



Product: **Prescription Drug**

Group Name: **Cherry Hill Township
820 MERCER STREET
CHERRY HILL, NJ 08002**

Group Number: **008516R-020, 085**

Effective Date: **01/01/2024**

70586779
LG Insured RX CPL



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

Dear Valued Customer:

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

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

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

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

Important Tips to Follow

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

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

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

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

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

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

Have a question about your benefits?

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jill Serin", is positioned above the printed name and title.

Jill Serin
Vice President, Chief Underwriter,
Public Sector Market
Horizon Healthcare Services, Inc.



Prescription Plan Information



What's Inside

Prescription Drug Coverage	4
Getting a prescription filled	4
Review and manage your prescription benefits online	5
Prior authorization for certain prescription drugs	5
Specialty medicines	6
Legal Notices	7



We're happy to have you
as a Horizon member.
We want you to understand
the benefits and services available
to you so you can achieve your
best health.



At Horizon, we're proud of our
commitment to diversity and inclusion
among our employees, members, doctors
and business partners. Diversity is part of
who we are as a Company. We embrace
and value differences of culture,
education, experience and
perspective in our workplace.
For more information, please visit
HorizonBlue.com/diversity.

**This document includes important information about your Horizon prescription plan.
Please read it and keep it in a safe place so you can refer back to it. Please refer to your
contract or benefits booklet for specific information about your plan.**



Activate your Horizon member account for 24/7 access to your prescription plan information

Your Horizon member account is just a click or tap away. Go to our website, HorizonBlue.com, and register there. Or, access it through the **Horizon Blue app** on your smartphone, tablet or other mobile device. Download the **Horizon Blue app** by texting **GetApp** to **422-272**, or search for Horizon Blue on the App Store® or Google Play™.



Pharmacy terms to know

Brand name drug

A medicine that is manufactured and sold by a pharmaceutical company that holds a patent on the actual drug or the drug name.

Formulary

A list of medicines that your pharmacy plan covers depending on your benefit. This list may change during the year. Also known as a drug list.

Generic drug

A lower-cost version of a brand name drug. Generic drugs are chemically equal to the brand name drug, but don't use the brand name. They are regulated by the U.S. Food and Drug Administration (FDA).

In network

Pharmacies that are contracted with your Horizon plan and have agreed to pay our negotiated rate.

Maintenance drug

A prescription drug that treats a chronic condition (for example: diabetes, arthritis, high blood pressure, or heart disease).

Non-formulary drugs

A drug that may be covered by your pharmacy plan, but is not on the drug list (formulary). A Formulary Exception will need to be submitted to seek coverage.

Non-preferred drugs

A drug that may be covered by your pharmacy plan, but is not on the drug list (formulary). You typically pay more out of pocket for non-preferred drugs than for preferred drugs.

Preferred drugs

A drug that is included on your plan's drug list (formulary). You typically pay less for Preferred drugs than non-Preferred drugs.

Quantity limits

The maximum amount of a medicine that you can get for each fill. Quantity limits are based on the number of days or number of units (pills, capsules, ounces, etc.).

Prescription Drug Coverage

Your Horizon prescription drug coverage is administered by Prime Therapeutics, LLC (Prime).

Horizon maintains a list of medicines covered under your plan. This list is also called a formulary. To view your plan's current formulary, register and sign in at HorizonBlue.com.

The Pharmacy and Therapeutics Committee, an independent group of doctors and pharmacists, manages the formulary. This Committee regularly reviews new and existing prescription medicines for clinical effectiveness and patient safety. Medicines may be added or removed based on the Committee's decisions.



Getting a prescription filled

The amount you pay for your medicines depends on where you get them, the type of medicine and the quantity (day supply). Your plan's formulary places covered medicines into tiers. The tier your medicine is in tells you how much you'll pay.

You have options on how and where you get your prescription medicines:

- You can go to an **in-network retail pharmacy** to get your medicine. You'll pay your retail copay or coinsurance for each 30-day supply.
- You can use Amazon Pharmacy for **home delivery** of your medicines. You'll pay your mail order copay or coinsurance for up to a 90-day supply.
- If you take specialty medicines, you can use an **in-network specialty pharmacy** and you'll pay your retail copay or coinsurance for a 30-day supply.





Review and manage your prescription benefits online

It's easy to manage your prescription benefits, view claims, learn about your medicines, including drug interactions, and more. Simply sign in at HorizonBlue.com or through the **Horizon Blue app**.

Sign in to:

- Find a nearby in-network pharmacy.
- See the current list of covered medicines (the formulary).
- Look up prescription medicine coverage and pricing.
- See if your medicines require prior authorization.
- Find out if there are any special requirements for your medicines, such as whether a generic must be used first.

You can also call Pharmacy Member Services, 24/7, at **1-800-370-5088**. This phone number is also listed on the back of your member ID card.

For home delivery of 90-day supplies of maintenance medicines, you can use Amazon Pharmacy. To set up your Amazon Pharmacy account, visit amazon.com/horizonblue and click *Get Started*. You'll need to enter your member ID number, RxBIN or RxPCN, which are listed on the front of your member ID card.



Prior authorization for certain prescription drugs

Some medicines require prior authorization before they will be covered by your plan and dispensed to you.

Prior authorization means that your doctor must give us information to show that the use of the medicine meets criteria that follows FDA-approved product labeling and accepted treatment guidelines to ensure safe and proper use of the medicine.

If your medicine requires prior authorization, your doctor can call Prime Clinical Review at **1-888-214-1784**, or complete the request online. Your Horizon prescription plan will not cover the medicine until the prior authorization is approved; or you can pay for the total cost of the medicine out of your pocket.



Should you use generic or brand name medicines?

The U.S. Food and Drug Administration (FDA) regulates generic medicines in the same way as brand name medicines, so they are just as safe and effective. If your doctor prescribes a brand name medicine, ask whether a money-saving generic alternative would work for you.

Prior authorization may be required for brand name medicines when FDA-approved generic equivalents are available.



Specialty medicines

Specialty medicines are prescription medicines designed to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty medicines are filled differently from other prescriptions, as some require special handling, patient education and monitoring, and some have restrictions on distribution. That's why all specialty medicines are subject to prior authorization.

Horizon has agreements with pharmacies that specialize in delivering high levels of service, education and support for specialty medicines.

Specialty pharmacies offer:

- Personal attention from a pharmacist-led team to provide helpful condition-specific education, medicine administration instruction and advice to help manage therapy
- Help to determine coverage and submit any paperwork
- Easy access to pharmacists and other health experts
- Easy ordering with a dedicated toll-free number
- Convenient delivery to the location of your choice (your home, doctor's office, vacation spot, etc.)
- Helpful follow-up care calls to remind you when it's time to refill a prescription, to check on therapy progress and to answer any questions you may have



For more information about specialty medicines and in-network specialty pharmacies, visit HorizonBlue.com/specialtyrx or call Pharmacy Member Services at **1-800-370-5088**.



Legal Notices

Your rights and responsibilities

As a Horizon member, you have the right to:

- Be provided with information in a way that works for you (in languages other than English and in alternate formats, such as large print). If you need help understanding information from Horizon, you have the right to get help in your language and at no cost to you. To speak with an interpreter, call **1-800-355-BLUE (2583)** during normal business hours.
- Timely access to covered services and medicines, as applicable.
- Get information about Horizon and its services, policies and procedures, products, doctors, appeal procedures, member rights and responsibilities, coverage limitations, and other information about the organization and care provided.
- Get the information needed to understand your benefits and obtain care.
- Receive prompt notification of material changes in benefits, services or network within 30 days prior to the date of any change or termination, as appropriate.
- Get information about whether a referring doctor has a financial interest in the facility or services to which a referral is being made.
- Go to an ER without prior approval when it appears to you that serious harm could result from not obtaining immediate treatment.

