



Product: **Direct Access**

Group Name: **CPC Integrated Health, Inc.**
10 INDUSTRIAL WAY
EATONTOWN, NJ 07724

Group Number: **00852C1-005**

Effective Date: **07/01/2025**

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CPL



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

Dear Valued Customer:

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

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

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

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

Important Tips to Follow

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

Call our Interactive Voice Response (IVR) system for information at your convenience.

Through our IVR system, you can get answers to your questions 24 hours a day (usually including weekends/holidays).

Be prepared if a medical emergency arises. If you or a covered dependent experiences a medical emergency, we suggest you follow these steps:

- Call **911** or go directly to the nearest Emergency Room.

- Call your Primary Care Physician (PCP) or personal doctor as soon as reasonably possible so that he/she may coordinate your follow up care. You do not need to call Member Services in a medical emergency.

Have a question about your benefits?

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

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Jared', followed by a long horizontal line that tapers to a point on the right.

Jared Ferguson
Vice President
Consumer, Small Group, and Midsize Markets
Horizon Healthcare Services, Inc.

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INTRODUCTION

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

This Plan offers the highest level of benefits when services are obtained from a Hospital or other Provider designated as a **Direct Access** In-Network Provider either in New Jersey or in another Blue Cross and Blue Shield service area.

In this Booklet, you'll find the important features of your group's **Direct Access** 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.

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

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

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

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

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

Allowance: Subject to the exceptions below, an amount determined by the Horizon BCBSNJ as follows:

- (a) in the case of In-Network Providers, the amount that the Provider has agreed to accept for the service or supply; or
- (b) in the case of Out-of-Network Providers, the amount will be limited to the lesser of:
 - (i) the amount determined as **180%** of the amount that would be reimbursed for the service or supply under Medicare or
 - (ii) another amount accepted by the Out-of-Network provider as full reimbursement less applicable cost-share.

Exceptions

- The above methods for determining an Allowance do not apply with respect to the Plan's coverage of Orthotic and Prosthetic Devices. The Allowance for any such covered device shall be the greater of: (i) the reimbursement rate for the device in the federal Medicare reimbursement schedule; and (ii) in the case of In-Network Providers, the amount that the Provider has agreed to accept for the device. If there is no such rate for the device, the amount determined for (i) shall be the Medicare reimbursement rate for the most similar device.
- The above methods for determining an Allowance do not apply if ERISA section 716 (addressing certain Emergency Services and certain charges from Out-of-Network Providers practicing in In-Network facilities) or ERISA section 717 (addressing air ambulance services by Out-of-Network Providers) applies. In such cases, the provider reimbursement will be the Surprise Billing Reimbursement Rate. The Surprise Billing Reimbursement Rate means the reimbursement rate required by ERISA section 716 or ERISA section 717 (whichever is applicable) for certain items and services. The Surprise Billing Reimbursement Rate applies to:

- (1) certain Emergency Services received from Out-of-Network Providers;
- (2) certain item(s) or service(s) furnished by an Out-of-Network Provider at an In-Network facility;
- and
- (3) air ambulance services by Out-of-Network Providers.

Unless state law applies, the Surprise Billing Reimbursement Rate will be the negotiated rate (i.e., the agreed upon amount) or the amount determined by the independent dispute resolution process required under ERISA section 716. Where state law applies, the Allowance for covered services for inadvertent Out-of-Network Provider services and/or Out-of-Network services provided on an emergency or urgent basis (and as such terms are defined under state law) shall be determined in a manner consistent with the New Jersey Out-of-network Consumer Protection, Transparency, Cost Containment, and Accountability Act (P.L. 2018, c. 32), as amended, or other controlling laws.

- In a case where a Covered Person's Primary Care Physician refers him/her to an Out-of-Network Provider, the Allowance for the Out-of-Network Provider's services will be the amount determined in accordance with (a), above.
- For methods above that rely on the Medicare reimbursement amount, Medicare does not prescribe a reimbursement rate for a Covered Services or Supplies, the Allowance for the Covered Services or supplies will be determined based on profiles utilized by Horizon BCBSNJ based on usual and amounts paid by Horizon BCBSNJ.

Alternate Payee:

- a. A custodial parent, who is not an Employee under the terms of the Plan, of a Child Dependent; or
- b. The Division of Medical Assistance and Health Services in the New Jersey Department of Human Services, which administers the State Medicaid Program.

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

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

- a. It must:
 1. be staffed by Practitioners and Nurses under the supervision of a physician;
 2. have permanent operating and recovery rooms;
 3. be staffed and equipped to give Medical Emergency care; and
 4. have written back-up arrangements with a local Hospital for Medical Emergency care.
- b. The Plan will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
 1. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
 2. approved for its stated purpose by Medicare.

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

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

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

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

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

Benefit Day: Each of the following:

- a. Each midnight the Covered Person is registered as an Inpatient; or
- b. Each day when Inpatient Admission and discharge occur on the same calendar day or
- c. Two Inpatient days in a Skilled Nursing Facility.

Benefit Month: The one-month period beginning on the Effective Date of the Plan each succeeding monthly period.

Benefit Period: The twelve-month period starting on July 1st and ending on June 30th. The first and/or last Benefit Period may be less than a calendar year. The first Benefit Period begins on the Employee's Coverage Date. The last Benefit Period ends when the Employee is no longer covered.

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

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

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

Blue Card PPO Provider: A Provider, not in New Jersey, which has a written agreement with another Blue Cross Blue Shield plan to provide care to both that plan's subscribers and other Blue Cross Blue Shield plans' subscribers.

For purposes of this Plan, a BlueCard PPO Provider is an In-Network Provider.

Booklet: A detailed summary of benefits covered.

Calendar Year: A year starting January 1.

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

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

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

- The natural born child or stepchild of you your Spouse or Domestic Partner;
- A child who is : (a) legally adopted by you your Spouse or Domestic Partner; 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 or Domestic Partner's legal ward. But, proof of guardianship satisfactory to the Plan must be furnished to us when we ask.

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

Complex Imaging Services: Includes the following services-

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

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

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

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

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

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

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

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

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

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

- a. Furnished or ordered by a Provider; and
- b. For Preventive Care, or Medically Necessary and Appropriate to diagnose or treat an Illness (including Mental Health Conditions and Substance Use Disorders) or Injury.

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

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

Custodial Care includes, but is not limited to: help in walking or getting into or out of bed; help in bathing, dressing and eating; help in other functions of daily living of a similar nature; administration of or help in using or applying creams and ointments; routine administration of medical gasses after a regimen of therapy has been set up; routine care of a patient, including functions such as changes of dressings, diapers and protective sheets and periodic turning and positioning in bed; routine care and maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags and indwelling catheters; routine tracheostomy care; general supervision of exercise Plans, including carrying out of maintenance Plans of repetitive exercises that do not need the skills of a therapist and are not skilled services.

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

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

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

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

- a. is attributable to a mental or physical impairment, or a combination of them;
- b. is likely to continue indefinitely;
- c. 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
- d. reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are: (i) of lifelong or extended duration; and (ii) individually planned or coordinated.

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

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

- a. radiology and ultrasound;
- b. lab and pathology; and
- c. EKG's, EEG's and other electronic diagnostic tests.

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

Domestic Partners: Persons who meet these criteria:

- (1) Both persons have a common residence and are otherwise jointly responsible for each other's common welfare, as evidenced by joint financial arrangements or joint ownership of real property, which shall be demonstrated by at least one of the following:
 - (a) A joint deed, mortgage agreement or lease;
 - (b) A joint bank account;
 - (c) Designation of one of the persons as a primary beneficiary in the other's will;
 - (d) Designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
 - (e) joint ownership of a motor vehicle;
- (2) Both persons agree to be jointly responsible for each other's basic living expenses during the Domestic Partnership;
- (3) Neither person is in a marriage recognized by New Jersey law or a member of another Domestic Partnership;
- (4) Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;
- (5) Both persons have chosen to share each other's lives in a committed relationship of mutual caring;
- (6) Both persons are at least 18 years of age;

Domestic Partnership: A relationship between the Employee and another person as the Employee that meets the requirements set forth under this Program. Proof that such a relationship exists, as determined by Horizon BCBSNJ, must be given to Horizon BCBSNJ when requested. Horizon BCBSNJ has the right to determine eligibility for coverage under this Plan.

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

- a. It is designed for and able to withstand repeated use;
- b. It is primarily and customarily used to serve a medical purpose;
- c. It is generally not useful to a person in the absence of an illness or injury; and
- d. It is suitable for use in the home.

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

Some examples of services and supplies that are not considered to be Durable Medical Equipment are: adjustments made to vehicles; furniture; scooters; all terrain vehicles (ATVs); non-hospital-type beds; air conditioners; air purifiers; humidifiers; dehumidifiers; elevators; ramps; stair glides; emergency

alert equipment; handrails; hearing aids; heat appliances; improvements made to the home or place of business; waterbeds; whirlpool baths; and exercise and massage equipment.

Elective Surgical Procedure: Non-emergency Surgery that may be scheduled for a day of the patient's choice without risking the patient's life or causing serious harm to the patient's bodily functions.

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

Employer: Collectively, all employers included under the Plan.

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

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

Experimental or Investigational: 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 Plan cover any drug that the FDA has determined to be Experimental, Investigational or contraindicated for the treatment for which it is prescribed.

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

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

This coverage for clinical trials does not include: (a) the cost of Experimental or Investigational drugs or devices themselves; (b) non-health services that the patient needs to receive the care and treatment; (c) the costs of managing the research; or (d) any other services, supplies or charges that this Plan 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 exam of the eye performed by a Practitioner, including: a diagnostic ophthalmic exam, with or without definitive refraction as medically indicated, with medical diagnosis and initiation of diagnostic and treatment Plans; prescription of medication and lenses; post-cycloplegic Visit if needed; and verification of lenses if prescribed.

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

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

FDA: The Food and Drug Administration.

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

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

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

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

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

- a. The care must be given on a part-time or intermittent basis, except if full-time or 24-hour services are Medically Necessary and Appropriate on a short-term basis.
- b. Continuing Inpatient stay in a Hospital would be needed in the absence of Home Health Care.
- c. The care is furnished under a physician's order and under a plan of care that: (a) is established by that physician and the Home Health Care Provider; (b) is established within 14 days after Home Health Care starts; and (c) is periodically reviewed and approved by the physician.

Home Health Care Services: Any of these services needed for the Home Health Care plan: nursing care; physical therapy; occupational therapy; medical social work; nutrition services; speech therapy; home health aide services; medical appliances and equipment, drugs and medicines, lab services and special meals, to the extent these would have been Covered Services and Supplies if the Covered Person was a Hospital Inpatient; diagnostic and therapeutic services (including Surgical services) performed in a Hospital Outpatient department, a physician's office, or any other licensed health care Facility, to the extent these would have been Covered Services and Supplies under this Plan if furnished during a Hospital Inpatient stay.

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

Hospice: A Provider which mainly provides palliative and supportive care for terminally ill or terminally injured people under a Hospice Care Program. 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. accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

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

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

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

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

Illness: A sickness or disease suffered by a Covered Person. Illness includes Mental Health Conditions and Substance Use Disorders.

