Product:	**HOSPITAL/MEDICAL-SURGICAL/MAJOR MEDICAL**
Company Name:	**MIDDLESEX COUNTY**
Group Number:	**0089740-001,005,007**

Horizon Blue Cross Blue Shield of New Jersey

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Horizon Blue Cross Blue Shield of New Jersey

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

Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Horizon BCBSNJ does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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

- Qualified sign language interpreters
- Information written in other languages

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

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

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

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

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

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

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

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Table of Contents

Introduction

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

In this Booklet, you'll find the important features of your group's Hospital, Medical-Surgical and Major Medical benefits provided by the Plan. You should keep this Booklet in a safe place and read it carefully so that you become familiar with the benefits that are available to you and your family. This Booklet replaces any booklets and/or certificates you may previously have received.

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

Definitions

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

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.

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.

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

Alcoholism – the abuse of or addiction to alcohol.

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

(a) the actual charge made by the Provider for the service or supply;

(b) in the case of In-Network Providers, the amount that the Provider has agreed to accept for the service or supply; or

(c) in the case of Out-of-Network Providers, the amount determined as **80%** of the reimbursement rate specified for the Covered Service or Supply in the databases developed by FAIR Health, Inc. (FAIR Health).

Exceptions:

With respect to part (c), above, if the databases developed by FAIR Health do not prescribe a reimbursement rate for a Covered Service or Supply, the Allowance for the Covered Service or Supply will be determined as **180%** of the amount that would be reimbursed for the Covered Service or Supply under Medicare.

And if Medicare does not prescribe a reimbursement rate for the Covered Service or Supply, the Allowance for it will be determined based on: (a) profiles compiled by Horizon BCBSNJ based on usual and prevailing payments made to Providers for similar services or supplies in specific geographical areas; or (b) similar profiles compiled by outside vendors other than FAIR Health.

Ambulance means a certified transportation vehicle for transporting Ill or Injured people that

contains all life-saving equipment and staff as required by state and local law.

Ambulatory Surgical Center – 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.

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

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

Benefit Day means each of the following:

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

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

c. Two inpatient days in a Skilled Nursing Facility; or

d. Three home health care Visits.

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

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. The Plan will recognize it if:

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

The Plan 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 the Plan or Horizon BCBSNJ to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.

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

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

- The natural born child or stepchild of you, your Spouse, regardless of where or with whom the child lives;

- A child who is: (a) legally adopted by you, your Spouse, regardless of where or with whom such child lives; or (b) placed with you for adoption. But, proof of such adoption or placement satisfactory to the Plan must be furnished to us when we ask;

- You, your Spouse's legal ward. But, proof of guardianship satisfactory to the Plan must be furnished to us when we ask.

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

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

Coinsurance – the 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.

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.

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

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

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

(c) is likely to continue indefinitely;

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

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

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

Durable Medical Equipment – equipment which is determined 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 a 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.

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

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

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

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

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

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

d. The Technology must be as safe and effective as any established modality. (If an alternative to the Technology is not available, The Plan may, to determine the safety and effectiveness of a Technology, consider opinions about and evaluations of the Technology from appropriate specialty advisory committees and/or specialty consultants.)

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

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

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

- The American Hospital Formulary Service Drug Information.

- The United States Pharmacopeia Drug Information.

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

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

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

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

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

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

Eye Examination - a comprehensive medical 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 the Plan: (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.

Foot Orthotics: Custom-made supportive devices designed to restrict, immobilize, strengthen or protect the foot.

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. The Plan will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

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

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

a. approved for its stated purpose by Medicare; or

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

a. accredited as a Hospital by the Joint Commission or

b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, 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.

The Plan 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 this 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.

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

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.

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.

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.

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

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

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

(2) Conditions related to behavior problems or learning disabilities, except with respect to the treatment of Mental or Nervous Disorders or Developmental Disabilities.

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

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

Mutually Exclusive Surgical Procedures: Surgical procedures that:

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

b. represent overlapping services or accomplish the same result;

c. in combination may be anatomically impossible.

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

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.

Plan: The MIDDLESEX COUNTY Medical Plan

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

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

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

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

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

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

Prescription Drugs: Drugs, biological and compound prescriptions which: (a) are dispensed only by prescription; and (b) are required to show on the manufacturer's label the words: "Caution-Federal Law Prohibits Dispensing Without A Prescription." The term also may include other drugs and devices (such as insulin) as determined by the Plan.

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

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

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

b. approved for its stated purpose by Medicare.

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

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

the Employer.

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

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

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

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

Special 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. The Plan will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

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

b. approved for its stated purpose by Medicare.

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

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

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

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

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

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

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

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.

We, Us, and Our: The Plan

Schedule of Covered Services and Supplies

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

NOTE: BENEFITS WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION MANAGEMENT PROVISIONS OF THIS PLAN.