As a Horizon member, you have the responsibility to:

- Read and understand your policy and all other materials about your plan and coverage.
- Be considerate and courteous to doctors and staff.
- Supply information, as best you can, that the organization and its practitioners and providers need to provide care.
- Follow plans and instructions for care that you have agreed to with your doctors.
- Pay for charges, including copays, deductibles and coinsurance as stated in your plan, as well as for any charges you incur for non-covered care.
- Understand your health issues and work with your doctors to create treatment goals, to the degree possible.

This is a partial list of your member rights and responsibilities. For a complete list of rights and responsibilities, visit HorizonBlue.com/rights or call Member Services.

How to make inquiries, complaints and appeals

We want you to have access to quality health care and services. But if you are ever dissatisfied with any aspect of your Horizon health plan, you, your doctor or authorized representative, acting on your behalf (and with your consent), may file an inquiry, complaint or appeal with Horizon. No one who makes an inquiry, files a complaint or pursues an appeal will be subject to disenrollment, discrimination or penalty by Horizon.

Our inquiry, complaint and appeal processes provide prompt responses and resolutions to all requests related to:

- Medical issues
- Our utilization management decision making
- Other non-utilization management issues

If you have an inquiry or a complaint, call Member Services at **1-800-355-BLUE (2583)**, or write to us. The address for inquiries and complaints is available at HorizonBlue.com/inquiries.



Evaluating new medical technology

We regularly review new medical technology to decide if it's eligible for coverage. Our review includes input from the professional and medical community (including medical practitioners in New Jersey), as well as research results published in medical literature. We also review our current policies related to existing technology and update them as needed.

Utilization management

We monitor our members' health care — the care they get and the care recommended by doctors — to assess its medical necessity and appropriateness. This is called utilization management (UM).

Specifically, we watch for:

- **Underutilization:** Members not getting the recommended annual checkups or preventive vaccinations
- **Overutilization:** Members getting medical care, medicines, lab tests or surgical procedures when they are not medically necessary

UM lets us help doctors provide care in medically appropriate and cost-effective ways. That's because, through UM, we identify best practices that produce high-quality care and health outcomes. We share what we learn with members, in-network doctors, health care professionals and employers through continuing education.

We want you to know that:

- We make UM decisions based only on the necessity and appropriateness of care and services within the provisions of the member's benefit package.
- We don't compensate anyone responsible for UM decisions in a way that rewards him or her for denying coverage for medically necessary and appropriate covered services.
- We don't offer incentives to anyone responsible for UM determinations to encourage denials of coverage or services, and we don't provide financial incentives to doctors to withhold covered health care services that are medically necessary and appropriate.
- We emphasize the delivery of medically necessary, appropriate and cost-effective health care services to members, and we encourage the reporting, investigation and elimination of underutilization.

Abortion Coverage

Please refer to your policy for more details.

Our Privacy Practices

Protecting our members' privacy is very important to us. Horizon and its affiliated companies¹ maintain a Notice of Privacy Practices that details how we protect members' information. We reserve the right to change the terms of the Notice of Privacy Practices and to make the new Notice of Privacy Practices provisions effective for all information that we maintain. Our policies may change as we periodically review and revise them. We will provide you with a new Notice of Privacy Practices if the changes are significant, as long as you maintain an ongoing insured customer relationship with us. A copy of our Notice of Privacy Practices is available at HorizonBlue.com/privacy-policy.

Privacy Complaints

If you have a privacy complaint, we want to know about it. You will not be retaliated against for filing a complaint.

You may file a complaint with Horizon and its affiliated companies by calling Member Services at **1-800-355-BLUE (2583)**, or by writing to:

**Horizon Privacy Office
Three Penn Plaza East, PP-16F
Newark, NJ 07105-2200**

You may also send your complaint to the U.S. Secretary of Health and Human Services.

Women's Health and Cancer Rights Act of 1998

Under federal law, we must tell you about your right to certain health coverage for breast reconstructive surgery in any health plan that provides medical and surgical benefits for mastectomies. This law is called the Women's Health and Cancer Rights Act of 1998.

If a member has a mastectomy and chooses to have breast reconstruction along with that mastectomy, the health plan must also provide coverage for the following, in a manner determined in consultation with the attending doctor and the patient:

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

These benefits are subject to deductibles and coinsurance to the same extent as for any other illness under your coverage.

This law does not affect any other features and benefits of your health plan.

¹ The Horizon Blue Cross Blue Shield of New Jersey affiliated companies, all of which are independent licensees of the Blue Cross Blue Shield Association, are:
Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey
Horizon Healthcare of New Jersey, Inc. d/b/a Horizon NJ Health, Horizon Insurance Company
Horizon Healthcare Dental, Inc.
Healthier New Jersey Insurance Company d/b/a Braven Health
Horizon Casualty Services, Inc. (This affiliate is not a covered entity subject to the federal privacy rules.)

Get 24/7 access to your member ID card, health plan details, care and more, with the **Horizon Blue app**. Text **GetApp** to **422-272**, or go to the App Store® or Google Play™ to download the app, and register or sign in using the same username and password as your HorizonBlue.com account. There's no charge to download the app, but rates from your wireless providers may apply.



Scan the code with your phone's camera
to download the app.

Minimum requirement: Android 9 Pie or iOS 11



Follow us:



Amazon Pharmacy is contracted by Horizon Blue Cross Blue Shield of New Jersey to provide pharmacy home delivery services to Horizon Blue Cross Blue Shield of New Jersey members. Amazon Pharmacy is independent from and not affiliated with Horizon Blue Cross Blue Shield of New Jersey.

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TABLE OF CONTENTS

	<u>PAGE</u>
Introduction.....	21
Certificate of Coverage.....	22
Definitions.....	23
Prescription Drug Expense Coverage.....	31
General Information.....	38
How To Enroll.....	38
Your Identification (ID) Card.....	38
Types Of Coverage Available.....	38
Change In Type Of Coverage.....	38
Enrollment of Dependents.....	39
Special Enrollment Periods.....	39
Individual Losing Other Coverage.....	39
New Dependents.....	40
Special Enrollment Due to Marriage.....	40
Special Enrollment Due to Newborn/Adopted Children.....	40
Multiple Employment.....	41
Eligible Dependents.....	41
When Coverage Ends.....	42
Benefits After Termination.....	42
If You Leave Your Group Due To Total Disability.....	42
Extension Of Coverage Due To Termination of the Group Policy.....	43
Continued Coverage Under The Federal Family And Medical Leave Act.....	43
Continued Coverage For Surviving Dependents.....	43
Continuation of Coverage under COBRA.....	44
Continuation of Coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).....	45
Continued Coverage for Over-Age Dependents.....	46
Conversion Coverage.....	49
Continuation of Care.....	49
Medical Necessity And Appropriateness.....	50
Cost Containment.....	50
Managed Care Provisions.....	50
Exclusions.....	52
Claims Procedures.....	54
Appeals Process.....	57
Covered Persons' Rights.....	65
Service Centers.....	66
Civil Union Rider.....	67

INTRODUCTION

This Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) Prescription Drug Program gives you and your covered Dependents broad protection to help meet the cost of Illnesses and Injuries. This Program offers the highest level of benefits when services are obtained from a Hospital or other Provider designated as a Prescription Drug In-Network Provider.