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

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

Inherited Metabolic Disease: A disease caused by an inherited abnormality of body chemistry for which testing is mandated.

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

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

In-Network Coverage: The level of coverage, shown in the Schedule of Covered Services and Supplies, which is provided if (a) an In-Network Provider provides the service or supply; (b) the PCP provides or

coordinates care, treatment, services and supplies for the Covered Person; or (c) the PCP refers the Covered Person to another provider for such care, treatment, services and supplies.

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

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

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

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

Maintenance Therapy: That point in the therapeutic process at which no further improvement in the gaining or restoration of a function, reduction in disability or relief of pain is expected. Continuation of therapy at this point would be for the purpose of holding at a steady state or preventing deterioration.

Medical Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to: severe pain; psychiatric disturbances; and/or symptoms of Substance Use Disorders) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in: (a) placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of a bodily organ or part.

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

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

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

Medically Necessary and Appropriate: 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 alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Covered Person's illness, injury or disease.

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

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

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

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

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

- a. accredited for its stated purpose by the Joint Commission;
- b. approved for its stated purpose by Medicare; or
- c. accredited or licensed by the state in which it is located to provide mental health services.

Mental Health Conditions: are defined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is a book published by the American Psychiatric Association. It describes all recognized mental disorders. In general, a mental disorder is a serious disturbance in a person's thought process, emotions or behavior that causes problems in mental functioning. Mental disorders are often connected to significant distress or disability in social, work or other important activities.

Mutually Exclusive Surgical Procedures: Surgical procedures that:

- (a) differ in technique or approach, but lead to the same outcome;
- (b) represent overlapping services or accomplish the same result;
- (c) in combination, may be anatomically impossible.

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

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

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

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

Optical Services: The following services when provided for lenses, including contact lenses, and frames:

- a. Facial measurements;
- b. Help in the selection of frames;
- c. Acquiring proper lenses and frames;
- d. Fitting and adjustment;
- e. After-care for verification of fitting and lens adjustment, and for maintenance of comfort and efficiency.

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

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

Out-of-Network Benefits: The coverage shown in the Schedule of Covered Services and supplies which is provided if (a) an Out-of-Network Provider provides the service or supply; or (b) the PCP does not authorize or coordinate the care, treatment, services and supplies.

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

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

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

Per Lifetime: During the lifetime of a person.

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

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

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

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

Plan: The CPC Integrated Health, Inc. Medical Plan.

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

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

Practitioner: A person that The Plan is required by law to recognize who:

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

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

As used in the Breastfeeding Support provision, Practitioner also means a person who is an International Board Certified Lactation Consultant or a Lactation Counselor.

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, or 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 Benefit Period under a self-insured stand-alone group prescription drug plan or an insured stand-alone group prescription drug plan provided by Horizon BCBSNJ or another carrier:

- a. Expenses that are applied toward the prescription drug plan's deductible, if any (excluding any such expenses, including any fourth quarter deductible carry over as defined in the prescription drug plan, that were carried over from the preceding Benefit Period).
- b. Amounts paid or payable by the Covered Person as copayments and/or coinsurance under the prescription drug plan.

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

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

Primary Care Practitioner (PCP): An In-Network physician or other health care professional who: (a) is licensed or otherwise authorized to provide health care services in the state or jurisdiction in which the services are furnished; and (b) supervises, coordinates and maintains continuity of care for Covered Persons. When services are rendered under the supervision or coordination of a PCP, PCPs include: nurse practitioners/clinical nurse specialists; physician assistants; and certified nurse midwives.

The Plan allows the designation of a PCP. A Covered Person has the right to choose any In-Network PCP who is available to accept the Covered Person as a patient. In the case of a Child Dependent, the parent may designate a pediatrician as the Child Dependent's PCP.

Also, a Covered Person does not need Prior Authorization from The Plan or from any other person (including a PCP) to access obstetrical or gynecological care from an In-Network health care Practitioner who specializes in obstetrics or gynecology. But the Practitioner may need to comply with certain procedures, including: obtaining Prior Authorization for certain services; following a pre-approved treatment plan; or procedures for making referrals.

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

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

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

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

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

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

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

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

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

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

Skilled Nursing Facility: A Facility which mainly provides full-time Skilled Nursing Care for ill or injured people who do not need to be in a Hospital. 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 Care Unit: A part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff and special equipment and supplies on hand at all times. Some types of Special Care Units are:

- a. intensive care units;
- b. cardiac care units;
- c. neonatal care units; and
- d. burn units.

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

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

Specialist Physician: A fully licensed physician who:

- a. is a diplomat of a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association; or
- b. is a fellow of the appropriate American specialty college or a member of an osteopathic specialty college; or
- c. is currently admissible to take the exam administered by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association; or has evidence of completion of an appropriate qualifying residency approved by the American Medical Association or American Osteopathic Association; or
- d. holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or
- e. is recognized in the community as a specialist by his or her peers.

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

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

Substance Use Disorders Centers: Facilities that mainly provide treatment for people with Substance Use Disorders problems. 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.

Surgery/Surgical:

- a. The performance of generally accepted operative and cutting procedures, including: surgical diagnostic procedures; specialized instrumentations; endoscopic exams; and other invasive procedures;
- b. The correction of fractures and dislocations;
- c. Pre-operative and post-operative care; or
- d. Any of the procedures designated by C.P.T. codes as Surgery.

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

Telemedicine/Telehealth Services: The delivery of or support of clinical health care services, provider consultation, patient and professional health-related education public health, health administration and other services including diagnosis, consultation, or treatment through the use of information and communication technologies, via live interactive audio and/or video, over a secure connection, including remote patient monitoring devices, phones, or other electronic means.

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

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

- a. ordered by a Practitioner;
- b. performed by a Provider;
- c. Medically Necessary and Appropriate for the treatment of a Covered Person's Illness or Injury.

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

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

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

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

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

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

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

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

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

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

- a. Speech therapy to restore speech after a loss or impairment of a demonstrated, previous ability to speak. Two examples of speech therapy that will not be covered are: (a) therapy to correct pre-speech deficiencies; and (b) therapy to improve speech skills that have not fully developed.
- b. Speech therapy to develop or improve speech to correct a defect that both: (a) existed at birth; and (b) impaired or would have impaired the ability to speak.
- c. Regardless of anything in a. or b. above to the contrary, speech therapy needed to treat a speech impairment of a Covered Person diagnosed with a Developmental Disability.

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

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

Urgent Care Claim: An Urgent Care Claim is any claim for medical care which, if denied, in the opinion of the Covered Person or his/her Provider, will cause serious medical consequences in the near future,

or subject the Covered Person to severe pain that cannot be managed without the medical services that have been denied.

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

Vision Survey: A survey and analysis performed by a Practitioner acting within the scope of his/her license, including, but not limited to: a case history; complete refraction; coordination measurements and tests; visual field charting; and prescription of lenses, as needed.

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

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

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

We, Us and Our: The Plan.

You, Your: An Employee.

SCHEDULE OF COVERED SERVICES AND SUPPLIES

POLICYHOLDER: CPC Integrated Health, Inc.
GROUP POLICY NO.: 00852C1-005

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

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

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

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

Services and supplies provided by an In-Network Provider are covered at the In-Network level.

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

Services and supplies provided by an Out-of-Network Provider are covered at the Out-of-Network level. However, this does not apply to services and supplies provided by an Out-of-Network Provider in a case where:

- (a) the Covered Person is an Inpatient in a Hospital;
- (b) the admitting physician was a Network Practitioner; and
- (c) where the Covered Person has not provided valid consent to the use of the Out-of-Network Provider
In this case, the Covered Services and Supplies provided by Out-of-Network Providers during the Inpatient stay will be covered at the In-Network level.

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

Coinsurance In-Network	100% of Covered Basic Charges. 100% of Covered Supplemental Charges.
Coinsurance Out-Of-Network	70% of Covered Basic Charges. 70% of Covered Supplemental Charges.
Out-of-Pocket Maximum In-Network	After \$5,000 /Covered Person, \$10,000 /Family, We provide 100% of Covered Allowance.
Out-of-Pocket Maximum Out-Of-Network	After \$5,000 /Covered Person, \$10,000 /Family, We provide 100% of Covered Allowance.
Deductible Out-of-Network	\$2,000 /Covered Person.
Applies to Basic/Supplemental Services.	two /Family. Deductible does not apply to Preventive Care.
Period of Confinement	\$200 Per Period of Confinement

Applies to **In-Network** and **Out-of-Network** services.

Note: The Period of Confinement Copayment/Deductible applies to all Inpatient Facility charges.

Professional Office Care

In-Network

PCP

Subject to **\$15** Copayment and **100%** Coinsurance.

Specialist

Subject to **\$25** Copayment and **100%** Coinsurance.

Out-of-Network

PCP

Subject to Deductible and **70%** Coinsurance.

Specialist

Subject to Deductible and **70%** Coinsurance.

Professional Office Care

(Outpatient)

In-Network

PCP

Subject to **100%** Coinsurance.

Specialist

Subject to **100%** Coinsurance.

Out-of-Network

PCP

Subject to Deductible and **70%** Coinsurance.

Specialist

Subject to Deductible and **70%** Coinsurance.

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

BENEFIT PERIOD MAXIMUM

**In-Network and
Out-of-Network**

Unlimited. Applies to all Covered Services and Supplies.

PER LIFETIME MAXIMUM

**In-Network and
Out-of-Network**

Unlimited. Applies to all Covered Services and Supplies.

A. COVERED BASIC SERVICES AND SUPPLIES

ALLERGY TESTING AND TREATMENT

In-Network

Subject to **\$25** Copayment and **100%** Coinsurance.

Out-of-Network

Subject to Deductible and **70%** Coinsurance.

AMBULATORY SURGERY

In-Network

Subject to **\$50** Copayment and **100%** Coinsurance.

Out-of-Network

Subject to Deductible and **70%** Coinsurance.

ANESTHESIA

In-Network

Subject to **100%** Coinsurance.

Out-of-Network

Subject to Deductible and **70%** Coinsurance.

AUDIOLOGY SERVICES

In-Network

Subject to **\$25** Copayment and **100%** Coinsurance.

Out-of-Network

Subject to Deductible and **70%** Coinsurance.

BREASTFEEDING SUPPORT

In-Network

Subject to **100%** Coinsurance.

Out-of-Network

Subject to Deductible and **70%** Coinsurance.

COMPLEX IMAGING SERVICES

In-Network

Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

DENTAL CARE AND TREATMENT

In-Network Subject to **\$25** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

DIAGNOSTIC X-RAY AND LAB

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

DIALYSIS CENTER CHARGES

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

EMERGENCY ROOM

**Emergent
In-Network and
Out-of-Network** Subject to **\$50** Copayment and **100%** Coinsurance.

**Non Emergent
In-Network** Subject to **\$50** Copayment and **100%** Coinsurance.

**Non-Emergent
Out-of-Network** Subject to Deductible and **70%** Coinsurance.

FACILITY CHARGES 365 days Inpatient Hospital Care.