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

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

2. For Outpatient services provided by a Network Hospital, the payment to the Hospital will be accepted by the Hospital as payment in full. The Plan will pay **100%** of its Allowance for Outpatient services.

b. Out-of-Network Hospital

The Plan will pay **100%** of its Allowance for Inpatient or Outpatient services. However, any Inpatient Deductible required will be subtracted from any payment otherwise eligible.

c. Blue Card Hospital

For Inpatient or outpatient services, the payment to the Hospital plus any Deductible payment the Covered Person must make will be accepted by the Hospital as payment in full.

d. Out-of-Network Government Hospital

1. The Plan 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 this coverage, and receive care in Facilities run by the Department of Defense or Veteran's Administration.

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

1. For Inpatient services, the Plan will pay **100%** of its Allowance.

2. For Outpatient services, the Plan will pay **100%** of its Allowance.

Benefit Period	**365** Days of Inpatient care per Benefit Period. Every two days in a member skilled nursing facility or every three home care visits will count as one benefit day for inpatient care. **30** benefit days in the following governmental hospitals: In-Network Facility located outside of New Jersey, Out-of-Network Facility, and New Jersey State. This does not apply to retired Military Personnel. **365** Days of Outpatient care per Benefit Period.
Renewal Interval	Benefit Period is renewed when **90** days without care as an Inpatient in a Hospital have elapsed and/or a new Benefit Year begins. Benefit Period is renewed for Outpatient days when a new Benefit Year begins.

COVERED SERVICES

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

The Plan 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 do not count toward the Covered Person's total Benefit Days.

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

Outpatient days do not count toward the Covered Person's total Benefit Days.

Home Health Agency Care Benefits	Subject to **100%** Coinsurance.
Hospice Care Benefits	Subject to **100%** Coinsurance. Subject to **Unlimited** Benefit Period maximum. Respite care benefits are limited to maximum of 10 days per Covered Person per Benefit Period. Benefits for bereavement counseling are limited to unlimited bereavement sessions during any calendar year.
Infertility	Subject to **100%** Coinsurance.
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.
Skilled Nursing Facility Charges	Subject to **100%** 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.

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 the 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. 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, 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, the Plan 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. The Plan is not liable to pay more than the Allowance for any service.

e. Benefits To Be Paid Under Horizon BCBSNJ's 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. This rule can be waived, but the decision to waive it is entirely up to the Plan.

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.

4. The first Hospital Stay which begins after the start of a new Benefit Year will be covered for the full number of Visits available under this program, even if **90** days have not passed since the Covered Person's last covered day of confinement.

Benefit Period — **365** days of Inpatient medical care per admission. Coverage is limited to services of only one physician per day. This rule can be waived, but it is entirely up to the Plan.

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

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

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

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

Physician Visits are subject to a one visit per week maximum. These benefits are available only as part of the eligible In-Hospital medical Visits that began during the Hospital confinement.

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

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

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

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

No more than 30 Physicians' Visits in the Skilled Nursing Facility will be covered during any calendar year.

Post-operative care in a Skilled Nursing Facility is not covered.

Surgical Services — 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 **$150** Benefit Period maximum.

Radium, Radioactive Isotope (Sealed Sources), Radon Therapy or X-ray Therapy Subject to **$560** Benefit Period maximum.

Physical Therapy Services Subject to $**50** Benefit Period maximum.

MAJOR MEDICAL BENEFITS

Coinsurance **80%** of Covered Charges.

Out-of-Pocket Maximum (Applies to all Benefits)

Per Covered Person – **$400**;

Per Covered Family – **$800.**

Deductible **$100**/Covered Person.

$200/family.

Note: May be aggregately satisfied by 2 or more separate Covered Persons.

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.

BENEFIT PERIOD MAXIMUM **Unlimited.**

LIFETIME MAXIMUM **Unlimited.**

Payment of Benefits

1. 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.

2. The Plan 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.

Durable Medical Equipment Subject to Deductible and **80%** Coinsurance.

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

Health Wellness

a. Mammography

Subject to **100%** Coinsurance.

b. Gynecological Examination

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

c. Prostate Cancer Screening

Subject to **100%** Coinsurance.

d. Routine Adult Physicals

Subject to **100%** Coinsurance.

e. Well-Child Care

Subject to **100%** Coinsurance.

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

Inpatient Medical Services Subject to Deductible and **80%** Coinsurance.

Medical Emergency or Accidental Injury Benefits 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.

Private Duty Nursing Care Benefits	Subject to Deductible and **80%** Coinsurance. This Plan covers **240** hours per year of Private Duty Nursing Care.

Prosthetic Devices

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

Second Opinion Charges	Subject to **100%** Coinsurance.
Skilled Nursing Facility Care	Subject to Deductible and **80%** Coinsurance. Subject to a **120** day 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.

Therapeutic Manipulations	Subject to Deductible and **80%** Coinsurance. Subject to a **30** Visit Benefit Period maximum.
Therapy Services	Subject to Deductible and **80%** Coinsurance. Subject to an **Unlimited** Benefit Period maximum.
Wigs Benefit	Subject to Deductible and **80%** Coinsurance.

Subject to a **$500** Benefit Period Maximum.

General Information

How To Enroll

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

Your Identification (ID) Card

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

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

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

Types Of Coverage Available

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

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

Change In Type Of Coverage

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

If: (a) you gain or lose a member of your family; or (b) someone covered under this Plan changes family status, you should check this Booklet to see if coverage should be changed. This can

happen in many ways, e.g., due to the birth or adoption of a child, divorce, or death of a Spouse.

