

Product: **HSA Direct Access**
Group Name: **The PromptCare Companies**
Group Number: **076352-0002**
Effective Date: **January 1, 2024**



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 that reads "Joseph J. Albano". The signature is written in a cursive style with a large, looping initial "J".

Joseph Albano
Vice President, Commercial and Specialty 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.

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 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:
 - (1) the amount determined as **150%** of the amount that would be reimbursed for the service or supply under Medicare or
 - (2) another amount accepted by the Out-of-Network Provider as full reimbursement less applicable cost-share.

Exceptions:

- (1) 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.

- (2) 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.

- (3) 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.
- (4) 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;
- 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 and each succeeding monthly period.

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

Birthing Centers: 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.

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

Calendar Year: A year starting January 1.

Care Manager: A person or entity designated by 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;
- A child who is: (a) legally adopted by you, your Spouse; or (b) placed with you for adoption. But, proof of such adoption or placement satisfactory to the Plan must be furnished to us when we ask;
- You, your Spouse's legal ward. But, proof of guardianship satisfactory to the Plan must be furnished to us when we ask.

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

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

Coinsurance: The 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 percents shown in this Booklet are the percents 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 an annually revised listing published by the American Medical Association, which assigns numerical codes to procedures and categories of medical care.

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

skills.

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

Even if a Covered Person is in a Hospital or other recognized Facility, 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, Civil Union 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, Diagnostic Services are not covered under the Plan if the procedures are ordered as part of a routine or periodic physical examination or screening.

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; 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 and substance use disorder services (including behavioral health treatment); rehabilitative and habilitative services and devices; lab services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).

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

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

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

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

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

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

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

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

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

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

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

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 programs; prescription of medication and lenses; post-cycloplegic Visit if needed; and verification of lenses if prescribed.

Facility: An entity or institution: (a) which provides health care services within the scope of its license, as defined by applicable law; and (b) which 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.

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

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

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

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

Home Health Agency: A Provider which mainly provides care for an ill or injured person in the person's home under a home health care program designed to eliminate Hospital stays. 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 program which provides an integrated set of services designed to provide Hospice care. Hospice services are centrally coordinated through an interdisciplinary team directed by a Practitioner.

Hospital: A Facility, which mainly provides Inpatient care for ill or injured people. 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.

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.

Mail-Order Pharmacy: A Pharmacy which, during the course of its daily business, dispenses Prescription Drugs primarily by mail. For the purposes of this Prescription Drug Expense Coverage, "Mail-Order Pharmacy", as used below, shall also be deemed to include any retail Pharmacy that has agreed to the same terms, conditions, price and services that apply to the Mail-Order Pharmacy.

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

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

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

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

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

sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Covered Person's illness, injury or disease.

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

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

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

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

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.

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

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

Out-of-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 an Inpatient; or (b) the services and supplies provided to such a Covered Person, depending on the context in which the term is used.

Partial Hospitalization: Intensive short-term non-residential day treatment services that are: (a) 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.

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 PromptCare Companies Medical Plan

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

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

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.

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

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

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

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

Prescription Drugs: Drugs, biological and compound prescriptions which: (a) are dispensed only by prescription; and (b) are required to show on the manufacturer's label the words: "Caution-

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

Prescription Mail Order: A Covered Person's request that a Prescription Order for drugs be filled and mailed to him or her by a licensed Mail-Order Pharmacy.

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

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

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 Horizon BCBSNJ or from any other person (including a PCP) to access obstetrical or gynecological care from an In-Network health care Practitioner who specializes in obstetrics or gynecology. But the Practitioner may need to comply with certain procedures, including: obtaining Prior Authorization for certain services; following a pre-approved treatment plan; or procedures for making referrals.

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

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

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

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

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

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

Routine Foot Care: The cutting, debridement, trimming, reduction, removal or other care of: corns; calluses; flat feet; fallen arches; weak feet; chronic foot strain; dystrophic nails; excrescences; helomas; hyperkeratosis; hypertrophic nails; non-infected ingrown nails; dermatomes; keratosis; 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 Physician services covered under this Program directly through an In-Network Provider, without the need for further Referrals from the PCP. A Special Referral may be limited in scope, e.g. as to: duration; diagnosis; condition; and other factors, as determined by Horizon BCBSNJ.

Specialist Physician: A fully licensed physician who:

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

Specialty Pharmaceutical Provider: Prime Specialty Pharmacy, a vendor that has contracted with Horizon BCBSNJ to exclusively dispense Specialty Pharmaceuticals on an In-Network basis.

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

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

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. 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.

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

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

Urgent Care: Outpatient 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.

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

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 **80%** of Covered Basic Charges.
In-Network **80%** of Covered Supplemental Charges.

Coinsurance **50%** of Covered Basic Charges.
Out-of-Network **50%** of Covered Supplemental Charges.

Deductible (Does not apply to Preventive Care):

In-Network

Single Coverage: **\$2,000** per Calendar Year.
Multiple Coverage: **\$4,000** per Calendar Year.

Out-of-Network

Single Coverage: **\$4,000** per Calendar Year.
Multiple Coverage: **\$8,000** per Calendar Year.

Out-of-Pocket Maximum:

In-Network

Single Coverage: **\$4,000** per Calendar Year.
Multiple Coverage: **\$8,000** per Calendar Year.

Out-of-Network

Single Coverage: **\$8,000** per Calendar Year.
Multiple Coverage: **\$16,000** per Calendar Year.

BENEFIT PERIOD MAXIMUM

In-Network **Unlimited.** Applies to all Covered Services and Supplies.
Out-of-Network **Unlimited.** Applies to all Covered Services and Supplies.

PER LIFETIME MAXIMUM

In-Network **Unlimited.** Applies to all Covered Services and Supplies.
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 Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

AMBULATORY SURGICAL CENTER

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

ANESTHESIA

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

AUDIOLOGY SERVICES

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

COMPLEX IMAGING SERVICES

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

DENTAL CARE AND TREATMENT

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

DIAGNOSTIC X-RAY AND LAB

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

DIALYSIS CENTER CHARGES

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

EMERGENCY ROOM

Emergent

In-Network and Out-of-Network Subject to Deductible and **80%** Coinsurance.