**In-Network
Inpatient** Subject to **\$200** Per Period of Confinement Copayment/ Deductible and **100%** Coinsurance.

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

**Out-of-Network
Inpatient** Subject to Deductible, **\$200** Per Period of Confinement Copayment/ Deductible, and **70%** Coinsurance.

Out-of-Network

Outpatient Subject to Deductible and **70%** Coinsurance.

FERTILITY SERVICES

In-Network Subject to **\$25** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

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

In-Network For the purchase of a hearing aid, benefits subject to **100%** Coinsurance.

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

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

Out-of-Network For the purchase of a hearing aid, benefits subject to Deductible and **70%** Coinsurance.

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

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

HOME HEALTH CARE

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

Benefits subject to a **100** Visit maximum per Benefit Period.

HOSPICE CARE

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

INPATIENT PHYSICIAN SERVICES

In-Network	Subject to 100% Coinsurance.
Out-of-Network	Subject to Deductible and 70% Coinsurance.

MATERNITY/OBSTETRICAL CARE

In-Network	Subject to \$25 Copayment for the initial Visit and 100% Coinsurance.
Outpatient Care	Subject to 100% Coinsurance.
Out-of-Network	Subject to Deductible and 70% Coinsurance.

MENTAL HEALTH CONDITIONS (INCLUDING GROUP THERAPY)

In-Network Inpatient	Subject to 100% Coinsurance.
Out-of-Network Inpatient	Subject to Deductible and 70% Coinsurance.
In-Network Outpatient	Subject to 100% Coinsurance.
Out-of-Hospital	Subject to \$25 Copayment and 100% Coinsurance.
Out-of-Network Outpatient and Out-of-Hospital	Subject to Deductible and 70% Coinsurance.

NUTRITIONAL COUNSELING

In-Network	Subject to \$25 Copayment and 100% Coinsurance.
Out-of-Network	Subject to Deductible and 70% Coinsurance.

Benefits subject to a **3** visit maximum per Benefit Period combined In-Network and Out-of-Network.

PRACTITIONER'S CHARGES FOR SURGERY

In-Network	Subject to \$25 Copayment and 100% Coinsurance.
Out-of-Network	Subject to Deductible and 70% Coinsurance.

PRE-ADMISSION TESTING

In-Network	Subject to 100% Coinsurance.
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Out-of-Network Subject to Deductible and **70%** Coinsurance.

PREVENTIVE CARE/HEALTH WELLNESS

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

Out-of-Network Subject to **70%** Coinsurance.

a. COLORECTAL CANCER SCREENING

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

Out-of-Network Subject to **70%** Coinsurance.

b. GYNECOLOGICAL EXAMINATIONS

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

Out-of-Network Subject to **70%** Coinsurance.

Limited to one exam per Benefit Period, combined In-Network and Out-of-Network.

c. MAMMOGRAPHY

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

Out-of-Network Subject to **70%** Coinsurance.

d. PAP SMEARS

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

Out-of-Network Subject to **70%** Coinsurance.

e. ROUTINE PROSTATE CANCER SCREENING

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

Out-of-Network Subject to **70%** Coinsurance.

f. ROUTINE ADULT PHYSICALS

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

Out-of-Network Subject to **70%** Coinsurance.

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

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

Out-of-Network Subject to **70%** Coinsurance.

h. WELL-CHILD CARE

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

Out-of-Network Subject to **70%** Coinsurance.

PRIMARY CARE SERVICES

In-Network Subject to **\$15** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

PROSTHETIC OR ORTHOTIC DEVICES

In-Network Benefits payable are the same as for an office Visit to a Provider who is a doctor specializing in: family practice, general practice, internal medicine, or pediatrics.

Out-of-Network Benefits payable are the same as for an office Visit to a Provider who is a Provider specializing in: family practice, general practice, internal medicine, or pediatrics.

SECOND OPINION CHARGES

In-Network Subject to **\$25** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

SKILLED NURSING FACILITY CHARGES

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

Benefit subject to **100** day limit per Benefit Period.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

Benefit subject to **60** days limit per Benefit Period.

SPECIALIST SERVICES

In-Network Subject to **\$25** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

SUBSTANCE USE DISORDERS

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

**Out-of-Network
Inpatient** Subject to Deductible and **70%** Coinsurance.

**In-Network
Outpatient and
Out-of-Hospital** Subject to **\$25** Copayment and **100%** Coinsurance

**Out-of-Network
Outpatient and
Out-of-Hospital** Subject to Deductible and **70%** Coinsurance.

SURGICAL SERVICES

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

**Out-of-Network
Inpatient** Subject to Deductible and **70%** Coinsurance.

**In-Network
Outpatient** Subject to **\$50** Copayment and **100%** Coinsurance.

**Out-of-Network
Outpatient** Subject to Deductible and **70%** Coinsurance.

TELEMEDICINE BEHAVIORAL HEALTH SERVICES, PROVIDED BY HORIZON CAREONLINE

In-Network Subject to **\$15** Copayment and **100%** Coinsurance.

Out-of-Network No Benefit.

TELEMEDICINE MEDICAL SERVICES, PROVIDED BY HORIZON CAREONLINE

In-Network Subject to **\$15** Copayment and **100%** Coinsurance.

Out-of-Network No Benefit

THERAPEUTIC MANIPULATIONS

In-Network Subject to **\$15** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

Subject to a **25** visit Benefit Period Maximum.

THERAPY SERVICES

a. CHELATION THERAPY

In-Network
Professional Office Care

PCP Subject to **\$15** Copayment and **100%** Coinsurance.

Specialist Subject to **\$25** Copayment and **100%** Coinsurance.

Professional Care
(Outpatient) Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

b. CHEMOTHERAPY

In-Network
Professional Office Care

PCP Subject to **\$15** Copayment and **100%** Coinsurance.

Specialist Subject to **\$25** Copayment and **100%** Coinsurance.

Professional Care
(Outpatient) Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

c. COGNITIVE REHABILITATION THERAPY

In-Network
Professional Office Care

PCP Subject to **\$15** Copayment and **100%** Coinsurance.

Specialist	Subject to \$25 Copayment and 100% Coinsurance.
Professional Care (Outpatient)	Subject to 100% Coinsurance.
Out-of-Network	Subject to Deductible and 70% Coinsurance.

Benefits subject to an **Unlimited** Visit Maximum per Benefit Period, combined In-Network and Out-of-Network.

d. DIALYSIS TREATMENT

**In-Network
Professional Office Care**

PCP	Subject to \$15 Copayment and 100% Coinsurance.
Specialist	Subject to \$25 Copayment and 100% Coinsurance.
Professional Care (Outpatient)	Subject to 100% Coinsurance.
Out-of-Network	Subject to Deductible and 70% Coinsurance.

e. INFUSION THERAPY

**In-Network
Professional Office Care**

PCP	Subject to \$15 Copayment and 100% Coinsurance.
Specialist	Subject to \$25 Copayment and 100% Coinsurance.
Professional Care (Outpatient)	Subject to 100% Coinsurance.
Out-of-Network	Subject to Deductible and 70% Coinsurance.

f. OCCUPATIONAL THERAPY

**In-Network
Professional Office Care**

PCP	Subject to \$15 Copayment and 100% Coinsurance.
Specialist	Subject to \$15 Copayment and 100% Coinsurance.
Professional Care (Outpatient)	Subject to 100% Coinsurance.
Out-of-Network	Subject to Deductible and 70% Coinsurance.

Benefits subject to a **30** Visit Maximum per Benefit Period, combined In-Network and Out-of-Network.

The **30** Visit maximum does not apply to certain mental health diagnoses, including the treatment of autism.

g. PHYSICAL THERAPY

**In-Network
Professional Office Care**

PCP Subject to **\$15** Copayment and **100%** Coinsurance.

Specialist Subject to **\$15** Copayment and **100%** Coinsurance.

**Professional Care
(Outpatient)** Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

Benefits subject to a **30** Visit Maximum per Benefit Period, combined In-Network and Out-of-Network.

The **30** Visit maximum does not apply to certain mental health diagnoses, including the treatment of autism.

h. RADIATION TREATMENT

**In-Network
Professional Office Care
PCP**

Subject to **\$15** Copayment and **100%** Coinsurance.

Specialist Subject to **\$25** Copayment and **100%** Coinsurance.

**Professional Care
(Outpatient)** Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

i. RESPIRATION THERAPY

**In-Network
Professional Office Care**

PCP Subject to **\$15** Copayment and **100%** Coinsurance.

Specialist Subject to **\$15** Copayment and **100%** Coinsurance.

**Professional Care
(Outpatient)** Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

Subject to a **30** visit Benefit Period Maximum.

j. SPEECH THERAPY

**In-Network
Professional Office Care**

PCP Subject to **\$15** Copayment and **100%** Coinsurance.

Specialist Subject to **\$15** Copayment and **100%** Coinsurance.

**Professional Care
(Outpatient)** Subject to **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

Benefits subject to a **30** Visit Maximum per Benefit Period, combined In-Network and Out-of-Network.

The **30** Visit maximum does not apply to certain mental health diagnoses, including the treatment of autism.

TRANSPLANT BENEFITS

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

URGENT CARE SERVICES

In-Network Subject to **\$25** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

VISION CARE

Covered Persons under Age 19

In-Network Subject to **\$25** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

Limited to Eye Examination and one Vision Survey per Contract Year, combined In-Network and Out-of-Network.

Hardware coverage limited to **\$50** in a 24-month period, combined In-Network and Out-of-Network (the coverage limit does not apply to routine pediatric vision services when hardware is obtained from an authorized collection of vision hardware).

Covered Persons Age 19 and Above

In-Network Subject to **\$25** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible and **70%** Coinsurance.

Limited to Eye Examination and one Vision Survey per Contract Year, combined In-Network and Out-of-Network.

Hardware coverage is limited to **\$50** in a 24-month period, combined In-Network and Out-of-Network.

WILM'S TUMOR

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

B. COVERED SUPPLEMENTAL SERVICES AND SUPPLIES

AMBULANCE SERVICES

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

BLOOD

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

DIABETES BENEFITS

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

DURABLE MEDICAL EQUIPMENT

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

HOME INFUSION THERAPY

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

INHERITED METABOLIC DISEASE MEDICAL FOODS

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

OXYGEN AND ADMINISTRATION

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

PHYSICAL REHABILITATION CENTER

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

**Out-of-Network
Inpatient** Subject to Deductible and **70%** Coinsurance.

Subject to a **60** day maximum per Benefit Period, combined In-Network and Out-of-Network.

PRIVATE DUTY NURSING

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

This Program covers **240** hours per Benefit Period of Private Duty Nursing Care.

SPECIALIZED NON-STANDARD INFANT FORMULAS

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

Out-of-Network Subject to Deductible and **70%** Coinsurance.

WIGS

Out-of-Network Subject to **100%** Coinsurance.

GENERAL INFORMATION

How To Enroll

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

Your Identification (ID) Card

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

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

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

Types Of Coverage Available

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

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

Change In Type Of Coverage

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

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

For example:

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

premium within 31 days of the completed adoption in order to continue the child's health coverage beyond that point.