For example:

- You must enroll a newly born or newly adopted Child Dependent within 31 days of the date or birth or adoption in order to have coverage for your Child Dependent. If you are enrolled for Family or Parent and Child(ren) coverage, you must submit an enrollment form within 31 days from the date of birth or adoption to notify the Plan of the addition. If you are enrolled for Single coverage, you must enroll your child and pay any required additional contributions within 31 days from the date of birth or adoption.

- If you have Single coverage and marry, or acquire a Civil Union Partner, your new Spouse or Civil Union Partner will be covered from the date you marry or acquire the Civil Union Partner if you apply for Husband and Wife or Family coverage within 31 days.

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

Enrollment of Dependents

The Plan cannot deny coverage for your Child Dependent on the grounds that:

- The Child Dependent was born out of wedlock;

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

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

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

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

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

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

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

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

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

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

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

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

Special Enrollment Periods

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

Individual Losing Other Coverage

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

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

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

c. The other health coverage:

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

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

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

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

New Dependents

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

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

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

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

Special Enrollment Due to Marriage or Acquiring a Civil Union Partner

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

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

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

Special Enrollment Due to Newborn/Adopted Children

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

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

Multiple Employment

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

Eligible Dependents

Your eligible Dependents are your Spouse or Civil Union Partner, your Child Dependents.

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

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

Coverage will continue for a Child Dependent beyond the age of 26 if, immediately prior to reaching that age**,** he/she was enrolled under this Plan and is incapable of self-sustaining employment by reason of mental retardation or physical handicap. For your handicapped Child Dependent to remain covered, you must submit proof of his/her inability to engage in self-sustaining employment by reason of mental retardation or physical handicap within 31 days of the child's attainment of age 26. The proof must be in a form that meets our approval. Such proof must be resubmitted every two years within 31 days before or after the Child Dependent's birth date.

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

When Coverage Ends

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

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

Coverage for a Dependent ends:

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

In addition to the above reasons for the termination of coverage under the Plan, if a Covered Person,

(1) performs an act, practice or omission that constitutes fraud; or

(2) makes an intentional misrepresentation of material fact,

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

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

Benefits After Termination

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

Continued Coverage Under The Federal Family And Medical Leave Act

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

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

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

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

Consult your benefits representative for application forms and further details.

Continuation of Coverage under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you and your enrolled Dependents, not including a Dependent who is your Civil Union Partner and any newborn or newly adopted child may have the opportunity to continue group health care coverage which would otherwise end, if any of these events occur:

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

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

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

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

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

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

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

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

- This Plan ends for the class you belong to.

- The person fails to make required payments for the coverage.

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

- The person becomes entitled to Medicare benefits.

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

NOTE: Any right to continue the Plan's coverage that is granted to an Employee's Spouse pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, shall not apply with respect to an Employee's Civil Union Partner.

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

Rights Act of 1994 (USERRA)

If the Employee is absent from work due to performing service in the uniformed services, this federal law gives the Employee the right to elect to continue the health coverage under this Plan (for himself/herself and the Employee's Dependents, if any, not including a Civil Union Partner.). If the Employee so elects, the coverage can be continued, subject to the payment of any required contributions, until the first to occur of the following:

- The end of the 24-month period starting on the date the Employee was first absent from work due to the service.

- The date on which the Employee fails to return to work after completing service in the uniformed services, or fails to apply for reemployment after completing service in the uniformed services.

- The date on which this Plan ends.

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

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

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

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

Uniformed services: The following:

1. The Armed Services.

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

3. The commissioned corps of the Public Health Service.

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

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

1. Active duty.

2. Active and inactive duty for training.

3. National Guard duty under federal statute.

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

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

Medical Necessity And Appropriateness

The Plan will make payment for benefits only when:

- Services are performed or prescribed by your attending physician;

- Services, in the Plan's judgment, are provided at the proper level of care (Inpatient; Outpatient; Out-of-Hospital; etc.);

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

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

MEDICAL EXPENSE.

Cost Containment

If it has been determined that an eligible service can be provided in a medically acceptable, cost-effective alternative setting, the Plan reserves the right to provide benefits for such a service when it is performed in that setting.

Your Health Care Program

Your Plan 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 the allowance, and are subject to deductible and coinsurance. If you receive care from physicians in the Horizon Traditional Physician's Network, they will accept the payment as payment in full. Physicians who are not in the Horizon Traditional Physician's network may balance bill to charges.

For Mental or Nervous Disorder, Substance Abuse and Alcoholism, the Care Manager must coordinate treatment. Please refer to the Schedule of Covered Services and Supplies and Summary of Covered Services and Supplies in this booklet for more information.

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, 2017** to **December 31, 2017** and then 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 **$100**.

The Deductible applies once to each Covered Person in a Benefit Period. However, the total Deductible for a family in any one Benefit Period will not be more than **$200**. The family Deductible can be satisfied by any combination of expenses from either all or some of the family members, except that no individual can contribute more than the individual Deductible amount. If one family member meets the individual Deductible, this program will pay for that person's additional covered medical expenses even if the Deductible for the entire family has not been met.

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.

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

will be **20%**. When two Covered Persons enrolled under the same family coverage have each reached the **100%** level in the same benefit period, the Plan will pay **100%** of the applicable allowance for covered medical expenses thereafter incurred by other Covered Persons enrolled under the same family coverage during that benefit period.

Out-of-Pocket Maximum (Applies to all Benefits)

Once a Covered Person has Incurred, during a Benefit Period, an amount of Covered Charges for which no benefits are paid or payable under the Plan equal to the Out-of-Pocket Maximum (see the Schedule of Benefits), the Plan will waive any applicable Deductible, Copayment or Coinsurance with respect to Covered Charges Incurred by the Covered Person for the remainder of that Benefit Period.

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

An Out-of-Pocket Maximum cannot be met with Non-Covered Charges. But solely for the purposes of this subsection, the following expenses, Incurred by a Covered Person or covered members of a family during a Benefit Period under a self-insured group stand-alone prescription drug plan or an insured stand-alone group prescription drug plan provided by Horizon BCBSNJ or another carrier, shall be deemed to be Covered Charges hereunder:

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

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

Benefits From Other Plans

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

Summary of Covered Services and Supplies

This section lists the types of charges the Plan will consider as Covered Services or Supplies up to its Allowance subject to all the terms of your Plan 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.

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 Plan covers a consultative opinion given by a qualified specialist physician who has agreed to provide second 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 Plan 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. The Plan 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. 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 the Plan or would be eligible for such benefits if enrolled for coverage with this Plan.

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

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. The Plan or 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 aide, 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.

15. Bereavement counseling.

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

"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.

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 **31** days of the newborn Child's birth. A newborn Child will be covered from birth if the application is submitted within **31** days of birth.

Inpatient or Outpatient Treatment of Alcoholism

a. Care in a health care Facility;

b. At a licensed detoxification Facility; 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

The Plan 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 Plan, and these rules:

The Plan will cover charges for:

(a) A mammogram exam at such age and intervals as deemed Medically Necessary and Appropriate by the female Covered Person's Practitioner if she is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors.

(b) One baseline mammogram exam for female Covered Persons who are between the ages of 35 and 40 years of age.

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

(d) An ultrasound evaluation; magnetic resonance imaging scan; three-dimensional mammography; or other additional testing of an entire breast or breasts after any baseline mammogram exam, if:

(i) The mammogram exam demonstrates extremely dense breast tissue;

(ii) The mammogram is abnormal within any degree of breast density, including not dense; moderately dense; heterogeneously dense; or extremely dense breast tissue; or

(iii) The patient has additional risk factors for breast cancer, including, but not limited to: (1) family history of breast cancer; (2) prior personal history of breast cancer; (3) positive genetic testing; (4) extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or (5) other indications, as determined by the patient's Practitioner.

Mental or Nervous Disorders and Substance Abuse

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

Coverage for the Inpatient treatment of these conditions will be provided at a reduced level if the Care Manager does not: manage; assess; coordinate; direct; and authorize a Covered Person's Inpatient treatment for a Mental or Nervous Disorder or Substance Abuse before expenses are Incurred. No benefits are payable with respect to any treatment that is not Medically Necessary and Appropriate.

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. Medical Emergency care, provided care is given immediately after the onset and while the symptoms are present. A medical emergency is characterized by sudden and unexpected onset of serious symptoms including acute chest pain as found in heart attacks, severe nausea and vomiting, convulsions, asthma attacks, acute abdominal pain, high fever and similar acute conditions.

l. 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.

m. 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 the Plan.

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

4. Physical Therapy Services.

Skilled Nursing Facility Charges

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

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. Heart-valve

i. Heart-lung

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 licensed health care Facility;

b. At a licensed detoxification Facility; 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 the Plan or would be eligible for such benefits if enrolled for coverage with the Plan.

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

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. The Plan or 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 or the Plan 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.

   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, 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 the Plan or 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.

Coverage for the Inpatient treatment of these conditions will be provided at a reduced level if the Care Manager does not: manage; assess; coordinate; direct; and authorize a Covered Person's

Inpatient treatment for a Mental or Nervous Disorder or Substance Abuse before expenses are Incurred. No benefits are payable with respect to any treatment that is not Medically Necessary and Appropriate.

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 **31** days of the newborn Child's birth. A newborn Child will be covered from birth if the application is submitted within **31** 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 Plan covers Second Opinion Charges, which is 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 Plan 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. The Plan 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 Plan can require evidence to verify that the stay in a Skilled Nursing Facility is Medically Necessary. After reviewing the evidence of Medical Necessity, the Plan 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 Plan.

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.

h. **Surgical Services**

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

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

b. Subject to the following exception, if more than one surgical procedure is performed: (i) on the same patient; (ii) by the same physician; and (iii) on the same day, the following rules apply:

1 The Plan will cover the primary procedure, plus 50% of what the Plan would have paid for each of the other procedures, up to five, had those procedures been performed alone.