In this Booklet, you'll find the important features of your group's Prescription Drug benefits provided by Horizon BCBSNJ. 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.

Coverage under this Program is provided according to the Group Policy for each Covered Person. Your Booklet's Schedule of Covered Services and Supplies shows the Policyholder and the Group Policy Number(s).

Benefits and Amounts:

The available benefits and the amounts of insurance are described in the Booklet.

This Booklet is an important document and should be kept in a safe place. When you become covered under the Program, you will receive a Certificate of Coverage. You should attach the Certificate of Coverage to this Booklet. Together, they form your Group Insurance Certificate.

The Booklet is made part of the Group Policy, which is delivered in and governed by the laws of the State of New Jersey. Future changes in coverage will be described in either a Booklet Notice of Change or in a new Booklet. All benefits are subject in every way to the entire Group Policy, which includes this Booklet.

Horizon Healthcare Services, Inc. (d/b/a Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ))

**3 Penn Plaza East
Newark, New Jersey 07105-2200**

HORIZON HEALTHCARE SERVICES, INC.

CERTIFICATE OF COVERAGE

Horizon Healthcare Services, Inc. (Horizon BCBSNJ) certifies that insurance is provided according to the applicable Group Policy for each insured Employee. Your Booklet's Schedule of Covered Services and Supplies shows the Group Policyholder and the Group Policy Number.

Insured Employee: You are insured under the Group Policy. This Certificate of Coverage together with your Booklet forms your Group Insurance Certificate.

Your Booklet and this Certificate of Coverage replace any older booklets and certificates issued to you for the coverage described in your Booklet. The Booklet and Certificate of Coverage are made part of the Group Policy, which is delivered in and governed by the laws of the State of New Jersey. Future changes in coverage will be described in either a Booklet Notice of Change or new Booklet. All benefits are subject in every way to the entire Group Policy, which includes this Group Insurance Certificate.

**Horizon Healthcare Services, Inc.
3 Penn Plaza East
Newark, New Jersey 07105-2200**

DEFINITIONS

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

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

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

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

Allowance: An amount determined by Horizon BCBSNJ as the least of the following amounts: (a) the actual charge made by the provider for the service or supply; or (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 for the service or supply based on the Resource Based Relative Value System promulgated by the Centers for Medicare and Medicaid Services; or (d) in the case of Out-of-Network Providers, an amount determined for the service or supply based on: (i) profiles compiled by Horizon BCBSNJ based on the usual and prevailing payments made to providers for similar services or supplies in specific geographical areas; or (ii) similar profiles compiled by outside vendors.

Alternate Payee:

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

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

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

Calendar Year: A year starting January 1.

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

- The natural born child or stepchild of you, your Spouse or Domestic Partner;
- A child who is: (a) legally adopted by you, your Spouse or Domestic Partner; or (b) placed with you for adoption. But, proof of such adoption or placement satisfactory to Horizon BCBSNJ must be furnished to us when we ask;
- You, your Spouse's or Domestic Partner's legal ward. But, proof of guardianship satisfactory to Horizon BCBSNJ 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*

*See Rider form GRP 2007 (NJ-Civil Union HSC) at the end of the Booklet for information about Civil Unions.

Clean Claim: A claim for benefits that: (a) is an eligible claim for a Covered Service or Supply rendered by an eligible Provider; (b) has no material defect or impropriety (including, but not limited to, missed coding or missing documentation); (c) is not disputed; (d) has not been submitted fraudulently, as determined by Horizon BCBSNJ; and (e) does not need special treatment that might prevent timely payment.

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

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

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

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

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

Coverage Date: The date on which coverage under this Program 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 Program, Horizon BCBSNJ provides coverage for Covered Services or Supplies Incurred by a Covered Person while the person is covered by this Program.

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

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.

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

Domestic Partners: Persons of the same sex who meet these criteria:

- (1) Both persons have a common residence and are otherwise jointly responsible for each other's common welfare, as evidenced by joint financial arrangements or joint ownership of real property, which shall be demonstrated by at least one of the following:
 - (a) A joint deed, mortgage agreement or lease;
 - (b) A joint bank account;
 - (c) Designation of one of the persons as a primary beneficiary in the other's will;
 - (d) Designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
 - (e) Joint ownership of a motor vehicle.
- (2) Both persons agree to be jointly responsible for each other's basic living expenses during the Domestic Partnership;
- (3) Neither person is in a marriage recognized by New Jersey law or a member of another Domestic Partnership;
- (4) Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;
- (5) Both persons are of the same sex and therefore unable to enter into a marriage with each other that is recognized by New Jersey law, except that two persons who are each 62 years of age or older and not of the same sex may establish a Domestic Partnership if they meet the requirements set forth in this section;
- (6) Both persons have chosen to share each other's lives in a committed relationship of mutual caring;
- (7) Both persons are at least 18 years of age.

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

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

Employer: Collectively, all employers included under the Group Policy.

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

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

- a. The Technology must either be: (a) approved by the appropriate federal regulatory agency and have been in use for the purpose defined in that approval; or (b) proven to Horizon BCBSNJ'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 Horizon BCBSNJ 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, Horizon BCBSNJ 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, Horizon BCBSNJ may, to determine the safety and effectiveness of a Technology, consider opinions about and evaluations of the Technology from appropriate specialty advisory committees and/or specialty consultants.)
- e. The Technology must demonstrate effectiveness when applied outside of the investigative research setting.

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

Regarding a. above, Horizon BCBSNJ 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, Horizon BCBSNJ will still deem it to be Medically Necessary and Appropriate if supportive clinical evidence for the particular use of the drug is given in a clinical study or published in a major peer-reviewed medical journal. But, in no event will this Program cover any drug that the FDA has determined to be Experimental, Investigational or contraindicated for the treatment for which it is prescribed.

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

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

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

With respect to coverage for clinical trials, Horizon BCBSNJ will not:

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

Family or Medical Leave of Absence: A period of time of predetermined length, approved by the Policyholder, 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 Program.

FDA: The Food and Drug Administration.

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

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

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

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

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

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

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

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

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

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

Medically Necessary and Appropriate: 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.

Member: A person who meets all rules to take part in a health and welfare benefit plan offered through a labor union or other qualified organization.

Non-Covered Charges: Charges for services and supplies which: (a) do not meet this Program'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.

Non-Preferred: With respect to covered Prescription Drugs, those drugs that are not Preferred.

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

Out-of-Network Benefits: The coverage shown in the Schedule of Covered Services and Supplies which is provided if an Out-of-Network Provider provides the service or supply.

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

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.

Policyholder: The employer or other entity that: (a) purchased the Group Policy; and (b) is responsible for paying the premiums for it.

Practitioner: A person that Horizon BCBSNJ 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 Program.

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.

Preferred: With respect to covered Prescription Drugs, those drugs that: (a) Horizon BCBSNJ has identified as such; and (b) are included on a list that is made available to Covered Persons and that may be changed from time to time.

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

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

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

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 Program.

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 Program.

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

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

Specialty Pharmaceutical Provider: A vendor that has contracted with Horizon BCBSNJ to provide Specialty Pharmaceuticals on an In-Network basis.

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

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.

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

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

We, Us and Our: Horizon BCBSNJ.

You, Your: An Employee.

PRESCRIPTION DRUG EXPENSE COVERAGE

COVERED CHARGES

Subject to the other applicable terms and conditions of this Program, this Program provides coverage for Prescription Drugs that: (a) are purchased from a Pharmacy for Out-of-Hospital use; (b) are (except for insulin) dispensed under a Prescription Order or Prescription Mail Order; and (c) in the usual course of medical practice are self-administered.

However, Covered Charges will not include charges made for more than:

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

Note that to ensure timely receipt of drugs prescribed for acute illnesses, they should be obtained through retail Pharmacies, rather than Mail-Order Pharmacies.

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

Synchronization of Prescription Drugs

This Program provides for synchronization of covered Prescription Drugs on at least one occasion per year for each Covered Person. For the purposes of this section "synchronized" and "synchronization" refers to the process by which a Covered Person refills his or her multiple Prescription Drugs at the same time and from the same Pharmacy.

Prescription Drugs may be dispensed by an In-Network Pharmacy in an amount equal to less than a 30-day supply in order to reduce the Copayment or Coinsurance, as applicable. Copayments and/or Coinsurance for Prescription Drugs dispensed for supplies of less than 30-days will be prorated on a daily basis and will only be provided when:

- (a) the Covered Person's Practitioner has determined that a reduced supply of Prescription Drugs is Medically Necessary and Appropriate; or
- (b) for purposes of synchronizing a Covered Person's Maintenance Prescription Drugs.

A Covered Person may also have his or her Maintenance Prescription Drugs synchronized pursuant to a written treatment plan developed by the Covered Person, the Provider, and the pharmacist showing the Provider's recommended synchronization of the Covered Person's Maintenance Prescription Drugs.

However, synchronization will not be provided for Prescription Drugs or Maintenance Prescription Drugs that are opioid analgesics, which is defined as a drug class prescribed to treat moderate to severe pain or other conditions, whether in immediate release or extended release form, and whether or not combined with other drug substances to form a single drug product or dosage form.

1. IN-NETWORK

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

- a. A **\$3.00** Copayment is required for Generic Prescription Drugs.
- b. A **\$18.00** Copayment is required for Preferred Brand Name Prescription Drugs.
- c. A **\$46.00** Copayment is required for Non-Preferred Prescription Drugs.

Note: If the cost of the Prescription Drug at the dispensing Pharmacy is less than the applicable Copayment, then the Covered Person will pay the cost of the Prescription Drug.

For Prescription Orders which are not dispensed by a Mail Order Pharmacy, one Copayment will apply for each **30 day** supply. Copayments shall be based upon the day supply as follows:

1 to 30 day supply - one Copayment

31 to 60 day supply - two Copayments

61 to 90 day supply - three Copayments

Refills, as authorized under a Prescription Order, will be subject to the same requirements as for original Prescription Orders.

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

- a. A **\$0.00** Copayment is required for Generic Prescription Drugs.
- b. A **\$36.00** Copayment is required for Preferred Brand Name Prescription Drugs.
- c. A **\$92.00** Copayment is required for Non-Preferred Prescription Drugs.

Note: If the cost of the Prescription Drug at the dispensing Pharmacy is less than the applicable Copayment, then the Covered Person will pay the cost of the Prescription Drug.

For Prescription Mail Orders, one Copayment will be applied to each Prescription Mail Order. Refills, as authorized under a Prescription Order, will be subject to the same limitations.

PAYMENT:

a. **Payment for Covered Charges for Prescription Drugs (including Specialty Pharmaceuticals) other than Prescription Drugs dispensed by a Mail-Order Pharmacy:**

- 1. A Pharmacy will not charge a Covered Person an amount exceeding the Copayment, if applicable, for Covered Charges for Prescription Drugs.
- 2. Once a Covered Person Incurs, during a Benefit Period, **\$1,820** of Covered Charges for Prescription Drugs for which no benefits have been paid or are payable under this Coverage due to the application of the Deductible, Copayments, or Coinsurance, Horizon BCBSNJ's payment for Covered Charges incurred by the Covered Person for Prescription Drugs for the remainder of that Benefit Period will be **100%**.
- 3. Once the covered members of a family unit (the Covered Person and his/her covered Dependents) collectively Incur, during a Benefit Period, **\$3,640** of Covered Charges for Prescription Drugs for which no benefits have been paid or are payable under this Coverage

due to the application of the Deductible, Copayments, or Coinsurance, Horizon BCBSNJ's payment for Covered Charges incurred by those members for Prescription Drugs for the remainder of that Benefit Period will be **100%**.

b. Payment for Covered Charges for Prescription Drugs dispensed by a Mail Order Pharmacy:

4. Once a Covered Person Incurs, during a Benefit Period, **\$1,820** of Covered Charges for Prescription Drugs for which no benefits have been paid or are payable under this Coverage due to the application of the Deductible, Copayments, or Coinsurance, Horizon BCBSNJ's payment for Covered Charges incurred by the Covered Person for Prescription Drugs for the remainder of that Benefit Period will be **100%**.
5. Once the covered members of a family unit (the Covered Person and his/her covered Dependents) collectively Incur, during a Benefit Period, **\$3,640** of Covered Charges for Prescription Drugs for which no benefits have been paid or are payable under this Coverage due to the application of the Deductible, Copayments, or Coinsurance, Horizon BCBSNJ's payment for Covered Charges incurred by those members for Prescription Drugs for the remainder of that Benefit Period will be **100%**.

Under certain circumstances, a Pharmacy may not be able to determine at the point of transaction whether a Prescription Drug is covered. For example, the information on the Prescription Order may not be sufficient to determine Medical Necessity and Appropriateness. In those circumstances, a Covered Person may elect to receive a 96-hour supply of the Prescription Drug, as a covered benefit, until the determination is made. Alternatively, the Covered Person may decide to purchase the Prescription Drug and submit a claim for benefits. If the claim is denied, no charge in excess of the charge for the 96-hour supply will be a Covered Charge for that Prescription Drug or any refill(s) of it.

2. OUT-OF-NETWORK:

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

- a. A **\$3.00** Copayment is required for Generic Prescription Drugs.
- b. A **\$18.00** Copayment is required for Preferred Brand Name Prescription Drugs.
- c. A **\$46.00** Copayment is required for Non-Preferred Prescription Drugs.

Note: If the cost of the Prescription Drug at the dispensing Pharmacy is less than the applicable Copayment, then the Covered Person will pay the cost of the Prescription Drug.

For Prescription Orders which are not dispensed by a Mail Order Pharmacy, one Copayment will apply for each **30 day** supply. Copayments shall be based upon the day supply as follows:

1 to 30 day supply - one Copayment

31 to 60 day supply - two Copayments

61 to 90 day supply - three Copayments

Refills, as authorized under a Prescription Order, will be subject to the same requirements as for original Prescription Orders.

PAYMENT:

Payment for Covered Charges for Prescription Drugs:

1. The Covered Person must pay for the Prescription Drug and submit a written notice of claim to Horizon BCBSNJ or its designee.
2. A Pharmacy will not charge a Covered Person an amount exceeding the Copayment, if applicable, for Covered Charges for Prescription Drugs.
3. Once a Covered Person Incurs, during a Benefit Period, **\$1,820** of Covered Charges for Prescription Drugs for which no benefits have been paid or are payable under this Coverage due to the application of the Deductible, Copayments, or Coinsurance, Horizon BCBSNJ's payment for Covered Charges incurred by the Covered Person for Prescription Drugs for the remainder of that Benefit Period will be **100%**.

Once the covered members of a family unit (the Covered Person and his/her covered Dependents) collectively Incur, during a Benefit Period, **\$3,640** of Covered Charges for Prescription Drugs for which no benefits have been paid or are payable under this Coverage due to the application of the Deductible, Copayments, or Coinsurance, Horizon BCBSNJ's payment for Covered Charges incurred by those members for Prescription Drugs for the remainder of that Benefit Period will be **100%**.

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

Contraceptives

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

- a) This Policy covers the following services, drugs, devices and procedures when obtained from or provided by network providers:
1. If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.
 2. Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.
 3. Coverage shall be provided without any infringement upon a subscriber's choice of contraception and medical necessity shall be determined by the Covered Person's Provider for covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

- b) Voluntary sterilization of a Covered Person whether male or female;
- c) Patient education and counseling on contraception for a Covered Person;
- d) Services related to the administration and monitoring of drugs, products and services covered under this Contraceptives provision, including, but not limited to:
 - 1. Management of side effects;
 - 2. Counseling for continued adherence to a prescribed regimen;
 - 3. Device insertion and removal;
 - 4. Coverage of alternative contraceptive drugs, devices or products the Covered Person's practitioner determines are medically necessary; and
 - 5. Diagnosis and treatment services provided pursuant to or as a follow-up to services covered under this Contraceptive provision.

The coverage provided shall include prescriptions for dispensing contraceptives for:

- (1) a three-month period for the first dispensing of the contraceptive; and
- (2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the Policy was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the Policy.

Except as provided in paragraph (2) of this subsection, the health care services shall be provided to the same extent as for any other service, drug, device, product, or procedure under the Policy, except no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

Coverage under this Contraceptives provision is provided without the application of any deductible, coinsurance or copayment. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

Retail vs. Mail-Order Pharmacies

No Covered Person shall be required to use a Mail-Order Pharmacy.

If a Covered Person chooses to use a retail Pharmacy, any Prescription Drug Deductible, Copayment and/or Coinsurance described above shall not differ between a Mail-Order Pharmacy and the retail Pharmacy if (a) the Prescription Drugs purchased are of the same strength, quality and days' supply; and (b) the retail Pharmacy has agreed to the same terms, conditions, price and services applicable to the Mail-Order Pharmacy.

No Copayment, fee, or other condition shall be imposed upon a Covered Person selecting a participating pharmacist or pharmacy that is not also equally imposed upon all Covered Persons selecting a participating pharmacist or Pharmacy.

Specialty Pharmaceuticals

When Specialty Pharmaceuticals as prescribed by a physician are required, such Prescription Drugs must be purchased through a Specialty Pharmaceutical Provider.

Drug Utilization, Cost Management and Rebates

Horizon BCBSNJ conducts various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, Covered Persons benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. Horizon BCBSNJ may, from time-to-time, also enter into agreements that result in us receiving rebates or other funds (collectively, "rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drug products across all of our business and not solely on anyone Covered Person's or one group's utilization of Prescription Drugs. Rebates will not change or reduce the amount of any Copayment, Coinsurance or Deductibles applicable under the Prescription Drug Program.

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

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

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

In the event the above criteria are met, the Covered Person or his/her health care Provider may request that the Non-Preferred Prescription Drug be covered at the Preferred Drug level. In the event the request is approved, the Prescription Drug will be covered at the appropriate Preferred level depending upon whether the drug is a Generic Prescription Drug or Brand Name Drug. A plan medical doctor licensed to practice medicine will perform all reviews of such requests. The plan medical doctor may be an employee of Horizon BCBSNJ or its affiliates, or may be a contracted delegate performing in accordance with Horizon BCBSNJ's policies and procedures.

To gain approval for a Non-Preferred Prescription Drug to be covered at the Preferred level, the Covered Person's health care Provider must contact Horizon BCBSNJ and provide the appropriate information for a determination to be made. Documentation must be provided certifying the Medical Necessity and Appropriateness of the Prescription Drug based upon the above definition. Documentation must include that part of the Covered Person's medical record that indicates which drugs have been prescribed as well as the reactions or ineffectiveness of each such drug. This may be demonstrated by prior patient experience with similar drugs or classes of drugs. Documentation may be submitted via facsimile. Once

the appropriate information is received by Horizon BCBSNJ, we will make a determination and respond to the prescribing health care Provider by telephone or other telecommunication device within one business day of receipt of such information. Our failure to respond within this time period can be deemed an approval of the request. Initial denials shall also be provided to the prescribing health care Provider and the Covered Person in writing within five business days of receipt of the necessary information and shall include the clinical reason for the denial. Horizon BCBSNJ or its delegate will maintain an on-call process for obtaining approval of the Prescription Drug in emergency situations 24 hours per day, 7 days per week. Denials can be appealed pursuant to those procedures described in this Booklet under "Appeals Process", including the right to appeal to the Independent Health Care Appeals Program in the Department of Health and Senior Services.

Obtaining Benefits for Out-of-Network Drugs

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

GENERAL INFORMATION

How To Enroll

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

Your Identification (ID) Card

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

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

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

Types Of Coverage Available

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

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

Change In Type Of Coverage

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

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

For example:

- If you are already enrolled, your newborn infant or adopted child is automatically included. However, if you are enrolled for Family or Parent and Child(ren) coverage, you must still submit an enrollment form to notify us of the addition. If you are enrolled for Single coverage, you must enroll your child and pay any required additional premium within 31 days in order to continue the child's coverage beyond that period.

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

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

Enrollment of Dependents

Horizon BCBSNJ cannot deny coverage for your Child Dependent on the grounds that:

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

If you are the non custodial parent of a Child Dependent, Horizon BCBSNJ will:

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

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

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

Special Enrollment Periods

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

Individual Losing Other Coverage

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

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

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

New Dependents

If the following conditions are met, Horizon BCBSNJ 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 Program (or have met any Waiting Period and are eligible to enroll but for a failure to enroll during a previous enrollment period).
- b. The person becomes your dependent through marriage, birth, or adoption (or placement for adoption).

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

Special Enrollment Due to Marriage

You may enroll a new Spouse under this Program. 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.

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

Special Enrollment Due to Newborn/Adopted Children

You may enroll a newly born or newly adopted Child Dependent. Horizon BCBSNJ will cover your newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31-day period as stated below:

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

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

Multiple Employment

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

Eligible Dependents

Your eligible Dependents are your Spouse or Domestic Partner and your Child Dependents.

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

Coverage for your Spouse will end: (a) on the date of your Spouse's death; (b) at the end of the Benefit Month in which you divorce; or (c) at the end of the Benefit Month in which you tell us to delete your Spouse from coverage following marital separation.

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

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

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

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

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

When Coverage Ends

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

- The end of the Benefit Month in which you cease to be eligible due to termination of your employment or any other reason.
- The date on which the Group Policy 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 Program ends.
- When you fail to make, when due, any required contribution for the Dependent coverage.
- As otherwise described under "Eligible Dependents", above.

In addition to the above reasons for the termination of coverage under the Program, an act or omission by a Covered Person which, as determined by Horizon BCBSNJ shows intent to defraud Horizon BCBSNJ (such as: (a) the intentional and/or repeated misuse of Horizon BCBSNJ'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), upon 30 days prior written notice, will result in the cessation of the Covered Person's coverage under this Program. 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. Horizon BCBSNJ retains the right to recoup from any involved person all payments made and/or benefits paid on his/her behalf.

Also, coverage under this Program will end for any Covered Person who misuses an ID card issued by Horizon BCBSNJ.

Benefits After Termination

If you or a Dependent are confined as an Inpatient in a Facility on the date coverage ends, the Program's benefits will be paid, subject to the Program'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 Program's coverage for you and your covered Dependents, if any, if:

- You were continuously enrolled under the Program 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 toward the group rate for the continued coverage.

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

Extension Of Coverage Due To Termination of the Group Policy

This applies if you or a covered Dependent are Totally Disabled on the date coverage under this Program ends due to termination of the Group Policy. In this event, benefits will continue to be available for that person for Covered Services and Supplies needed due to the Illness or Injury that caused the disability. Benefits will continue to be paid during the uninterrupted period of the disability, but not for more than 90 days from the date the coverage ends.

Continued Coverage Under The Federal Family And Medical Leave Act

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

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

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

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

Consult your benefits representative for application forms and further details.

Continued Coverage For Surviving Dependents

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

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

Consult your benefits representative for further details.

Continuation of Coverage under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you and your enrolled Dependents, and any newborn or newly adopted child may have the opportunity to continue group health care coverage which would otherwise end, if any of these events occur:

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

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

- Your death;
- Your work hours are reduced;
- Your employment ends for reasons other than gross misconduct;*
- You became entitled to Medicare benefits;
- In the case of your Spouse, the Spouse ceased to be eligible due to divorce or legal separation; or
- In the case of a Child Dependent, he/she ceased to be a Child Dependent under this Program'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 Program ends for the class you belong to.
- The person fails to make required payments for the coverage.
- The person becomes covered under any other group health plan. But, coverage will not end due to this rule until the end of any period for which benefits for them are limited, under the other plan.
- The person becomes entitled to Medicare benefits.

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

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.

If you get divorced, your former Spouse may also have the option to transfer to direct payment coverage at the end of this extended period of coverage. See the "Conversion Coverage" section below.

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 Policy (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 Policy 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 the full premium for it.

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

Uniformed services: The following:

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

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

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

Continued Coverage for Over-Age Dependents

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

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

- is 30 years of age or younger;
- is not married, or in a Civil Union or Domestic Partnership;
- has no dependents of his/her own;
- is either a New Jersey resident or enrolled as a full-time student at an accredited school;

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

If a Dependent Is Over the Limiting Age for Dependent Coverage

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

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

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

Conditions for Election

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

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

Election of Continuation

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

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

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

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

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

Payment of Premiums

Horizon BCBSNJ will set the premiums for the continued coverage, in a manner that is consistent with the requirements of applicable New Jersey law.

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

Subsequent premiums must be paid monthly, in advance, and will be remitted by the Policyholder.

Grace Period for the Payment of Premiums

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

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

Scope of Continued Coverage

The continued coverage will be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an Employee under this Policy and will be evidenced by a separate Booklet and ID card being issued to the Over-Age Dependent. Subject to the following subsection, if this Policy's coverage for other dependents who are Covered Persons is modified, the coverage for Over-Age Dependents will be modified in like manner. Evidence of insurability is not required for the continued coverage.

Single Coverage for Over-Age Dependents

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

When Continuation Ends

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

- The date on which the Over-Age Dependent fails to meet any one of the conditions to be an Over-Age Dependent.
- The end of a period during which a required premium payment for the continued coverage is not made when due, subject to the "Grace Period for the Payment of Premiums" subsection above.
- The date on which the Employee's coverage ends.
- The date on which this Policy coverage for Dependents is ended.

- The date on which the Employee waives this Policy's Dependents coverage. However, if the Employee has no other Dependents, the Over-Age Dependent's coverage under this Policy will not end due to that waiver.

Inapplicability of Other Continuation Provisions

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

Conversion Coverage

If coverage under this Program for your Spouse ends due to divorce, the former Spouse may apply to Horizon BCBSNJ for individual non group health care coverage. To do so, he/she must apply to Horizon BCBSNJ in writing no later than 31 days after the coverage under this Program ends.

The former Spouse does not need to prove he/she is in good health.

The coverage will be at least equal to the basic benefits under contracts then being issued by Horizon BCBSNJ to new non-group applicants of the same age and family status. This coverage is called "conversion coverage." The conversion coverage, if provided, may be different than the coverage provided by this Program. We will provide details of this conversion coverage upon request.

If Horizon BCBSNJ determines that the former Spouse is entitled to conversion coverage (according to the above rules), it will go into effect on the day after his/her coverage under this Program ends, if the application is furnished timely and the premium for the coverage is paid when due.

If the former Spouse is not located in New Jersey when he/she becomes eligible for this conversion coverage, we will provide information whereby the former Spouse can apply for any individual health coverage made available by the Blue Cross/Blue Shield plan in the area where the Spouse is located.

Continuation of Care

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

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

In the event that a Covered Person is receiving post-operative follow-up care, Horizon BCBSNJ shall continue to cover services rendered by the Provider for the duration of the treatment, up to six months. In the event that a Covered Person is receiving oncological or psychiatric treatment, Horizon BCBSNJ shall continue to cover services rendered by the Provider for the duration of the treatment, up to one

year. If the services are provided in an acute care Facility, Horizon BCBSNJ will continue to cover them regardless of whether the Facility is under contract or agreement with Horizon BCBSNJ.

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

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

Medical Necessity And Appropriateness

We will make payment for benefits under this Program 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 we determine 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 Program and to assist in managing their care. To contact Member Services, a Covered Person should call the number on his/her Identification (ID) Card.

Miscellaneous Provisions

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

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

EXCLUSIONS

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:

Any part of a charge to the extent it exceeds the Allowance.

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

Drugs for weight reduction or control, unless there is a diagnosis of morbid obesity; special foods; food supplements; liquid diets; diet plans; or any related products.

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

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

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

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

Drugs purchased in connection with Cosmetic Services.

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

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

Drugs that are eligible to be paid for under either federal or state programs (except Medicare and Medicaid when, by law, this Program is primary). This provision applies whether or not the Covered Person asserts his/her rights to obtain the coverage or payments for the drugs.

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

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

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

Drugs that are not Medically Necessary and Appropriate.

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

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

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

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

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

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

Experimental or Investigational drugs.

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

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

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

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

Drugs to enhance normal functions, such as: steroids to improve athletic performance; drugs to improve memory; or growth drugs.

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

CLAIMS PROCEDURES

Claim forms and instructions for filing claims will be provided to Covered Persons by the Employer. Completed claim forms and any other required materials must be submitted to Horizon BCBSNJ or its designees for processing. Covered Persons do not need to file claims for In-Network Covered Services and Supplies. For Out-of-Network Covered Services and Supplies, Covered Persons will generally have to file a claim for benefits, unless a state law requires Providers to file claims on behalf of Covered Persons. In this case, however, a Covered Person still has the option to file claims on his/her own behalf.

If Horizon BCBSNJ fails to furnish claim forms to the Employer for delivery to Covered Persons, or if the Covered Person fails to receive them from the Employer within 15 days after requesting them, the Covered Person making a claim will be deemed to have met the requirements for giving proofs of loss (see item b. under "Submission of Claims", below) if he or she submits written proof of loss covering the occurrence, character and extent of the loss within the time limit for submitting such proof.

Submission of Claims

These procedures apply to the filing of claims. All notices from Horizon BCBSNJ will be in writing.

- a. If a Deductible applies under the Program, we recommend that it should be met before a claim is filed. Once the first claim is filed, we recommend that you send later claims: (a) when you or a covered Dependent Incurs \$100.00 or more in Covered Charges; or (b) whenever a lesser amount has been Incurred and four months have passed from the time you submitted your first claim.
- b. Claim forms must be filed no later than 18 months after the date the services were Incurred.
- c. 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.
- d. Bills for Prescription Drugs must contain: the prescription number; and the name, strength and quantity of the drug dispensed.
- e. Horizon BCBSNJ will pay all Clean Claims no later than 30 calendar days of receipt. If the claim is not a Clean Claim, we will pay any part of it that is complete and proper according to these time limits.
- f. If a claim is disputed or denied due to missing information or documentation, Horizon BCBSNJ will pay the claim within 30 calendar days after receipt of the missing information or documentation.
- g. 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 the applicable time frame specified in the section Appeals Process.

The denial notice will set forth:

1. the reason(s) the claim is denied;
2. specific references to the main Program provision(s) on which the denial is based;
3. a specific description of any further material or information needed to complete the claim, and why it is needed;

4. a statement that the claim is disputed, if this is so. If the dispute is about the amount of the claim, we will explain why and also explain any change of coding that we make;
 5. a statement of the special needs to which the claim is subject, if this is the case;
 6. an explanation of the Program'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 Program 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.
- h. If Horizon BCBSNJ does not process claims within any applicable time frame, Horizon BCBSNJ will pay interest on the claims as and to the extent required by law.
 - i. This applies if an Employee is 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 Program. We 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 the Employee's 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. Except for claims involving emergent or inadvertent services and/or unless you have assigned the benefits in accordance with the Assignment provision in this Booklet, payment for services of an Out-of-Network Provider, Facility or Practitioner will be made to you. A Covered Person may direct Horizon BCBSNJ, in writing, to pay for claims to the Provider, Facility or Practitioner who provided the Covered Service or Supply for which benefits became payable. Horizon BCBSNJ will Determine to pay the Covered Person, Provider, Facility or Practitioner, as applicable. But, Horizon BCBSNJ will not assume responsibility for making sure that the assignment was prepared correctly and/or that it correctly conveys the intention of the person who made it. We will not be held to know that one has been made unless it or a copy is filed with Horizon BCBSNJ. For more information about assignments under this Policy, please see the Assignment provision in the General Rules Section.
- 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 an Employee is the non custodial parent of a Child Dependent, Horizon BCBSNJ will pay claims filed as described in paragraph d. of the section "Submission of Claims" directly to: the Provider or Custodial parent; or the Division of Medical Assistance and Health Services in the Department of Human Services which administers the State Medicaid program, as appropriate.

If Horizon BCBSNJ pays anyone who is not entitled to benefits under this Program, Horizon BCBSNJ has the right to recover those payments.

APPEALS PROCESS

For the purposes of this "Appeals Process" section, the following terms used below have these meanings:

Adverse Benefit Determination (ABD): A denial, reduction or termination of, or a failure to make payment (in whole or in part) for a benefit. This includes such a denial, reduction, termination or failure that is due to: (a) eligibility; (b) a Rescission; (c) a policy exclusion or limitation that is not based on medical judgment or necessity; and/or (d) a decision involving the use of medical judgment.

Adverse Benefit Determination that is benefits based (ABD-Benefits): An ABD decision that: (a) is based on eligibility; (b) involves a Rescission; or (c) involves a policy exclusion or limitation that is not based on medical judgment.

Adverse Benefit Determination involving medical judgment (ABD-Medical): An ABD decision involving the use of medical judgment, e.g., that an item or service is deemed by the plan to be: not Medically Necessary or Appropriate; Experimental or Investigational; a Cosmetic Service; a dental item or service and therefore excluded.

Claim: A request by a Covered Person or Provider for payment relating to health care services or supplies.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination:

- (a) that has been upheld by Horizon BCBSNJ at the completion of the internal review process;
- (b) with respect to which Horizon BCBSNJ has waived its right to conduct an internal review;
- (c) for which Horizon BCBSNJ did not fully comply with internal appeals process requirements within the regulations promulgated by the State of New Jersey; or
- (d) for which the Covered Person or his/her Provider has applied for an expedited external review at the same time as applying for an expedited internal review.

Post-service Claim: Any Claim for a benefit that is not a Pre-service Claim.

Pre-service Claim: Any Claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on its approval in advance of obtaining medical care.

Rescission: A cancellation or discontinuance of coverage that has a retroactive effect. This does not include a loss of coverage due to a failure to timely pay: (a) required premiums; or (b) contributions to the cost of the coverage.

Urgent Care Claim: A Claim for medical care or treatment with respect to which application of the time periods for making a non-urgent determination:

- (a) could, in the judgment of a prudent layperson possessing an average knowledge of health and medicine, seriously jeopardize the life or health of the Covered Person, or the ability of the Covered Person to regain maximum function; or
- (b) would, in the opinion of a physician with knowledge of the Covered Person's medical condition, subject him/her to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Time Frame for Initial ABDs

A Covered Person shall be notified of Horizon BCBSNJ's initial Adverse Benefit Determination as quickly as possible based on the medical circumstances, but in no event later than:

- (a) 72 hours from receipt of an Urgent Care Claim;
- (b) 15 days from receipt of a Pre-service Claim (excluding claims made for Substance Use Disorders); or
- (c) 30 days from receipt of a Post-service Claim;
- (d) 24 hours from the receipt of a Pre-service Claim relating to Substance Use Disorders.

Horizon BCBSNJ will provide written notice of the decision within two business days and will include an explanation of the applicable appeals process.

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) may appeal Horizon BCBSNJ's ABD, as described below. Requests for administrative and utilization management determinations may be made by the Covered Person or by the attending health care provider acting on behalf of the member. The attending health care providers in those instances are deemed as the Covered Person's authorized representative. No Covered Person or Provider who files an appeal will be subject to disenrollment, discrimination or penalty by Horizon BCBSNJ.

Appeals Process for ABD-Medical - Excluding those related to Substance Use Disorders

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) may appeal an ABD-Benefits. Such an appeal must be filed within 180 days from the date of the ABD.

The appeal process for an ABD-Benefits consists of: (a) an informal internal review by Horizon BCBSNJ; and (b) if the initial decision is upheld, a formal second level internal review by Horizon BCBSNJ.

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) can appeal an ABD-Benefits by calling or writing Horizon BCBSNJ at the telephone number or address on the Covered Person's ID card. The Covered Person must include the following information:

- 1) the name(s) and address(es) of the Covered Person(s) or Provider(s) involved;
- 2) the Covered Person's ID number;
- 3) the date(s) of service;
- 4) the details regarding the actions in question;
- 5) the nature of and reason behind the appeal;
- 6) the remedy sought; and
- 7) the documentation to support the appeal.

Following the plan's review of the appeal, if the initial ABD-Benefits is upheld, the Covered Person, if still dissatisfied, can file an appeal for a formal second level review that will be decided by Horizon BCBSNJ professionals who were not involved in the prior decisions. All ABD-Benefits denials include

a written explanation of the appeals process with instructions on how to proceed to the next level of the appeals process.

The time frames for deciding appeals for ABD-Benefits are as follows:

- (a) For ABD-Benefits involving: an Urgent Care Claim; an Inpatient admission; the availability of medical care; the continuation of an Inpatient Facility stay; or a Claim for medical services for a Covered Person who has received emergency care, but who has not been discharged from a Facility: 72 hours.
- (b) For all other ABD-Benefits: 15 calendar days for Pre-service Claims; 30 calendar days for Post-service Claims. The same time frames apply for the formal second level internal review.