- If Your health Plan offers child Dependent coverage, a newborn child born to the Employee or Spouse or Domestic Partners will be covered under the health Plan for 60 days from the date of birth. The newborn child must be enrolled within 60 days from the date of birth and any applicable premium must be paid within 60 days from the date of birth.
- If you have Single coverage and marry or acquire a Domestic Partner, your new Spouse or Domestic Partner will be covered from the date you marry or meet the rules for covering Domestic Partners if you apply for Husband and Wife/Domestic Partners 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 Enrollee may enroll only during the next Open Enrollment Month(s). Coverage for them will be effective as of the Open Enrollment Effective Date.

Enrollment of Dependents

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:

- The person was covered under a group or other health plan at the time coverage under this Plan was previously offered.
- You stated in writing that coverage under the other plan was the reason for declining enrollment when it was offered.
- The other health coverage:
 - was under a COBRA (or other state mandated) continuation provision and the COBRA or other coverage is exhausted; or
 - 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.
- 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:

- 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).
- 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 Domestic Partner

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

You must request enrollment of your Spouse or Domestic Partner within 31 days after the marriage or Acquiring or Domestic 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 Child(ren)

You may enroll a newborn child.

The Plan will cover your newborn child for injury or sickness, including necessary care and treatment of medically diagnosed congenital defects and abnormalities, for 60 days from the date of birth when you enroll your newborn child within 60 days of birth and any applicable premium is paid. Health benefits may be continued beyond such 60-day period by following the requirements stated below:

- (a) The above coverage continues beyond the initial 60 days, provided the premium required for the coverage is still paid within the 60 days from the date of birth.
- (b) If you are enrolled, but not covered for child Dependent coverage on the date the newborn child is born, you must:
 - make written request to enroll the child within 60 days from the date of birth; and
 - contribute toward any applicable premium amount for the coverage within 60 days from the date of birth.

If you do not make the request and the premium is not paid within such 60-day period, the newborn child will be a Late Enrollee.

An Eligible Employee, or Spouse or Domestic Partners who previously declined coverage under the Plan, can use "Special Enrollment due to Newborn Child(ren)". A new enrollee will have 60 days from the date of the newborn child's birth to enroll their newborn child(ren). The newborn child coverage must be effective on the date of birth.

Special Enrollment Due to Adoption

You may enroll a newly adopted Child Dependent.

The Plan will cover your newly adopted child for 31 days from the date of completed adoption/placement. Health benefits may be continued beyond such 31-day period as stated below:

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

- contribute towards the premium for the coverage within 31 days from the date of completed adoption.

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

A Spouse can be enrolled separately, within 31 days, when a Child Dependent is adopted/placed.

An Employee who is Eligible, but who previously declined coverage under the Contract, can utilize the Special Enrollment due to adoption. These new enrollees have 31 days from the date of the completed adoption/placement to enroll themselves or their newly adopted dependents. The coverage must be effective on the date of adoption/placement.

Multiple Employment

If you work for both the Planholder 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 Domestic Partner and your Child Dependents.

To enroll a Domestic Partner, you must provide proof that a Domestic Partnership exists by providing the Planholder and Horizon BCBSNJ with an acceptable proof of the Domestic Partnership.

Coverage for your Spouse will end: (a) at the end of the month in which you divorce; or (b) at the end of the month in which you tell us to delete your Spouse from coverage following marital separation.

Coverage for a Domestic Partner will end when the Domestic Partnership ends.

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

Coverage will continue for a Child Dependent beyond the age of **26** if, immediately prior to reaching that age: (1) the child is unmarried; and (2) he/she was enrolled under this Plan or another policy/contract and is incapable of self-sustaining employment by reason of intellectual disability or physical handicap. For your handicapped Child Dependent to remain covered, you must submit proof of his/her inability to engage in self-sustaining employment by reason of intellectual disability within 31 days of the child's attainment of age **26**. The proof must be in a form that meets our approval. Such proof must be resubmitted every two years within 31 days before or after the Child Dependent's birth date.

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 intellectual disability or physical handicap.

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

When Coverage Ends

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

- The end of the Benefit Month in which you cease to be eligible due to termination of your employment or any other reason.
- The date on which the 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.

If You Leave Your Group Due To Total Disability

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

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

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

- Failure by you to make timely payment of any contribution required by your Employer. If this happens, coverage stops at the end of the period for which contributions were made.

- The date you become employed and eligible for benefits under another group health plan; or, in the case of a Dependent, the date the Dependent becomes employed and eligible for such benefits.
- The date this Plan ends for the class of which you were a member.
- In the case of a Dependent, the date that he/she ceases to be an eligible Dependent.

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

Extension Of Coverage Due To Termination of the Plan

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

Prescription Drugs will also continue to be paid during the uninterrupted period of the disability, but not for more than 90 days from the date coverage ends.

Continued Coverage Under The Federal Family And Medical Leave Act

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

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

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

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

Consult your benefits representative for application forms and further details.

Continued Coverage For Surviving Dependents

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

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

- The date the Plan's coverage for the deceased Employee's class ends.

Consult your benefits representative for further details.

Continuation of Coverage under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you and your enrolled Dependents, not including a Dependent who is your Domestic 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 reasons other than gross misconduct;*
- You became entitled to Medicare benefits;
- In the case of your Spouse, the Spouse ceased to be eligible due to divorce or legal separation; or
- In the case of a Child Dependent, he/she ceased to be a Child Dependent under this Plan's rules.

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

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

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

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

- Up to 18 months in the event of the end of your employment or a reduction in your hours. Further, if you or a covered Dependent are determined to be disabled, according to the Social Security Act, at the time you became eligible for COBRA coverage, or during the first 60 days of the continued coverage, that person and any other person then entitled to the continued coverage may elect to extend this 18-month period for up to an extra 11 months. To elect this extra 11 months, the person

must give the Employer written proof of Social Security's determination before the first to occur of: (a) the end of the 18 month continuation period; or (b) 60 days after the date the person is determined to be disabled.

- Up to 36 months for your Dependent(s) in the event of: your death; your divorce or legal separation; your entitlement to Medicare; or your child ceasing to qualify as a Child Dependent.

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

- This 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 Domestic 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.

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

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

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

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

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

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

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

Uniformed services: The following:

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

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

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

Continued Coverage for Over-Age Dependents

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

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

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

If a Dependent Is Over the Limiting Age for Dependent Coverage

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

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

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

Conditions for Election

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

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

Election of Continuation

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

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

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

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

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

Payment of Contributions

The Plan will set the contributions for the continued coverage.

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

Subsequent contributions must be paid monthly, in advance.

Grace Period for the Payment of Contributions

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

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

Scope of Continued Coverage

The continued coverage will be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an Employee under this Plan. Subject to the following subsection, if this Plan's coverage for other dependents who are Covered Persons is modified, the coverage for Over-Age Dependents will be modified in like manner. Evidence of insurability is not required for the continued coverage.

Single Coverage for Over-Age Dependents

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

When Continuation Ends

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

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

Inapplicability of Other Continuation Provisions

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

Continuation of Care

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

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

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

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

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

Medical Necessity And Appropriateness

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

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

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

Cost Containment

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

Managed Care Provisions

Choosing a PCP

A Covered Person is encouraged to choose a PCP from the Horizon BCBSNJ Managed Care Doctor & Hospital Finder when he/she first obtains this coverage.

The choice of a PCP or other Practitioner is solely up to a Covered Person. However, Horizon BCBSNJ cannot guarantee the availability of a particular Practitioner.

If the PCP chosen cannot accept more patients, the Covered Person will be notified and given a chance to make another PCP selection.

Changing a PCP

A Covered Person must contact Horizon BCBSNJ to select a new PCP from the Network.

Horizon BCBSNJ will process the form within 30 days. We will then send a Covered Person a letter that confirms the selection and indicates the date that the change is effective.

Until the Covered Person receives this letter, he/she must continue to use the current PCP. But, if the current PCP is no longer in the Network, the Covered Person may start to use the new PCP right away.

Member Services

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

Referral Forms

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

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

Miscellaneous Provisions

- a. This Plan is intended to pay for Covered Services and Supplies as described in this booklet. The Plan does not provide the services or supplies themselves, which may, or may not, be available.
- b. The Plan is only required to provide its Allowance for Covered Services and Supplies, to the extent stated in the Group Plan. The Plan has no other liability.

Your Direct Access (DA) Program

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

If you use In-Network Providers, you will not have to file claims. If you use Out-of-Network Providers, you will generally need to file claims to receive benefits.

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

Note: Coverage will be reduced if a Covered Person does not comply with the Utilization Review and Management and Prior Authorization requirements contained in this Plan.

BENEFIT PROVISIONS

The Deductible

Each Benefit Period, each Covered Person must have Covered Charges that exceed the Deductible before the Plan provides coverage for that person. The Out-of-Network Deductible(s) is/are shown in the Schedule of Covered Services and Supplies. The Deductible(s) cannot be met with Non Covered Charges. Only Covered Charges Incurred by the Covered Person while covered by this Plan can be used to meet this Deductible. Once the Deductible is met, the Plan provides benefits up to its Allowance, for other Covered Charges above the Deductible Incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Benefit Period. But, all charges must be incurred while that Covered Person is covered by this Plan. Also, what coverage the Plan provides is based on all the terms of this Plan.

Family Deductible Limit

This Plan has a family Deductible limit of **two** Deductibles for each Benefit Period. Once **two** Covered Persons in a family meet their individual Deductibles, in a Benefit Period, Horizon BCBSNJ provides benefits for other Covered Charges Incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Benefit Period.

Out-of-Pocket Maximum

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

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

An Out-of-Pocket Maximum cannot be met with Non-Covered Charges. But solely for the purposes of this subsection, a Covered Person's or covered family's Prescription Drug Cost Share Amount shall be applied towards the applicable In-Network Out-of-Pocket Expense Maximum under this Plan.

Payment Limits

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

Benefits From Other Plans

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

A. COVERED BASIC SERVICES AND SUPPLIES

Allergy Testing and Treatment

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

Ambulatory Surgery

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

Anesthesia

This Plan covers anesthetics and their administration.

Audiology Services

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

Birthing Centers

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

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

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

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

Breastfeeding Support

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

This Policy covers breastfeeding equipment as follows:

- a) Purchase of single user breast pump which can be a double electric breast pump, or if requested by the Covered Person a manual pump. Such coverage does not require a prescription for the equipment nor are pre-authorization or evidence of medical necessity required. We also cover necessary repairs or replacement of the pump.
- b) Rental or purchase of a multi-user breast pump, as recommended by a Practitioner who is a licensed health care provider. We may require a letter of medical necessity from a Practitioner.
- c) Purchase of two breast pump kits; appropriate size breast pump flanges; and other lactation accessories as recommended by a Practitioner.

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

- a) In person, one-on-one services at a hospital, office, home or any other location.
- b) Telephonic lactation assistance in addition to the services described in item a) above.
- c) Group lactation counseling including educational classes and support groups, in addition to the services described in item a) above.