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

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

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. Heart-valve

i. Heart-lung

C. MAJOR MEDICAL BENEFITS

Acupuncture

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

Alcoholism

Inpatient or Outpatient treatment of Alcoholism as follows:

a. Care in a licensed health care Facility;

b. At a licensed detoxification Facility; 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 consists 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 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.

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

Diagnosis and Treatment of Autism

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

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

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

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

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

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

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

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

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

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

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

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. The Plan 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/Preventive Care

This Plan provides coverage for the following tests and services:

a. Mammography -The Plan 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 Plan, and these rules:

The Plan will cover charges for:

(a) A mammogram exam at such age and intervals as deemed Medically Necessary and Appropriate by the female Covered Person's Practitioner if she is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors.

(b) One baseline mammogram exam for female Covered Persons who are between the ages of 35 and 40 years of age.

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

(d) An ultrasound evaluation; magnetic resonance imaging scan; three-dimensional mammography; or other additional testing of an entire breast or breasts after any baseline mammogram exam, if:

(i) The mammogram exam demonstrates extremely dense breast tissue;

(ii) The mammogram is abnormal within any degree of breast density, including not dense; moderately dense; heterogeneously dense; or extremely dense breast tissue; or

(iii) The patient has additional risk factors for breast cancer, including, but not limited to: (1) family history of breast cancer; (2) prior personal history of breast cancer; (3) positive genetic testing; (4) extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or (5) other indications, as determined by the patient's Practitioner.

b. Pap Smears – This Plan provides for charges incurred in conducting a Pap smear.

c. 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.

d. The following preventive services, to the extent not already covered under the program, shall be covered without being subject to any Deductibles, Copayments or Coinsurance:

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

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

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

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

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

Hearing Exams

This Plan covers routine hearing exams/evaluations.

Fertility Services

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

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 Plan 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 your Plan.

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. The Plan 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.

Coverage for the Inpatient treatment of these conditions will be provided at a reduced level if the Care Manager does not: manage; assess; coordinate; direct; and authorize a Covered Person's Inpatient treatment for a Mental or Nervous Disorder or Substance Abuse before expenses are Incurred. No benefits are payable with respect to any treatment that is not Medically Necessary and Appropriate.

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 **31** days of the newborn Child's birth. A newborn Child will be covered from birth if the application is submitted within **31** days of birth.

Operating or Treatment Rooms

Use of operating or treatment rooms of a Hospital.

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**.**

Private-Duty Nurse

Services of an actively practicing Private-Duty Nurse, medically necessary for the care of the patient and ordered by a physician, as follows:

> Other than in a Hospital, services of a registered professional nurse (R.N.) or Licensed Practical Nurse (LPN).
>
> Services are available to a Covered Person in the Covered Person's home if the services provided require the skills of a Nurse. No benefits will be provided for the services of a Nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person immediate family.

Prosthetic Devices

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

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 the Plan 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. Benefits are available for 120 days of care during any one calendar year**.**

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. Heart-valve

i. 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.

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 Plan 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 Plan.

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 PLAN DOES NOT COVER ANY INPATIENT ADMISSION, OR ANY OTHER SERVICES OR SUPPLIES THAT IS NOT MEDICALLY NECESSARY AND APPROPRIATE.

The Plan 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 Review section, you will not be eligible for full benefits under your Plan. Your Plan has Medical Appropriateness Review features. Under these features, Horizon BCBSNJ reviews the medical appropriateness of the care that is expected to be rendered.

d. plan to seek treatment for Mental or Nervous Disorders or Substance Abuse or Alcoholism.

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

Your Plan 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

The Plan has the right to conduct a continued stay review of any Inpatient Facility Admission. To do this, Horizon BCBSNJ may contact the Covered Person's Practitioner or Facility by phone or in writing.

The Covered Person or his/her Provider must ask for a continued stay review whenever it is Medically Necessary and Appropriate to increase the authorized length of an Inpatient Facility stay. This must be done before the end of the previously authorized length of stay.

The continued stay review will determine:

a. the Medical Necessity and Appropriateness of the extended stay ;

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

c. the appropriateness of health care alternatives.

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

ALTERNATE TREATMENT FEATURES/INDIVIDUAL CASE MANAGEMENT

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

Definitions

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

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

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

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

a. head injury requiring an Inpatient stay;

b. spinal cord injury;

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

d. multiple injuries due to an accident;

e. premature birth;

f. CVA or stroke;

g. congenital defect which severely impairs a bodily function;

h. brain damage due to: an Injury; or cardiac arrest; or a Surgical procedure;

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

j. Acquired Immune Deficiency Syndrome (AIDS);

k. Substance Abuse;

l. a Mental or Nervous Disorder; or

m. any other Illness or Injury determined to be catastrophic.

Alternate Treatment/Individual Case Management Plan

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

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

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

    2. the Covered Person's attending Practitioner; and

    3. Horizon BCBSNJ or its designee.

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

    1. treatment plan objectives;

    2. a course of treatment to accomplish those objectives;

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

        (a) Horizon BCBSNJ;

        (b) the attending Practitioner;

        (c) the Covered Person;

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

4. the estimated cost of the plan and savings.

