Product:	**BlueCard PPO**
Group Name:	**BAYADA Home Health Care Inc.**
	76021-BUY UP PLAN
Group Number:	**Effective Date 7/1/15**

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INTRODUCTION

This 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 BlueCard PPO 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 BlueCard PPO 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.

Acupuncture: The practice of piercing specific sites with needles to induce Surgical anesthesia. Acupuncture is also used as a therapeutic agent for relief of pain.

Admission: Consecutive 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.

Affidavit of Domestic Partnership: A formal instrument executed by two persons documenting their status as Domestic Partners. Submission of an Affidavit of Domestic Partnership to the Plan is required prior to Domestic Partner coverage becoming effective.

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.

Alcoholism: The abuse of or addiction to alcohol.

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

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

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

(c) in the case of Out-of-Network Providers, the amount determined as **180%** of the amount that would be reimbursed for the service or supply under Medicare:

Exceptions:

(1) With respect to (i) a Medical Emergency; or (ii) Covered Services and Supplies provided in an In-Network Hospital, the Allowance determined in accordance with (c), above, for any Covered Services and Supplies provided by Out-of-Network Providers shall be increased as needed to

ensure that the Covered Person has no greater liability than he/she would have if they were provided by In-Network Providers. But this (ii) shall not apply if the Covered Person: (a) had or was given the opportunity to select In-Network Providers to provide the Covered Services and Supplies; and (b) elected the services of Out-of-Network Providers.

(2) With respect to (c), above, if Medicare does not prescribe a reimbursement rate for a Covered Service or Supply, the Allowance for the Covered Service or Supply will be determined based on profiles compiled by Horizon BCBSNJ based on usual and prevailing payments made to Providers for similar services or supplies in specific geographical areas, or similar profiles compiled by outside vendors.

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.

Benefit Day: Each of the following:

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

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

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 **July 1st and ending on June30th**. 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.

BlueCard PPO Provider: A Provider, not in New Jersey, which has a written agreement with another Blue Cross and/or Blue Shield plan to provide care to both that plan's subscribers and other Blue Cross and/or Blue Shield plans' subscribers. For purposes of this Plan, a BlueCard PPO Provider is an In-Network Provider.

Booklet: A detailed summary of benefits covered.

Calendar Year: A year starting January 1.

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

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

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

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

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

- You, your Spouse's or Domestic Partner'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 **80%**, then the Covered Person's Coinsurance for that item is **20%**. Unless the context indicates otherwise, the Coinsurance percents shown in this Booklet are the percents that the Plan will pay.

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 or Nervous 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.

Day Programs: Outpatient personalized or packaged programs that: (a) are designed primarily for patients who are medically stable enough to live at home, but who may require certain therapies; (b) offer multiple therapies in a day setting; and (c) are usually scheduled for three to five days a week and five to nine and a half hours per day. Some examples of the therapies offered are: cognitive therapy; recreation therapy; work hardening programs; vocational therapy; group cognitive/interpersonal

therapy; remedial treatments; and treatments to improve interpersonal communication and social skills. "Day Programs" do not include outpatient programs for the treatment of mental illnesses.

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

Detoxification Facility: A Facility licensed by the State of New Jersey as a Detoxification Facility for the treatment of Alcoholism, or one that meets the same standards if located in another state.

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

a. radiology, ultrasound and nuclear medicine;

b. lab and pathology; and

c. EKG's, EEG's and other electronic diagnostic tests.

Domestic Partners: Persons who meet these criteria:

(1) Both persons have a common residence and are otherwise jointly responsible for each other's common welfare, as evidenced by joint financial arrangements or joint ownership of real property, which shall be demonstrated by at least one of the following:

   (a) A joint deed, mortgage agreement or lease;

   (b) A joint bank account;

   (c) Designation of one of the persons as a primary beneficiary in the other's will;

   (d) Designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or

   (e) joint ownership of a motor vehicle;

(2) Both persons agree to be jointly responsible for each other's basic living expenses during the Domestic Partnership;

(3) Neither person is in a marriage recognized by the State in which he or she resides or a member of another Domestic Partnership;

(4) Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;

(5) Both persons have chosen to share each other's lives in a committed relationship of mutual caring;

(6) Both persons are at least 18 years of age;

(7) Both persons file jointly an Affidavit of Domestic Partnership; and

(8) Neither person has been a partner in a Domestic Partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except that his prohibition shall not apply if one of the partners died: and in all cases in which a person registered a prior Domestic Partnership, the Domestic Partnership shall have been terminated.

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

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

a. It is designed for and able to withstand repeated use;

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

c. It is generally not useful to a person in the absence of an Illness or Injury; and

d. It is suitable for use in the home.

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

Some examples of services and supplies that are <u>not</u> 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.

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 may still deem it to be Medically Necessary and Appropriate if supportive clinical evidence for the particular use of the drug: (a) is given in a clinical study or published in a major peer-reviewed medical journal; and (b) meets the Plan's criteria. But, in no event will this Plan cover any drug that the FDA has determined to be Experimental, Investigational or contraindicated for the treatment for which it is prescribed**.**

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

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

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.

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 Abuse 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.

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 an In-Network Provider provides the service or supply.

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.