Contraceptives

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

- a) This Plan covers the following services, drugs, devices and procedures when obtained from or provided by network providers:
 - 1. Contraceptive drugs, devices or products approved by the United States Food and Drug Administration; or
 - 2. Therapeutic equivalents of contraceptive drugs, devices or products that are approved by the United States Food and Drug Administration.
 - 3. The medical necessity for contraceptive drugs, devices or products shall be as determined by the Covered Person's Practitioner.
- b) Voluntary sterilization of a Covered Person whether male or female;
- c) Patient education and counseling on contraception for a Covered Person;
- d) Services related to the administration and monitoring of drugs, devices, products and services covered under this Contraceptives provision, including, but not limited to:
 - 1. Management of side effects;
 - 2. Counseling for continued adherence to a prescribed regimen;
 - 3. Device insertion and removal;

4. Coverage of alternative contraceptive drugs, devices or products the Covered Person's practitioner determines are medically necessary; and
5. Diagnosis and treatment services provided pursuant to or as a follow-up to services covered under this Contraceptive provision.

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

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

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

Dental Care and Treatment

This Plan covers:

- a. the diagnosis and treatment of oral tumors and cysts;
- b. the surgical removal of bony impacted teeth; and
- c. Surgical and non-Surgical treatment of Temporomandibular joint dysfunction syndrome (TMJ) in a Covered Person. But, this Plan does not cover charges for orthodontia, crowns or bridgework. "Surgery", if needed, includes the pre-operative and post-operative care connected with it.

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

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

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

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

Diagnosis and Treatment of Autism

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: (i) the services are for the Medically Necessary and Appropriate Therapy Services described below; and (ii) the Medically Necessary and Appropriate Therapy Services described below are provided in the Covered Person's home (In Home Health), 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 Plans 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 Plans 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.

Diagnostic X-rays and Lab Tests

This Plan covers diagnostic X-ray and lab tests.

Donated Breast Milk

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

- a) The Covered Person is medically or physically unable to receive maternal breast milk or participate in breast feeding, or the Covered Person's mother is medically or physically unable to produce breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; and
- b) The Covered Person's Practitioner issued an order for the donated human breast milk

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

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

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

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

Emergency Room

This Plan covers services provided by a Hospital emergency room to treat a Medical Emergency or provide a Medical Screening Examination. Each time a Covered Person uses the Hospital emergency room, he/she must pay a Copayment, as shown in the Schedule of Covered Services and Supplies. But, this does not apply if the Covered Person is admitted to the Hospital within 24 hours.

Facility Charges

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

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

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

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

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

Fertility Services

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

- a Assisted hatching;
- b Diagnosis and diagnostic tests;
- c 4 Completed egg retrievals while covered under this plan or any plan with the same employer. Unsuccessful completed egg retrievals will count towards the limit;
- d Gamete intrafallopian transfer (requires Prior Authorization);

- e Medications, including injectable infertility medications;
- f Ovulation induction;
- g Surgery, including microsurgical sperm aspiration;
- h Artificial insemination;
- i In vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate (requires Prior Authorization);
- j Fresh and frozen embryo transfer;
- k Zygote intrafallopian transfer (requires Prior Authorization);
- l Intracytoplasmic sperm injections.

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

1. Services for in vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer shall be limited to a Covered Person who:
 - (i) has used all reasonable, less expensive, and medically appropriate treatments for infertility;
 - (ii) has not reached the limit of 4 covered completed egg retrievals.
2. Coverage of Prescription Drugs is not included if Infertility medication benefits are provided under another group health insurance Plan or contract issued to the Employer.
3. To be covered, the services described in this section must be provided at a Facility that conforms to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.
4. The following services are not covered:
 - a. Medical services given to a surrogate, for purposes of childbearing, if the surrogate is not a Covered Person.
 - b. Medical costs of a live donor used in egg retrieval after the donor has been released by the reproductive endocrinologist.
 - c. Non-medical costs of an egg or sperm donor.
 - d. Ovulation kits and sperm testing kits and supplies.
 - e. Reversal of voluntary sterilization.
 - f. The cryopreservation and storage of sperm, eggs and embryos.

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

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

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

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

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

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

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

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

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

Fertilization: The penetration of the egg by the sperm.

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

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

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

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

- a a determination of infertility is made pursuant to American Society for Reproductive Medicine practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology; or
- b the Covered Person meets one of the following conditions:
 - i the inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing or any combination of those factors;
 - ii the need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner; or
 - iii in patients having regular, unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be initiated at twelve

(12) months when the female partner is under 35 years of age and at six (6) months when the female partner is 35 years of age or older.

Nothing in this definition shall be used to deny or delay treatment to our Covered Person, regardless of relationship status or sexual orientation.

The term does not apply to infertility resulting from voluntary sterilization procedures unless the voluntary sterilization is successfully reversed.

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

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

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

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

Oocyte: The female egg or ovum.

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

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

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

Zygote: A fertilized egg before cell division begins.

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

Hearing Aids, Cochlear Implants, and Related Services

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

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

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

- the purchase of the hearing aid;
- hearing tests;

- fittings;
- modifications;
- repairs (but not battery replacement); and
- Cochlear implants and services covered pursuant to the mandate.

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

Home Health Care

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

In order for Home Health Agency charges to be considered Covered Charges the Covered Person's Admission to Home Health Agency care may be direct to Home Health Agency care with no prior Inpatient Admission.

This Plan does not cover:

- a. services furnished to family members, other than the patient; or
- b. services and supplies not included in the Home Health Care plan; or
- c. services that are mainly Custodial Care.

Hospice Care

Hospice Care benefits will be provided for:

1. part-time professional nursing services of an R.N., L.P.N. or Licensed Viatical Nurse (L.V.N.);
2. home health aide services provided under the supervision of an R.N.;
3. medical care rendered by a Hospice Care Plan Practitioner;
4. therapy services;
5. diagnostic services;
6. medical and Surgical supplies and Durable Medical Equipment if given Prior Authorization by Horizon BCBSNJ;
7. Prescription Drugs;
8. oxygen and its administration;
9. medical social services;
10. respite care;
11. psychological support services to the Terminally Ill or Injured patient;

12. family counseling related to the patient's terminal condition;
13. dietician services; and
14. Inpatient room, board and general nursing services.

No Hospice Care benefits will be provided for:

1. medical care rendered by the patient's private Practitioner;
2. volunteer services or services provided by others without charge;
3. pastoral services;
4. homemaker services;
5. food or home-delivered meals;
6. Private-Duty Nursing services;
7. dialysis treatment;
8. treatment not included in the Hospice Care Plan;
9. services and supplies provided by volunteers or others who do not normally charge for their services;
10. funeral services and arrangements;
11. legal or financial counseling or services;
12. bereavement counseling; or
13. any Hospice Care services that are not given Prior Authorization by Horizon BCBSNJ.

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

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

Inpatient Physician Services

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

Mastectomy Benefits

This Plan covers a Hospital stay of at least 72 hours following a modified radical mastectomy and a Hospital stay of at least 48 hours following a simple mastectomy. A shorter length of stay may be covered if the patient, in consultation with her physician, determines that it is Medically Necessary and Appropriate. The patient's Provider does not need to obtain Prior Authorization from Horizon BCBSNJ

for prescribing 72 or 48 hours, as appropriate, of Inpatient care. But, any rule of this Plan that the patient or her Provider notify Horizon BCBSNJ about the stay remains in force.

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

Maternity/Obstetrical Care

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

- (a) at the time of delivery; or
- (b) in the case of multiple births, at the time of the last delivery; or
- (c) if the delivery occurs out of the Hospital, at the time the mother or newborn is admitted to the Hospital.

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

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

Maternity/Obstetrical Care for Child Dependents

This Plan does not cover a Child Dependent's routine obstetrical care, including any services furnished to or for the Child Dependent's newborn. But, complications of the pregnancy and interruptions of the pregnancy, except for elective abortion, will be covered, subject to the Plan's terms.

Medical Emergency and Medical Screening Examinations

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

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

Coverage for Emergency and Urgent Care includes coverage of trauma at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the

judgment of the attending physician, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another facility. Horizon BCBSNJ shall provide coverage for a medical screening examination provided upon a Covered Person's arrival in a Hospital, as required to be performed by the hospital in accordance with federal law, but only as necessary to determine whether an Emergency Medical Condition exists.

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

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

Mental Health Conditions (including Group Therapy) and Substance Use Disorders

The Plan covers treatment for Mental Health Conditions and Substance Use Disorders.

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

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

- (a) the prospective determination of Medically Necessary and Appropriate is made by the Covered Person's Practitioner for the first 180 days of treatment during each Plan Year and for the balance of the Plan Year the determination of Medically Necessary and Appropriate is made by Horizon BCBSNJ;
- (b) Prior Authorization is not required for the first 180 days of Inpatient and/or Outpatient treatment during each Plan Year but may be required for Inpatient treatment for the balance of the Plan Year;
- (c) concurrent and retrospective review are not required for the first 28 days of Inpatient treatment during each Plan Year but concurrent and retrospective review may be required for the balance of the Plan Year;
- (d) retrospective review is not required for the first 28 days of intensive Outpatient and partial hospitalization services during each Plan Year but retrospective review may be required for the balance of the Plan Year;
- (e) retrospective review is not required for the first 180 days of Outpatient treatment including Outpatient Prescription Drugs, during each Plan Year but retrospective review may be required for the balance of the Plan Year;and
- (f) If no In-Network Facility is available to provide Inpatient services, Horizon BCBSNJ shall approve an in-plan exception and provide benefits for Inpatient services at an Out-of-Network Facility.

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

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

- (a) a Hospital;

- (b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
- (c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of The Joint Commission;
- (d) a Mental Health Center;
- (e) a Substance Use Disorders Center; or
- (f) a combination Mental Health Center and Substance Use Disorders Center.

Appeals for Substance Use Disorders will be conducted in accordance with New Jersey's Substance Use Disorder Legislation, P.L.2017, c.28. This includes the expedited Substance Use Disorder appeal process provided for under the law.

A Covered Person may receive covered treatment as an Inpatient in a Hospital or a Substance Use Disorders Center. He/she may also receive covered treatment at a Hospital Outpatient Substance Use Disorders Center, or from any Practitioner (including a psychologist or social worker).

The benefits for the covered treatment of Mental Health Conditions or Substance Use Disorders are provided on the same basis and subject to the same terms and conditions as for other Illnesses.

Nutritional Counseling

This Plan covers charges for nutritional counseling for the management of a medical condition that has a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner. This section does not apply to nutritional counseling related to "Diabetes Benefits".

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

Orthotic Devices

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

Practitioner's Charges for Non-Surgical Care and Treatment

This Plan covers Practitioner's charges for the non-Surgical care and treatment of an Illness, Injury, Mental Health Conditions or Substance Use Disorders. This includes Medically Necessary pharmaceuticals which in the usual course of medical practice are administered by a Practitioner, if the pharmaceuticals are billed by the Practitioner or by a Specialty Pharmaceutical Provider.

Practitioner's Charges for Surgery

This Plan covers Practitioners' charges for Surgery. This Plan does not cover Cosmetic Surgery. Surgical procedures include: (a) those after a mastectomy on one or both breasts; (b) reconstructive breast Surgery; and (c) Surgery to achieve symmetry between both breasts.

Pre-Admission Testing Charges

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

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

Preventive Care/Health Wellness

This Plan provides benefits for certain Covered Services and Supplies relating to Preventive Care including: related diagnostic X rays and lab tests; and screening tests.