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

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

Benefits payable under the Alternate Treatment/Individual Case Management Plan will be counted toward any Benefit Period and/or Per Lifetime maximum that applies to the Covered Person.

Exclusion

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

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 Horizon BCBSNJ directly. You and the Physician must complete the claim form required by Horizon BCBSNJ.

Claim forms are available from Horizon BCBSNJ and will be furnished 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.

Bills for services of private duty nurses must show that the nurse is a registered nurse (R.N.), or a licensed practical nurse (L.P.N.) and must include his or her license number. Along with the bill, you must submit a letter from the attending Physician explaining why the services of the nurse were Medically Necessary for the patient.

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.

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 Plan, Horizon BCBSNJ has the right to recover those payments on behalf of the Plan.

BLUECARD

Overview

Horizon BCBSNJ has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Arrangements.” These Inter- Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever Covered Persons access healthcare services outside

the geographic area we serve, the claims for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

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

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

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

BlueCard® Program

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

Liability Calculation Method Per Claim – In General

Covered Person's Liability Calculation

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

Claims Pricing

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

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect

at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of billed Covered Charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

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

Negotiated (non-BlueCard Program) National Account Arrangements

With respect to one or more Host Plans, instead of using the BlueCard Program, Horizon BCBSNJ may process the Covered Person's claims for Covered Services and Supplies through Negotiated National Account Arrangements.

In addition, if Horizon BCBSNJ and the group have agreed that (a) Host Blue(s) shall make available (a) custom healthcare provider network(s) in connection with this agreement, then the terms and conditions set forth in Horizon BCBSNJ's Negotiated National Account Arrangement(s) with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of claims when Covered Persons access such network(s). In negotiating such Negotiated National Account Arrangements, Horizon BCBSNJ is not acting on behalf of or as an agent for the group or the group health plan.

Covered Person's Liability Calculation.

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

The BlueCard Program may use reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates. If the Plan uses reference-based benefits, a Covered Person will be responsible for the amount that the healthcare provider bills for a specified procedure above the reference benefit limit for that procedure. For a BlueCard Provider, that amount will be:

(i) The difference between the negotiated price; and

(ii) The reference benefit limit.

For a nonparticipating provider, that amount will be:

(i) The difference between the provider's billed charge; and

(ii) The reference benefit limit.

Where a reference benefit limit exceeds either a negotiated price or a provider's billed charge, the Covered Person will incur no liability, other than any applicable Covered Person cost sharing under this Booklet.

Special Cases: Value-Based Programs

Value-Based Programs Overview

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

Value-Based Programs under the BlueCard Program

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

Value-Based Programs under Negotiated National Account Arrangements

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

Return of Overpayments

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

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

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

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

Covered Person's Liability Calculation

In General

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

Exceptions

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

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

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

BCBS Global Core Coverage TM

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

Inpatient Services

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

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

Outpatient Services

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

Submitting a BCBS Global Core Claim

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

Exclusions Under Your Program

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

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

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

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, except as otherwise stated in this Booklet. This includes, but is not limited to: (a) the restoration of tooth structure lost by decay, fracture, attrition, or erosion; (b) endodontic treatment of teeth; (c) Surgery and related services to treat periodontal disease; (d) osseous Surgery and any other Surgery to the periodontium; (e) replacing missing teeth; (f) the removal and re-implantation of teeth (and related services); (g) any orthodontic treatment; (h) dental implants and related services; and (i) orthognathic Surgery. For the purposes of this Plan, orthognathic Surgery will always be deemed a dental treatment.

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.

Food products (including enterally administered food products, except when used as the sole source of nutrition).

Hearing aids or fitting of hearing aids.

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 Accidental.

Illness or 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.

Injections or injection treatment for any condition, except as otherwise stated in this Contract.

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 means that the Plan 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 Booklet.

Nutritional counseling and related services.

Pastoral counseling.

Personal comfort and convenience items.

Prescription Drugs that in the usual course of medical practice are self-administered or dispensed by a retail or mail-order Pharmacy.

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, calluses, warts, horrified 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 and supplies related to: hearing exams to determine the need for hearing aids; the purchase, modification, repair and maintenance of hearing aids; and the need to adjust them.

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

Services 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, or Civil Union Partner, 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; Exception: As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition;

- not specifically covered under your Plan;

- 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 Plan, 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.

- 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.

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.

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

Telephone consultations, except as the Plan 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 Booklet.

COORDINATION OF BENEFITS AND SERVICES

PURPOSE OF THIS PROVISION

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

d) Group hospital indemnity benefit amounts that exceed $150.00 per day;

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

Plan does not include:

a. Individual or family insurance contracts or subscriber contracts;

b. Individual or family coverage through a Health Maintenance Organization HMO or under any other prepayment, group practice and individual practice plans;

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

d. Group hospital indemnity benefit amounts of $150.00 per day or less;

e. School accident-type coverage;

f. A State plan under Medicaid.

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

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

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

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

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

PRIMARY AND SECONDARY PLAN

The Plan considers each Plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration

the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

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

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

RULES FOR THE ORDER OF BENEFIT DETERMINATION

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

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

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

If a Child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

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

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

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

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

If a Child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

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

b. The benefits of the Plan of the spouse of the parent with custody shall be determined second.