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

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

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

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

(2) Conditions that the Plan determines to be due to developmental disorders. These include, but are not limited to: mental retardation; academic skills disorders; or motor skills disorders. But, this does not apply: (i) to the extent required by law for the treatment of Mental or Nervous Disorders

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

Mutually Exclusive Surgical Procedures: Surgical procedures that:

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

(b) represent overlapping services or accomplish the same result;

(c) in combination, may be anatomically impossible.

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 an Out-of-Network Provider provides the service or supply.

Out-of-Pocket Expense Maximum: The maximum amount that a Covered Person or covered family has to pay under the Coverage during a Benefit Period for covered In-Network retail and mail-order Prescription Drugs.

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 or Nervous Disorders; chemical dependency; or Alcoholism; 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 Medical Plan.

Plan: The BAYADA Home Health Care Inc. Health & Welfare Plan.

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.

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. A paper provider directory 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.

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; onychauxis; 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.

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.

Specialist: A health care Practitioner who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Specialist Physician: A fully licensed physician who:

(a) is a diplomat of a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association; or

(b) is a fellow of the appropriate American specialty college or a member of an osteopathic specialty college; or

(c) is currently admissible to take the exam administered by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic

Association; or has evidence of completion of an appropriate qualifying residency approved by the American Medical Association or American Osteopathic Association; or

(d) holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or

(e) is recognized in the community as a specialist by his or her peers.

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

Substance Abuse: The abuse or addiction to drugs or controlled substances, not including alcohol.

Substance Abuse Centers: Facilities that mainly provide treatment for people with Substance Abuse problems or Alcoholism. The Plan will recognize 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 by a qualified speech therapist and is described below:

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 after Surgery to correct a defect that both: (a) existed at birth; and (b) impaired or would have impaired the ability to speak.

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.

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.

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), 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.

Please note that you may be responsible for paying charges which exceed the Allowance, when services are rendered by an Out-of-Network Provider.

Coinsurance	**80%** of Covered Basic Charges.
In-Network	**80%** of Covered Supplemental Charges.
Coinsurance	**60%** of Covered Basic Charges.
Out-of-Network	**60%** of Covered Supplemental Charges.
Out-of-Pocket Maximum In- Network	After **$3,250**/Covered Person, **$6,500**/family, the Plan provides **100%** of Covered Allowance.
Out-of-Pocket Maximum Out-of-Network	After **$8,125**/Covered Person, **$16,250**/family, the Plan provides **100%** of Covered Allowance.

Note: The Out-Pocket Maximum cannot be met with:

- Non-Covered Charges

Deductible	
In-Network	**$750**/Single
Applies to	**$1,500/**Family (**Note**: May be aggregately met by covered family
Basic/Supplemental	members.)

Services.

Out-of-Network **$1,500**/Single

Applies to **$3,000**/Family (**Note**: May be aggregately met by covered family

Basic/Supplemental members.)

Services.

Deductible does not apply to Preventive Care.

Inpatient

Copayment

In-Network **$75** per day up to a maximum of 5 days per Admission.

Out-of-Network **$150** per day up to a maximum of 5 days per Admission.

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

BENEFIT PERIOD MAXIMUM

In-Network **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

ACUPUNCTURE

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

Combined In-Network and Out-of-Network, benefits subject to a **20** Visit maximum per Benefit Period.

ALCOHOLISM

In-Network	Subject to Deductible, and **80%** Coinsurance.
Out-of-Network	Subject to Deductible, and **60%** Coinsurance.

ALLERGY TESTING AND TREATMENT

In-Network	Subject to **100%** Coinsurance. The applicable PCP/specialist copay will apply when an office visit is billed.
Out-of-Network	Subject to Deductible, and **60%** Coinsurance.

AMBULATORY SURGICAL CENTER

In-Network	Subject to Deductible, and **80%** Coinsurance.
Out-of-Network	Subject to Deductible, and **60%** Coinsurance.

ANESTHESIA

Inpatient

In-Network	Subject to **100%** Coinsurance.
Out-of-Network	Subject to Deductible and **60%** Coinsurance.

Outpatient

In Network	Subject to Deductible and **80%** Coinsurance.
Out-of-Network	Subject to Deductible, and **60%** Coinsurance.

AUDIOLOGY SERVICES

In-Network	Subject to **$30.00** Copayment, and **100%** Coinsurance.
Out-of-Network	Subject to Deductible, and **60%** Coinsurance.

DENTAL CARE AND TREATMENT

Inpatient

In-Network	Subject to Prior Authorization, **$75.00** Copayment per day up to a maximum of **5** days per Admission, and **100%** Coinsurance.

Out-of-Network Subject to Prior Authorization, **$150.00** Copayment per day up to a maximum of **5** days per Admission, and **60%** Coinsurance.

Outpatient

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

DIAGNOSTIC X-RAY AND LAB

Routine Inpatient/Outpatient and Non-Routine Inpatient

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

Non-Routine/Outpatient

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

DIALYSIS CENTER CHARGES

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

EMERGENCY ROOM

In-Network and Subject to **$250.00** Copayment and **100%**

Out-of-Network Coinsurance.

The Copayment is waived if admitted. This benefit is applicable to the facility charges of an Emergency Room. Charges for other providers that bill separately from the facility (such as emergency room physicians, lab, radiology, etc.) are paid in accordance with the plan provisions applicable to those services.