Preventive Care Services shall not be subject to any Deductible, Copayment, or Coinsurance.

The covered Preventive Care is as follows:

- For all Covered Persons 20 years of age and older, annual tests to determine blood, hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density lipoprotein (LDL) level and high-density lipoprotein (HDL) level.
- For all Covered Persons 35 years of age or older, a glaucoma eye test every five years.
- For all Covered Persons 40 years of age or older, a yearly stool exam for presence of blood.
- For all Covered Persons 45 years of age or older, a left-sided colon exam of 35 to 60 centimeters every five years.
- For all adult Covered Persons recommended immunizations; and
- For all Covered Persons 20 years of age and older, a yearly consultation with a Provider to discuss lifestyle behaviors that promote health and well-being, including but not limited to: smoking control; nutrition and diet recommendations; exercise plans; lower back protection; weight control; immunization practices; breast self-exam; testicular self-exam; and seat belt usage in motor vehicles.
- For all female Covered Persons 20 years of age or older, a Pap smear. The term "Pap smear" means: an initial Pap smear; any confirmatory test when Medically Necessary and Appropriately and ordered by a Covered Person's physician; and all lab costs related to the initial Pap Smear and any such confirmatory test.
- For all female Covered Persons 40 years of age or older, a yearly mammogram exam.

- **Gynecological Examinations**

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

- **Mammography**

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

The Plan will cover charges for:

1. A mammogram exam at such age and intervals as deemed Medically Necessary and Appropriate by the Covered Person's Practitioner if they are under 40 years of age and has a family history of breast cancer or other breast cancer risk factors.
2. One baseline mammogram exam for Covered Persons who are 40 years of age.
3. One mammogram exam each year for Covered Persons age 40 and over.
4. An ultrasound evaluation; magnetic resonance imaging scan; three-dimensional mammography; or other additional testing of an entire breast or breasts after any baseline mammogram exam, if:
 - a. The mammogram exam demonstrates extremely dense breast tissue;
 - b. The mammogram is abnormal within any degree of breast density, including not dense; moderately dense; heterogeneously dense; or extremely dense breast tissue; or
 - c. The patient has additional risk factors for breast cancer, including, but not limited to: (1) family history of breast cancer; (2) prior personal history of breast cancer; (3) positive genetic testing; (4) extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or (5) other indications, as determined by the patient's Practitioner.

5. Digital Tomosynthesis Charges

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

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

- **Prostate Cancer Screening**

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

- **Routine Adult Physicals and Immunizations**

This Plan covers routine adult physical exam(s) (including X-rays and lab tests) and immunizations for you and your spouse or Domestic Partner and Child Dependents over the age of 20.

- **Well Child Immunizations and Lead Poisoning Screening and Treatment**

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

- (i) childhood immunizations must be as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health.
- (ii) screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing must be as specified by the Department of Health. Medical evaluation and any necessary follow-up and treatment for lead-poisoned children are also covered.

- **Colorectal Cancer Screening**

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

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

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

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

No Deductible, Coinsurance, Copayment, or any other cost-sharing requirement shall be imposed for a colonoscopy performed following a positive result on a non-colonoscopy, colorectal cancer screening test recommended by the USPSTF.

- **Newborn Hearing Screening**

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

For the purposes of this part:

- a. "newborn" means a child up to 28 days old;
- b. "infant" means a child between the ages of 29 days and 36 months;
- c. "electrophysiologic screening measures" means the electrical result of the application of physiologic agents. This includes, but is not limited to: (i) the procedures currently known as: Auditory Brainstem Response testing (ABR); and Otoacoustic Emissions testing (OAE); and (ii) any other procedure adopted by New Jersey's Commissioner of Health and Senior Services.

- **Well Child Care**

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

- **Additional Preventive Services**

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

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person;
3. For infants and children (if coverage under the Plan 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 be administratively updated.

Prosthetic Devices

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

Second Opinion Charges

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

- a. are board certified and qualified, by reason of his/her specialty, to give an opinion on the proposed Surgery or Hospital Admission;
- b. are not a business associate of the Practitioner who recommended the Surgery; and
- c. does not perform or assist in the Surgery if it is needed.

Skilled Nursing Facility Charges

This Plan covers bed and board (including diets, drugs, medicines and dressings and general nursing service) in a Skilled Nursing Facility. The Covered Person must be admitted to the Skilled Nursing Facility within 14 days of discharge from a Hospital, for continuing medical care and treatment prescribed by a Practitioner.

Specialist Services

This Plan covers services rendered by a Network Provider who provides services within his/her specialty to Covered Persons. This includes coverage for speech-language pathology services rendered by a physician or a licensed speech-pathologist. Such services must: (a) be determined to be Medically Necessary and Appropriate, and (b) be within the scope of the Practitioner's practice.

Speech-Language Pathology Services

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

Surgical Services

Subject to all of the 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:
 - (a) 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.
 - (b) If more than five surgical procedures are performed, each of the procedures beyond the fifth will be reviewed. The amount that the Plan will pay for each such procedure will then be based on the circumstances of the particular case.

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

As part of the coverage for Surgery, if a Covered Person is receiving benefits for a mastectomy, the Plan will also cover the following, as determined after consultation between the attending physician and the Covered Person:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prosthesis and the treatment of physical complications at all stages of the mastectomy, including lymphodemas.

Also, see "Transplant Benefits".

Telemedicine Services, provided by Horizon CareOnline

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

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

Members can enroll online or may call **1-877-716-5657** to enroll by phone. For information on how to connect with a Telemedicine Services Provider, access <https://www.horizoncareonline.com>. Members may access telemedicine providers online through Horizon BCBSNJ's member portal or may download the mobile application available for iPhone, android or tablet.

Therapeutic Manipulation

This Plan provides benefits for Therapeutic Manipulations.

Therapy Services

This Plan covers all Therapy Services.

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

Transplant Benefits

This Plan covers services and supplies:

- a. Cornea;
- b. Kidney;
- c. Lung;
- d. Liver;
- e. Heart;
- f. Heart valve;
- g. Pancreas;
- h. Small bowel;
- i. Chondrocyte (for knee);
- j. Heart/Lung;
- k. Kidney/Pancreas;
- l. Liver/Pancreas;

- m. Double lung;
- n. Heart/Kidney;
- o. Kidney/Liver;
- p. Liver/Small Bowel;
- q. Multi-visceral transplant (small bowel and liver with one or more of the following: stomach; duodenum; jejunum; ileum; pancreas; colon);
- r. Allogeneic bone marrow;
- s. Allogeneic stem cell;
- t. Non-myeloablative stem cell;
- u. Tandem stem cell.

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

- a. by institutions approved by the National Cancer Institute; or
- b. pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists. Such treatment will be covered to the same extent as for any other illness.

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

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

- a. The search for a donor (benefits not to exceed \$10,000 per transplant).
- b. Typing (immunologic).
- c. The harvesting of the organ tissue, and related services.
- d. The processing of tissue.

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

Urgent Care

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

Vision Care

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, Horizon BCBSNJ covers the vision benefits described in this Booklet.

For Covered Person's under the age of 19, Horizon BCBSNJ covers one pair of standard frames in a 12 month period through the end of the month in which the Covered Person turns 19. "Standard frames" refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

Wilm's Tumor

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

B. COVERED SUPPLEMENTAL SERVICES AND SUPPLIES

Ambulance Services

This Plan covers charges for transporting a Covered Person to:

- a. a local Hospital, if it can provide the needed care and treatment;
- b. the nearest Hospital that can furnish the needed care and treatment, if: (a) a local Hospital cannot provide it; and (b) the person is admitted as an Inpatient; or
- c. another Inpatient Facility when Medically Necessary and Appropriate.

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

Blood

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

This Plan also covers expenses incurred in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia. The home treatment program must be under the supervision of a State approved hemophilia treatment center. A home treatment program will not preclude further or additional treatment or care at an eligible Facility. But, the number of home treatments, according to a ratio of home treatments to Benefit Days cannot exceed the total number of Benefit Days allowed for any other illness under this Plan.

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

Diabetes Benefits

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

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

- b. test strips for glucose monitors and visual reading and urine testing strips;
- c. insulin;
- d. injection aids;
- e. cartridges for the legally blind;
- f. syringes;
- g. insulin pumps and appurtenances to them;
- h. insulin infusion devices; and
- i. oral agents for controlling blood sugar.

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

- a. Benefits for self-management education and education relating to diet shall be limited to Visits that are to a professional described in b., below and that are Medically Necessary and Appropriate upon:
 - 1. the diagnosis of diabetes;
 - 2. the diagnosis by a physician or nurse practitioner/clinical nurse specialist of a significant change in the Covered Person's symptoms or conditions which requires changes in the Covered Person's self-management; and
 - 3. determination of a physician or nurse practitioner/clinical nurse specialist that reeducation or refresher education is needed.
- b. Diabetes self-management education is covered when rendered by:
 - 1. a dietician registered by a nationally recognized professional association of dieticians;
 - 2. a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators; or
 - 3. a registered pharmacist in New Jersey qualified with regard to management education for diabetes by any institution recognized by the Board of Pharmacy of the State of New Jersey.

Durable Medical Equipment

This Plan covers charges for the rental of Durable Medical Equipment needed for therapeutic use. The Plan may decide to cover the purchase of such items when it is less costly and more practical than to rent them.

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

This Plan does not cover:

- a. replacements or repairs determined to be not medically necessary under Horizon BCBSNJ's Medical Policy; or
- b. the rental or purchase of any items that do not fully meet the definition of Durable Medical Equipment. Such items include: air conditioners; exercise equipment; saunas and air humidifiers.

Home Infusion Therapy

This Plan covers home infusion therapy. "Home infusion therapy" is a method of administering intravenous (IV) medications or nutrients via pump or gravity in the home. The services and supplies that are covered are:

- a. Solutions and pharmaceutical additives.
- b. Pharmacy compounding and dispensing services.
- c. Ancillary medical supplies.
- d. Nursing services associated with: (a) patient and/or alternative caregiver training; (b) Visits needed to monitor intravenous therapy regimen; (c) Medical Emergency care (but not for administration of home infusion therapy).

Examples of home infusion therapy include: chemotherapy; intravenous antibiotic therapy; total parenteral nutrition; hydration therapy; continuous subcutaneous pain management therapies and continuous intrathecal pain management; gammaglobulin infusion therapy (IVIG); and prolastin therapy.

To be covered, home infusion therapy must be given Prior Authorization by Horizon BCBSNJ.

Inherited Metabolic Disease

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

Oxygen and Its Administration

This Plan covers oxygen and its administration.

Physical Rehabilitation

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

Private Duty Nursing Care

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

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

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

Specialized Non-Standard Infant Formulas

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

- a. The covered infant's physician has diagnosed him/her as having multiple food protein intolerance;
- b. The physician has determined that the formula is Medically Necessary and Appropriate; and
- c. The infant has not responded to trials of standard non-cow milk-based formulas, including soybean and goat milk.