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

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

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

PROCEDURES TO BE FOLLOWED BY THE SECONDARY PLAN TO CALCULATE BENEFITS

In order to determine which procedure to follow it is necessary to consider:

a. The basis on which the Primary Plan and the Secondary Plan pay benefits; and

b. Whether the Provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the Provider bills a charge and the Covered Person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a Reasonable and Customary Charge is called a "Reasonable and Customary Charge Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a Provider, called an In- Network Provider, bills a charge, the Covered Person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Covered Person uses the services of an Out-of-Network Provider, the Plan will be

treated as a Reasonable and Customary Charge Plan even though the Plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means that the carrier pays the Provider a fixed amount per member. The Covered Person is liable only for the applicable Deductible, Coinsurance and/or Copayment. In this section, a Plan that pays Providers based upon capitation is called a "Capitation Plan."

In the rules below, "Provider" refers to the provider who provides or arranges the services or supplies.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the Provider is an In-Network Provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a. The amount of any Deductible, Coinsurance and/or Copayment required by the Primary Plan; or

b. The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the Provider receives from the Primary Plan, the Secondary Plan and the Covered Person shall not exceed the fee schedule of the Primary Plan. In no event shall the Covered Person be responsible for any payment in excess of the Copayment, Coinsurance and/or Deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Reasonable & Customary Plan

If the Provider is an In-Network Provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a. The amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or

b. The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Reasonable & Customary Plan or Fee Schedule Plan

If the Primary Plan is an HMO Plan that does not allow for the use of Out-of-Network Providers except in the event of Urgent Care or a Medical Emergency and the service or supply the Covered Person receives from an Out-of-Network Provider is not considered as Urgent Care or a Medical Emergency, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or Reasonable & Customary Plan

If the Covered Person receives services or supplies from a Provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

a. The amount of any Deductible, Coinsurance and/or Copayment required by the Primary Plan; or

b. The amount the Secondary plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or Reasonable & Customary Plan and Secondary Plan is Capitation Plan

If the Covered Person receives services or supplies from a Provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the Provider and shall not be liable to pay the Deductible, Coinsurance and/or Copayment imposed by the Primary Plan. The Covered Person shall not be liable to pay any Deductible, Coinsurance and/or Copayment of either the Primary Plan or the Secondary Plan.

SUBROGATION AND REIMBURSEMENT

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

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

1. In the event that benefits are provided under this Plan, the Plan shall be subrogated to all of the Covered Person's or the Covered Person's representative's (representative for this purpose includes, if applicable, heirs, administrators, legal representatives, parents (if a minor), successors, or assignees) rights of recovery against any person or organization to the extent of the benefits provided to the Covered Person. The Covered Person shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Covered Person shall do nothing after loss to prejudice such rights. The Covered Person hereby agrees to cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any injury, illness, or accident as the Plan or the Plan representatives deem necessary to fully investigate the incident.

2. The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan. The Plan is entitled under its right of recovery to be reimbursed for the full amount of the Plan's benefit payments even if the Covered Person is not "made whole" for all of his or her damages in the recoveries that he or she receives.

3. The Plan's right to reimbursement is, and shall be, prior and superior to the right of any other person or entity, including the Covered Person.

4. By accepting benefits hereunder, the Covered Person hereby grants an automatic lien against and assigns to the Plan, in an amount equal to the benefits paid by the Plan, any recovery, whether by settlement, judgment, or other payment intended for, payable to, or received by the Covered Person, or on behalf of the Covered Person. The Covered Person hereby consents to said lien and/or assignment and agrees to take whatever steps are necessary to help the Plan secure said lien and/or assignment. The Covered Person agrees that said lien and/or assignment shall constitute a charge upon the proceeds of any recovery and the Plan shall be entitled to assert security interest thereon.

5. By the acceptance of benefits under the Plan, the Covered Person and his or her representatives agree to serve as a constructive trustee and to hold the proceeds of any settlement, judgment and/or other payment in constructive trust for the benefit of the Plan to the extent of 100% of all benefits paid on behalf of the Covered Person.

6. The subrogation and reimbursement rights and liens apply to any recoveries made by the Covered Person as a result of the injuries sustained, including but not limited to the following:

   a. Payments made directly by the third party tortfeasor, or any insurance company on behalf of the third party tortfeasor, or any other payments on behalf of the third party tortfeasor.

   b. Any payments or settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Covered Person or other person.

   c. Any other payments from any source designed or intended to compensate a Covered Person for injuries sustained.

   d. Any worker's compensation award or settlement.

   e. Any recovery made pursuant to no-fault insurance.

   f. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

7. The Covered Person shall not take action that may prejudice the Plan's right of recovery, including but not limited to the assignment of any rights of recovery from any tortfeasor or other person or entity. No Covered Person shall make any settlement which specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Plan. The Plan will not reduce its share of any recovery unless, in the exercise of its discretion, the Plan agrees in writing.

8. The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Covered Person, which right shall not be defeated nor reduced by the application of any doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages. Accordingly, the Plan is entitled under its right of recovery to be reimbursed for its benefit payments even if the Covered Person is not "made whole" for all of his or her damages in the recoveries he or she receives; there shall be no application of the "made whole" doctrine, "rimes doctrine" or any such doctrine defeating the Plan's right of recovery.

9. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the prior express written consent of the Plan and the Plan's right of recovery is not subject to reduction of attorney's fees

and costs under the “common fund” or any other doctrine.

10. In the event that a Covered Person shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including but not limited to attorney’s fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future Plan benefits hereunder until the Covered Person has fully complied with his or her reimbursement obligations hereunder, regardless of how those future Plan benefits are incurred.

11. Any reference to state law in any other provision of this policy shall not be applicable to this provision, if the Plan is governed by ERISA. By acceptance of benefits under the Plan, the Covered Person agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

THE EFFECT OF MEDICARE ON BENEFITS

IMPORTANT NOTICE

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

For the purpose of this section:

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

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

c. Under the rules for coordination of benefits and services described earlier, a "Primary Plan" pays benefits for a Covered Person's Covered Charges first, ignoring what the Covered Person's "Secondary Plan(s)" pays. The "Secondary Plan(s)" then pays the remaining unpaid Allowable Expenses in accordance with the provisions of the Covered Person's secondary health plan.

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

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

Medicare Eligibility by Reason of Age

This section applies to a Covered Person who:

a. is the Employee or covered Spouse ;

b. is eligible for Medicare by reason of age; and

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

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

This section does **not** apply to:

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

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

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

When a Covered Person becomes eligible for Medicare by reason of age, this Plan permits the Covered Person to make a prospective election change that cancels coverage under this Plan and elects Medicare as the primary health plan.

If a Covered Person cancels coverage under this Plan, the Covered Person will no longer be covered by this Plan. Medicare will be the primary payer. Coverage under this plan will end on the last day of the month in which the Covered Person elects Medicare the primary health plan.

If a Covered Person does not make an election upon becoming eligible for Medicare by reason of age, this Plan will continue to be the primary health plan. This plan pays first, ignoring Medicare. Medicare will be considered the secondary health plan.

Medicare Eligibility by Reason of Disability

This part applies to a Covered Person who:

a. is under age 65;

b. is eligible for Medicare by reason of disability; and

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

This part does **not** apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or

b. a Covered Person who is eligible for Medicare solely on the basis of ESRD.

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

Medicare Eligibility by Reason of End Stage Renal Disease

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

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

a. eligible for Medicare by reason of age ; or

b. eligible for Medicare by reason of disability.

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

The coordination period starts on the earlier of:

a. the first month of a Covered Person's Medicare Part A entitlement based on ESRD; or

b. the first month in which he/she could become entitled to Medicare if he/she filed a timely application.

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

Dual Medicare Eligibility

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

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

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

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

How To File A Claim If You Are Eligible For Medicare

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

New Jersey Providers:

- The Covered Person should give the Practitioner or other Provider his/her identification

number. This number is shown on the Medicare Request for Payment (claim form) under "Other Health Insurance";

- The Provider will then submit the Medicare Request for Payment to the Medicare Part B carrier;

- After Medicare has taken action, the Covered Person will receive an Explanation of Benefits form from Medicare;

- If the remarks section of the Explanation of Benefits contains this statement, no further action is needed: "This information has been forwarded to Horizon Blue Cross Blue Shield of New Jersey for their consideration in processing supplementary coverage benefits;"

- If the above statement does not appear on the Explanation of Benefits, the Covered Person should include his/her Identification number and the name and address of the Provider in the remarks section of the Explanation of Benefits and send it to Horizon BCBSNJ.

Out-of-State Providers:

- The request for Medicare payment should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information;

- Upon receipt of the Explanation of Benefits, show the Identification Card number and the name and address of the Provider in the remarks section and send the Explanation of Benefits to Horizon BCBSNJ for processing.

Appeals Process

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

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

Appeals Process for Adverse Administrative Decisions

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

a. For Urgent Care Claims, 72 hours from receipt of the claim;

b. For Pre-Service Claims, 15 calendar days from receipt of the claim;

c. For Post-Service Claims, 30 calendar days from receipt of the claim.

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

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

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

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

Appeals Process for Adverse Utilization Management Decisions

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

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

Your appeal must include the following information:

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

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

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

External Appeal Rights

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

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

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

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

STATEMENT OF ERISA RIGHTS

As a participant in **Middlesex County** Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Receive information about your plan and benefits.

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to **$110.00** a day until you receive

the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plans' decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If your have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

SERVICE CENTERS

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

Telephone personnel are available:

Monday, Tuesday, Wednesday and Friday from 8:00a.m. to 6:00p.m.

Thursday from 9:00 a.m. to 6:00pm (E.T.) Eastern Time

For questions and assistance with your benefits and services, please call:

1-800-355-BLUE
(2583)

For Mental Health and Substance Abuse, please call:

1-800-626-2212

For Individual Case Management, please call:

1-800-664-BLUE
(2583)

Always have your identification card handy when calling. Your ID number helps to get prompt answers to your questions about enrollment, benefits or claims.