Non Emergent

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

FACILITY CHARGES 365 days Inpatient Hospital Care.

In-Network Inpatient Subject to Deductible and **80%** Coinsurance.

In-Network Outpatient Subject to Deductible and **80%** Coinsurance.

Out-of-Network Inpatient Subject to Deductible and **50%** Coinsurance.

Out-of-Network Outpatient Subject to Deductible and **50%** Coinsurance.

FERTILITY SERVICES

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

HEARING EXAMS

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

HOME HEALTH CARE

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

Combined In-Network and Out-of-Network benefits subject to a **60** Visit maximum per Benefit Period.

HOSPICE CARE

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

INPATIENT PHYSICIAN SERVICES

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

MATERNITY/OBSTETRICAL CARE

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

MENTAL HEALTH CONDITIONS DISORDERS (INCLUDING GROUP THERAPY) AND SUBSTANCE ABUSE

**In-Network
Inpatient** Subject to Deductible and **80%** Coinsurance.

**In-Network
Outpatient and
Out-Of-Hospital** Subject to Deductible and **80%** Coinsurance.

**Out-of-Network
Inpatient** Subject to Deductible and **50%** Coinsurance.

**Out-of-Network
Outpatient and
Out-Of-Hospital** Subject to Deductible and **50%** Coinsurance.

NUTRITIONAL COUNSELING

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

PHYSICAL REHABILITATION CENTER

In-Network

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

Out-of-Network

Inpatient Subject to Deductible and **50%** Coinsurance.

Combined In-Network and Out-of-Network benefits subject to a **60** Visit maximum per Benefit Period.

PRACTITIONER'S CHARGES FOR NON-SURGICAL CARE AND TREATMENT

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

PRACTITIONER'S CHARGES FOR SURGERY

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

PRE-ADMISSION TESTING

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

PREVENTIVE CARE

a. COLORECTAL CANCER SCREENING

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

Out-of-Network Subject to Deductible and **50%** Coinsurance.

b. GYNECOLOGICAL EXAMINATIONS

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

Out-of-Network Subject to Deductible and **50%** 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 Deductible and **50%** Coinsurance.

d. PAP SMEARS

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

Out-of-Network Subject to Deductible and **50%** Coinsurance.

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

e. ROUTINE PROSTATE CANCER SCREENING

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

Out-of-Network Subject to Deductible and **50%** Coinsurance.

f. ROUTINE ADULT PHYSICALS

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

Out-of-Network Subject to Deductible and **50%** Coinsurance.

g. WELL-CHILD IMMUNIZATIONS

In-Network Well-child care, immunizations, lead poisoning screening and hearing screening and monitoring subject to 100% Coinsurance. Deductible does not apply.

Medical evaluation and follow-up treatment of lead-poisoned children subject to Deductible and 100% Coinsurance.

Out-of-Network Well-child care, immunizations, lead poisoning screening and hearing screening and monitoring subject to 50% Coinsurance. Deductible does not apply.

Medical evaluation and follow-up treatment of lead-poisoned children subject to Deductible and 50% Coinsurance.

h. WELL-CHILD CARE

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

Out-of-Network Subject to Deductible and **50%** Coinsurance.

PRIMARY CARE PHYSICIAN

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

PROSTHETIC OR ORTHOTICS DEVICES

In-Network and Out-of-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.

SECOND OPINION CHARGES

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

SKILLED NURSING FACILITY CHARGES

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

SPECIALIST SERVICES

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

SURGICAL SERVICES

In-Network Inpatient Subject to Deductible and **80%** Coinsurance.

In-Network Outpatient Subject to Deductible and **80%** Coinsurance.

Out-of-Network Inpatient Subject to Deductible and **50%** Coinsurance.

Out-of-Network Outpatient Subject to Deductible and **50%** Coinsurance.

TELEMEDICINE BEHAVIORAL HEALTH SERVICES, PROVIDED BY HORIZON CAREONLINE

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network No Benefit.

TELEMEDICINE MEDICAL SERVICES, PROVIDED BY HORIZON CAREONLINE

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network No Benefit.

THERAPEUTIC MANIPULATIONS

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

THERAPY SERVICES

a. CHELATION THERAPY

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

b. CHEMOTHERAPY

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

c. COGNITIVE REHABILITATION THERAPY

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

Combined In-Network and Out-of-Network benefits subject to a **90** Visit maximum per Benefit Period.

d. DIALYSIS TREATMENT

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

e. INFUSION THERAPY

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

f. OCCUPATIONAL THERAPY

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

Benefits Subject to a **90** visit maximum per Benefit Period. The **90** Visit maximum does not apply to certain mental health diagnosis, including the treatment of autism.

g. PHYSICAL THERAPY

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

Benefits Subject to a **90** visit maximum per Benefit Period. The **90** Visit maximum does not apply to certain mental health diagnosis, including the treatment of autism.

h. RADIATION TREATMENT

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

i. RESPIRATION THERAPY

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

Combined In-Network and Out-of-Network benefits subject to a **90** Visit maximum per Benefit Period.

j. SPEECH THERAPY

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

Benefits Subject to a **90** visit maximum per Benefit Period. The **90** Visit maximum does not apply to certain mental health diagnosis, including the treatment of autism.

TRANSPLANT BENEFITS

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

URGENT CARE SERVICES

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

B. COVERED SUPPLEMENTAL SERVICES AND SUPPLIES

AMBULANCE SERVICES

Emergent

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

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

Non Emergent

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

BLOOD

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

DIABETES BENEFITS

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

DURABLE MEDICAL EQUIPMENT

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

HEARING AIDS

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

Ages 16 years and under: Hearing aids are subject to a maximum benefit of 1 hearing aid for each hearing impaired ear every 24 months.

Ages 16 years and over: Hearing aids are subject to a maximum benefit of **\$5,000** per hearing aid for each hearing impaired ear every 24 months.

Note: Implantable devices are covered.