Wigs Benefit

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

UTILIZATION REVIEW AND MANAGEMENT

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

BENEFITS WILL BE REDUCED FOR NON COMPLIANCE WITH THE UR REQUIREMENTS OF THIS SECTION. THIS PLAN DOES NOT COVER ANY INPATIENT ADMISSION OR ANY OTHER SERVICE OR SUPPLY THAT IS NOT MEDICALLY NECESSARY AND APPROPRIATE.

This Plan has Utilization Review features described below. These features must be complied with if a Covered Person:

- a. is admitted, or is scheduled to be admitted as an Inpatient or Outpatient to a Hospital or other Facility;
or
- b. needs an extended length of stay; or
- c. plans to obtain a service or supply to which the section "Medical Appropriateness Review Procedure", below, applies.

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

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

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

UTILIZATION REVIEW-REQUIRED HOSPITAL STAY REVIEW

Notice of Hospital Admission Required

Except as explained below for certain admissions to treat Substance Use Disorders, if a Covered Person plans to use an In-Network Hospital, the Hospital will usually make all needed arrangements for Pre-Admission Review. If a Covered Person plans to use an Out-of-Network Hospital, the Covered Person or his/her Provider must advise Horizon BCBSNJ of the Admission. The time and manner in which the notice must be given is described below. When a Covered Person or his/her Practitioner does not comply with this rule, Horizon BCBSNJ reduces benefits for the Covered Charges.

Pre Admission Review (PAR)

Except as explained below for certain admissions to treat Substance Use Disorders, All non-Medical Emergency Hospital and other Facility Admissions must be reviewed by Horizon BCBSNJ before they occur. The Covered Person or his/her Provider must notify Horizon BCBSNJ and request a PAR by phone. We must receive the notice and request at least five business days (or as soon as reasonably possible) before the Admission is scheduled to occur.

- a. When Horizon BCBSNJ receives the notice and request, We determine:
 1. the Medical Necessity and Appropriateness of the Admission;

2. the anticipated length of stay; and
3. the appropriateness of health care alternatives, like Home Health Care or other Outpatient or Out-of-Hospital care.

Horizon BCBSNJ notifies the Covered Person or his/her Provider, by phone, of the outcome of our review. If a review results in a denial, Horizon BCBSNJ confirms that outcome in writing.

- b. If Horizon BCBSNJ authorizes a Hospital or other Facility Admission, the authorization is valid for:
 1. the specified Provider;
 2. the named attending Practitioner;
 3. the specified Admission date;
 4. the authorized length of stay; and
 5. the diagnosis and treatment plan.
- c. The authorization becomes invalid, and the Covered Person's Admission must be reviewed by Horizon BCBSNJ again, if:
 1. he/she enters a Facility other than the specified Facility;
 2. he/she changes attending Practitioners;
 3. there is an alteration in condition or treatment plan.

Continued Stay Review

Except as explained below for certain admissions to treat Substance Use Disorders, Horizon BCBSNJ has the right to conduct a continued stay review of any Inpatient Hospital Admission. To do this, Horizon BCBSNJ may contact the Covered Person's Practitioner or Facility by phone or in writing.

The Covered Person or his/her Provider must ask for a continued stay review whenever it is Medically Necessary and Appropriate to increase the authorized length of an Inpatient Hospital 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 Admission;
- b. the anticipated length of stay and extended length of stay; and
- c. the appropriateness of health care alternatives.

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

Admissions for the Treatment of Substance Use Disorders

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

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

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

Results of Non-Compliance

Non-compliance with the Admission review features in this Plan occur when:

1. the Covered Person or his/her Provider does not request a PAR;
2. the Covered Person or his/her Provider does not request a PAR five business days or as soon as reasonably possible before the Admission is scheduled to occur;
3. Horizon BCBSNJ's authorization becomes invalid and the Covered Person or his/her Provider does not obtain a new one;
4. the Covered Person or his/her Provider, does not request a continued stay review when necessary;
5. the Covered Person or his/her Provider does not receive an authorization for such continued stay;
6. The Covered Person does not otherwise comply with all the terms of this Plan.

If the Covered Person does not comply with these Admission review features and Horizon BCBSNJ determines retrospectively that all or part of the Hospital or Facility stay or continued stay was not Medically Necessary or Appropriate, no benefits will be payable for the stay or the part of it that was not Medically Necessary or Appropriate.

MEDICAL APPROPRIATENESS REVIEW PROCEDURE

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

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

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

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

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

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

ALTERNATE TREATMENT FEATURES/INDIVIDUAL CASE MANAGEMENT

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

Definitions

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

- a. They are determined, in advance, by Horizon BCBSNJ to be Medically Necessary and Appropriate and cost-effective in meeting the long term or intensive care needs of a Covered Person: (a) in connection with a Catastrophic Illness or Injury; or (b) in completing a course of care outside of the acute Hospital setting (for example, completing a course of IV antibiotics at home).
- b. Benefits for charges Incurred for them would not otherwise be covered under this Plan.

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

- a. head injury requiring an Inpatient stay;
- b. spinal cord injury;
- c. severe burn over 20% or more of the body;
- d. multiple injuries due to an accident;
- e. premature birth;
- f. CVA or stroke;
- g. congenital defect, which severely impairs a bodily function;
- h. brain damage due to: an Injury; or cardiac arrest; or a Surgical procedure;
- i. terminal Illness, with a prognosis of death within six months;
- j. Acquired Immune Deficiency Syndrome (AIDS);
- k. Substance Use Disorders;
- l. Mental Health Conditions; or

m. any other Illness or Accidental Injury determined by Horizon BCBSNJ to be catastrophic.

Alternate Treatment/Individual Case Management Plan

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

- a. An Alternate Treatment/Individual Case Management Plan is a specific written document. It is developed by Horizon BCBSNJ through discussion and agreement with:
 1. the Covered Person, or his/her legal guardian if necessary;
 2. the Covered Person's attending Practitioner; and
 3. Horizon BCBSNJ or its designee.
- b. The Alternate Treatment/Individual Case Management Plan includes:
 1. treatment plan objectives;
 2. a course of treatment to accomplish those objectives;
 3. the responsibility of each of these parties in carrying out the plan:
 - (a) Horizon BCBSNJ;
 - (b) the attending Practitioner;
 - (c) the Covered Person;
 - (d) the Covered Person's family, if any; and
 4. the estimated cost of the plan and savings.

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

SCHEDULE OF PROCEDURES REQUIRING PRIOR AUTHORIZATION

- All Admissions to a Skilled Nursing Facility or Subacute Facilities.
- All Possible Cosmetic or Plastic Services.
- All Surgical Procedures performed in an Out-of-Network Ambulatory Surgical Center.
- Cardiac Catheterization.
- CT/CTA Scans.
- Cochlear Implants.
- Durable Medical Equipment Rentals, or Purchases over \$500.00.
- Elective Inpatient Admissions.
- Gamete Intra Fallopian Transfer (GIFT).
- Gastric Bypass/Bariatric Procedures.
- Home Health Care.
- Home IV Infusions.
- Hospice Care.
- Implantable Cardioverter/Defibrillators (ICD).
- In-Vitro Fertilization (IVF).
- Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA).
- Nuclear Medicine Imaging (including cardiac procedures).
- Occupational Therapy, Physical Therapy and Cognitive Therapy.
- Pacemakers.
- Pain Management Services.
- Positron Emission Tomography (PET) Scans.
- Reconstructive Surgery.
- Sinus (Nasal) Surgery.
- Specialty Pharmaceuticals
- Ultrasound Echo Stress and Echocardiography, including nuclear and gated studies.
- Varicose Vein Surgery.
- Vestibular Rehabilitations.

- Zygote Intra Fallopian Transfer (ZIFT).

EXCLUSIONS

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

Acupuncture.

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

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

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

Any part of a charge that exceeds the Allowance.

Any therapy not included in the definition of Therapy Services.

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

Court ordered treatment that is not Medically Necessary and Appropriate.

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

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

Diversional/recreational therapy or activity.

Blood or blood plasma or other blood derivatives or components that are replaced by a Covered Person.

Broken appointments.

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

Completion of claim forms.

Consumable medical supplies.

Employment/career counseling.

Expenses Incurred after any payment, duration or Visit maximum is or would be reached.

Experimental or Investigational treatments; procedures; hospitalizations; drugs; biological products; or medical devices, except as otherwise stated in this Booklet.

Eye Exams; eyeglasses; contact lenses; and all fittings, except as otherwise stated in this Booklet; orthoptic therapy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Eye refractions except as otherwise stated in this booklet.

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

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

Home Health Care Visits: connected with administration of dialysis.

Hospice Services, except as otherwise stated in this Booklet.

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

Illness or Injury, including a condition which is the result of an Illness or Injury, which: (a) occurred on the job; and (b) is covered or could have been covered for benefits provided under a workers' compensation, employer's liability, occupational disease or similar law. However, this exclusion does not apply to the following persons for whom coverage under workers' compensation is optional, unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership; members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

Immunizations, except as otherwise stated in this Booklet.

Light box therapy, and the appliance that radiates the light.

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

Maintenance therapy for:

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

Marriage, career or financial counseling; sex therapy.

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

Milieu Therapy:

Inpatient services and supplies which are primarily for milieu therapy even though covered treatment may also be provided.

This means that Horizon BCBSNJ has determined that:

1. the purpose of all or part of an Inpatient stay is chiefly to change or control a patient's environment;
and
2. an Inpatient setting is not Medically Necessary and Appropriate for the treatment furnished, if any.

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

Pastoral counseling.

Personal comfort and convenience items.

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

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

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

Psychological testing for educational purposes.

Removal of abnormal skin outgrowths and other growths. This includes, but is not limited to, paring or chemical treatments to remove: corns; callouses; warts; hornified nails; and all other growths, unless it involves cutting through all layers of the skin. This does not apply to services needed for the treatment of diabetes.

Rest or convalescent cures.

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

Routine exams (including related diagnostic X rays and lab tests) and other services connected with activities such as the following: pre marital or similar exams or tests; research studies; education or experimentation; mandatory consultations required by Hospital regulations.

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

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

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

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

Services performed by any of these:

- a. A Hospital resident, intern or other Practitioner who: is paid by a Facility or other source; and is not allowed to charge for Covered Services and Supplies, whether or not the Practitioner is in training. But, Hospital-employed physician Specialists may bill separately for their services.
- b. Anyone who does not qualify as a Practitioner.