FACILITY CHARGES **365** days In-Network Inpatient Hospital Care, per Benefit Period.

70 days Out-of-Network Inpatient Hospital Care, per Benefit Period.

In-Network

Inpatient	Subject to Prior Authorization, **$75.00** Copayment per day up to a maximum of **5** days per Admission, and **100%** Coinsurance
In-Network	
Outpatient	Subject to Deductible, and **80%** Coinsurance.
Out-of-Network	
Inpatient	Subject to Prior Authorization, **$150.00** Copayment per day up to a maximum of **5** days per Admission, and **60%** Coinsurance.
Out-of-Network	
Outpatient	Subject to Deductible, and **60%** Coinsurance.

HEARING EXAMS

Routine Exams	
In-Network	Subject to **100%** Coinsurance.
Out-of-Network	Subject to Deductible, and **60%** Coinsurance.
Non-Routine Exams	
In-Network	Subject to Deductible, and **80%** Coinsurance.
Out-of-Network	Subject to Deductible, and **60%** Coinsurance.

HOME HEALTH CARE

In-Network	Subject to Prior Authorization, Deductible and **80%** Coinsurance.
Out-of-Network	Subject to Prior Authorization, Deductible, and **60%** Coinsurance.

HOSPICE CARE

Inpatient	
In-Network	Subject to Prior Authorization, and **100%** Coinsurance.
Out-of-Network	Subject to Prior Authorization, and **60%** Coinsurance.
Outpatient	

In-Network Subject to Prior Authorization, and **80%** Coinsurance.

Out-of-Network Subject to Prior Authorization, and **60%** Coinsurance.

The Inpatient Copayment applies to both In-Network and Out-of-Network Inpatient facility charges.

INPATIENT PHYSICIAN SERVICES

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

MATERNITY/OBSTETRICAL CARE

In-Network Subject to **$30.00** Copayment for the initial Visit, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

MENTAL OR NERVOUS DISORDERS (INCLUDING GROUP THERAPY) AND SUBSTANCE ABUSE

Inpatient

In-Network and

Out-of-Network Pursuant to federal law, benefits for these conditions must be provided on the same basis as for other conditions under the Plan.

Outpatient and

Out-of-Hospital

In-Network and

Out-of-Network Pursuant to federal law, benefits for these conditions must be provided on the same basis as for other conditions under the Plan.

NUTRITIONAL COUNSELING

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

Subject to **3** visit Benefit Period Maximum; covered only when diagnosis is for Morbid Obesity.

PHYSICAL REHABILITATION CENTER

Inpatient

In-Network	Subject to Prior Authorization, **$75.00** Copayment per day up to a maximum of **5** days per Admission, and **100%** Coinsurance

Inpatient

Out-of-Network	Subject to Prior Authorization, **$150.00** Copayment per day up to a maximum of **5** days per Admission, and **60%** Coinsurance.

PRACTITIONER'S CHARGES FOR NON-SURGICAL CARE AND TREATMENT

In-Network	Subject to **$15.00** Copayment, and **100%** Coinsurance.
Out-of-Network	Subject to Deductible, and **60%** Coinsurance.

PRACTITIONER'S CHARGES FOR SURGERY

Inpatient

In-Network	Subject to **100%** Coinsurance. Deductible does not apply.
Out-of-Network	Subject to Deductible, and **60%** Coinsurance.

Outpatient

In-Network	Subject to Deductible, and **80%** Coinsurance.
Out-of-Network	Subject to Deductible, and **60%** Coinsurance.

PRE-ADMISSION TESTING

In-Network	Subject to Deductible, and **80%** Coinsurance.
Out-of-Network	Subject to Deductible, and **60%** Coinsurance.

PREVENTIVE CARE

a. COLONOSCOPY

In-Network	Subject to **100%** Coinsurance.
Out-of-Network	Subject to Deductible and **60%** Coinsurance.

b. GYNECOLOGICAL EXAMINATIONS

In-Network	Subject to **100%** Coinsurance.
Out-of-Network	Subject to Deductible and **60%** Coinsurance.

c. MAMMOGRAPHY

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

Out-of-Network Subject to Deductible and **60%** Coinsurance.

d. PAP SMEARS

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

Out-of-Network Subject to Deductible and **60%** Coinsurance**.**

e. ROUTINE PROSTATE CANCER SCREENING

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

Out-of-Network Subject to Deductible and **60%** Coinsurance.

f. ROUTINE ADULT PHYSICALS

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

Out-of-Network Subject to Deductible and **60%** Coinsurance.

g. WELL-CHILD IMMUNIZATIONS

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

Out-of-Network Subject to Deductible and **60%** Coinsurance.

h. WELL-CHILD CARE

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

Out-of-Network Subject to Deductible and **60%** Coinsurance.

i. ROUTINE HEARING EXAM

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

Out-of-Network Subject to Deductible and **60%** Coinsurance.

PRIMARY CARE PHYSICIAN

In-Network Subject to **$15.00** Copayment and **100%** Coinsurance.

Out-of-Network Subject to Deductible and **60%** Coinsurance.

SECOND OPINION CHARGES

Outpatient Out-of-Hospital

In-Network Subject to **$30.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

SKILLED NURSING FACILITY CHARGES

In-Network Subject to Prior Authorization, and **100%** Coinsurance.

Out-of-Network Subject to Prior Authorization, Deductible and **60%** Coinsurance.

Precertification is required for an Inpatient admission.

The Inpatient Copayment applies to both In-Network and Out-of-Network Inpatient facility charges.

SPECIALIST SERVICES

In-Network Subject to **$30.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

SURGICAL SERVICES

In-Network Subject to Prior Authorization, **$75.00** Copayment per day up to a maximum of **5** days per Admission, and **100%** Coinsurance.

Out-of-Network Subject to Prior Authorization, **$150.00** Copayment per day up to a maximum of **5** days per Admission, and **60%** Coinsurance..

Outpatient

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

Out-of-Network Subject to Prior Authorization, Deductible and **60%** Coinsurance.

THERAPEUTIC MANIPULATIONS

In-Network Subject to **$30.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

THERAPY SERVICES

a. CHELATION THERAPY

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

b. CHEMOTHERAPY

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

c. CARDIAC REHABILITATION THERAPY

In-Network Subject to **$30.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

Combined In-Network and Out-of-Network benefits subject to a **36** session maximum per Benefit Period.

d. COGNITIVE REHABILITATION THERAPY

In-Network Subject to **$30.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

e. DIALYSIS TREATMENT

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

f. INFUSION THERAPY

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

g. OCCUPATIONAL THERAPY

In-Network Subject to **$30.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

h. PHYSICAL THERAPY

In-Network Subject to **$30.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

i. PULMONARY REHABILITATION THERAPY

In-Network Subject to **$30.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

Combined In-Network and Out-of-Network benefits subject to a **36** session maximum per Benefit Period.

j. RADIATION TREATMENT

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

k. RESPIRATION THERAPY

In-Network Subject to **$30.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

l. SPEECH THERAPY

In-Network Subject to **$30.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

TRANSPLANT BENEFITS

In-Network Subject to Prior Authorization, **$75.00** Copayment per day up to a maximum of **5** days per Admission, and **100%** Coinsurance.

Out-of-Network Subject to Prior Authorization, **$150.00** Copayment per day up to a maximum of **5** days per Admission, and **60%** Coinsurance.

Outpatient

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

Out-of-Network Subject to Prior Authorization, Deductible and **60%** Coinsurance.

B. COVERED SUPPLEMENTAL SERVICES AND SUPPLIES

AMBULANCE SERVICES

In-Network&

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

BLOOD

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

DURABLE MEDICAL EQUIPMENT

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

FOOT ORTHOTICS

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

HOME INFUSION THERAPY

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

Out-of-Network Subject to Prior Authorization, Deductible, and **60%** Coinsurance.

OXYGEN AND ADMINISTRATION

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

PRIVATE DUTY NURSING

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

Out-of-Network Subject to Prior Authorization, Deductible, and **60%** Coinsurance.

PROSTHETIC DEVICES

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

Out-of-Network Subject to Deductible, and **60%** Coinsurance.

VISION CARE (Non-Routine-Medical Conditions)

In-Network Subject to **$30.00** Copayment, and **100%** Coinsurance.

Out-of-Network Subject to Deductible, and **60%** Coinsurance**.**

Routine vision care is not covered. Hardware is also not covered.

WIGS

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

Benefits subject to a **$500** maximum per Benefit Period. Wigs are eligible for chemotherapy patients and **3rd** degree burn victims.

GENERAL INFORMATION

How To Enroll

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

Your Identification (ID) Card

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

Always carry this card and use your ID number when you or a Dependent receives 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:

- **Employee Coverage** – provides coverage for you only.
- **Employee + Spouse** – provides coverage for you and your spouse or Civil Union Partner or Domestic Partner
- **Employee + Child** – provides coverage for you and one Dependent.
- **Employee Children** – provides coverage for you and your Dependent Children.
- **Family** – provides coverage for you and your family or Civil Union Partner or Domestic Partner

Change In Type Of Coverage

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

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

For example:

- If you have Employee coverage and marry, or acquire a Civil Union Partner, or acquire a Domestic Partner, your new Spouse or Civil Union Partner or Domestic Partner will be covered from the date you marry or acquire the Civil UnionPartner or meet the rules for covering Domestic Partners if you apply for Two Adults or Employee + Two or More 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 or Domestic Partner

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

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

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

Special Enrollment Due to Newborn/Adopted Children

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

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 or Domestic Partner, your Child Dependents.

To enroll a Domestic Partner, you must provide proof that a Domestic Partnership exists by providing us with acceptable proof of the Domestic Partnership.

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 Domestic Partner will end when the Domestic Partnership ends.

Coverage will continue for a Child Dependent beyond the age of 26 if:

- He/she was enrolled in the Plan prior to age 19 and has been continuously covered under the plan up to age 26; and
- He/she was disabled prior to age 19 and has been incapable of self-sustaining employment by reason of mental retardation or physical handicap~~;~~ and continues to be incapable of self-sustaining employment by reason of mental retardation or physical handicap

For your disabled Child Dependent to remain covered, you must submit proof of his/her inability to engage in self-sustaining employment by reason of mental retardation or physical handicap within 31 days of the child's attainment of age 19. The proof must be in a form that meets our approval. Such proof may need to be resubmitted during the continuation of coverage, at the discretion of the Plan.

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

When Coverage Ends

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

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

Coverage for a Dependent ends:

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

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

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

(2) makes an intentional misrepresentation of material fact,

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

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

Benefits After Termination

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

If You Leave Your Group Due To Total Disability

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

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

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

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

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

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 or Domestic Partner and any newborn or newly adopted child may have the opportunity to continue group health care coverage which would otherwise end, if any of these events occur:

- Your death;
- Your work hours are reduced;

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;
- 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 or Domestic Partner.

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

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

If the Employee is absent from work due to performing service in the uniformed services, this federal law gives the Employee the right to elect to continue the health coverage under this Plan (for himself/herself and the Employee's Dependents, if any, 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.

- has no dependents of his/her own;

- is not covered under any other group or individual health benefits plan; group health plan; church plan; or health benefits plan; and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

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

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.

The Care Manager

In order to receive In-Network benefits, a Horizon BCBSNJ Care Manager must manage treatment for Mental or Nervous Disorders, Alcoholism and Substance Abuse. A Covered Person must contact the Care Manager when there is a need for these types of care. The phone number is shown on his/her ID card.

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.

YOUR PREFERRED PROVIDER ORGANIZATION (PPO) PROGRAM

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

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

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

BENEFIT PROVISIONS

The Deductible

Each Benefit Period, each Covered Person must have Covered Charges that exceed the Deductible before the Plan provides coverage for that person. The In-Network and Out-of-Network Deductible(s) are shown in the Schedule of Covered Services and Supplies. The Deductible cannot be met with Non-Covered Charges. Only Covered Charges Incurred by the Covered Person while covered by this Plan can be used to meet this Deductible.

Once the Deductible is met, the Plan provides benefits, up to its Allowance, for other Covered Charges above the Deductible Incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Benefit Period. But, all charges must be incurred while that Covered Person is covered by this Plan. Also, what coverage the Plan provides is based on all the terms of this Plan.

Family Aggregate Deductible

The total Deductible for a family in any one Benefit Period will not be more than **$1,500**_for In-Network Services and **$3,000** for Out-of-Network Services. This family Deductible can be met by any combination of Covered Charges Incurred by some of all of the covered family members, except that no individual can contribute more than the individual Deductible amount. If a covered family member meets the individual Deductible, the Plan will cover that person's additional Covered Charges Incurred during that Benefit Period even if the Deductible for the entire family has not been met.

Out-of-Pocket Maximum

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

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

Payment Limits

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

Benefits From Other Plans

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

SUMMARY OF COVERED SERVICES AND SUPPLIES

This section lists the types of 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

Acupuncture

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

Alcoholism

This Plan covers the treatment of Alcoholism if the treatment is prescribed by a Practitioner.

Inpatient or Outpatient treatment may be furnished as follows:

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

b. At a Detoxification Facility; or

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

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

Allergy Testing and Treatment

This Plan covers allergy testing and treatment, including routine allergy injections.

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 in full. 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.

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.

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. The Copayment is waived if admitted. This benefit is applicable to the facility charges of an Emergency Room. Charges for other providers that bill separately from the facility (such as emergency room physicians, lab, radiology, etc.) are paid in accordance with the plan provisions applicable to those services.

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 Admission Deductible as shown in the Schedule of Covered Services and Supplies.

Hearing Exams

This Program 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 Viatical Nurse (L.V.N.);

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

3. medical care rendered by a Hospice Care 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; and

14. Inpatient room, board and general nursing services.

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.

Respite care benefits are limited to a maximum of seven days per Covered Person per Benefit Period.

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

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

Inpatient Physician Services

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

Mastectomy Benefits

This Plan covers a Hospital stay of at least 72 hours following a modified radical mastectomy and a Hospital stay of at least 48 hours following a simple mastectomy. A shorter length of stay may be covered if the patient, in consultation with her physician, determines that it is Medically Necessary and Appropriate. The patient's Provider does not need to obtain Prior Authorization for prescribing 72 or 48 hours, as appropriate, of Inpatient care. But, any rule of this Plan that that the patient or her Provider notifies 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

This Plan covers charges relating to a Medical Emergency. This includes diagnostic X-ray and lab charges Incurred due to the Medical Emergency.

Benefits include coverage of trauma at any designated level I or II trauma center, as Medically Necessary and Appropriate. The coverage continues at least until, in the judgment of the attending physician, the Covered Person: (a) is medically stable; (b) no longer requires critical care; and (c) can be safely transferred to another Facility, if needed. The Plan will also cover a medical screening exam that is: (a) rendered upon a Covered Person's arrival at a Hospital; (b) required under federal law to be performed by the Hospital; and (c) needed to determine whether a Medical Emergency situation exists.

In the event of a potentially life-threatening condition, the Covered Person should use the 911 emergency response system. Further 911 information is available on the Identification Card.

Mental or Nervous Disorders (including Group Therapy) and Substance Abuse

The Plan covers treatment for Mental or Nervous Disorders and Substance Abuse.

When the Care Manager: manages; assesses; coordinates; directs; and authorizes a Covered Person's Inpatient treatment for a Mental or Nervous Disorder or Substance Abuse, coverage for that treatment will be provided at the In-Network level of benefits, unless, as part of this process, the Covered Person elects treatment from an Out-of-Network Provider. Coverage will always be provided at a reduced level if the Care Manager does not: manage; assess; coordinate; direct; and authorize a Covered Person's Inpatient treatment for a Mental or Nervous Disorder or Substance Abuse before expenses are Incurred. No benefits are payable with respect to any treatment that is not Medically Necessary and Appropriate.

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

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

Nutritional Counseling

This Plan covers charges for nutritional counseling for the management of a medical condition that has a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner.

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 or Nervous Disorder or Substance Abuse. 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:

a. **Gynecological Examinations**

This Plan covers routine gynecological examinations including Pap smears.

b. **Mammography**

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

The Plan will cover charges for:

(a) A mammogram exam at such age and intervals as deemed Medically Necessary and

Appropriate by the female Covered Person's Practitioner if she is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors.

(b) One baseline mammogram exam for female Covered Persons who are 40 years of age.

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

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

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

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

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

c. **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**.**

d. **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 Domestic Partner or Civil Union Partner, and Child Dependents over the age of 18.

e. **Well Child Immunizations and Lead Poisoning Screening and Treatment**

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

(i) childhood immunizations must be as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health..

(ii) screening by blood lead measurement for lead poisoning for children, including

confirmatory blood lead testing, must be as specified by the Department of Health. Medical evaluation and any necessary follow-up and treatment for lead-poisoned children are also covered**.**

f. **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.

g. **Well Child Care**

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

h. **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 administratively updated.

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.

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 lymphodemas.

Also, see "Transplant Benefits".

Therapeutic Manipulation

This Plan provides benefits for Therapeutic Manipulations.

Therapy Services

This Plan covers all Therapy Services.

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. Chondrocycte (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-myeloblative 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.

Donor charges and donor searches are not covered.

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.

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 does not cover:

a. replacements or repairs; 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.

Foot Orthotics

This Plan covers Foot Orthotics that are: (a) needed after bone Surgery of the foot, to maintain post-surgical bone alignment; and (b) furnished within six months after the Surgery**.**

Home Infusion Therapy

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

a. Solutions and pharmaceutical additives.

b. Pharmacy compounding and dispensing services.

c. Ancillary medical supplies.

d. Nursing services associated with: (a) patient and/or alternative caregiver training; (b) Visits needed to monitor intravenous therapy regimen; (c) Medical Emergency care (but not for

administration of home infusion therapy).

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

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

Oxygen and Its Administration

This Plan covers oxygen and its administration.

Private Duty Nursing Care

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

a. The care must be ordered by a physician.

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

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

Prosthetic Devices

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

Vision Care

This Plan covers Eye Examinations in connection with non-routine care. Vision Surveys, Optical Services, routine Eye Examinations exams and hardware are not covered. Discounts for routine vision services and hardware are available.

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

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)

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

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.

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 Abuse;

l. a Mental or Nervous Disorder; or

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

Alternate Treatment/Individual Case Management Plan

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

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

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

    2. the Covered Person's attending Practitioner; and

    3. Horizon BCBSNJ or its designee.

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

    1. treatment plan objectives;

    2. a course of treatment to accomplish those objectives;

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

        (a) Horizon BCBSNJ;

        (b) the attending Practitioner;

        (c) the Covered Person;

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

4. the estimated cost of the plan and savings.

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

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

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

Exclusion

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

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.
- Cardiac Catheterization.
- Elective Inpatient Admissions.
- Gastric Bypass/Bariatric Procedures
- Home Health Care.
- Home IV Infusions.
- Hospice Care.
- Implantable Cardioverter/Defibrillators (ICD).
- Private Duty Nursing.
- Reconstructive Surgery.
- Sinus (Nasal) Surgery.
- Specialty Pharmaceuticals.
- Ultrasound Echo Stress and Echocardiography, including nuclear and gated studies.

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:

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.

Expenses Incurred for Day Programs.

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

Diversional/recreational therapy or activity.

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.

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.

Methadone maintenance.

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.

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

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

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

Psychological testing for educational purposes.

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

Rest or convalescent cures.

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

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

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

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

Services performed by any of these:

a. A Hospital resident, intern or other Practitioner who: is paid by a Facility or other source; and (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, or Domestic 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;

- 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.

Smoking cessation aids of all kinds and the services of stop-smoking providers, except as otherwise stated in this Booklet.

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.

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

Telephone consultations, except as Horizon BCBSNJ may request.

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

Transplants, except as otherwise stated in this Booklet.

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

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

Vitamins and dietary supplements.

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

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

Non-Duplication of Benefits

As with most group health care programs, this Plan contains a type of coordination of benefits provision called "non-duplication of benefits." This provision is used when you and your covered dependents (spouse or child) receive services, which are eligible for payment under more than one group health program. The main objective is to assure that your covered expenses will be paid, but that the combined payments do not amount to more than the amount this Plan would pay if it were the only program. Under this arrangement, the benefits of one program are reduced to the extent they are payable by another program.

Here is how the order of benefits works:

- When the other group coverage does not have a "coordination of benefits" provision then that coverage pays first.

- When the person who received care is covered as an employee under one group coverage, and as a dependent under another, then the employee coverage pays first.

- When a dependent child is covered under two group coverage and his parents are not separated or divorced, the coverage of the parent whose birthday (according to month and day) falls earlier in the year first; if both parents have the same birthday, the Plan covering the parent for the longer time pays first.

- If the dependent child's parents are separated or divorced, the following applies:

    1. The coverage of the parent with custody of the child pays first;

    2. Then, the coverage of the spouse (if any) of the parent with custody of the child pays; and

    3. Finally, the coverage of the parent without custody of the child pays.

    4. Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

- The Plan that covers a person as an active employee or his dependent will pay before the plan that covers such person as a laid off or retired employee or his dependent. If the other plan does not have a coordination of benefits provision concerning laid off or retired employees, then this rule does not apply.

- When none of the above circumstances applies, the coverage you have had for the longest time pays first.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment.

This Plan will provide its regular benefits in full when it is primarily liable (the program which pays first). When this Plan is secondary liable (pays second), it will provide a reduced amount. This reduced amount is determined as follows:

1. The benefits that would be payable for allowable expenses under this Plan (without considering other programs' benefits) are calculated;

2. The benefits payable under all other programs (for the same allowable expenses) are subtracted from (1); and

3. The difference, if any, is payable by this Plan.

In no event will this Plan's liability as a secondary program exceed its liability as a primary program**.**

BENEFITS PAYABLE FOR AUTOMOBILE RELATED INJURIES

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

Definitions

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

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

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

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

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

Application of this Provision

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

Determination of Primary or Secondary Coverage

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

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

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

Benefits This Plan Will Pay if it is Primary to PIP or OSAIC

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

Benefits This Plan Will Pay if it is Secondary to PIP

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

a. the Allowable Expenses left uncovered after PIP has provided coverage (minus this Plan's Deductibles, Copayments, and/or Coinsurance); or

b. the actual benefits that this Plan would have paid if it provided its coverage primary to PIP.

Medicare

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

SUBROGATION AND REIMBURSEMENT

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

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

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

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

3. By accepting benefits hereunder, the Covered Person hereby grants an automatic lien against and assigns to the Plan, in an amount equal to the benefits paid by the Plan, any recovery, whether by settlement, judgment, or other payment intended for, payable to, or received by the Covered Person, or on behalf of the Covered Person. The Covered Person hereby consents to said lien and/or assignment and agrees to take whatever steps are necessary to help the Plan secure said lien and/or assignment. The Covered Person agrees that said lien and/or assignment shall constitute a charge upon the proceeds of any recovery and the Plan shall be entitled to assert security interest thereon. By the acceptance of benefits under the Plan, the Covered Person and his or her representatives agree to hold the proceeds of any settlement, judgment and/or other payment in trust for the benefit of the Plan to the extent of 100% of all benefits paid on behalf of the Covered Person.

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

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

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

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

d. Any worker's compensation award or settlement.

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

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

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

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

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

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

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

THE EFFECT OF MEDICARE ON BENEFITS

IMPORTANT NOTICE

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

For the purpose of this section:

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

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

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

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

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

This section applies to a Covered Person who is:

a. The Employee or covered spouse;

b. eligible for Medicare by reason of age; and

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

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

This section does not apply to:

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

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

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

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

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

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

Medicare Eligibility by Reason of Disability

This part applies to a Covered Person who:

a. is under age 65;

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

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

This part does **not** apply to:

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

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

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

Medicare Eligibility by Reason of End Stage Renal Disease

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

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

a. eligible for Medicare by reason of age ; or

b. eligible for Medicare by reason of disability.

When (a) a Covered Person becomes eligible for Medicare solely on the basis of ESRD; and (b) Incurs a charge for the treatment of ESRD for which benefits are payable under both this Plan and Medicare, this

Plan is deemed the Primary Plan for a specified time, referred to as the "coordination period". This Plan pays first, ignoring Medicare. Medicare is the Secondary Plan. The coordination period is up to 30 consecutive months.

The coordination period starts on the earlier of:

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

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

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

Dual Medicare Eligibility

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

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

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

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

How To File A Claim If You Are Eligible For Medicare

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

New Jersey Providers:

- The Covered Person should give the Practitioner or other Provider his/her identification number. This number is shown on the Medicare Request for Payment (claim form) under "Other Health Insurance";
- The Provider will then submit the Medicare Request for Payment to the Medicare Part B carrier;
- After Medicare has taken action, the Covered Person will receive an Explanation of Benefits form from Medicare;

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

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

Out-of-State Providers:

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

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

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

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.

OUT-OF-AREA SERVICES

Horizon BCBSNJ has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. These are referred to generally as “Inter-Plan Programs.” When you obtain covered

services and supplies outside of Horizon BCBSNJ's service area, the claims for these services and supplies may be processed through one of these Inter-Plan Programs. These programs include the BlueCard Program, described below.

Typically, when you access medical care outside Horizon BCBSNJ's service area, you will obtain it from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other area ("Host Blue"). But in some cases, you may obtain care from non-participating providers. Horizon BCBSNJ's payment practices in both cases are generally described below.

A. BlueCard® Program

Under the BlueCard® Program, when you obtain covered services and supplies within the geographic area served by a Host Blue, Horizon BCBSNJ will still fulfill its contractual obligations. But the Host Blue is responsible for: (a) contracting with its providers; and (b) handling its interactions with those providers.

When you obtain covered services and supplies outside Horizon BCBSNJ's service area and the claim is processed through the BlueCard Program, the amount you pay, if not a flat copayment, is calculated based on the lower of:

- The billed covered charges for the covered services or supplies; or
- The negotiated price that the Host Blue makes available to Horizon BCBSNJ.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the provider. Sometimes it is an estimated price that takes into account a special arrangement with that provider or provider group. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of providers. Estimated and average pricing arrangements may also involve: types of settlements; incentive payments; and/or other credits or charges.

Estimated and average pricing arrangements also take into account certain adjustments to their basic rates. These may be made to correct for an over- or underestimation of changes of the past pricing for the types of transactions noted above. But, such adjustments will not affect the price on the claim that will be used to determine the amount you pay.

Also, laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If any state law mandates other liability calculation methods, including a surcharge, a covered person's liability for any covered service or supply will be calculated according to applicable law.

B. Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program described above, a covered person's claims for covered services and supplies may be processed through a negotiated national account

arrangement with one or more Host Blues.

If Horizon BCBSNJ has arranged with one or more Host Blues to provide customized networks with respect to the Plan, then the terms of any such arrangement shall apply.

The amount you pay for covered services and supplies under such an arrangement will be calculated based on the lower of either: (a) billed covered charges; or (b) the price that Horizon BCBSNJ has negotiated with the Host Blue under that arrangement. (Please refer to the description of negotiated price under section A. BlueCard Program.)

Determinations of Covered Healthcare Services

If it is determined that healthcare services are covered under the Plan, coverage of those services cannot be denied based on the Host Blue's network protocols. Also, under the BlueCard Program, you cannot be denied coverage of healthcare services received outside of the geographic area served by Horizon BCBSNJ if those services: (a) are covered by the network protocols of the Host Blue; and (b) are not specifically limited or excluded by the Plan.

Summary

To summarize the above, the BlueCard Program is basically a means by which you can benefit from the discounts that another Blue Cross and Blue Shield Association Licensee has negotiated with providers in its area of operation when you obtain covered services and supplies outside of Horizon BCBSNJ's service area. The Program in no way affects the terms of the Plan with respect to your contractual liability for charges incurred for a covered service or supply. The calculation of that liability will be based on the lower of: (a) the billed charge for the covered service or supply received in the other Licensee's area; or (b) a negotiated price that the Host Blue makes available to Horizon BCBSNJ. The calculation of your liability can also be affected by regulatory requirements of the state in which you obtain the covered service or supply.

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: **BAYADA Home Health Care, Inc. Health & Welfare Plan**

Plan Sponsor: **BAYADA Home Health Care, Inc.**
101 Executive Drive,
Moorestown, NJ 08057

Plan Administrator: **BAYADA Home Health Care, Inc.**
101 Executive Drive,
Moorestown, NJ 08057

Employer Identification Number: 23-1943113

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.

Claims Administrator: Horizon Blue Cross Blue Shield of New Jersey, Inc.

Agent for Service of Legal Process: Plan Administrator

The Plan Year begins on July 1 and ends on June 30.

Plan Administrator Authority and Powers:

The Plan Administrator shall have exclusive discretionary authority and power to determine eligibility for benefits and to construe the terms and provisions of this Plan, to determine questions of fact and law arising under this Plan, and to exercise all of the powers necessary for the operation of this Plan.

Plan Modification and Termination Information

Not withstanding anything to the contrary in this Summary Plan Description, the Plan Sponsor/Administrator expressly reserves the right, at any time, for any reason and without limitation to terminate, modify or otherwise amend this Plan and any or all of the benefits provided thereunder, either in whole or in part, whether to all persons covered thereby or one or more groups thereof. These rights include specifically, but are not limited to, (1) the right to terminate benefits under the Plan with respect to any participant therein; (2) the right to modify benefits under this Plan to all or any group of participants therein; (3) the right to require or increase contributions by any participants therein towards the cost of this Plan; and (4) the right to amend this Plan or any term or condition thereof; in each case, whether or not such rights are exercised with respect to any other participant or group of participants in this plan.

Not a Contract of Employment

No provision of the Plan described in this Booklet is to be considered a contract of employment. The Employer's rights with respect to disciplinary actions and termination of Employees are in no way changed by the provisions of the Plan.

If you have any questions about the Plan, contact the Plan Administrator.

STATEMENT OF ERISA RIGHTS

As a participant in **BAYADA Home Health Care Inc. Health & Welfare** 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 fights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

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

SERVICE CENTERS

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

Telephone personnel are available:

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

Thursday from 9:00 a.m. to 8:00pm (E.T.) Eastern Time

For questions and assistance with your Blue Card PPO benefits and services, please call at:

1-800-355-BLUE

(2583)

When you are outside of New Jersey and need to locate a **nationwide Network PPO Provider,** please call:

1-800-810-BLUE

(2583)

For Mental Health and Substance Abuse, please call:

1-800-626-2212

For Pre-Admission Review and **Individual Case Management**, please call:

1-800-664-BLUE

(2583)