HOME INFUSION THERAPY

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

OXYGEN AND ADMINISTRATION

In-Network Subject to Deductible and **80%** Coinsurance.

Out-of-Network Subject to Deductible and **50%** Coinsurance.

PRESCRIPTION DRUGS

Copayments for Prescription Drugs dispensed by a Retail Pharmacy and Specialty Pharmaceuticals:

In-Network and Out-of-Network

- a. A **\$15** Copayment is required for Preferred Generic Prescription Drugs for up to a 30-day supply.
- b. A **\$15** Copayment is required for Non-Preferred Generic Prescription Drugs for up to a 30-day supply.
- c. A **\$40** Copayment is required for Preferred Brand Name Prescription Drugs for up to a 30-day supply.
- d. A **\$80** Copayment is required for Non-Preferred Prescription Drugs for up to a 30-day supply.
- e. A **\$250** Copayment is required for Preferred Specialty Pharmaceuticals for up to a 30-day supply.

- f. A **\$250** Copayment is required for Non-Preferred Specialty Pharmaceuticals for up to a 30-day supply.

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

- a. A **\$30** Copayment is required for Preferred Generic Prescription Drugs for up to a 90-day supply.
- b. A **\$30** Copayment is required for Non-Preferred Generic Prescription Drugs for up to a 90-day supply.
- c. A **\$80** Copayment is required for Preferred Brand Name Prescription Drugs for up to a 90-day supply.
- d. A **\$160** Copayment is required for Non-Preferred Prescription Drugs for up to a 90-day supply.
- e. A **\$250** Copayment is required for Preferred Specialty Pharmaceuticals for up to a 30-day supply.
- f. A **\$250** Copayment is required for Non-Preferred Specialty Pharmaceuticals for up to a 30-day supply.

Note (Applies to both In-Network and Out-of-Network Coverage): If the cost of the Prescription Drug at the dispensing Pharmacy is less than an applicable Copayment or minimum, then the Covered Person will pay the cost of the Prescription Drug.

Note (Applies to both In-Network and Out-of-Network Coverage): If a Non-Preferred Brand Name Prescription Drug is purchased when there is a Generic Prescription Drug equivalent, Horizon BCBSNJ will cover the cost of the Generic Prescription Drug, less the Copayment. The Covered Person will then be responsible for the difference between the cost of the Non-Preferred Prescription Drug and the Generic Prescription Drug. But this will not apply if the physician prescribes “Dispense as written.”

WIGS

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

Benefits subject to a maximum of 1 Per Lifetime.

GENERAL INFORMATION

How To Enroll

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

Important! Under IRS regulations, you are eligible to enroll in the **HSA option** only if:

- you are not covered under another medical plan (such as your spouse's plan),
- you are not eligible for Medicare benefits, and
- you are not claimed as a dependent on another person's tax return.

Members are responsible for their compliance with IRS regulations.

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

Change In Type Of Coverage

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

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

For example:

- You must enroll a newly born or newly adopted Child Dependent within 31 days of the date of birth or adoption in order to have coverage for your Child Dependent. If you are enrolled for Family or Parent and Child(ren) coverage, you must submit an enrollment form within 31 days from the date of birth or adoption to notify the Plan of the addition. If you are enrolled for Single coverage, you must enroll your child and pay any required additional contributions within 31 days from the date of birth or adoption.
- If you have Single coverage and marry, or acquire a Civil Union Partner, your new Spouse or Civil Union Partner will be covered from the date you marry or acquire the Civil Union Partner if you apply for Husband and Wife or Family coverage within 31 days.

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

Enrollment of Dependents

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

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

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

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

Services, which administers Medicaid, as appropriate.

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

- Permit you to enroll your Child Dependent, without any enrollment restrictions;
- Permit: (a) the Child Dependent's other parent; (b) the Division of Medical Assistance and Health Services; or (c) the Division of Family Development as the State IV-D agency, in the Department of Human Services, to enroll the Child Dependent in this Plan, if the parent who is the Covered Person fails to enroll the Child Dependent; and
- Not terminate coverage of the Child Dependent unless the parent who is the Covered Person provides Horizon BCBSNJ or the Plan with satisfactory written proof that:
 - the court or administrative order is no longer in effect; or
 - the Child Dependent is or will be enrolled in a comparable health benefits plan which will be effective on the date coverage under this Plan ends.

Special Enrollment Periods

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

Individual Losing Other Coverage

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

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

as described in item (c)(ii) above.

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

New Dependents

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

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

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

Special Enrollment Due to Marriage or Acquiring a Civil Union Partner

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

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

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

Special Enrollment Due to Newborn/Adopted Children

You may enroll a newly born or newly adopted Child Dependent

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

Multiple Employment

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

Eligible Dependents

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

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

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

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

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

When Coverage Ends

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

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

Coverage for a Dependent ends:

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

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

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

(2) makes an intentional misrepresentation of material fact,

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

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

Benefits After Termination

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

Continued Coverage Under The Federal Family And Medical Leave Act

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

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

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

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

Consult your benefits representative for application forms and further details.

Continuation of Coverage under COBRA

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

- Your death;
- Your work hours are reduced;

- Your employment ends for a reason other than gross misconduct.

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

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

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

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

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

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

Continuation coverage for a person will cease before the end of a maximum period just described

if one of these events occurs:

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

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

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

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

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, not including a Civil Union Partner). If the Employee so elects, the coverage can be continued, subject to the payment of any required contributions, until the first to occur of the following:

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

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

as follows:

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

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

Uniformed services: The following:

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

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

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

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 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 Horizon BCBSNJ medical director's opinion that the Provider is an imminent danger to the patient or the public health, safety or welfare.

The Plan 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, the Plan 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, the Plan 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, the Plan 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.

The Plan shall not allow continued services in cases where the Provider was terminated due to: (a) Horizon BCBSNJ 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, the availability of a particular Practitioner cannot be guaranteed.

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. Horizon BCBSNJ 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 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 Plan. The Plan has no other liability.

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

24 Hour Nurse Line

The PromptCare Companies has selected a program for Direct Access members through Horizon BCBSNJ, that will provide you with answers to your health questions twenty four hours a day seven days a week, access to registered nurses and doctor approved information to guide your health care decisions.

Here is how the process works:

1. You may call a toll free number (1-888-624-3096) to speak with nurse. When you call, a registered nurse can help you:
 - Understand if the Emergency Room, a doctor visit or self-care is right for your needs.
 - Learn more about a diagnosis.
 - Explore the risks, benefits and possible outcomes of treatment options.
 - Get tips on nutrition and exercise to help you maintain a healthy weight.
 - Learn about health screenings and immunizations.
2. You may also access online resources to receive health advise:
 - You can access Live Chat, and have an individual, secure and confidential online discussion with a health care resource and get the health information you need.

Horizon Care Management Plus Program

This program is a combination of case and high risk disease management, conducted by a team comprised of registered nurses and non-clinical coordinators. The program is designed to:

- Offer assistance to members with the management of chronic conditions (e.g., diabetes, asthma, heart disease);
- Provide support in the management of severe, complex episodes of care, including cancer, high risk maternity/NICU, transplants and infusion therapy;
- Help you understand your benefits and navigate the health care system, so you can get the most from your benefits.

- Work with vendors (disability, behavioral health, pharmacy) to connect our members with all resources available to them in managing their health;

If you think that this program could benefit you or a family member, or if you have questions about this program, 1-888-621-5894, option 2, followed by option 3, between 8 a.m. and 5 p.m., Eastern Time, Monday through Friday.

Horizon Nurses cannot diagnose problems or recommend specific treatment. They are not a substitute for your doctor's care. Services are not an insurance program and may be discontinued at any time. Always speak with your doctor before starting an exercise program or diet.

YOUR HORIZON DIRECT ACCESS 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

The services and supplies covered under the Plan (except Preventive Care services) are subject to a Deductible (as described below) which must be met during a Calendar Year before any benefits are payable. There are separate Deductibles: (a) for Single Coverage and for Other than Single Coverage; and (b) for In-Network Coverage and for Out-of-Network Coverage. After an applicable Deductible is met, the Covered Services and Supplies are further subject to any applicable Copayment or Coinsurance described in the Schedule of Covered Services and Supplies.

For Single Coverage (applies when only the Employee is covered):

Each Calendar Year, each Covered Person covered for Single Coverage must have Covered Charges that exceed the Deductible for Single Coverage before Horizon BCBSNJ pays any benefits to that person. There are separate Single Coverage Deductibles for In-Network and Out-of-Network coverage. The Deductibles are shown in the Schedule of Covered Services and Supplies. The applicable Deductible cannot be met with Non-Covered Charges. And only Covered Charges Incurred by the Covered Person while covered by the Plan can be used to meet the applicable Deductible.

Once the applicable Deductible is met, Horizon BCBSNJ pays benefits for other Covered Charges above the Deductible (In-Network or Out-of-Network, as the case may be) Incurred by that Covered Person, less any applicable Copayments or Coinsurance, for the rest of that Calendar Year. But all charges must be Incurred while that person is covered by the Plan. And what Horizon BCBSNJ pays is based on all of the Plan's terms.

For Other than Single Coverage (applies when the Employee and at least one other family member (collectively, the “Covered Family”) are covered.

Each Calendar Year, each Covered Family must have Covered Charges that exceed the Deductible before Horizon BCBSNJ pays any benefits to or for any member of that family. There are separate Other than Single Coverage Deductibles for In-Network and Out-of-Network coverage. The Deductibles are shown in the Schedule of Covered Services and Supplies. The applicable Deductible cannot be met with Non-Covered Charges. And only Covered Charges Incurred by the Covered Family while covered by the Policy can be used to meet the applicable Deductible.

Once one or more members of a Covered Family have Incurred a combined total of Covered Charges toward the applicable Deductible equal to the Other than Single Coverage Deductible, Horizon BCBSNJ pays benefits for other Covered Charges Incurred by those members (In-Network or Out-of-Network, as the case may be), less any applicable Copayments or Coinsurance, for the rest of that Calendar Year. But all charges must be Incurred while those members are covered by the Plan. And what Horizon BCBSNJ pays is based on all of the Policy’s terms.

OUT-OF-POCKET MAXIMUM

Single Coverage (Applies when only the Employee is covered)

This Plan limits the amount that an Employee has to pay “out-of-pocket” during a Calendar Year for Covered Services and Supplies. This “Out-of-Pocket Maximum” is described in the “Schedule of Covered Services and Supplies” (the Schedule). There are separate maximums for In-Network and Out-of-Network expenses.

Once the Employee has Incurred, during a Calendar Year, an amount of Covered Charges for which no benefits have been paid or are payable equal to a Single Coverage Out-of-Pocket Maximum, The Plan will pay 100% of any additional Covered Charges (In-Network or Out-of-Network, as the case may be) Incurred by the Employee for the rest of that year.

Any Covered Charge used to meet either or both of the Single Coverage Deductibles can also be used to meet both the In-Network and Out-of-Network Out-of-Pocket Maximums. Otherwise, however, only unpaid In-Network Covered Charges can be used to meet the In-Network maximum, and only unpaid Out-of-Network Covered Charges can be used to meet the Out-of-Network maximum.

Multiple Coverage (Applies when the Employee and at least one other family member are covered)

This Plan limits the amount that the covered members of a family have to pay “out-of-pocket” during a Calendar Year for Covered Services and Supplies. This “Out-of-Pocket Maximum” is described in the “Schedule of Covered Services and Supplies” (the Schedule). There are separate maximums for In-Network and Out-of-Network expenses.

Once the covered members of a family individually or collectively have Incurred, during a Calendar Year, an amount of Covered Charges for which no benefits have been paid or are payable equal to a Multiple Coverage Out-of-Pocket Maximum, The Plan will pay 100% of any additional

Covered Charges (In-Network or Out-of-Network, as the case may be) Incurred by those members for the rest of the year.

Any Covered Charge used to meet either or both of the Multiple Coverage Deductibles can also be used to meet both the In-Network and Out-of-Network Multiple Coverage Out-of-Pocket Maximums. Otherwise, however, only unpaid In-Network Covered Charges can be used to meet the In-Network maximum, and only unpaid Out-of-Network Covered Charges can be used to meet the Out-of-Network maximum.

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

Payment Limits

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

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 the Plan 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

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

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

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

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 Policy, 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; and
- b. the surgical removal of bony impacted teeth; and

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.

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 given Prior Authorization; and (ii) the services are for the following Medically Necessary and Appropriate Therapy Services, as prescribed in a treatment plan:

- (a) Occupational Therapy needed to develop the Covered Person's ability to perform the ordinary tasks of daily living;
- (b) Physical Therapy needed to develop the Covered Person's physical functions; and
- (c) Speech Therapy needed to treat the Covered Person's speech impairment.

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

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

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

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

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

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

Diagnostic X-rays and Lab Tests

This Plan covers diagnostic X-ray and lab tests.

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. The Plan 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 Period of Confinement Deductible as shown in the Schedule of Covered Services and Supplies.

Hearing Exams

This Plan covers routine hearing exams/evaluations.

Home Health Care

This Plan covers Home Health Care services furnished by 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 Vocational 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 Program 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;
14. Inpatient room, board and general nursing services; and

15. Bereavement counseling.

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 Program;
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; or
12. 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".

Infertility 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. Four 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 four covered completed egg retrievals; and
 - (iii) is 45 years of age or younger.
- 2. Coverage of Prescription Drugs is not included if infertility medication benefits are provided under another group health insurance policy or contract issued to the Policyholder.
- 3. To be covered, the services described in this section must be provided at a Facility that conforms to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.
- 4. The following services are **not** covered:
 - a. Medical services given to a surrogate, for purposes of childbearing, if the surrogate is not a Covered Person.
 - b. Medical costs of a live donor used in egg retrieval after the donor has been released by the reproductive endocrinologist.
 - c. Non-medical costs of an egg or sperm donor.
 - d. Ovulation kits and sperm testing kits and supplies.

- e. Reversal of voluntary sterilization.
- 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 oocytes.

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

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

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

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

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

Fertilization: The penetration of the egg by the sperm.

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

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

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

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

such that:

- a. a determination of infertility is made pursuant to American Society for Reproductive Medicine practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology; or
- b. the Covered Person meets one of the following conditions:
 - (i) a male is unable to impregnate a female;
 - (ii) a female with a male partner and under 35 years of age is unable to conceive after twelve months of unprotected sexual intercourse;
 - (iii) a female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;
 - (iv) a female without a male partner and under 35 years of age who is unable to conceive after twelve failed attempts of intrauterine insemination under medical supervision;
 - (v) a female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;
 - (vi) partners are unable to conceive as a result of involuntary medical sterility;
 - (vii) the Covered Person is unable to carry a pregnancy to live birth; or
 - (viii) a previous determination of Infertility.

The term does not apply to infertility resulting from voluntary sterilization procedures, regardless of whether there have been attempts to reverse the sterilization.

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

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

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

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

Oocyte: The female egg or ovum.

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

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

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

Zygote: A fertilized egg before cell division begins.

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

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 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 BSBSNJ 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 Care for Child Dependents

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

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.

Horizon BCBSNJ 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.

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 and 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 criterion that can be verified. The nutritional counseling must be prescribed by a Practitioner.

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

This 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.

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.

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 and 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

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

Preventive Care Services shall not be subject to any Deductible, Copayment or Coinsurance. The covered Preventive Care is as follows:

This Plan covers these tests and services:

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

This 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.

j. **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:

- (a) 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.
- (b) One baseline mammogram exam for Covered Persons who are 40 years of age.
- (c) One mammogram exam each year for Covered Persons age 40 and over.
- (d) An ultrasound evaluation; magnetic resonance imaging scan; three-dimensional mammography; or other additional testing of an entire breast or breasts after any baseline mammogram exam, if:
 - 1. The mammogram exam demonstrates extremely dense breast tissue;
 - 2. The mammogram is abnormal within any degree of breast density, including not dense; moderately dense; heterogeneously dense; or extremely dense breast tissue; or
 - 3. 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.
- (e) 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 the detection and screening for breast cancer in a Covered Person age 40 years and older, the Plan will cover charges for digital tomosynthesis as Preventive Care which means they are covered without application of any Copayment, Deductible and/or Coinsurance, as applicable.

k. **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.

l. **Routine Adult Physicals and Immunizations**

This Program covers routine adult physical exam(s) (including related X-rays and lab tests) and immunizations for you and your Spouse or Civil Union Partner, and Child Dependents over the age of 20.

m. **Well Child Immunizations**

This Plan covers Well Child immunizations.

n. **Colorectal Cancer Screening**

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

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

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

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

p. **Well Child Care**

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

q. **Additional Preventive Services**

In addition to any other Preventive Care benefits described above, the Plan 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 are 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. do 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 is not a PCP and who provides services within his/her specialty to Covered Persons. In-Network Specialist services require a referral from a Covered Person's PCP. 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:
 1. The Plan will cover the primary procedure, plus 50% of what the Plan would have paid for each of the other procedures, up to five, had those procedures been performed alone.
 2. If more than five surgical procedures are performed, each of the procedures beyond the fifth will be reviewed. The amount that the Plan will pay for each such procedure will then be based on the circumstances of the particular case.

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

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.
- Prostheses and the treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Also, see “Transplant Benefits”.

Telemedicine Services, provided by Horizon Care Online

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 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 health 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 for the following types of transplants:

- 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.

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, the 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.

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, ground 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 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.

Hearing Aids

This Plan covers hearing aids.

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; gamma globulin infusion therapy (IVIG); and prolastin therapy.

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

Oxygen and Its Administration

This Plan covers oxygen and its administration.

Supplemental Prescription Drug Benefits

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

- a. when prescribed for an FDA-approved treatment; or
- b. when prescribed for a non-FDA-approved treatment. In this case, the drug must be deemed Medically Necessary and Appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia:
 1. The American Hospital Formulary Service Drug Information; or
 2. The United States Pharmacopeia Drug Information;

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

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

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

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

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

Covered Charges will not include charges made for more than:

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

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

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

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

Benefits of Using an In-Network Pharmacy:

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

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

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

Using an Out-of-Network Pharmacy:

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

Mail Order Prescription Service:

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

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

The advantages of the mail order services are:

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

To use this service, simply mail your prescription to **PrimeMail** in the appropriate mail order envelope and include a completed mail order form. If you do not have a mail order envelope or

form, you may request one by calling **PrimeMail** at **1-855-549-1760**.

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

If you have any questions concerning your **Mail Order Prescription Drug** program, please call **PrimeMail** at **1-855-549-1760**.

Specialty Pharmaceuticals:

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

Drug Utilization and Cost Management:

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

Limitations:

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

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

1-800-355-BLUE

Prior Authorization Requirement

Horizon BCBSNJ has identified certain Prescription Drugs for which Prior Authorization is required. Horizon BCBSNJ will provide the list of Prescription Drugs for which Prior Authorization is required to each Employee. Horizon BCBSNJ will give at least 30 days advance written notice to the Employee before revising the list of Prescription Drugs to add a Prescription Drug to the list.

If a Covered Person brings a prescription for a Prescription Drug for which Horizon BCBSNJ requires Prior Authorization to a Pharmacy, and Prior Authorization has not yet been obtained, the Pharmacy will contact the Practitioner to request that the Practitioner contact Horizon BCBSNJ to secure Prior Authorization. The Pharmacy will dispense a 96-hour supply of the Prescription Drug. Horizon BCBSNJ will review the Prior Authorization request within the time period allowed by law. If Horizon BCBSNJ gives Prior Authorization, Horizon BCBSNJ will notify the Pharmacy, and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of this Plan. If Horizon BCBSNJ does not give Prior Authorization, the Covered Person may ask that the Pharmacy dispense the balance of the Prescription Drug and then pay for it. The Covered Person may then submit a claim for the Prescription Drug. If the claim is denied, the Covered Person may appeal the denial by following the Appeals Procedure process described in this Plan.

Prime Vaccine Network Program

Your Prescription Drug Plan has a feature called the Prime Vaccine Network Program. You and your covered dependents can receive flu, shingles, pneumonia, and other vaccines listed below at participating pharmacies free of charge.

- Diphtheria – Tetanus Combinations (Toxoids)
- Human Papillomavirus (HPV)
- Influenza
- Pneumonia
- Shingles
- Meningitis

You may get these shots at any of the participating national retail pharmacy locations. All you need to do is present your ID card. The shot is given on-site by a qualified clinician.

Age limitations, advanced registration or other requirements may apply. Please note: The availability of each vaccine may differ by pharmacy location. For your convenience, you may contact the pharmacy in advance if you have questions or to make sure these services are available.

To learn more about this program and where you can receive the shots, please call: 1-800-370-5088.

Prior Authorization Requirement

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written notice to the Employee before revising the list of Prescription Drugs to add a Prescription Drug to the list.

If a Covered Person brings a prescription for a Prescription Drug for which Horizon BCBSNJ requires Prior Authorization to a Pharmacy, and Prior Authorization has not yet been obtained, the Pharmacy will contact the Practitioner to request that the Practitioner contact Horizon BCBSNJ to secure Prior Authorization. The Pharmacy will dispense a 96-hour supply of the Prescription Drug. Horizon BCBSNJ will review the Prior Authorization request within the time period allowed by law. If Horizon BCBSNJ gives Prior Authorization, Horizon BCBSNJ will notify the Pharmacy, and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of this Plan. If Horizon BCBSNJ does not give Prior Authorization, the Covered Person may ask that the Pharmacy dispense the balance of the Prescription Drug and then pay for it. The Covered Person may then submit a claim for the Prescription Drug. If the claim is denied, the Covered Person may appeal the denial by following the Appeals Procedure process described in this Plan.

Obtaining Coverage of a Non-Preferred Prescription Drug at the Preferred Level of Benefits

The Plan employs a three tier Copayment structure. When purchasing a Prescription Drug, a Covered Person's Copayment will vary depending upon whether the Prescription Drug is a Preferred Generic Prescription Drug, Preferred Brand Name Prescription Drug or a Non-Preferred Generic or Brand Name Drug. In the event that a Non-Preferred Prescription Drug is determined to be Medically Necessary and Appropriate, a Covered Person or his/her health care Provider may request that the Prescription Drug be covered at the Preferred Drug level. A Non-Preferred Prescription Drug is deemed to be Medically Necessary and Appropriate if the health care Provider certifies that:

1. It is approved under the Federal Food, Drug and Cosmetic Act; or
2. Its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia; or
3. It is recommended by a clinical study or review article in a major-peer reviewed professional journal, and
4. The prescribing health care Provider demonstrates that all Preferred Drugs used to treat the diseased state have been ineffective in the treatment of the Covered Person's disease or condition, or all such drugs have caused or are reasonably expected to cause adverse or harmful reactions in the Covered Person.

In the event the above criteria are met, the Covered Person or his/her health care Provider may request that the Non-Preferred Prescription Drug be covered at the Preferred Drug level. In the event the request is approved, the Prescription Drug will be covered at the appropriate Preferred level depending upon whether the drug is a Generic Prescription Drug or Brand Name Drug. A plan medical doctor licensed to practice medicine will perform all reviews of such requests. The

plan medical doctor may be an employee of Horizon BCBSNJ or its affiliates, or may be a contracted delegate performing in accordance with Horizon BCBSNJ's policies and procedures.

To gain approval for a Non-Preferred Prescription Drug to be covered at the Preferred level, the Covered Person's health care Provider must contact Horizon BCBSNJ and provide the appropriate information for a determination to be made. Documentation must be provided certifying the Medical Necessity and Appropriateness of the Prescription Drug based upon the above definition. Documentation must include that part of the Covered Person's medical record that indicates which drugs have been prescribed as well as the reactions or ineffectiveness of each such drug. This may be demonstrated by prior patient experience with similar drugs or classes of drugs. Documentation may be submitted via facsimile. Once the appropriate information is received by Horizon BCBSNJ, we will make a determination and respond to the prescribing health care Provider by telephone or other telecommunication device within one business day of receipt of such information. Our failure to respond within this time period can be deemed an approval of the request. Initial denials shall also be provided to the prescribing health care Provider and the Covered Person in writing within five business days of receipt of the necessary information and shall include the clinical reason for the denial. Horizon BCBSNJ or its delegate will maintain an on-call process for obtaining approval of the Prescription Drug in emergency situations 24 hours per day, 7 days per week. Denials can be appealed pursuant to those procedures described in this in this Booklet under "Appeals Process", including the right to appeal to the Independent Health Care Appeals Program in the Department of Health and Senior Services.

Obtaining Benefits for Out-Of-Network Drugs

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

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 the Plan 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 Facility, the Facility will usually make all needed arrangements for Pre-Admission Review. If a Covered Person plans to use an Out-of-Network Facility, 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, the Plan 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. Horizon BCBSNJ 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, Horizon BCBSNJ determines:
 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 the 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, The Plan has the right to conduct a continued stay review of any Inpatient Facility Admission. To do this, Horizon BCBSNJ may contact the Covered Person's Practitioner or Facility by phone or in writing.

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

The continued stay review will determine:

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

- b. the anticipated length of stay and extended length of stay; and
- c. the appropriateness of health care alternatives.

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

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.

Penalties for Non-Compliance

- a. As a penalty for non-compliance with the Admission review features in this Plan, the Plan reduces what it otherwise pays for Covered Services and Supplies by **50%** 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.

- b. Penalties cannot be used to meet this Plan's:
 - 1. Deductible(s)
 - 2. Out-of-Pocket Limit(s)
 - 3. Copayment(s)

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, the Plan 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 **50%**.

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 Facility on an Inpatient basis, only one authorization for both the Inpatient Admission and the treatment or procedure is needed. If Prior Authorization is required for a supply, the request must be made before the supply is obtained.

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

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

Horizon BCBSNJ notifies the Covered Person, his/her Practitioner or Facility, by phone, of the outcome of the review. Horizon BCBSNJ also confirms 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.

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 Injury determined to be catastrophic.

Alternate Treatment/Individual Case Management Plan

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

- a. An Alternate Treatment/Individual Case Management Plan is a specific written document. It is developed by Horizon BCBSNJ through discussion and agreement with:
 - 1. the Covered Person, or his/her legal guardian if necessary;
 - 2. the Covered Person's attending Practitioner; and
 - 3. Horizon BCBSNJ or its designee.

- b. The Alternate Treatment/Individual Case Management Plan includes:
1. treatment plan objectives;
 2. a course of treatment to accomplish those objectives;
 3. the responsibility of each of these parties in carrying out the plan:
 - (a) Horizon BCBSNJ;
 - (b) the attending Practitioner;
 - (c) the Covered Person;
 - (d) the Covered Person's family, if any; and
 4. the estimated cost of the plan and savings.

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

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

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

Exclusion

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

SCHEDULE OF PROCEDURES, TREATMENT AND SUPPLIES 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.
- 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).
- Occupational Therapy, Physical Therapy and Cognitive Therapy.
- Pacemakers.
- Pain Management Services.
- Reconstructive Surgery.
- Sinus (Nasal) Surgery.
- Specialty Pharmaceuticals.
- Varicose Vein Surgery.
- Vestibular Rehabilitations.
- Zygote Intra Fallopian Transfer (ZIFT).

EXCLUSIONS

The following are not Covered Services and Supplies under this Plan. The Plan 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.

Ancillary charges connected with self-administered services such as: patient-controlled analgesia; related diagnostic testing; self-care; and self-help training.

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

Any part of a charge that exceeds the Allowance.

Any therapy not included in the definition of Therapy Services.

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

Broken appointments.

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

Completion of claim forms.

Consumable medical supplies.

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

Court ordered treatment that is not Medically Necessary and Appropriate.

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

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

Diversional/recreational therapy or activity.

Employment/career counseling.

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

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

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

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).

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 the Plan has determined that:

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

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

Pastoral counseling.

Personal comfort and convenience items.

Private Duty Nursing.

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 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: (a) is paid by a Facility or other source; and (b) 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 Civil Union Partner, child, parent, in-law, brother or sister;
- connected with any procedure or exam not needed for the diagnosis or treatment of an Injury or Illness for which a bona fide diagnosis has been made because of existing symptoms;
- needed due to an Injury or Illness to which a contributing cause was the Covered Person's commission of, or attempt to commit, a felony; or to which a contributing cause was the Covered Person's engagement in an illegal occupation. Exception: As required by 29 CFR

2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition;

- provided by a Practitioner if the Practitioner bills the Covered Person directly for the services or supplies, regardless of the existence of any financial or contractual arrangement between the Practitioner and the Provider;
- provided by or in a government Hospital, or provided by or in a Facility run by the Department of Defense or Veteran's Administration for a service-related Illness or Injury, unless coverage for the services is otherwise required by law;
- 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.

TMJ syndrome treatment.

Transplants, except as otherwise stated in this Booklet.

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

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

Vitamins and dietary supplements, except prenatal and children's vitamins requiring a Prescription.

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

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

(APPLICABLE TO PRESCRIPTION DRUG COVERAGE)

LIMITATIONS AND EXCLUSIONS

In addition to any other applicable limitations and exclusions set forth above or described elsewhere in this Booklet, the following apply specifically to this Prescription Drug Expense Coverage. This Prescription Drug Expense Coverage does not cover:

Refills that: (a) are not authorized by a Prescription Order; or (b) are obtained beyond one year from the original Prescription Order date ; or (c) are dispensed before 75% of the prior Prescription Order or refill would be used or consumed when used or taken as directed⁷.

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.