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

Services or supplies:

- eligible for payment under either federal or state programs (except Medicare and Medicaid when, by law, this Plan is primary). This provision applies whether or not the Covered Person asserts his/her rights to obtain this coverage or payment for these services;
- for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
- for which the Provider has not received a certificate of need or such other approvals as are required by law;
- for which the Covered Person would not have been charged if he/she did not have health care coverage;
- furnished by one of these members of the Covered Person's family, unless otherwise stated in this Booklet: Spouse, or Domestic Partner, child, parent, in-law, brother or sister;
- connected with any procedure or exam not needed for the diagnosis or an existing symptoms;
- needed due to an Injury or Illness to which a contributing cause was the Covered Person's commission of, or attempt to commit, a felony; or to which a contributing cause was the Covered Person's engagement in an illegal occupation; Except: As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition;
- provided by a Practitioner if the Practitioner bills the Covered Person directly for the services or supplies, regardless of the existence of any financial or contractual arrangement between the Practitioner and the Provider;
- provided by or in a government Hospital, or provided by or in a Facility run by the Department of Defense or Veteran's Administration for a service-related Illness or Injury unless law otherwise requires coverage for the services;
- provided by a licensed pastoral counselor in the course of his/her normal duties as a pastor or minister;
- provided by a social worker, except as otherwise stated in this Booklet;

- provided during any part of a stay at a Facility, or during Home Health Care, chiefly for: bed rest; rest cure; convalescence; custodial or sanatorium care, diet therapy or occupational therapy;
- provided to treat an Injury or Illness suffered: (a) as a result of War or an Act of War, if the injury or Illness occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization; and (b) as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the Injury or Illness occurs while the Covered Person is serving in such forces and is outside the Home Area.
- provided to treat an Injury or Illness suffered: (a) as a result of War or an Act of War while the Covered Person is serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and (b) as a result of the special hazards incident to such service, provided the Injury or Illness occurs while; (i) the Covered Person is serving in such unit; and (ii) is outside the Home Area.
- provided to treat an Injury or Illness suffered as a result of War or an Act of War while the Covered Person is not in the military, naval or air forces of any country, combination of countries or international organization or in any civilian non-combatant unit supporting or accompanying such forces, if the Injury or Illness occurs outside the Home Area.
- rendered prior to the Covered Person's Coverage Date or after his/her coverage under this Plan ends, except as otherwise stated in this Booklet;
- which are specifically limited or excluded elsewhere in this Booklet;
- which are not Medically Necessary and Appropriate; or
- for which a Covered Person is not legally obligated to pay.

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

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

Sterilization reversal.

Sunglasses, even if by prescription.

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

Telephone consultations, except as Horizon BCBSNJ may request.

The administration or injection of any drugs; except that this will not apply to a drug that: (a) has been prescribed for a treatment for which it has not been approved by the FDA; and (b) has been recognized as being medically appropriate for such treatment in: the American Hospital Formulary Service Drug Information; the United States Pharmacopoeia Drug Information; or by a clinical study or review article in a major peer-reviewed professional journal.

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

Transplants, except as otherwise stated in this Booklet.

Transportation; travel, except as otherwise provided in this Booklet for ambulance service.

Vision therapy; vision or visual acuity training; orthoptics; pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods; food supplements; liquid diets; diet plans; or any related products, except as otherwise stated in this Booklet.

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

COORDINATION OF BENEFITS AND SERVICES

PURPOSE OF THIS PROVISION

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

DEFINITIONS

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

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

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

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

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

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

- a. Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- b. Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- c. Group or group-type coverage through a Health Maintenance Organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
- d. Group hospital indemnity benefit amounts that exceed \$150.00 per day
- e. Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

- a. Individual or family insurance contracts or subscriber contracts;
- b. Individual or family coverage through a Health Maintenance Organization HMO or under any other prepayment, group practice and individual practice plans;
- c. Group or group-type coverage where the cost of coverage is paid solely by the Covered Person except when coverage is being continued pursuant to a Federal or State continuation law;
- d. Group hospital indemnity benefit amounts of \$150.00 per day or less;
- e. School accident-type coverage;
- f. A State plan under Medicaid

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

- a. The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
- b. All Plans which cover the Covered Person use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the Plan determines its benefit first.

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

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

PRIMARY AND SECONDARY PLAN

Horizon BCBSNJ considers each Plan separately when coordinating payments.

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

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

the amount to pay is set forth below in the **Procedures to be Followed by the Secondary Plan to Calculate Benefits** section of this provision.

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

RULES FOR THE ORDER OF BENEFIT DETERMINATION

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

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.

This section applies to a Covered Person who is:

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

Under this section, such a covered person is referred to as a "Medicare eligible".

This section does not apply to:

- a. a Covered Person, other than an Employee or covered Spouse;
- b. a Covered Person who is under age 65; or

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

When a Covered Person becomes eligible for Medicare by reason of age, this Plan permits the Covered Person to make a prospective election change that cancels coverage under this Plan and elect 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 us for processing.

CLAIMS PROCEDURES

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

Submission of Claims

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

- a Claim forms must be filed no later than 18 months after the date the services were incurred.
- b Itemized bills must accompany each claim form. A separate claim form is needed for each claim filed. In general, the bills must contain enough data to identify: the patient; the Provider; the type of service and the charge for each service and the Provider's license number.
- c Bills for Private Duty Nursing must state that the Nurse is a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) and must contain the Nurse's license number.
- d If a claim is denied or disputed, in whole or in part, Horizon BCBSNJ will notify the claimant (or his/her agent or designee) of it within 30 calendar days after receipt of the claim.

The denial notice will set forth:

1. the reason(s) the claim is denied;
2. specific references to the main Program provision(s) on which the denial is based;
3. a specific description of any further material or information needed to complete the claim, and why it is needed;
4. a statement that the claim is disputed, if this is so. If the dispute is about the amount of the claim, Horizon BCBSNJ will explain why and also explain why any coding changes were made;
5. a statement of the special needs to which the claim is subject, if this is the case;
6. an explanation of the Plan's claim review procedure, including any rights to pursue civil action;
7. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either the specific rule or a statement that such a rule was relied upon in making the decision, and that a copy of such rule will be provided free of charge upon request;
8. if the decision is based on Medical Necessity and Appropriateness or an Experimental or Investigational (or similar) exclusion or limitation, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request;
9. if the decision involves a Medical Emergency or Urgent Care, a description of the expedited review process applicable to such claims; and

10. the toll free number that the Covered Person or his/her Provider can call to discuss the claim.

- e This applies if You are the non-custodial parent of a Child Dependent. In this case, Horizon BCBSNJ will give the custodial parent the information needed for the Child Dependent to obtain benefits under the Plan. Horizon BCBSNJ will also permit the custodial parent, or the Provider with the authorization of the custodial parent, to submit claims for Covered Services and Supplies without Your approval.

To Whom Payment Will Be Made

1. Payment for services of an In-Network Provider or a BlueCard Provider will be made directly to that Provider if the Provider bills Horizon BCBSNJ, as Horizon BCBSNJ determines. To receive In-Network coverage, a Covered Person must show his/her ID card when requesting Covered Services and Supplies from a Provider that has such an agreement.
2. Except for claims involving emergent or inadvertent services and/or unless you are eligible to assign the benefits in accordance with any Assignment provision in this Booklet, payment for services of Out-of-Network Provider, Facility or Practitioner may be made to you. A Covered Person may direct Horizon BCBSNJ, in writing, to pay for claims to the Provider, Facility or Practitioner who provided the Covered Service or Supply for which benefits became payable. Horizon BCBSNJ will Determine to pay the Covered Person, Provider, Facility or Practitioner, as applicable. But, Horizon BCBSNJ will not assume responsibility for making sure that the assignment was prepared correctly and/or that it correctly conveys the intention of the person who made it. We will not be held to know that one has been made unless it or a copy is filed with Horizon BCBSNJ.

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.

3. 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.
4. If an Employee is the non custodial parent of a Child Dependent, Horizon BCBSNJ will pay claims filed as described in paragraph d of the section "Submission of Claims" directly to: the Provider or Custodial parent; or the Division of Medical Assistance and Health Services in the Department of Human Services which administers the State Medicaid program, as appropriate.

If Horizon BCBSNJ pays anyone who is not entitled to benefits under this 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.

Covered Person's Liability Calculation.

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

Special Cases: Value-Based Programs

Value-Based Programs Overview

The Covered Person may access Covered Services and Supplies from providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or 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. Payment 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 the 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 for true medical emergencies/urgent care when accessing Covered Services and Supplies. Before travelling, Covered Persons should contact Us for coverage details. The BCBSGlobal 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 if eligible.

Inpatient Services

In most cases, if Covered Persons contacts the BCBS Global Core Service 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.bcbsglobalcore.com. If Covered Persons need assistance with their claim submissions, they should call BCBS Global Core at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

APPEALS PROCESS

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

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

Appeals Process for Adverse Administrative Decisions

For this type of adverse claim 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.

ERISA INFORMATION

The following information, together with the information contained in the rest of this Booklet, comprise the Summary Plan Description required by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Name of Plan: The CPC Integrated Health, Inc. Medical Plan

Plan Sponsor: CPC Integrated Health, Inc.
10 Industrial Way
Eatontown, NJ 07724

Plan Administrator: N/A
CPC Integrated Health, Inc.
10 Industrial Way
Eatontown, NJ 07724

Employer Identification Number: 21-0719369

Plan Number: N/A

Classification and Funding

The Plan described in this Booklet is classified as a welfare benefits plan by the Department of Labor. It is funded by both the company and Employee contributions.

Type of Administration: Contract Administration. Benefits are provided in accordance with the provisions of the Plan Sponsor. Horizon Blue Cross Blue Shield of New Jersey provides administrative services only and does not assume any financial risk or obligation with respect to Claims.

Claims Administrator: Horizon Blue Cross Blue Shield of New Jersey, Inc.

Agent for Service of Legal Process: Plan Administrator

The Plan Year begins on January and ends on December.

Plan Administrator Authority and Powers:

The Plan Administrator shall have exclusive discretionary authority and power to determine eligibility for benefits and to construe the terms and provisions of this Plan, to determine questions of fact and law arising under this Plan, and to exercise all of the powers necessary for the operation of this Plan.

Plan Modification and Termination Information

Notwithstanding anything to the contrary in this Summary Plan Description, the Plan Sponsor/Administrator expressly reserves the right, at any time, for any reason and without limitation to terminate, modify or otherwise amend this Plan and any or all of the benefits provided thereunder, either in whole or in part, whether to all persons covered thereby or one or more groups thereof. These rights include specifically, but are not limited to, (1) the right to terminate benefits under the Plan with respect to any participant therein; (2) the right to modify benefits under this Plan to all or any group of participants therein; (3) the right to require or increase contributions by any participants therein towards the cost of

this Plan; and (4) the right to amend this Plan or any term or condition thereof; in each case, whether or not such rights are exercised with respect to any other participant or group of participants in this plan.

Not a Contract of Employment

No provision of the Plan described in this Booklet is to be considered a contract of employment. The Employer's rights with respect to disciplinary actions and termination of Employees are in no way changed by the provisions of the Plan.

If you have any questions about the Plan, contact the Plan Administrator.

STATEMENT OF ERISA RIGHTS

As a participant in **CPC Integrated Health, Inc.** 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 that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court

may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

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

SERVICE CENTERS

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

Telephone personnel are available:

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

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

For questions and assistance with your **Direct Access** benefits and services, please call us at:

**1-800-355-BLUE
(2583)**

When you are outside of New Jersey and need to locate a **nationwide Network PPO Provider**, please call:

**1-800-810-BLUE
(2583)**

For **Mental Health Conditions and Substance Use Disorders**, please call:

1-800-626-2212

For **Pre-Admission Review** and **Individual Case Management**, please call:

**1-800-664-BLUE
(2583)**

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

Use this space for information you will need when asking about your coverage.

The company office or enrollment official to contact about coverage:

The identification number shown on my identification card:

The effective date when my coverage begins:

My group number is:
