Product:	**COMPREHENSIVE HEALTH PLAN**
Company Name:	**BAYADA Home Health Care, Inc.**
Group Number:	**76021 –HDHP**
	Effective Date 7/1/15

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Introduction

Your Comprehensive Health Plan benefit program gives you broad protection to help meet the costs of Illnesses and Accidental Injuries.

In this booklet you'll find the important features of your group's BlueCard Comprehensive Health Plan 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.

Accidental Injury: Medical care for the treatment of traumatic bodily injuries resulting from an accident

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

Active: 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 (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.

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 Cancer Clinical Trial: A scientific study of a new therapy or intervention for the treatment, palliation or prevention of cancer in human beings, as defined by the New Jersey Cancer Clinical Trials Work Group**.**

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 June 30th**. The first and/or last Benefit Period may be less than a Calendar Year. The first Benefit Period begins on the Employee's Coverage Date. The last Benefit Period ends when the Employee is no longer covered.

Birthing 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. **Booklet:** A detailed summary of benefits covered.

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.

Calendar Year: A year starting January 1.

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, Domestic Partner, or Civil Union Partner regardless of where or with whom the child lives;

- A child who is: (a) legally adopted by you, your Spouse, Domestic Partner, or Civil Union 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, Domestic Partner's, or Civil Union 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.. For example, if the Plan's Coinsurance for an item of expense is **70%**, then the Covered Person's Coinsurance for that item is **30%**. 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.

Creditable Coverage: With respect to a person, prior coverage of the person under any of the following: a group health plan; a group or individual heath benefits plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of said Title XIX (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a public health plan, as defined by federal regulation; or a health benefits plan under section 5(e) of the "Peace Corps Act".

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

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 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 not considered to be Durable Medical Equipment are: adjustments made to vehicles; furniture; scooters; all terrain vehicles (ATVs); non-hospital-type beds; air conditioners; air purifiers; humidifiers; dehumidifiers; elevators; ramps; stair glides; emergency alert equipment; handrails; heat appliances; improvements made to the home or place of business; waterbeds; whirlpool baths; and exercise and massage equipment.

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

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

Employer: Collectively, all employers included under the Plan.

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

Essential Health Benefits: This has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act, and as further defined by the Secretary of the U.S. Department of Health and Human Services. The term includes: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); **Prescription Drugs;** 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 (in the case of a Prescription Drug, for at least six months); 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.

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.

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

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.

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.

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 related to behavior problems or learning disabilities,

(3) Conditions that the Plan determines to be due to developmental disorders. These include, but are not limited to: mental retardation; academic skills disorders; or motor skills disorders. But, this does not apply:

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

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-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, and 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: BAYADA Home Health Care Inc. Health & Welfare Plan.

Plan Year: A year starting July 1.

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.

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

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.

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.

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 Accidental 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.

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

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

Urgent Care Claim - An Urgent Care Claim is any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations -

- Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claims.

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

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

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

We, Us and Our: The Plan.

You, Your: An Employee.

Schedule of Covered Services and Supplies

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

NOTE: OUR BENEFITS WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION MANAGEMENT PROVISIONS CONTAINED IN THIS BOOKLET.

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

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

Coinsurance	**70%** of Covered Charges.
Out-of-Pocket Maximum	After **$6,350**/Covered Person, **$12,700**/family, We provide **100%** of Covered Allowance – must be satisfied by 2 or more Covered Persons.

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

- Non-Covered Charges

Deductible

Applies to Facility, Professional	**$1,500**/Covered Person. And Supplemental Services **$3,000**/family. Note: May be aggregately satisfied by **2** or more separate Covered Persons.

Medicare Alternate Deductible – For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been covered as such by Medicare.

After a specific coordination period ends, with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been covered as such by Medicare.

Benefit Period Maximum	**Unlimited.** Applies to all Covered Services and Supplies.

Per Lifetime Maximums	**Unlimited.** Applies to all Covered Services and Supplies.