All Food and Drug Administration approved female prescription contraceptive drug or device, which includes but is not limited to birth control pills and diaphragms.

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

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

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

Drugs to enhance normal functions, such as: (a) steroids to improve athletic performance; or (b) drugs to improve memory.

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

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

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

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

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

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

Experimental or Investigational drugs.

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

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

Drugs provided by or in a Government Hospital, or provided by or in a Facility run by the Department of Defense or Veteran's Administration, for a service-related condition, unless coverage for the services is otherwise required by law.

Drugs that are needed due to condition to which a contributing cause was the Covered Person's commission of, or attempt to commit, a felony; or to which a contributing cause was the Covered Person's engagement in an illegal occupation.

Drugs that are not Medically Necessary and Appropriate.

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

Drugs not purchased at an In-Network Pharmacy.

Any part of a charge that exceeds the Allowance.

Drugs purchased in connection with Cosmetic Services.

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

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

Drugs used for methadone maintenance.

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

Drugs to treat an Injury or Illness suffered: (a) as a result of War or an Act of War while the Covered Person is serving in any civilian non-combatant unit supporting or accompanying any

military, naval or air forces of any country, combination of countries or international organization; and (b) as a result of the special hazards incident to such service, provided the Injury or Illness occurs while (i) the Covered Person is serving in such unit; and (ii) is outside the Home Area.

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

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

Vitamins and dietary supplements, except prenatal and children's vitamins requiring a Prescription

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

Drugs to enhance normal functions, such as: (a) steroids to improve athletic performance; or (b) drugs to improve memory.

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

Drugs to treat baldness.

Diagnostic agents administered by a Practitioner in an Inpatient or Outpatient setting, such as diabetic test strips.

Drugs dispensed that are repackaged and not in their original packaging.

General anesthesia administered by a Practitioner in an Inpatient or Outpatient setting.

Medical devices, products and supplies used by Practitioners in an Inpatient or Outpatient setting, such as lancets, spacers, tubing, filter needles and ports.

Products and supplies listed in the Devices or Pharmaceutical Aids classifications published by AHFS Drug Information®.

Products, items or supplies with a Universal Product Code (UPC) or a Health Related Item Code (HRI), such as surgical stockings, exercise equipment, home delivered meals, incontinence supplies, slings and splints.

CLAIMS PROCEDURES

Claim forms and instructions for filing claims will be provided to Covered Persons. 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 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.

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

- c. 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 Plan 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.
- d. 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

- a. Payment for services of an In-Network Provider or a BlueCard Provider will be made directly to that Provider if the Provider bills Horizon BCBSNJ, as Horizon BCBSNJ determines. To receive In-Network coverage, a Covered Person must show his/her ID card when requesting Covered Services and Supplies from a Provider that has such an agreement.
- b. Payment for services of Out-of-Network Providers will be made to you.
- c. Except as stated above, in the event of a Covered Person's death or total incapacity, any payment or refund due will be made to his/her heirs, beneficiaries, trustees or estate.
- d. If you are the non-custodial parent of a Child Dependent, Horizon BCBSNJ will pay claims filed as described above under "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

Licenses referred to generally as “Inter-Plan Arrangements.” These Inter- Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever Covered Persons access healthcare services outside the geographic area we serve, the claims for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

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

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

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

BlueCard® Program

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

Liability Calculation Method Per Claim – In General

Covered Person's Liability Calculation

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

Claims Pricing

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

- (i) An actual price. An actual price is a negotiated rate of payment in effect at

the time a claim is processed without any other increases or decreases; or

- (ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or
- (iii) An average price. An average price is a percentage of billed Covered Charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

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

Negotiated (non-BlueCard Program) National Account Arrangements

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

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

Covered Person's Liability Calculation.

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

Special Cases: Value-Based Programs

Value-Based Programs Overview

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

Value-Based Programs under the BlueCard Program

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

Value-Based Programs under Negotiated National Account Arrangements

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

Return of Overpayments

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

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

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

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

Covered Person's Liability Calculation

In General

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

Exceptions

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

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

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

BCBS Global Core Coverage TM

General Information. If Covered Persons are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of BCBS Global Core when accessing Covered Services and Supplies. The BCBS Global Core Coverage is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although BCBS Global Core assists Covered Persons with accessing a network of inpatient, outpatient and professional providers, the

network is not served by a Host Blue. As such, when Covered Persons receive care from providers outside the BlueCard service area, the Covered Persons will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

Inpatient Services

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

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

Outpatient Services

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

Submitting a BCBS Global Core Claim

When Covered Persons pay for Covered Services and Supplies outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Covered Persons should complete a BCBS Global Core claim form and send the claim form with the provider's itemized bill(s) to the BCBS Global Core Service Center address on the form to initiate claims processing. The claim form is available from Horizon BCBSNJ, BCBS Global Core Service Center, or online at www.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:

- For Urgent Care Claims, 72 hours from receipt of the claim;
- For Pre-Service Claims, 15 calendar days from receipt of the claim;
- For Post-Service Claims, 30 calendar days from receipt of the claim.

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

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

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

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

Appeals Process for Adverse Utilization Management Decisions

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

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

Your appeal must include the following information:

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

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

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

External Appeal Rights

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

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

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

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

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 PromptCare Companies Medical Plan

Plan Sponsor: The PromptCare Companies
41 Spring St Suite 103
New Providence, NJ 07974

Plan Administrator: The PromptCare Companies
41 Spring St Suite 103
New Providence, NJ 07974

Employer Identification Number: 222773861

Plan Number: 501

Classification and Funding:

The Plan described in this Booklet is classified as a welfare benefits plan by the Department of Labor.

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 1 and ends on December 31.

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. However, the Plan has delegated to the Claims Administrator the authority to make final claims determinations and to decide initial and final claims appeals on the Plan's behalf.

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 there under, 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 **The PromptCare Companies** 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 plans' decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If 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 Horizon Direct Access benefits and services, please call at:

1-800-355-BLUE

(2583)

For Mental Health and Substance Use Disorder, 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. Your ID number helps to get prompt answers to your questions about enrollment, benefits or claims.

