when full-time or **24** hour service is needed on a short-term basis, and if the patient is receiving Hospital benefits for home health care through Horizon BCBSNJ or would be eligible for such benefits if enrolled for coverage with Us.

The home health care plan must be established in writing by the Covered Person's Practitioner within **14** days after home health care starts and it must be reviewed by the Covered Person's Practitioner at least once every 60 days. In order for Home Health Agency charges to be considered Covered Charges the Covered Person's Admission to Home Health Agency care must occur within 14 days of an Inpatient Admission lasting 3 or more days.

When these conditions are met, the patient is entitled to benefits for physician's Visits for such home care. Home care is available only if the Covered Person would otherwise have to stay in a Hospital or Skilled Nursing Facility. Only Medically Necessary care is covered. Horizon BCBSNJ can require evidence that the home care is necessary, and that institutional care would otherwise be needed. Home medical service does not cover any of the following: post-operative care; care for mental, psychoneurotic and personality disorders.

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

This program does not cover:

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

b. services and supplies not included in the home health care plan.

Hospital-Employed Physician Specialist Services

This program covers Hospital-Employed Physician Specialist services. Benefits for the services listed below are eligible if performed on an Inpatient basis and billed for separately by a Hospital-employed physician specialist:

a. making and interpreting electromyograms and nerve conduction studies

b. interpreting electrocardiograms, electroencephalograms and other graphic studies approved by Horizon BCBSNJ and,

c. anatomical pathology.

These same services are eligible on an Outpatient basis when performed and billed for by a Hospital-Employed Physician Specialist if they are performed in connection with accidental injury, surgery of a cutting or cauterizing nature, the diagnostic surgical procedures as stated in Paragraph B. 1., or the initial diagnostic evaluation of Alcoholism.

In-Hospital Dental Surgical Service

This program covers In-Hospital dental Surgical Service, which is Surgical service to the alveolar processes, gums, cheeks, jaws or mouth, or to one or more teeth.

a. Dental surgery is covered when it is performed in a Hospital and meets at least one of the following conditions:

    i. It must be necessary because of an accidental injury, and must be given during a hospitalization immediately after the accident takes place; or

    ii. It must involve the extraction of one or more bony impacted teeth, or treatment of a malignancy of the mouth;. Dental surgical services include extraction of bony impacted teeth wherever performed; or

    iii. It must involve Surgical Services that are recognized as common to both the medical and dental professions, such as setting a fractured jaw.

Coverage shall be provided for covered individuals who are severely disabled or Child Dependents under age 6 for the following:

a. general anesthesia and Hospitalization for dental services; or

b. dental services rendered by a dentist regardless of where the dental services are provided for medical conditions covered by this Contract which require Hospitalization or general anesthesia.

This coverage shall be subject to the same utilization requirements imposed upon all impatient stays.

In-Hospital Consultation Service

This program covers In-Hospital consultation service, a physician's personal examination of an Inpatient covered under this program in connection with a diagnosed condition, subject to the following:

a. The attending physician must have requested the consulting physician to make the examination.

b. The consulting physician's findings and recommendations must be entered on the Inpatient's Hospital chart.

c. After giving the consultation, the consulting physician must not give further services as an attending physician.

Only one In-Hospital consultation per Hospital Stay is covered.

In-Hospital Medical Service

This program covers In-Hospital medical service, which is one or more Visits by a physician to a Hospital Inpatient. The Visits must be for necessary medical treatment of a diagnosed condition. Care of a healthy newborn is covered when provided by a doctor who was not involved in the delivery service.

Initial Emergency Medical Service

This program covers an initial emergency medical service. When medical service is given for an accidental injury or a medical emergency from an external cause, the initial services are covered if they are performed by a Practitioner and if they are given within 48 hours after the accident, in either the Hospital Outpatient department or Out-of-Hospital. Only the first Visit is covered.

Joint Hospital and Medical-Surgical Additional Benefits

This program covers the following Joint Hospital and Medical-Surgical Additional Benefits on an Outpatient or Out-of-Hospital basis:

a. X-ray therapy for a proven malignancy, radioactive isotope therapy (non-sealed sources), and Chemotherapy for a proven malignancy.

b. Diagnostic X-ray and radioactive isotope studies, pathology including laboratory examinations, electrocardiograms, electroencephalograms, one routine pap smear per Benefit Year, and other tests of a non-experimental nature approved by Horizon BCBSNJ.

c. Radium, radioactive isotope (sealed sources) or radon therapy.

d. Physical Therapy Services.

Mental or Nervous Disorders and Substance Abuse

This part of the Program covers treatment for Mental or Nervous Disorders and Substance Abuse.

The benefits for the treatment of Mental or Nervous Disorders or Substance Abuse are provided on the same basis and subject to the same terms and rules as for other conditions.

Obstetrical Services

This program covers obstetrical services given for pregnancy or childbirth, or for any related diseases, injuries or conditions. Care of healthy newborn children, while both mother and child are hospitalized, is included in the payment for this service. But if the child's care is given by a different physician from the one who gave obstetrical care to the mother, both services are eligible for separate payment.

These services are payable regardless of where the services are provided following completion of 28 weeks of pregnancy. But if the pregnancy ends before it has run 28 weeks, obstetrical service will be covered only if it is given in a Hospital or for a legal abortion in a New Jersey licensed abortion clinic.

Visits by a physician for complications of pregnancy also are covered for Inpatients who are eligible for obstetrical services. These Visits are eligible for payment in addition to the delivery services. They are covered as part of the In-Hospital medical service described in this Section, and are subject to the limits on In-Hospital medical service coverage.

Maternity care benefits are extended to Child Dependents. For the newborn infant of a Child Dependent to be covered beyond the initial, joint Hospital Stay, the Child Dependent must apply for a change to a non-group Parent and Child contract. This change will be approved

automatically if the application is submitted within **60** days of the newborn Child's birth. A newborn Child will be covered from birth if the application is submitted within **60** days of birth.

Out-of-Hospital Dental Surgical Service

This program covers Out-of-Hospital dental surgical service, but only in cases of emergency. The emergency must result from an accidental injury, and the Surgical Service must take place within 48 hours after the accident. NOTE: Many dental procedures are specifically excluded from coverage under this program. They are discussed in Exclusions section of this booklet.

Outpatient

This program covers the following services when given to an Outpatient if they are Medically Necessary and performed by a physician: cardiac pacemaker follow-up examination; dialysis treatment; removal of implanted orthopedic hardware; initial treatment of poisoning; cardioversion.

Second Opinion Charges

This Policy covers a consultative opinion given by a qualified specialist physician who has agreed to provide second surgical opinions, and directly related Diagnostic Services to confirm the need for elective surgery as first recommended by a physician. The consultation services must be performed before the Covered Person is admitted to the Hospital or Facility for the recommended Surgery. This Policy covers such charges if:

a. the second opinion consultant must not be the physician who first recommended elective Surgery;

b. elective Surgery is covered Surgery that may be deferred and is not an emergency;

c. use of a second opinion is at the Covered Person's option;

d. if the first opinion for elective Surgery and the second conflict, then a third opinion and directly related Diagnostic Services are Covered Services;

e. if the consultant's opinion is against elective Surgery and the Covered Person decides to have the elective Surgery, the Surgery is a Covered Service;

f. Horizon BCBSNJ will not pay for a second opinion consultation for the following kinds of elective Surgery: cosmetic Surgery.

Skilled Nursing Facilities

Patients covered under this program are eligible for coverage in Skilled Nursing Facilities, subject to the following condition:

> The Covered Person must be admitted to the Skilled Nursing Facility within 14 days of discharge from a Hospital, following an Inpatient stay of at least 3 days, for continuing medical care and treatment prescribed by a Practitioner.
>
> Horizon BCBSNJ can require evidence to verify that the stay in a Skilled Nursing Facility is Medically Necessary the determination of which is up to us. After reviewing the evidence of Medical Necessity, Horizon BCBSNJ can decide to cover additional Visits by a physician.

Shock Therapy

This program covers shock therapy. These are shock treatments that induce coma or convulsions, including electroshock treatments, insulin shock treatments and other similar treatments given for a psychiatric condition to an Inpatient or Outpatient. Payment for this service includes payment for anesthesia in connection with the shock treatment and for all other covered services performed on that day for the psychiatric condition. Benefits for these connected services may not be claimed separately under other provisions of this program.

Surgical Services

This program covers Surgical Services subject to the following: Outpatient coverage includes the application of casts for any condition, blood transfusions, and paracenteses.

a. Cutting or cauterizing surgery and the setting of fractures or dislocations are covered at Hospitals on either an Inpatient or Outpatient basis or at In-Network Ambulatory Surgical Centers.

b. When Surgical Service is needed because of an accidental injury, it is covered at a Hospital on an Inpatient or Outpatient basis or at an In-Network Ambulatory Surgical Center. Emergency surgery for accidental injury is also covered, But if it is given outside a Hospital or an In-Network Ambulatory Surgical Center, the Surgical Service must take place within 48 hours after the accident.

c. The removal of tonsils and/or adenoids is covered regardless of where this service is performed.

d. The following diagnostic surgical procedures are covered at Hospitals on either an Inpatient or an Outpatient basis: amniocentesis (subject to eligibility for obstetrical benefits) angiocardiography, aortography, arthrogram, bronchoscopy, cardiac catheterization, cerebral arteriography, colonoscopy, cystoscopy (under general

anesthesia), esophagoscopy, gastroscopy, laparoscopy, myelography, peritoneoscopy, pneumoencephalography, thoracoscopy, ventriculography.

e. Surgical service includes services of a physicians who actively assist the operating surgeon in the performance of surgical services. Surgical assistance in a Hospital is covered when the service is medically necessary, when the type of surgical service requires assistance, and when interns, residents or house staff of the Hospital are not available.

f. Surgical services including, but not limited to, those following a mastectomy on one breast or both breasts, reconstructive breast surgery and surgery to achieve symmetry between the two breasts.

If you are receiving benefits in connection with a mastectomy and elect to have breast reconstruction along with that mastectomy, your plan must provide in a manner determined in consultation with the attending physician and you, coverage for the following:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided to the same extent as for any other sickness under your group's policy.

g. The following surgical services performed outside a Hospital:

1. Cutting or cauterizing surgery to treat non-accidental conditions;

2. Any of the following diagnostic surgical procedures: angiocardiography, bronchoscopy, cerebral arteriography, colonoscopy, cystoscopy, esophagogastroscopy, esophagoscopy, gastroscopy, laryngoscopy, lumbar aortography, peritoneoscopy/laparoscopy, proctoscopy, sigmoidoscopy, thoracic aortography, and thoracoscopy.

Transfusions

This program covers the administration of exchange and direct transfusions. There is no separate coverage for other transfusions except when they are administered on an Outpatient basis.

Transplant Benefits

This program covers Transplant Benefits.

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

a. Cornea

b. Kidney

c. Lung

d. Liver

e. Heart

f. Pancreas

g. Allogeneic bone marrow

h. This program provides benefits for the treatment of cancer by dose-intensive Chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants when performed by institutions approved by the National Cancer Institute or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists. Such treatment shall be provided to the same extent as for any other Illness.

i. Heart-valve

j. Heart-lung

Wilm's Tumor

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

C. MAJOR MEDICAL BENEFITS

Acupuncture

Acupuncture services are eligible when the Acupuncture is performed for anesthetic or therapeutic (for relief of pain) purposes by a Practitioner**.**

Alcoholism

Inpatient or Outpatient treatment of Alcoholism as follows:

a. Care in a health care Facility licensed pursuant to P.L. 1971, c. 136 (N.J.S.A. 26:2H-1 et seq.);

b. At a detoxification Facility licensed pursuant to Section 8 of P.L. 1975, C. 305 (N.J.S.A. 26:2B-14); or

c. As an Inpatient or Outpatient at a licensed, certified or State approved residential treatment Facility, under a program which meets minimum standards of care equivalent to those prescribed by the Joint Commission.

Treatment or confinement at any Facility shall not preclude further or additional treatment at any other eligible Facility, if the Benefit Days used do not exceed the total number of Benefit Days provided for any other Illness under the program. Treatment or confinement consist of:

1. Bed and board in a Semi-Private Room (Inpatient only);

2. Routine Nursing Care;

3. Services of the staff (voluntary or paid employees of the Facility) including necessary trained professionals contracted or paid for by the Facility;

4. Biologicals, solutions, drugs, medicines and medications used while the patient is in the Facility and which, at the time prescribed are in commercial production and commercially available to the Facility;

5. Laboratory tests necessary for patient care;

6. Psychological testing by a licensed psychologist;

7. Individual and group therapy or counseling;

8. Family counseling; and

9. Occupational Therapy but not diversional/recreational therapy or activity.

Ambulatory services must be provided under a program approved by the New Jersey State Division of Alcoholism.

Allergy Testing

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

Ambulance

This program covers charges for Ambulance services for transporting a Covered Person to:

a. a local Hospital, if needed care and treatment can be provided by a local Hospital;

b. the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide it. It must be connected with an Inpatient Admission; or

c. another Inpatient Facility when Medically Necessary and Appropriate.

Coverage can be by professional Ambulance service, ground or air. This program does not cover chartered air flights. This program will also not cover other travel or communication expenses of patients, Practitioners, Nurses or family members.

Anesthetics

Anesthetics and their administration.

Audiology Services

This program covers audiology services rendered by a physician or a licensed audiologist, where such services are Determined to be Medically Necessary and Appropriate and when performed within the scope of practice.

Bed and Board, Including Special Diets, and Routine Nursing Care in a Hospital

Bed and board, including special diets, and Routine Nursing Care in a Hospital except for daily charges in excess of the Hospital's average Semi-Private Room rate.

Blood Transfusions

Blood transfusions, including cost of blood, blood plasma and blood plasma expanders when it is not donated or replaced through a blood bank or otherwise.

Dental Treatment

Dental treatment, dental surgery or dental appliances made necessary by accidental bodily injury occurring after the Covered Person is covered under this program. This program covers dental surgical services of a kind recognized as common to both the medical and dental professions such as treatment of malignancy of the mouth. This program also covers:

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

b. the surgical removal of bony impacted teeth; and

c. charges for Surgical and non-Surgical treatment of temporo-mandibular joint dysfunction syndrome (TMJ) in a Covered Person. However, this program does not cover any charges for orthodontia, crowns or bridgework.

This Policy also covers treatment of an Injury to natural teeth or the jaw, but only if:

a. the Injury occurs while the Covered Person is covered under this program; and

b. the Injury was not caused, directly or indirectly, by biting or chewing.

Treatment includes replacing natural teeth lost due to such Injury, in no event does it include orthodontic treatment.

For a Covered Person who is severely disabled or who is a Child Dependent under age 6, coverage shall be provided for the following:

a. general anesthesia and Hospitalization for dental services; or

b. dental services rendered by a dentist regardless of where the dental services are provided for medical conditions covered by this Contract which require Hospitalization of general anesthesia.

This coverage shall be subject to the same utilization requirements imposed upon all inpatient stays.

Diabetes Benefits

This program provides benefits for expenses incurred 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 thereto;

h. insulin infusion devices; and

i. oral agents for controlling blood sugar.

This program provides benefits for expenses incurred for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of his condition, including information on proper diet.

Benefits for self-management education and education relating to diet shall be limited to Visits Medically Necessary upon:

a. the diagnosis of diabetes;

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

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

Diabetes self-management education is covered when provided by:

a. a dietitian registered by a nationally recognized professional association of dietitians,

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

c. 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.

Domestic Violence

Coverage shall not be denied for those Covered Services and Supplies incurred in the treatment of an Injury or Injuries sustained as the result of domestic violence.

Drugs

Drugs, medicines and dressings used in a Hospital.

Durable Medical Equipment

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

a. replacements or repairs; or

b. the rental or purchase of any items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not fully meet the definition of Durable Medical Equipment.

Health Wellness

This policy provides coverage for the following tests and services:

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

b. For all Covered Persons 35 years of age or older, a glaucoma eye test every 5 years;

c. For all Covered Persons 40 years of age or older, an annual stool examination for presence of blood;

d. For all Covered Persons 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every 5 years;

e. For all adult Covered Persons recommended immunizations;

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

g. Gynecological Examination – This Policy covers a routine gynecological examination including 1 pap smear per Benefit Period as designated in the Schedule of Covered Services and Supplies;

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

Horizon BCBSNJ will cover charges for:

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

b. one mammogram each year for female Covered Persons age 40 and older.

i. Pap Smears – This Policy provides for charges incurred in conducting a Pap smear. This benefit, except as may be Medically Necessary and Appropriate for diagnostic purposes, shall be limited to one pap smear per Benefit Period.

j. Prostate Cancer Screening – This Policy covers one routine office visit per Benefit Period for Adult Covered Persons, including a digital rectal examination and a prostate–specific antigen test for adult male Covered Persons.

k. Well-Child Immunizations and Lead Poisoning Screening and Treatment – Benefits for immunizations and lead poisoning screening and treatment are covered as described below. They are not limited to any age restriction.

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

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

l. Well-Child Care Benefits

Benefits are provided for well-child care for your enrolled child dependents through the end of the day before the child attains age twenty.

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

For the purposes of this part:

(a) “newborn” means a child up to 28 days old;

(b) “infant” means a child between the ages of 29 days and 36 months old ; and

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

n. Colorectal Cancer Screening – Coverage is provided for colorectal cancer screening rendered at regular intervals for Covered Persons 50 years of age or older and for Covered Persons of any age who are deemed to be at high risk for this type of cancer.

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

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

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

Hearing Aids and Related Services

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

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

- the purchase of the hearing aid;
- hearing tests;
- fittings;
- modifications; and

- repairs (but not battery replacement).

Infertility Services

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

a. Assisted hatching;

b. Diagnosis and diagnostic tests

c. Gamete intrafallopian transfer;

d. Medications, including injectible infertility medications;

e. Ovulation induction;

f. Surgery, including microsurgical sperm aspiration;

g. Artificial insemination;

h. In vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate;

i. Fresh and frozen embryo transfer;

j. Zygote intrafallopian transfer;

k. Intracytoplasmic sperm injections.

l. The cryopreservation and storage of sperm, eggs and embryos for the initial service only. The process of cryopreservation of sperm is covered for a male undergoing cancer treatment who may become infertile. Expenses for storage are not covered.

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

1. Services for in vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer shall be limited to a Covered Person who has used all reasonable, less expensive, and medically appropriate treatments for infertility.

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

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

4. The following services are not covered:

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

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

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

   (d) Ovulation kits and sperm testing kits and supplies.

   (e) Reversal of voluntary sterilization.

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

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

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

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

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

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

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

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

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

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

Fertilization: The penetration of the egg by the sperm.

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

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

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

Infertility: A disease or condition that results in the abnormal function of the reproductive system such that: (i) a male is unable to impregnate a female; (ii) the male or female is medically sterile; or (iii) the female is unable to carry a pregnancy to live birth. The term does not apply to a person who has been voluntarily sterilized, regardless of whether the person has attempted to reverse the sterilization.

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

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

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

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

Oocyte: The female egg or ovum.

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

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

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

Zygote: A fertilized egg before cell division begins.

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

Inherited Metabolic Disease

This program covers therapeutic treatment of Inherited Metabolic Disease the same way it covers charges for any other Illness. This includes the purchase of Medical Foods and Low Protein Modified Food Products, when diagnosed and determined to be Medically Necessary and Appropriate by the Covered Person's physician.

Mastectomy

This program covers surgical procedures including, but not limited to, those following a mastectomy on one breast or both breasts, reconstructive breast surgery and surgery to achieve symmetry between the two breasts. This coverage includes breast prostheses following a mastectomy on one breast or both breasts. This Policy also covers a Hospital stay for at least 72 hours following a modified radical mastectomy and a hospital stay for at least 48 hours following a simple mastectomy, unless the subscriber, in consultation with his physician, determines that a shorter length of stay is medically appropriate. While there is no requirement that the subscriber's provider obtain preapproval from BCBSNJ for prescribing 72 or 48 hours, as appropriate, of Inpatient care as set forth in this subsection, any notification requirements under this program remain in full force and effect.

If you are receiving benefits in connection with a mastectomy and elect to have breast reconstruction along with that mastectomy, your plan must provide in a manner determined in consultation with the attending physician and you, coverage for the following:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided to the same extent as for any other sickness under the your group's policy.

Medical Emergency

Coverage for Emergency and Urgent Care includes coverage of trauma at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgment of the attending physician, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another facility. Horizon BCBSNJ shall provide coverage for a medical screening examination provided upon a Covered Person's

arrival in a Hospital, as required to be performed by the hospital in accordance with federal law, but only as necessary to determine whether an Emergency Medical Condition exists.

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

Mental or Nervous Disorders and Substance Abuse

This part of the Program covers treatment for Mental or Nervous Disorders and Substance Abuse.

The benefits for the treatment of Mental or Nervous Disorders or Substance Abuse are provided on the same basis and subject to the same terms and rules as for other conditions.

Obstetrical Services

This program covers obstetrical services given for pregnancy or childbirth, or for any related diseases, injuries or conditions. Care of healthy newborn children, while both mother and child are hospitalized, is included in the payment for this service. But if the child's care is given by a different physician from the one who gave obstetrical care to the mother, both services are eligible for separate payment.

These services are payable regardless of where the services are provided following completion of 28 weeks of pregnancy. But if the pregnancy ends before it has run 28 weeks, obstetrical service will be covered only if it is given in a Hospital or for a legal abortion in a New Jersey licensed abortion clinic.

Maternity care benefits are extended to Child Dependents. For the newborn infant of a Child Dependent to be covered beyond the initial, joint Hospital Stay, the Child Dependent must apply for a change to a non-group Parent and Child contract. This change will be approved automatically if the application is submitted within **60** days of the newborn Child's birth. A newborn Child will be covered from birth if the application is submitted within **60** days of birth.

Operating or Treatment Rooms

Use of operating or treatment rooms of a Hospital.

Orthotic Devices

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

Oxygen

Oxygen and its administration.

Prescription Drugs

There are no benefits under your Major Medical program for prescription drugs purchased from a Pharmacy. However, the Prescription Drug Copayment amount required under your freestanding prescription drug program is eligible for payment under this program.

Prosthetic Devices

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

Radiation Therapy

Radiation Therapy, including administration, materials and supplies, and use of equipment.

Services of a Physician

Services of a physician who regularly charges for his services as a private physician; but subject to the following conditions and limitations:

For Covered Persons whose Basic Coverage provides payment on the basis of the Allowance, charges by an In-Network Practitioner in excess of the Allowance for a particular service as Determined by Horizon BCBSNJ are not Covered Services or Supplies.

Skilled Nursing Facility

This program covers bed and board, including diets, drugs, medicines and dressings and Routine Nursing Care in a Skilled Nursing Facility.

Specialized Non-Standard Infant Formulas

Coverage is provided for specialized non-standard infant formulas, if these conditions are met:

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

b. The covered infant has determined that the non-standard infant formula is medically necessary; and

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

Speech-Language Pathology

This program covers speech-language pathology services rendered by a physician or a licensed speech-language pathologist, where such services are Determined to be Medically Necessary and Appropriate and when performed within the scope of practice.

Therapeutic Manipulations

This program covers charges for Therapeutic Manipulations.

Therapy Services

Inpatient/Outpatient/Out-of-Hospital Therapy Services.

Treatment of Diseases and Injuries of the Eye

This program also covers treatment of diseases and injuries of the eye; special eyeglasses and contact lenses following cataract removal; and contact lenses which perform the function of the human lens lost as a result of intra-ocular surgery, injury or congenital disease (but replacement of such contact or eyeglass lenses is covered only when necessitated by a change in prescription). Any lenses referred to in this paragraph will be covered only when the lenses become necessary for the correction of conditions arising out of injury or illness occurring while the Covered Person is covered under this section.

Transplant Benefits

This program covers Pre-approved services and supplies for the following types of transplants:

a. Cornea

b. Kidney

c. Lung

d. Liver

e. Heart

f. Pancreas

g. Allogeneic bone marrow

h. This program provides benefits for the treatment of cancer by dose-intensive Chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants when performed by institutions approved by the National Cancer Institute or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists. Such treatment shall be provided to the same extent as for any other Illness.

i. Heart-valve

j. Heart-lung

Urgent Care

Coverage is provided for Urgent Care.

Wigs Benefit

Wigs are covered as a result of hair loss due to radiation therapy, chemotherapy, and second degree burns.

Wilm's Tumor

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

Women's Health and Cancer Rights Treatment

If a Covered Person is receiving benefits in connection with a mastectomy and elects to have breast reconstruction along with such mastectomy, this Policy covers the following in a manner determined in consultation with the attending physician and the Covered Person:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance;
- Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided to the same extent as for any other sickness under your group's policy.

X-ray and Diagnostic Laboratory Procedures

X-ray and diagnostic laboratory procedures.

Utilization Management

IMPORTANT NOTICE – THIS NOTICE APPLIES TO ALL FEATURES UNDER THIS UTILIZATION MANAGEMENT SECTION.

BENEFITS WILL BE REDUCED FOR NON-COMPLIANCE WITH THE PROVISIONS OF THIS UTILIZATION MANAGEMENT SECTION. YOUR GROUP'S POLICY DOES NOT COVER ANY INPATIENT ADMISSION, OR ANY OTHER SERVICES OR SUPPLIES, THAT IS NOT MEDICALLY NECESSARY AND APPROPRIATE. HORIZON BCBSNJ DETERMINES WHAT IS MEDICALLY NECESSARY AND APPROPRIATE UNDER YOUR GROUP'S POLICY.

Your group's policy has Utilization Management features under which Horizon BCBSNJ or its designee reviews Hospital Admissions and listed procedures. These features must be complied with if you:

a. are admitted as an inpatient or outpatient to a Hospital or other Facility or on an out-of-hospital basis; or

b. are advised to enter a Hospital or other Facility; or

c. plan to have a listed procedure performed. If you or your Provider do not comply with this Utilization Management section, you will not be eligible for full benefits under your group's policy. Your group's policy has Medical Appropriateness Review features. Under these features, Horizon BCBSNJ reviews the medical appropriateness of the care that is expected to be rendered.

In addition, what Horizon BCBSNJ covers is subject to all of the terms and conditions of your group's policy.

Your group's policy has Individual Case Management features. Under these features, a case coordinator reviews your medical needs in clinical situations with the potential for catastrophic claims to Determine whether alternative treatment may be available and appropriate. See the Alternative Treatment Features description for details.

Continued Stay Review

Horizon BCBSNJ has the right to initiate a continued stay review of any inpatient admission; and Horizon BCBSNJ may contact your Practitioner or Facility by phone or in writing.

You or your Provider must initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of an inpatient stay. This must be done before the end of the previously authorized length of stay.

In the case of an Admission, the continued stay review Determines:

a. the Medical Necessity and Appropriateness of Admission;

b. the anticipated length of stay and extended length of stay; and

c. the appropriateness of health care alternatives.

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

NOTE: YOUR GROUP'S POLICY DOES NOT COVER ANY CHARGES THAT ARE INCURRED WITH RESPECT TO INPATIENT SERVICES OR SUPPLIES THAT ARE NOT AUTHORIZED IN ACCORDANCE WITH THIS CONTINUED STAY REVIEW.

ALTERNATE TREATMENT FEATURES/INDIVIDUAL CASE MANAGEMENT

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are Determined, in advance, by Horizon BCBSNJ to be Medically Necessary and Appropriate and cost effective in meeting your long-term or intensive care needs in connection with a Catastrophic Illness, Accidental Injury, Mental or Nervous Disorders or Substance Abuse; or in completing a course of care outside of the acute Hospital setting, for example, completing a course of IV antibiotics at home.

b. Benefits for charges Incurred for the services and supplies would not otherwise be payable under this program.

"Catastrophic Illness or Injury" means one of the following:

a. head injury requiring an inpatient stay;

b. spinal cord injury;

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

d. multiple injuries due to an accident;

e. premature birth;

f. CVA or stroke;

g. congenital defect which severely impairs a bodily function;

h. brain damage due to either an accident or cardiac arrest or resulting from a Surgical procedure;

i. terminal Illness, with a prognosis of death within 6 months;

j. Acquired Immune Deficiency Syndrome (AIDS);

k. Substance Abuse;

l. Mental or Nervous Disorders and psychoneurotic disorders; or

m. any other Illness or injury Determined by Horizon BCBSNJ to be catastrophic.

Alternate Treatment/Individual Case Management Plan

Horizon BCBSNJ will identify cases of Catastrophic Illness or Accidental Injury. The appropriateness of the level of patient care given to you as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for you, Horizon BCBSNJ will develop an Alternate Treatment/Individual Case Management Plan.

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

    1. you, or your legal guardian if necessary;

    2. your attending Practitioner; and

    3. Horizon BCBSNJ or its designee.

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

1. treatment plan objectives;

2. course of treatment to accomplish the stated objectives;

3. the responsibility of each of the following parties in implementing the plan:

   (a) Horizon BCBSNJ
   (b) attending Practitioner
   (c) you
   (d) your family, if any; and

4. estimated cost and savings.

If Horizon BCBSNJ, the attending Practitioner, and you agree in writing on an Alternate Treatment/Individual Case Management Plan, the services and supplies required in connection with such Alternate treatment plan/Individual Case Management will be considered as Covered Charges under the terms of your group's program.

The agreed upon alternate treatment must be ordered by your Practitioner.

Benefits payable under the Alternate Treatment/Individual Case Management Plan will be considered in the accumulation of any Benefit Period and Per Lifetime maximums.

Exclusion

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

Important Notice: You are not required, in any way, to accept an Alternate Treatment/Individual Case Management Plan recommended by Horizon BCBSNJ.

Submitting A Claim

How To Claim Benefits

When eligible expenses exceed your Deductible within your benefit period, you may file a claim.

If you receive services from a Physician, he or she should bill us directly. You and the Physician must complete the claim form required by us.

Claim forms are available from us and will be furnished to your Employer or to you upon request.

Itemized Bills Are Necessary

You must obtain itemized bills from the providers of services for all covered medical expenses. The itemized bills must include the following:

- Name and address of provider;
- Name of patient;
- Date of service;
- The diagnosis;
- Type of service;
- Charge for each service.

If payment has been made by another carrier or Medicare for any of the expenses being submitted to Horizon BCBSNJ, you must include a copy of the explanation of benefits from the other carrier or Medicare along with the itemized bills.

Completing The Claim Form

Be sure to fill out the claim form completely. Include your identification number and your group number. These appear on your identification card. Fill out all applicable portions of the claim form and sign it. A separate claim form must be submitted for each individual and each time you file a claim.

Submitting Your Claim

Send each completed claim form together with all itemized bills that apply to the claim to the address shown on the claim form.

Once you have satisfied your Deductible and have submitted your first claim, send additional claims when you accumulate **$100** or more in covered medical expenses, or whenever a lesser amount has been incurred and four months have passed from the time you submitted your first claim. Claims for benefits must be submitted not later than 18 months from the date in which expenses were incurred.

If a claim is wholly or partially denied for reasons other than plan limitations, the claimant will be notified of the decision within 30 days after Horizon BCBSNJ received the completed notice of claim.

Horizon BCBSNJ will provide to the claimant (or his agent or assignee) a notice that will set forth:

1. the reason for the denial;

2. a statement as to what substantiating documentation or other documentation is needed to complete the claim;

3. a statement that the claim is disputed, if applicable; and

4. a statement of the special needs to which the claim is subject, if applicable.

All Clean Claims shall be paid no later than 30 calendar days of receipt of the completed claim of notice if the claim is submitted to Us by electronic means, or within 40 calendar days of receipt of the completed notice of claim if the claim is submitted by other than electronic means. In addition, any portion of a claim that is complete and proper shall be paid according to the above time limits.

To Whom Payment Will Be Made

a. Payment for services of a Provider that has an agreement with Horizon BCBSNJ or a BlueCard Provider will be made directly to that Provider, if the Provider bills Horizon BCBSNJ. Otherwise, payment will be made to you.

b. 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.

c. If an Employee is the non-custodial parent of a Child Dependent, Horizon BCBSNJ will pay claims filed as described in the section "Submitting Your Claim" directly to: the Provider; or Alternate Payee/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. If Horizon BCBSNJ made an overpayment to you, Horizon BCBSNJ will provide 45 days advance notice and a right of appeal prior to recovery, and will not offset against future claims prior to the later of: (a) 45 days from the date of notice; or (b) the exhaustion of any such appeal right.

BlueCard Claims

When you obtain health care services through BlueCard outside the geographic area Horizon BCBSNJ serves, the amount you pay for covered services is calculated on the **lower** of:

- The billed charges for your covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over-or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating member liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

You will be entitled to benefits for health care services received by you either inside or outside the geographic area we serve, if your medical plan covers those health care services. Due to variations in Host Blue medical practice protocols, you may also be entitled to benefits for some health care services obtained outside the geographic area we serve, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area we serve. But in no event will you be entitled to benefits for health care services, wherever you received them, that are specifically excluded or limited from coverage by your medical plan.

Exclusions Under Your Program

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

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

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

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

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

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

Any charge to the extent it exceeds the Allowance.

Any therapy not included in the definition of Therapy Services.

Balances for services and supplies after Payment has been made under this program.

Blood or blood plasma or other blood derivatives or components which is replaced by a Covered Person.

Broken appointments.

Charges Incurred during a person's temporary absence from an Eligible Provider's grounds before discharge.

Completion of claim forms.

Copayments, Deductibles, and the individual's part of any Coinsurance; expenses Incurred after any Payment maximum is or would be reached.

Cosmetic Services, including cosmetic Surgery, procedures, treatment, drugs or biological products, unless required as a result of an accidental Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Court ordered treatment which is not Medically Necessary.

Custodial Care or domiciliary care, including respite care except as specifically covered under your group's program.

Dental care or treatment, including appliances, except as otherwise stated in this booklet.

Diversional/recreational therapy or activity.

Drugs, obtained from a State or local public health agency, for the treatment of venereal disease or mental disease.

Drugs dispensed by other than a Pharmacist or a Pharmacy or for services rendered by a Pharmacist which are beyond the scope of his license. Benefits are not provided for drugs given by a physician or other practitioner.

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

Employment/career counseling.

Experimental or Investigational treatments, procedures, Hospitalizations, drugs, biological products or medical devices.

Eye Examinations, eyeglasses, contact lenses, and all fittings, except as specified in this booklet; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

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

Herbal medicine.

Home health care Visits in connection with administration of dialysis.

Housekeeping services except as an incidental part of the Eligible services of a Home Health Care Agency.

Hypnotism.

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

Illnesses, including conditions which are the result of disease or bodily infirmity, which are covered or could have been covered for benefits provided under workers' compensation, employer's liability or similar law; or Illnesses or Injuries occurring while the individual is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit or intended for wage or profit.

Immunizations, except as otherwise specified in this booklet.

Infertility enhancement treatments, except as otherwise stated in this booklet.

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

Maintenance therapy for:

- Physical Therapy;
- Manipulative Therapy;
- Occupational Therapy; and
- Speech Therapy.

Marriage, career or financial counseling; sex therapy.

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

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

Methadone maintenance.

Milieu Therapy:

> Inpatient services and supplies which are primarily for milieu therapy even though Eligible treatment may also be provided. This includes, but is not limited to, residential treatment for Mental or Nervous Disorders.
>
> This means that Horizon BCBSNJ has Determined:
>
> 1. the purpose of an entire or portion of an inpatient stay is chiefly to change or control a patient's environment; and
>
> 2. an inpatient setting is not Medically Necessary for the treatment provided, if any.

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

Non-Prescription Drugs or supplies, except as may be Medically Necessary and Appropriate for the treatment of certain Illness or Injury, except as otherwise stated in this Policy.

Nutritional counseling and related services.

Pastoral counseling.

Personal comfort and convenience items.

Private-Duty Nursing care.

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

Psychological testing for educational purposes.

Removal of abnormal skin outgrowths and other growths including, but not limited to, paring or chemical treatments to remove corns, callouses, warts, hornified nails and all other growths, unless it involves cutting through all layers of the skin.

Rest or convalescent cures.

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

Routine examinations or preventive care, including related diagnostic x-rays and laboratory tests, except as otherwise stated in this booklet; pre-marital or similar examinations or tests not required to diagnose or treat Illness, Accidental Injury; screening, research studies, education or experimentation, mandatory consultations required by Hospital regulations, routine pre-operative consultations.

Routine foot care, except as may be Medically Necessary and Appropriate for the treatment of certain Illness or Accidental Injury, including treatment for corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet.

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

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

Services performed by any of the following:

a. A Hospital resident, intern or other Practitioner who is paid by a Facility or other source, who is not permitted to charge for services covered under this program, whether or not the Practitioner is in training. However, Hospital-Employed Physician Specialists may bill separately for their services.

b. Anyone who does not qualify as a physician.

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

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

Services or supplies:

- eligible for payment under either federal or state policies (except Medicaid). This provision applies whether or not the Covered Person asserts his rights to obtain this coverage or payment for these services;

- for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;

- for which the Provider has not received a certificate of need or such other approvals as are required by law;

- for which the Covered Person would not have been charged if he did not have health care coverage;

- furnished by one of the following members of the Covered Person's family, unless otherwise stated in this booklet: Spouse, Child, parent, in-law, brother or sister;

- in connection with any procedure or examination not necessary for the diagnosis or treatment of injury or sickness for which a bonafide diagnosis has been made because of existing symptoms.

- needed because the Covered Person engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;

- not specifically covered under your group's policy;

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

- provided by or in a Government Hospital unless the services are for treatment:

  a. of a non-service Medical Emergency;

  b. by a Veterans' Administration Hospital of a non-service related Illness or Accidental Injury; or the Hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;

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

- provided by a licensed pastoral counselor in the course of his normal duties as a pastor or minister;

- provided by a social worker, except as otherwise stated in this booklet;

- provided during any part of a stay at a Facility, or during Home Health Care chiefly for bed rest, rest cure, convalescence, custodial or sanatorium care, diet therapy or occupational therapy;

- provided to treat an Injury or Illness suffered: (a) as a result of War or an Act of War, if the Injury or Illness occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization; and (b) as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the Injury or Illness occurs while the Covered Person is serving in such forces and is outside the Home Area.

- provided to treat an Injury or Illness suffered: (a) as a result of War or an Act of War while the Covered Person is serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and (b) as a result of the special hazards incident to such service, provided the Injury or Illness occurs while((i) the Covered Person is serving in such unit; and (ii) is outside the Home Area.

- provided to treat an Injury or Illness suffered as a result of War or an Act of War while the Covered Person is not in the military, naval or air forces of any country, combination of countries or international organization or in any civilian non-combatant unit supporting or accompanying such forces, if the Injury or Illness occurs outside the Home Area.

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

- rendered prior to the Covered Person's Effective Date or after his termination date of coverage under the program, unless specified otherwise;

- which are specifically limited or excluded elsewhere in this booklet;

- which are not Medically Necessary and Appropriate; or

- which a Covered Person is not legally obligated to pay for;

Smoking cessation aids of all kinds and the services of stop-smoking providers except as provided under Preventive Care.

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

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

Sterilization reversal.

Sunglasses even if by Prescription.

Surrogate Motherhood.

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

Telephone consultations, except as Horizon BCBSNJ may request.

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

Transplants, except as otherwise stated in this booklet.

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products, except as specifically covered under this program.

Wigs; toupees; hair transplants; hair weaving; or any drug used to eliminate baldness, unless otherwise stated in this Policy.

Services For Automobile Related Injuries

Under this program, Horizon BCBSNJ will provide secondary coverage to PIP unless we have been elected as primary coverage by or for the Covered Person covered under this contract. This election is made by the named insured under the PIP program and affects that person's family members who are not themselves the named insured under another auto policy. Horizon BCBSNJ may be primary for one Covered Person, but not for another if the persons have separate auto policies and have made different selections regarding primacy of health coverage.

Horizon BCBSNJ is secondary to Other Automobile Insurance Coverage. However, if the Other Automobile Insurance contains provisions which made it secondary or excess to Horizon BCBSNJ, then we will be primary.

If there is a dispute as to whether Horizon BCBSNJ is primary or secondary, we will pay benefits as if we were primary.

If Horizon BCBSNJ is primary to PIP or other Automobile Insurance Coverage, we will pay benefits subject to the terms, conditions and limits set forth in your Contract and only for those services normally covered under your Contract.

If Horizon BCBSNJ is one of several health insurance plans which provide benefits for Automobile Related Injuries and the Covered Person has elected health coverage as primary, these plans may coordinate benefits as they normally would in the absence of this provision.

If Horizon BCBSNJ is secondary to PIP, the actual benefits payable will be the lesser of:

- the remaining uncovered allowable expenses after PIP has provided coverage after application of copayments, coinsurance and deductible or

- the actual benefits that would have been payable had We been providing coverage primary to PIP.

Medicare And Your Benefits

IMPORTANT NOTICE

Your benefits may be affected by whether you are eligible for Medicare and whether the Medicare as Secondary Payer rules apply to the Employer's policy. The following section, on Medicare as Secondary Payer, or parts of it, may not apply to the Employer's policy. You must contact the Employer to find out if the Employer is subject to Medicare as Secondary Payer rules.

With respect to 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 considered to be eligible for Medicare by reason of age from the first day of the month during which he reaches age 65. However, if he is born on the first day of a month, he is considered to be eligible for Medicare from the first day of the month which is immediately prior to his 65th birthday. A Covered Person may also be eligible for Medicare by reason of disability or End-Stage Renal Disease (ESRD).

c. A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid Allowable Expenses in accordance with the provisions of the Covered Person's secondary health plan.

d. "Allowable Expense" means any necessary, reasonable, and usual item of expense for health care Incurred by a Covered Person under either this program or which would be covered under any other plan. When a plan provides service instead of cash payment, Horizon BCBSNJ views the reasonable cash value of each service as an Allowable Expense and as a benefit paid. Horizon BCBSNJ also views items of expense covered by another plan as an Allowable Expense, whether or not a claim is filed under that plan.

The following provisions 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 reasons of age, disability or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility as explained below:

If the Employer is NOT subject to such rules, and a Covered Person is eligible for Medicare, Medicare will be the primary health plan and your group's policy will be the secondary health plan for Covered Persons who are eligible for Medicare. If a Covered Person does not have both Part A and/or Part B of Medicare this program is still the secondary health plan. The Allowable Expenses under this program will be reduced by what Medicare would have paid if the Covered Person had enrolled in Medicare.

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

This section applies to a Covered Person who is:

a. The Employee or covered Spouse;

b. eligible for Medicare by reason of age; and

c. has coverage under this program due to the current employment status of the Employee.

Under this section, such a Covered Person is referred to as a “Medicare eligible”.

This section does not apply to:

a. a Covered Person, other than an Employee or covered Spouse;

b. a Covered Person who is under age 65; or

c. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When a Covered Person becomes eligible for Medicare by reason of age, he must choose one of the following options:

Option (A) – Choose this program as his primary health plan.

When a Medicare eligible person chooses this program as his primary health plan, if he incurs a Covered Charge for which benefits are payable under this program and Medicare, this program is considered primary. This program pays first, ignoring Medicare. Medicare is considered the secondary health plan.

Option (B) – Choose Medicare as his primary health plan.

When a Medicare eligible person chooses Medicare as his primary health plan, he will no longer be covered by this program. Coverage under this program will end on the date the Covered Person elects Medicare as his primary health plan.

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

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

This section applies to a Covered Person who is:

a. under age 65;

b. eligible for Medicare by reason of disability; and

c. has coverage under this program due to the current employment status of the Employee.

This section 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 End Stage Renal Disease.

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.)

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, if he incurs a charge for the treatment of ESRD for which benefits are payable under both this Policy and Medicare, this Policy is considered primary for a specified time, referred to as the "coordination period". This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan. For Covered Persons who become eligible for Medicare due to ESRD before March 1, 1996, the coordination period is 18 months. For Covered Persons who become eligible for Medicare due to ESRD after March 1, 1996, the coordination period is 30 months.

This section applies to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease (ESRD).

This section 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.

The coordination period begins for those becoming eligible for Medicare due to ESRD on or after 2/1/90 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/he 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 Policy and Medicare, Medicare is the primary plan and this Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, and he is not covered by both Parts A and B, the Allowable Expense under this Policy will be reduced by what Medicare would have paid if the Covered Person had enrolled in Medicare.

Dual Medicare Eligibility

This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (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 from the categories listed below when filing your claim.

New Jersey Physicians Or Providers:

- You should provide the Physician or provider with your identification number. This number is indicated on the Medicare Request for Payment (claim form) under "Other Health Insurance;"
- The Physician or provider will then submit the Medicare Request for Payment to the Medicare Part B carrier;
- After Medicare has taken action, you will receive an Explanation of Benefits form from Medicare;

- If the remarks section of the Explanation of Benefits contains the following statement, you need not take any action: “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, you should indicate your identification number and the name and address of the Physician or provider in the remarks section of the Explanation of Benefits and send it to us.

Out-Of-State Physicians Or 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;
- When you receive the Explanation of Benefits, indicate your identification number and the name and address of the Physician or provider in the remarks section and send the Explanation of Benefits to us for processing.

Appeals Process

A Covered Person (or a Provider acting on behalf of the Covered Person and with their consent) may appeal administrative and utilization management determinations. Administrative determinations involve benefit issues. Utilization management determinations involve a denial, termination or other limitation of covered health care services. No Covered Person or Provider who files an appeal will be subject to disenrollment, discrimination or penalty by Horizon BCBSNJ.

The appeal process consists of an informal internal review by Horizon BCBSNJ, a formal internal review by Horizon and a formal external review by an Independent Utilization Review Organization (IURO). Nothing in Horizon BCBSNJ's 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 the Member Handbook and/or Evidence of Coverage. 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 Horizon BCBSNJ fails to comply with the appeals process or expressly waives its rights to an internal review of any appeal, then the Covered Person (or Provider acting on behalf of the Covered Person and with their 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 their consent) can file a First Level Appeal by calling or writing Horizon BCBSNJ at the telephone number and address on the Covered Person's identification card. At the First Level Appeal, a Covered Person may discuss any medical Determination made by Horizon BCBSNJ directly with the Horizon BCBSNJ physician who issued that Determination or the medical director designated by Horizon BCBSNJ. All First Level Appeals must be made within 12 months from the date the Covered Person was notified by Horizon BCBSNJ 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(s) and address(es) of the Covered Person(s) or Provider(s) involved

2) the Covered Person's identification number

3) the date(s) of service

4) the details regarding the actions in question

5) the nature and reason behind the appeal

6) the remedy sought

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 management First Level Appeals from Medical Emergency or Urgent Care decisions within 72 hours from receipt of the required documentation (including all situations in which the Covered Person is confined as an Inpatient) and within 5 business days of receipt of the required documentation for all others. Horizon BCBSNJ 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 their 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 Horizon BCBSNJ who have not been involved in the utilization management Determination at issue. At the Covered Person's request, the Provider involved in the original medical Determination may participate in the decision with the panel.

Horizon BCBSNJ will acknowledge Second Level Appeals in writing within 10 business days of receipt. Within 72 hours of receipt for utilization management appeals that, due to Medical Necessity and Appropriateness require review on an expedited basis (including all situations in which the Covered Person is confined as an Inpatient), and within 20 business days of receipt for all other utilization management appeals, the Covered Person will receive written notification of the final Determination of the appeal. Horizon BCBSNJ may extend the review for up to an additional 20 business days where reasonable cause for the delay exists which is beyond Horizon BCBSNJ's control and the explanation is to the satisfaction of the Department. Horizon will provide the Covered Person or Provider with written notice within the original 20 day period. If the Second Level Appeal is denied, Horizon BCBSNJ will provide the Covered Person and/or Provider with written notification of the reasons for the denial together with a written notification of his or her right to proceed to an external appeal. Horizon BCBSNJ will include specific instructions as to how the Covered Person and/or Provider may arrange for an external appeal and will also include any forms required to initiate an appeal.

c. **External Appeal**

A Covered Person (or a Provider acting on behalf of the Covered Person and with their consent) who is dissatisfied with the results from Horizon BCBSNJ's internal appeal process can pursue an External Appeal with an Independent Utilization Review Organization (IURO) assigned by the DOBI. The Covered Person's right to such an appeal is contingent upon their full compliance with both stages of Horizon BCBSNJ's internal appeal process.

To initiate an External Appeal, the Covered Person or Provider who filed the appeal must submit a written request within 60 business days from receipt of the written action from the Second Level Appeal. The Covered Person or Provider shall submit the request on the required forms with a $25 check made payable to "New Jersey Department of Banking and Insurance" and an executed release to obtain all medical records pertinent to the appeal to:

Office of Managed Care
New Jersey Department of Banking and Insurance
CN 325
Trenton, NJ 08625-0325

If the Covered Person cannot afford to pay the $25.00 fee, the fee may be reduced to a $2.00 fee if the Covered Person can show proof of financial hardship. Proof of financial hardship can be demonstrated through evidence that one or more members of the household is receiving assistance or benefits under Pharmaceutical Assistance to the Aged and Disabled, Medicaid, General Assistance, Social Security Insurance, NJ KidCare, or New Jersey Unemployment Assistance.

Upon receipt of the appeal, together with the executed release and the appropriate fee, the DOBI shall immediately assign the appeal to an IURO to conduct a preliminary review and accept it for process if it determines that:

1) the individual is or was a Covered Person of Horizon BCBSNJ;

2) the service which is the subject of the appeal reasonably appears to be a Covered Service under the Covered Person's Policy;

3) the Covered Person has fully complied with both levels of Horizon BCBSNJ's internal appeals system; and

4) the Covered Person has provided all information required by the IURO and the DOBI to make the preliminary determination including the appeal form and a copy of any information provided by Horizon BCBSNJ regarding its decision to deny, reduce or terminate the Covered Service, as

well as a fully executed release to obtain any necessary medical records from Horizon BCBSNJ and any other relevant Provider.

Upon completion of this review, the IURO will immediately notify the Covered Person or Provider who filed the appeal in writing as to whether or not the appeal has been accepted for processing, and if not accepted, the reasons therefore. If the appeal is accepted, the IURO shall complete its review and issue its recommended decision within 30 business days from receipt of all documentation necessary to complete its review. The IURO may extend the period of review for a reasonable period of time as may be necessary due to circumstances beyond its control, except in no event shall it render its determination later than 90 days following receipt of a completed application. In such an event, prior to the conclusion of the 30 business day review, the IURO shall provide written notice to the Covered Person or Provider who filed the appeal, the DOBI and Horizon BCBSNJ setting forth the status of its review and the specific reasons for the delay.

If the IURO determines that the Covered Person was deprived of Medically Necessary and Appropriate Covered Services, the IURO shall recommend to the Covered Person or Provider who filed the appeal, the DOBI and Horizon BCBSNJ the appropriate health care services the Covered Person should receive. Within 10 business days from receipt of the determination of the IURO, Horizon BCBSNJ must submit a written report to the IURO, the Covered Person and Provider, if the Provider made the appeal and the DOBI indicating whether it accepts the IURO’s recommendation in whole or in part. The written report of Horizon BCBSNJ shall state with specificity the reasons for rejection, in whole or in part, of the recommendation(s) of the IURO, and Horizon BCBSNJ’s report shall not be complete unless such reasons are set forth in the report. Horizon BCBSNJ's Determination to accept or reject the IURO’s recommendation shall be the final Determination of Horizon BCBSNJ in connection with the appeal filed.

Coordination of Benefits

PURPOSE OF THIS PROVISION

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

DEFINITIONS

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

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

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

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

Calendar Year: A year starting January 1.

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

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

a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;

b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;

c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;

d) Group hospital indemnity benefit amounts that exceed $150 per day;

e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

a) Individual or family insurance contracts or subscriber contracts;

b) Individual or family coverage through an HMO or under any other prepayment, group practice and individual practice plans;

c) Group or group-type coverage where the cost of coverage is paid solely by the Covered Person except when coverage is being continued pursuant to a Federal or State continuation law;

d) Group hospital indemnity benefit amounts of $150 per day or less;

e) School accident-type coverage;

f) A State plan under Medicaid.

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

a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or

b) All Plans which cover the Covered Person use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the Plan determines its benefit first.

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

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

has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

Horizon BCBSNJ considers each Plan separately when coordinating payments.

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

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

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

RULES FOR THE ORDER OF BENEFIT DETERMINATION

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

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

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

If a Child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, or, in the case of a Civil Union Partnership, are still Civil Union

Partners, the following rules apply:

a) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.

b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the Plan covering the parent for a shorter period of time.

c) Birthday, as used above, refers only to month and day in a Calendar Year, not the year in which the parent was born.

d) If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a Child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, or, in the case of a Civil Union Partnership, they are no longer Civil Union Partners, the following rules apply:

a) The benefits of the Plan of the parent with custody of the Child shall be determined first.

b) The benefits of the Plan of the Spouse or former Civil Union Partner of the parent with custody shall be determined second.

c) The benefits of the Plan of the parent without custody shall be determined last.

d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the Child, and if the entity providing coverage under that Plan has knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

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

PROCEDURES TO BE FOLLOWED BY THE SECONDARY PLAN TO CALCULATE BENEFITS

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

a) The basis on which the Primary Plan and the Secondary Plan pay benefits; and

b) Whether the Provider who provides or arranges the services and supplies is in the Network of either the Primary Plan or the Secondary Plan.

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

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a Provider, called an In- Network Provider, bills a charge, the Covered Person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Covered Person uses the services of an Out-of-Network Provider, the Plan will be treated as an R&C Plan even though the Plan under which he or she is covered allows for a fee schedule.

Payment to the Provider may be based on a "capitation." This means that the carrier pays the Provider a fixed amount per Covered Person. The Covered Person is liable only for the applicable Deductible, Coinsurance or Copayment. In this section, a Plan that pays Providers based upon capitation is called a "Capitation Plan."

In the rules below, "Provider" refers to the provider who provides or arranges the services or supplies.

<u>Primary Plan is an R&C Plan and Secondary Plan is an R&C Plan</u>

The Secondary Plan shall pay the lesser of:

a) The difference between the amount of the billed charges and the amount paid by the Primary Plan; or

b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the Plan.

<u>Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan</u>

If the Provider is an In-Network Provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a) The amount of any Deductible, Coinsurance and/or Copayment required by the Primary Plan; or

b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the Provider receives from the Primary Plan, the Secondary Plan and the Covered Person shall not exceed the fee schedule of the Primary Plan. In no event shall the Covered Person be responsible for any payment in excess of the Copayment, Coinsurance and/or Deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan

If the Provider is an In-Network Provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a) The amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or

b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan

If the Primary Plan is an HMO Plan that does not allow for the use of Out-of-Network Providers except in the event of Urgent Care or a Medical Emergency and the service or supply the Covered Person receives from an Out-of-Network Provider is not considered as Urgent Care or a Medical Emergency, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan

If the Covered Person receives services or supplies from a Provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

a) The amount of any Deductible, Coinsurance and/or Copayment required by the Primary Plan; or

b) The amount the Secondary plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan

If the Covered Person receive services or supplies from a Provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the Provider and shall not be liable to pay the Deductible, Coinsurance and/or Copayment imposed by the Primary Plan. The Covered Person shall not be liable to pay any Deductible, Coinsurance and/or Copayment of either the Primary Plan or the Secondary Plan.

Covered Person's Rights and Responsibilities

You have the right to:

- Formulate and have advance directives implemented under the laws of this State;

- Have prompt written notification of changes in benefits or termination of benefits or services no later than 30 days following the date of any change or termination;

- File a complaint with the Department of Banking and Insurance;

- Have access to services, and payment of appropriate benefits therefore, when medically necessary, including availability of care 24 hours a day, seven days a week for urgent or emergency conditions;

- Appeal a denial, reduction or termination of health care services or the payment of benefits resulting from a utilization management decision by or on behalf of Horizon BCBSNJ;

- Be treated with courtesy, consideration and with respect to your dignity and need for privacy; and

- Obtain information regarding Our policies and procedures with respect to the above, as applicable.

RIDER FORM (CIVIL UNIONS)

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 Booklet 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 Booklet'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 of 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.

Lifetime Dollar Limits

Any lifetime dollar limit on any essential health benefits in the Policy/Booklet is deleted.

The Policy/Booklet is amended to provide that if an individual's coverage under the Policy/Booklet had terminated due to reaching a lifetime dollar limit, the individual may enroll during the first 30 days of a plan year that begins on or after September 23, 2010, and coverage will begin on the first day of the plan year that begins on or after September 23, 2010.

Annual Dollar Limits

Any annual dollar limit on any essential health benefits in the Policy/Booklet is amended to be the greater of (1) the annual dollar limit shown below; and (2) the annual dollar limit described in the Policy/Booklet.

- For a plan year beginning on or after September 23, 2010, but before September 23, 2011, $750,000;
- For a plan year beginning on or after September 23, 2011, but before September 23, 2012, $1,250,000;
- For plan years beginning on or after September 23, 2012, but before September 23, 2014, $2,000,000;

For plan years beginning on or after September 23, 2014, no limit may apply.

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.

Preventive Services

In addition to any other preventive benefits described in the Policy/Booklet, Horizon BCBSNJ shall cover the following preventive services and shall not impose any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any covered individual receiving any of the following benefits for services received from participating providers:

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

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

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

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

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

Prohibition on Pre-Existing Conditions for Children

Any provision of the Policy/Booklet described below shall not apply to any child who is under the age of 19:

(1) Any provision that describes a pre-existing condition exclusion or limitation;

(2) Any provision that indicates that a pre-existing condition exclusion or limitation is applicable;

(3) Any provision that indicates that benefits are contingent on an injury occurring or a sickness first manifesting itself while the child is covered under the Policy/Booklet; and

(4) Any provision of the Policy/Booklet that describes possible denial or rejection of coverage due to underwriting.

This rider is part of the Policy/Booklet. Except as stated above, nothing in this rider changes or affects any other terms of the Policy/Booklet.

Service Centers

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

Telephone personnel are available:

Monday, Tuesday, Wednesday and Friday from 8:00 a.m. to 6:00 p.m.

Thursday from 9:00 a.m. to 6:00 p.m. (E.T.) Eastern Time

Please call:

1-800-355-BLUE

For **Individual Case Management,** please call:

1-800-664-BLUE

Always have your identification card handy when calling us. Your ID number helps us get prompt answers to your questions about enrollment, benefits or claims.

Use this space for information you will need when asking about your coverage.

The company office or enrollment official to contact about coverage:

____

The identification number shown on my identification card:

____

The effective date when my coverage begins:

____

My group number is:

____

This booklet is not a contract and contains only a general description of your benefits. These benefits are subject to the terms, conditions, and limitations of the Group Master Contract issued to your group and the provisions of the applicable State Law. If you need additional information, contact your Enrollment Official.

In the event there appears to be a contradiction between the benefits described in this booklet and those provided in the Group Master Contract, the Group Master Contract shall prevail.