A. ELIGIBLE BASIC SERVICES AND SUPPLIES

Accidental Injury	Subject to Deductible and **70%** Coinsurance.
Acupuncture	Subject to Deductible and **70%** Coinsurance**.**
Alcoholism	Subject to Deductible and **70%** Coinsurance.
Allergy testing and treatment	Subject to Deductible and **70%** Coinsurance.
Ambulatory Surgery	Subject to Deductible and **70%** Coinsurance.
Audiology Services	Subject to Deductible and **70%** Coinsurance.
Anesthesia	Subject to Deductible and **70%** Coinsurance.
Dental Care and Treatment	Subject to Deductible and **70%** Coinsurance.
Diagnostic X-ray and Laboratory	Subject to Deductible and **70%** Coinsurance.
Dialysis Center Charges	Subject to Deductible and **70%** Coinsurance.
Emergency Room	Subject to Deductible and **70%** Coinsurance.
Facility Charges	365 days Inpatient Hospital care. Subject to Deductible and **70%** Coinsurance.
Hearing Exams	Subject to Deductible and **70%** Coinsurance.

Home Health Agency Care	Subject to Prior Authorization, Deductible and **70%** Coinsurance.
Hospice Care	Subject to Prior Authorization (for inpatient), Deductible and **70%** Coinsurance
Inpatient Physician Services	Subject to Deductible and **70%** Coinsurance.
Maternity/Obstetrical Care	Subject to Deductible and **70%** Coinsurance.
Mental or Nervous Disorders or Substance Abuse	Subject to Deductible and **70%** Coinsurance.
Nutritional Counseling	Subject to **100%** Coinsurance.

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

PREVENTIVE CARE

a.	**Colonoscopy**	Subject to **100%** Coinsurance.
b.	**Gynecological Examinations**	Subject to **100%** Coinsurance.
c.	**Mammography**	Subject to **100%** Coinsurance.
d.	**PAP Smears**	Subject to **100%** Coinsurance.
e.	**Routine Prostate Cancer Screening**	Subject to **100%** Coinsurance.
f.	**Routine Adult Physicals**	Subject to **100%** Coinsurance.
g.	**Well-Child Immunizations**	Subject to **100%** Coinsurance.
h.	**Well-Child Care**	Subject to **100%** Coinsurance.
i.	**Routine Hearing Exam**	Subject to **100%** Coinsurance.

Physical Rehabilitation		
Inpatient		Subject to Deductible and **70%** Coinsurance.
Practitioner's Charges for Non-Surgical Care and Treatment		Subject to Deductible and **70%** Coinsurance.
Practitioner's Charges for Surgery		Subject to Deductible and **70%** Coinsurance.
Preadmission Testing		Subject to Deductible and **70%** Coinsurance.
Second Opinion Charges		Subject to Deductible and **70%** Coinsurance.
Skilled Nursing Facility Charges		Subject to Deductible and **70%** Coinsurance.
Therapeutic Manipulations		Subject to Deductible and **70%** Coinsurance.
Therapy Services		
a.	**Cardiac Rehabilitation**	Subject to Deductible and **70%** Coinsurance. Subject to a maximum limit of **36** visits per Benefit Period.
b.	**Chelation Therapy**	Subject to Deductible and **70%** Coinsurance.
c.	**Chemotherapy**	Subject to Deductible and **70%** Coinsurance.
d.	**Cognitive Rehabilitation Therapy**	Subject to Deductible and **70%** Coinsurance.
e.	**Dialysis Treatment**	Subject to Deductible and **70%** Coinsurance.
f.	**Infusion Therapy**	Subject to Deductible and **70%** Coinsurance.
g.	**Occupational Therapy**	Subject to Deductible and **70%** Coinsurance.
h.	**Physical Therapy**	Subject to Deductible and **70%** Coinsurance.
	Pulmonary Rehabilitation	Subject to Deductible and **70%** Coinsurance. Subject to a maximum limit of **36** visits per Benefit Period.
i.	**Radiation Therapy**	Subject to Deductible and **70%** Coinsurance.
j.	**Respiration Therapy**	Subject to Deductible and **70%** Coinsurance.

j. Speech Therapy	Subject to Deductible and **70%** Coinsurance.
Transplant Benefits	Subject to Deductible and **70%** Coinsurance.

B. ELIGIBLE SUPPLEMENTAL SERVICES AND SUPPLIES

Ambulance Services	Subject to Deductible and **70%** Coinsurance**.**
Blood	Subject to Deductible and **70%** Coinsurance.
Durable Medical Equipment	Subject to Deductible and **70%** Coinsurance.
Foot Orthotics	Subject to Deductible and **70%** Coinsurance.
Oxygen and Administration	Subject to Deductible and **70%** Coinsurance.
Private Duty Nursing	Subject to Deductible and **70%** Coinsurance.
Vision Care (Non-Routine Only)	Subject to Deductible, and **70%** Coinsurance. Vision Hardware is not covered.
Wigs Benefit	Subject to Deductible and **70%** Coinsurance.

Subject to a **$500.00** Benefit Period Maximum. Wigs are eligible only for chemotherapy patients and 3rd degree burn victims.

General Information

How To Enroll

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

When Your Coverage Begins

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

Your Identification Card

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

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

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

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:

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

- If you have Employee only 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 Union Partner or meet the rules for covering Domestic Partners if you apply for Family coverage within 31 days.

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

Enrollment of Dependents

Horizon BCBSNJ cannot deny coverage for your child dependents on the grounds that:

- The child dependent was born out of wedlock;
- The child dependent is not claimed as a dependent on your federal tax return; or
- The child dependent does not reside with you or in Horizon BCBSNJ's Service Area.

If you are the non-custodial parent of a child dependent, Horizon BCBSNJ will:

- Provide such information to the custodial parent as may be necessary for the child dependent to obtain benefits through this program;
- Permit the custodial parent, or the health care provider with the authorization of the custodial parent, to submit claims for covered services without your approval; and
- Make payments on claims submitted as specified above directly to the custodial parent, the health care provider, or the Division of Medical Assistance and Health Services in the Department of Human Services which administers the State Medicaid program, as appropriate.

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

- Permit you to enroll your child as a child dependent, without any enrollment season restrictions:
- Permit the child's other parent or the Division of Medical Assistance and Health Services as the State Medicaid agency or the Division of Family Development as the State IV-D agency, in the Department of Human Services, to enroll the child dependent under your group's policy if the parent who is the subscriber fails to enroll the child dependent; and
- Not terminate coverage of the child dependent unless the parent who is the subscriber provides Horizon BCBSNJ with satisfactory written evidence that:
    - the court or administrative order is no longer in effect: or
    - the child dependent is or will be enrolled in a comparable health benefits plan whose coverage will be effective on the date of the termination of coverage.

Special Enrollment Periods

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

Individual Losing Other Coverage

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

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

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

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

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

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

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

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

New Dependents

If the following conditions are met, 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 laterof: (a) the date dependent coverage is made available pursuant to this section; or (b) the date of the marriage, birth, or adoption/placement.

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

Special Enrollment Due to Marriage

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

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

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

Special Enrollment Due to Newborn/Adopted Children

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

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

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

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

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

Multiple Employment

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

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 for a Child Dependent ends the last day of the month in which the Child Dependent reaches age 26.

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 day, as determined by the Plan, on 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, an act or omission by a Covered Person which, as determined by the Plan. shows intent to defraud the Plan (such as: (a) the intentional and/or repeated misuse of the Plan's services; or (b) the omission or misrepresentation of a material fact on a Covered Person's application for enrollment, health statement or similar document) will result in the immediate cessation of the Covered Person's coverage under this Plan. Such an act includes, but is not limited to:

- The submission of any claim and/or statement with materially false information.
- Any information which conceals for the purpose of misleading.
- Any act which could constitute a fraudulent insurance act.

Any termination for fraud will be retroactive to the Coverage Date. The Plan retains the right to recoup from any involved person all payments made and/or benefits paid on his/her behalf.

Also, coverage under this Plan will end for any Covered Person who misuses an ID card.

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

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

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

- Your death;
- Your work hours are reduced;
- Your employment ends for reason other than gross misconduct
- You became entitled to Medicare benefits;
- In the case of your Spouse, the Spouse ceased to be eligible due to divorce or legal separation; or
- In the case of a Child Dependent, he/she ceased to be a Child Dependent under this Plan's rules.
- (See "If You Leave Your Group Due To Total Disability" above for your continuation rights if your employment ends due to total disability.)

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

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

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

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

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

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

- This Plan ends for the class you belong to.

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

- The person becomes covered under any other group health plan. But, coverage will not end due to this rule until the end of any period for which pre-existing conditions are excluded, or 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.The above is a general description of COBRA's requirements. If coverage for you or a Dependent ends for any reason, you should immediately contact your benefits representative to find out if coverage can be continued. Your Employer is responsible for providing all notices required under COBRA.

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

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

- The end of the 24-month period starting on the date the Employee was first absent from

work due to the service.

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

- The date on which this Plan ends.

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

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

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

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

Uniformed services: The following:

1. The Armed Services.

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

3. The commissioned corps of the Public Health Service.

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

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

1. Active duty.

2. Active and inactive duty for training.

3. National Guard duty under federal statute.

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

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

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

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 Comprehensive Health Plan

The Comprehensive Health Plan program provides you with broad protection for your health care needs. It combines hospital, medical-surgical and major medical coverage in a single program, with the advantage of having a large statewide network of Network providers who will accept our applicable allowance (the lesser of the provider's charge or a dollar amount set by us), with any applicable deductible or coinsurance you may owe, as payment in full. This program provides you with the freedom to choose any provider. However, your choice of providers will determine how your benefits are paid. Out-of-Network providers may not accept our applicable allowance as payment in full. They may balance bill you for the difference between our applicable allowance and their actual charges. Therefore, when you receive eligible services from a Out-of-Network provider, you may be responsible for not only the deductible and coinsurance but also the balance bill amount. To receive the highest level of benefits, it is recommended that you utilize the services of Network providers whenever possible.

How The Program Works

Benefit Period

The benefit period is from **July1, 2014 to June 30, 2015** and then from July 1 to June 30th each year while the coverage remains in effect.

Deductible

The deductible amount that must be paid by a Covered Person before he or she will be eligible for benefits is **$1,500**.

Family Aggregate Deductible

The total deductible for a family in any one Benefit Period will not be more than **$3,000.** This family deductible can be satisfied by any combination of expenses from either all, some or just one of the family members. No benefits will be paid for any family member until the Family Aggregate Deductible has been met.

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

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.

Summary of Covered Services and Supplies

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

A. ELIGIBLE BASIC SERVICES AND SUPPLIES

Accidental Injury

This program covers charges relating to a Medical Emergency, including diagnostic x-ray and laboratory charges as outlined in the Schedule of Covered Services and Supplies.

Acupuncture

Acupuncture services are eligible when the Acupuncture is performed for anesthetic and or therapeutic purposes by a Practitioner**.**

Alcoholism

This program covers the treatment of Alcoholism the same way it would any other Illness, if such 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 licensed pursuant to Section 8 of P. L. 1975, C. 305 (N.J.S.A. 26:2B-14); or

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

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

Allergy Testing and Treatment

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

Ambulatory Surgery

This program covers charges for 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 program 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

If you are eligible for maternity coverage, services including pre-natal, delivery and post-natal care, will be covered in full as long as delivery takes place. If complications occur during labor, delivery may take place in a Hospital because of the need for emergency and/or inpatient care. Delivery must occur within 24 hours of the transfer from the birthing center.

If the patient is transferred to a Hospital maternity program while receiving pre-natal care, any expenses for pre-natal care incurred at the center will be the responsibility of the patient. If, for any reason, the pregnancy does not go to term, we will not provide payment to the birthing center.

Dental Care and Treatment

This program covers:

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

b. the surgical removal of bony impacted teeth; and

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

This Program also covers treatment of an Accidental Injury to natural teeth or the jaw is covered, but only if:

a. the Accidental Injury occurs while the Covered Person is covered under your group's policy

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

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

Diagnostic X-rays and Laboratory Tests

This program covers charges for diagnostic x-rays and laboratory tests.

Domestic Violence

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

Emergency Room

This program covers services provided by a Hospital emergency room.

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 Inpatient Copayment as shown in the Schedule of Covered Services and Supplies.

Hearing Exams

This Plan covers routine hearing exams/evaluations. Hearing aids are not covered.

Home Health Agency Care

Home Health Agency care services and supplies are covered only if furnished by Providers on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.

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

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

Your group's policy does not cover:

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

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

Hospice Care

a. Hospice Care benefits will be provided for:

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

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

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

    4. Therapy Services;

    5. Diagnostic Services;

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

    7. Prescription Drugs;

    8. oxygen and its administration;

    9. medical social services;

10. respite care;

11. psychological support services to the Terminally Ill or Injured patient;

12. family counseling related to the patient's terminal condition;

13. dietitian services; and

14. Inpatient room, board and general nursing services.

b. No Hospice Care benefits will be provided for:

1. medical care rendered by the patient's private Practitioner;

2. volunteer services or services provided by others without charge;

3. pastoral services;

4. homemaker services;

5. food or home-delivered meals;

6. Private-Duty Nursing services;

7. dialysis treatment;

8. treatment not included in the Hospice care plan;

9. services and supplies provided by volunteers or others who do not regularly charge for their services;

10. funeral services and arrangements;

11. legal or financial counseling or services; or

12. bereavement counseling.

Respite care benefits are limited to a maximum of 10 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

Services provided to a Covered Person who is a registered inpatient in a Facility.

Mastectomy Benefits

The program 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, unless the patient in consultation with his physician, determines that a shorter length of stay is medially appropriate. While there is no requirement that the patient's provider obtain preapproval from Horizon BCBSNJ for prescribing 72 or 48 hours, as appropriate, of inpatient care, any notification requirements under your group's policy remain in force.

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

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

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

Maternity/Obstetrical Care

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

Services and supplies provided by a Hospital to a newborn Child during the initial Covered Hospital stay of the mother and Child are covered as part of the obstetrical care benefits. However, 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.

This program also covers Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post-partum care in connection with a Covered Person's pregnancy.

Maternity Care for Child Dependents

This Policy covers Obstetrical Benefits for a Child Dependent. A female Child Dependent is covered under the Policy for any services incident to or resulting from her pregnancy. However, this Policy does not provide coverage to a child of a Child Dependent**.**

Medical Emergency

This program covers charges relating to a Medical Emergency, including diagnostic x-ray and laboratory charges as outlined in the Schedule of Covered Services and Supplies.

Coverage for Emergency and Urgent Care includes coverage of trauma at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgment of the attending physician, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another facility. Horizon BCBSNJ shall provide coverage for a medical screening examination provided upon a Covered Person's arrival in a Hospital, as required to be performed by the hospital in accordance with federal law, but only as necessary to determine whether an Emergency Medical Condition exists.

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

Mental or Nervous Disorders and Substance Abuse

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

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

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

Nutritional Counseling

This Plan covers charges for nutritional counseling for the management of morbid obesity only. The nutritional counseling must be prescribed by a Practitioner. Gastric bypass surgery is eligible when medically necessary and paid at the surgery coinsurance level.

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

b. Mammography

This Plan covers charges made for mammograms provided to a female Covered Person regardless of age.

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 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 the you and your Spouse or Domestic Partner or Civil Union Partner, and Child Dependents over the age of 18.

e. Well Child Immunizations

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

f. Colorectal Cancer Screening

This Plan covers colorectal cancer screening rendered at regular intervals for 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 18th birthday.

h. Additional Preventive Services

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

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

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

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

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

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

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 doesnot apply if the Admission or Surgery is deferred solely due to a change in the Covered Person's health.

Reconstructive Breast Surgery

This program will provide benefits, following a mastectomy on one or both breasts, for reconstructive breast surgery as follows:

- surgery to restore and achieve symmetry between the two breasts
- cost of breast prosthesis
- outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer.

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

Second Opinion Charges

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

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

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

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

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

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

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

Skilled Nursing Facility Charges

This program covers bed and board, including diets, drugs, medicines and dressings and general nursing service in a Skilled Nursing Facility. The Covered Person must be admitted to the Skilled Nursing Facility within 14 days of discharge from a Hospital, following an inpatient stay of at least 3 days, for continuing medical care and treatment prescribed by a Practitioner. Benefits are available for 120 days of care during any one Benefit Period.

Speech-Language Pathology Services

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

Surgical Services

This program covers surgical procedures subject to the following:

a. Horizon BCBSNJ will not make separate payment for pre- and post operative services.

b. If more than one surgical procedure is performed during the same operation through only one route of access, Horizon BCBSNJ will cover the primary procedure only. There will be no payment for any other procedures performed at the same time.

c. If more than one surgical procedure is performed during the same operation through more than one route of access, Horizon BCBSNJ's will cover the primary procedure, plus 50% of what Horizon BCBSNJ would have paid for each of the other procedures had those procedures been performed alone.

d. Surgical procedures include, but are not limited to, those following a mastectomy on one breast or both breasts, reconstructive breast Surgery and surgery to achieve symmetry between the two breasts.

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

Therapeutic Manipulation

This program covers charges for Therapeutic Manipulations.

Therapy Services

This program covers charges for all Therapy Services.

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

Transplant Benefits

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

a. Cornea

b. Kidney

c. Lung

d. Liver

e. Heart

f. Pancreas

g. Allogeneic bone marrow

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

i. Heart-valve

j. Heart-lung

Benefits include surgical, storage and transportation services which are directly related to the donation of the organ and billed for by the hospital. THE FACILITY WHERE YOU ARE BEING ADMITTED MUST PRE-NOTIFY US OF ANY TRANSPLANT PROCEDURE.

Urgent Care

Coverage is provided for Urgent Care.

Ambulance Services

This program covers charges for transporting a Covered Person to:

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

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

c. another inpatient Facility when Medically Necessary and Appropriate.

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

Blood

Blood, blood products, blood transfusions and the cost of testing and processing blood are covered. This program does not pay for blood which has been donated or replaced on behalf of the Covered Person.

Blood transfusions including the cost of blood, blood plasma and blood plasma expanders are covered from the first pint and only to the extent that the first pint and any additional pints to follow are not donated or replaced without charge through a blood bank or otherwise.

This program covers expenses Incurred in connection with the treatment of routine bleeding episodes associated with hemophilia for 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 when the home treatment program is under the supervision of a State approved hemophilia treatment center. Participation in a home treatment program shall not preclude further or additional treatment or care at any eligible Facility if the number of home treatments, in accordance with a ratio of home treatments to Benefit Days established by regulation by the Commissioner of Insurance, does not exceed the total number of Benefit Days provided for any other Illness under this program. As used in the paragraph, "blood product" includes but is not limited to Factor VIII, Factor IX and cryopreciptate; and "blood infusion equipment" includes but is not limited to syringes and needles.

Durable Medical Equipment

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

a. replacements or repairs; or

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

Oxygen and its Administration

This program covers oxygen and its administration.

Private Duty Nursing Care

This program covers charges by a Nurse for Private Duty Nursing care by a Nurse when ordered by a physician.

Services are available to a Covered Person in the Covered Person's home if the services provided require the skills of a Nurse. No benefits will be provided for the services of a Nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person immediate family.

Wigs Benefit

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

Utilization Management

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

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

This Plan has Utilization Management features under which Horizon BCBSNJ or its designee reviews Hospital Admissions and listed procedures. These features must be complied with if you:

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

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

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

d. plan to seek treatment for Mental or Nervous Disorders Biologically–based Mental Illness and Non–Biologically–based Mental Illness or Substance Abuse or Alcoholism.

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

With respect to Covered Charges Incurred in connection with Mental or Nervous Disorders Substance Abuse or Alcoholism, all notices required to be given in accordance with this Utilization Management section must be given to the Care Manager.

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

REQUIRED HOSPITAL STAY REVIEW

Notice of Hospital Admission Required

If you plan to use a Hospital in our Horizon Hospital Network, the Hospital will make all necessary arrangements for Pre Admission Review. If you plan to use a Out-of-Network Hospital, you must notify Horizon BCBSNJ of the Hospital Admission. The time and manner in which the notice must be given is described below. When you or your Provider do not comply with the requirements of this section, Horizon BCBSNJ reduces coverage for those 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 the Network Hospital or his Practitioner must notify Horizon BCBSNJ and request a PAR by phone. Horizon BCBSNJ must receive the notice and request at least 5 business days or as soon as reasonably possible before the Admission is scheduled to occur. For a maternity Admission, such notice must be given to Horizon BCBSNJ at least 60 days before the expected date of delivery, or as soon as reasonably possible.

a. When Horizon BCBSNJ receives the notice and request, We determine:

   1. the Medical Necessity and Appropriateness of the Hospital Admission;

   2. the anticipated length of stay; and

   3. the appropriateness of health care alternatives, like Home Health Agency care or other Outpatient or Out-of-Hospital care.

Horizon BCBSNJ notifies the Covered Person or his Provider, by phone, of the outcome of Our review. If a review results in a denial, Horizon BCBSNJ will confirm 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. 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

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

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

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

a. the Medical Necessity and Appropriateness of Admission;

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

c. the appropriateness of health care alternatives.

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

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

Penalties for Non-Compliance

a. As a penalty for non-compliance with the Required Hospital Stay Review features in this program, Horizon BCBSNJ reduces what it otherwise pays for Covered Services and Supplies by **20% up to a maximum of $1,000** if:

1. you or your Provider do not request a PAR;
2. you or your Provider do not request a PAR within 5 business days (60 days for a maternity Admission) or as soon as reasonably possible before the Admission is scheduled to occur;
3. Horizon BCBSNJ authorization becomes invalid and you or your Provider do not obtain a new one;

4. you or your Provider, do not request a continued stay review when necessary;
5. you or your Provider do not receive an authorization for such continued stay;
6. you do not otherwise comply with all the terms of your group's policy.

b. Penalties cannot be used to meet this program's:

1. Deductible

2. Coinsurance Cap/Charge Limits

3. Copayment(s)

4. Benefit maximums.

ALTERNATE TREATMENT FEATURES/INDIVIDUAL CASE MANAGEMENT

Definitions

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

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

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

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

a. head injury requiring an inpatient stay;

b. spinal cord injury;

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

d. multiple injuries due to an accident;

e. premature birth;

f. CVA or stroke;

g. congenital defect which severely impairs a bodily function;

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

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

j. Acquired Immune Deficiency Syndrome (AIDS);

k. Substance Abuse;

l. Mental and Nervous Disorders and psychoneurotic disorders; or

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

Alternate Treatment/Individual Case Management Plan

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

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

    1. you, or your legal guardian if necessary;
    2. your attending Practitioner; and
    3. Horizon BCBSNJ or its designee.

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

    1. treatment plan objectives;
    2. course of treatment to accomplish the stated objectives;
    3. the responsibility of each of the following parties in implementing the plan:
        (a) Horizon BCBSNJ
        (b) attending Practitioner
        (c) you
        (d) your family, if any; and
    4. estimated cost and savings.

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

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

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

Exclusion

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

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

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 12 months after the date the services were Incurred.

b. Itemized bills must accompany each claim form. A separate claim form is needed for each claim filed. In general, the bills must contain enough data to identify: the patient; the Provider; the type of service and the charge for each service and the Provider's license number.

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

   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. This provision also describes how your and Horizon BCBSNJ's liability for claims may be determined under negotiated non-BlueCard Program national account arrangements.

Exclusions Under The Comprehensive Health Plan Program

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

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

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

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

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

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

Any charge to the extent it exceeds the Allowance.

Any therapy not included in the definition of Therapy Services.

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

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

Broken appointments.

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

Completion of claim forms.

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

Court ordered treatment which is not Medically Necessary.

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

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

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

Diversional/recreational therapy or activity.

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

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

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

Employment/career counseling.

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

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

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

Hearing aids or fitting of hearing aids.

Herbal medicine.

Home health care Visits [for care of Non-Biologically based Mental Illness, or] in connection with administration of dialysis.

Hospice services.

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

Hypnotism.

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

Illnesses, including conditions which are the result of disease or bodily infirmity, which are covered or could have been covered for benefits provided under workers' compensation,

employer's liability or similar law; or Illnesses or Injuries occurring while the individual is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit or intended for wage or profit.

Immunizations, except as otherwise specified in this booklet.

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

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

Maintenance therapy for:

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

Marriage, career or financial counseling; sex therapy.

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

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

Methadone maintenance.

Milieu Therapy:

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

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

Nutritional counseling and related services.

Pastoral counseling.

Personal comfort and convenience items.

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

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

Psychological testing for educational purposes.

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

Rest or convalescent cures.

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

Routine examinations or Health Wellness, including related diagnostic x-rays and laboratory tests, except as otherwise stated in this booklet; pre-marital or similar examinations or tests not required to diagnose or treat Illness, Accidental Injury, [Biologically–based Mental Illness and Non–Biologically–based Mental Illness or Substance Abuse]; screening, research studies, education or experimentation, mandatory consultations required by Hospital regulations, routine pre-operative consultations.

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

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

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

Services performed by any of the following:

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

b. Anyone who does not qualify as a physician.

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

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

Services or supplies:

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

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

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

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

- furnished by one of 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;

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

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

- not specifically covered under your group’s policy;

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

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

  a. of a non-service Medical Emergency;

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

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

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

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

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

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

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

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

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

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

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

- which are not Medically Necessary and Appropriate; or

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

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

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

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

Sterilization reversal.

Sunglasses even if by Prescription.

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.

Surrogate motherhood.

Telephone consultations, except as Horizon BCBSNJ may request.

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

Transplants, except as otherwise stated in this booklet.

Transportation; travel.

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

Vitamins and dietary supplements.

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

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

Services For Automobile Related Injuries

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

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

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

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

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

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

- the remaining uncovered allowable expenses after PIP has provided coverage after application of copayments, or
- the actual benefits that would have been payable had We been providing coverage primary to PIP.

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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

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THE EFFECT OF MEDICARE ON BENEFITS

IMPORTANT NOTICE

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

For the purpose of this section:

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

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

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

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

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

Medicare Eligibility by Reason of Age

This part applies to a Covered Person who:

a. is the Employee or covered Spouse;and

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

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

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

This part 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 ESRD.

When a Covered Person becomes eligible for Medicare by reason of age, he/she must choose one of these options:

Option (A) - Choose this Plan as the primary health plan.

When (a) a Medicare eligible person chooses this Plan as the primary health plan; and (b) Incurs a Covered Charge for which benefits are payable under this Plan and Medicare, this Plan is deemed primary. This Plan pays first, ignoring Medicare. Medicare is deemed the secondary health plan.

Option (B) - Choose Medicare as the primary health plan.

When a Medicare eligible person chooses Medicare as the primary health plan, he/she will no longer be covered by this Plan, as required by Medicare's rules. Coverage under this Plan will end on the date the Covered Person elects Medicare as his/her primary health plan.

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

If the Medicare eligible person chooses Options (B), he/she can subsequently change the election and choose Option (A), subject to the Employer's requirements for enrolling in this Plan.

Medicare Eligibility by Reason of Disability

This part applies to a Covered Person who:

a. is under age 65;

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

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

This part does **not** apply to:

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

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

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

Medicare Eligibility by Reason of End Stage Renal Disease This part applies to a Covered Person who is eligible for Medicare solely on the basis of ESRD.

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

a. eligible for Medicare by reason of age ; or

b. eligible for Medicare by reason of disability.

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

The coordination period starts on the earlier of:

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

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

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

Dual Medicare Eligibility

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

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

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

ESRD, this Plan continues to be the secondary payer.

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

How To File A Claim If You Are Eligible For Medicare

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

New Jersey Providers:

- The Covered Person should give the Practitioner or other Provider his/her identification number. This number is shown on the Medicare Request for Payment (claim form) under "Other Health Insurance";
- The Provider will then submit the Medicare Request for Payment to the Medicare Part B carrier;
- After Medicare has taken action, the Covered Person will receive an Explanation of Benefits form from Medicare;
- If the remarks section of the Explanation of Benefits contains this statement, no further action is needed: "This information has been forwarded to Horizon Blue Cross Blue Shield of New Jersey for their consideration in processing supplementary coverage benefits;"
- If the above statement does not appear on the Explanation of Benefits, the Covered Person should include his/her Identification number and the name and address of the Provider in the remarks section of the Explanation of Benefits and send it to Horizon BCBSNJ.

Out-of-State Providers:

- The request for Medicare payment should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information;
- Upon receipt of the Explanation of Benefits, show the Identification Card number and the name and address of the Provider in the remarks section and send the Explanation of Benefits to Horizon BCBSNJ for processing.

APPEALS PROCESS

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

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

Appeals Process for Adverse Administrative Decisions

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

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

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

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

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

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

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

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

Appeals Process for Adverse Utilization Management Decisions

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

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

Your appeal must include the following information:

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

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

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

External Appeal Rights

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

If the process for obtaining this review is successfully completed, and your claim is deemed eligible, you will be notified and your appeal will be assigned to an IRO. Once it is assigned, the IRO will notify you about any additional steps that must be taken to complete your appeal. Once all of these additional steps are completed, the IRO will review all of the information in your case as if it were new. The IRO is not bound by any decisions or conclusions that were reached during the internal appeals process.

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

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 coverages 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 which covers a person as an active employee or his dependent will pay before the plan which 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**.**

Service Centers

If you have any questions about this Program, call your nearest Service Center.

Telephone personnel are available:

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

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

Please call:

1-800-355-BLUE
(2583)

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

1-800-664-BLUE
(2583)

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

Use this space for information you will need when asking about your coverage.

The company office or enrollment official to contact about coverage:

_____

The identification number shown on my identification card:

_____

The effective date when my coverage begins:

_____

My group number is:

_____

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 the 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.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request if up to 24 months after losing coverage. Without evidence of creditable coverage you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage**.**

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to **$110.00** a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plans' decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your 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 you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.