For each level of appeal, Horizon BCBSNJ will provide the Covered Person and/or the Provider with notice of the outcome, and if the ABD-Benefits is upheld, instructions for filing for the next level of review. If the initial ABD-Benefits is upheld through both levels of the internal review process, no further remedies are available from Horizon BCBSNJ. In this event, Horizon BCBSNJ will provide the Covered Person with information regarding the availability of and contact information for the consumer assistance program of the New Jersey Department of Banking and Insurance. The Department's address and phone number appear below in subsection d. of the following section.

Appeals Process for ABD-Medical

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) may appeal an ABD-Medical. The appeal process for Adverse Benefit Determinations involving medical judgment (ABD-Medical) consists of: (a) an informal Stage 1 internal review by Horizon BCBSNJ; (b) a formal Stage 2 internal review by Horizon BCBSNJ; and (c) a formal external review by an Independent Utilization Review Organization (IURO). The initial appeal must be filed within 180 days after Horizon BCBSNJ's initial ABD-Medical.

Any ABD-Medical will be culturally and linguistically appropriate and will include the following timely information:

- 1) Information identifying the claim involved, including: the date of service; the health care Provider; the claim amount (if applicable); and a statement about the availability, upon request, of the diagnosis and treatment codes, and their corresponding meaning.
- 2) The reason(s) for the denial, including: the denial code and its meaning; and a description of the standard used by Horizon BCBSNJ in the denial.
- 3) Information regarding the availability of, and contact information for, the consumer assistance program of the New Jersey Department of Banking and Insurance. (The Department's address and phone number appear below in subsection d.)

Also, Horizon BCBSNJ will timely provide to the Covered Person and/or the Provider acting on his/her behalf, free of charge, any new or additional evidence or rationale, however generated, that Horizon BCBSNJ will rely upon, consider or use in connection with an ABD-Medical.

Except as otherwise provided below, a Covered Person must follow the steps for filing the three levels of appeal. If these steps are not followed, the Covered Person's appeal review may be delayed or forfeited.

a. First Level Appeal - Stage 1

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) can file a First Level Stage 1 Appeal by calling or writing Horizon BCBSNJ at the telephone number or address on the Covered Person's ID card. At the First Level Appeal, a Covered Person may discuss the ABD-Medical directly with the Horizon BCBSNJ physician who made it, or with the medical director designated by Horizon BCBSNJ.

To submit a First Level Appeal, the Covered Person must include the following information:

- 1) the name(s) and address(es) of the Covered Person(s) or Provider(s) involved;
- 2) the Covered Person's ID number;
- 3) the date(s) of service;
- 4) the details regarding the actions in question;
- 5) the nature of and reason behind the appeal;
- 6) the remedy sought; and
- 7) the documentation to support the appeal.

Horizon BCBSNJ will decide First Level Appeals within 72 hours in the case of an ABD-Medical involving:

- (a) an Urgent Care Claim or a Medical Emergency;
- (b) an Inpatient admission;
- (c) the availability of medical care;
- (d) the continuation of an Inpatient Facility stay; or
- (e) a Claim for medical services for a Covered Person who has received emergency care, but who has not been discharged from a Facility.

Horizon BCBSNJ will decide all other First Level Stage 1 ABD-Medical Appeals within ten calendar days of receipt of the required documentation. Horizon BCBSNJ will provide the Covered Person and/or the Provider with: (a) written notice of the outcome; (b) the reasons for the decision; and (c) if the initial ABD-Medical is upheld, instructions for filing a Second Level Stage 2 Appeal.

b. Second Level Appeal - Stage 2

If a Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) is not satisfied with Horizon BCBSNJ's First Level Appeal decision, the Covered Person or Provider can file for, orally or in writing, a Second Level Stage 2 Appeal of the ABD-Medical to be decided by a panel of physicians and/or other health care professionals selected by Horizon BCBSNJ who were not involved in the original and First Level Appeal decisions. The panel shall have access to consultant Practitioners who are trained or who practice in the same specialty that would typically manage the case at issue being appealed. Upon the Covered Person's or Provider's request, such Consultant Practitioners will participate in the Second Level Stage 2 Appeal.

Horizon BCBSNJ will acknowledge the filing of Second Level Appeals in writing within ten business days of receipt and include instructions regarding the scheduling and how to participate in the Second Level Stage 2 Appeal hearing. Following the hearing, Horizon BCBSNJ will then provide written notice of the final decision on the appeal within 72 hours in the case of an ABD-Medical involving:

- (a) an Urgent Care Claim or a Medical Emergency;
- (b) an Inpatient admission;
- (c) the availability of medical care;
- (d) the continuation of an Inpatient Facility stay; or
- (e) a Claim for medical services for a Covered Person who has received emergency care, but who has not been discharged from a Facility.

Horizon BCBSNJ will decide all other Second Level Stage 2 Appeals of ABD-Medical within 20 business days.

If the Second Level Appeal is denied, Horizon BCBSNJ will provide the Covered Person and/or Provider with written notice of the reasons for the denial, together with a written notice of his/her right to proceed to an external appeal. Horizon BCBSNJ will include: (a) specific instructions as to how the Covered Person and/or Provider may arrange for such an external appeal; and (b) any forms needed to start the appeal.

c. Right to Waive Horizon BCBSNJ's Internal Appeal Process

In certain circumstances, a Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) may not have to complete Horizon BCBSNJ's internal appeals process with respect to an ABD-Medical, and may proceed directly to the external appeal process described below, if:

- (a) Horizon BCBSNJ does not meet a time frame described above for the First and Second Level Appeals;
- (b) Horizon BCBSNJ waives its right to an internal review; or
- (c) the Covered Person or his/her Provider has applied for an expedited external review at the same time as applying for an expedited internal review.

With respect to (a), above, this right to proceed to the external appeal without completing the internal appeals process will not apply if Horizon BCBSNJ can show that: (a) the violation did not cause, and is not likely to cause, prejudice or harm to the Covered Person and/or Provider; (b) the violation was for a good reason or due to matters beyond Horizon BCBSNJ's control; (c) the violation occurred in the context of an ongoing, good faith exchange of information between Horizon BCBSNJ and the Covered Person and/or Provider; and (d) the violation is not reflective of a pattern or practice of non-compliance by Horizon BCBSNJ.

If Horizon BCBSNJ claims this exception, the Covered Person or his/her Provider may ask for a written explanation of the violation from Horizon BCBSNJ. Horizon BCBSNJ must then provide the explanation within ten calendar days. It must include a description of the basis for the assertion that the violation should not cause the internal process to be waived. Questions regarding this exception shall be decided by an external reviewer.

If it is determined that Horizon BCBSNJ meets the standard for the exception to part (a), the Covered Person and/or his/her Provider may then resubmit and pursue the internal appeal. Horizon BCBSNJ will then, within ten calendar days after that determination, notify the Covered Person and/or his/her Provider of that right. The time frame for refiling the Claim will start upon the Covered Person's and/or Provider's receipt of the notice.

d. External Appeal

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) who is dissatisfied with the results of Horizon BCBSNJ's internal appeal process with respect to an ABD-Medical can pursue an external appeal with an IURO assigned by the State of New Jersey Department of Banking and Insurance (the DOBI). Except as otherwise described above under part (c), the Covered Person's right to such an appeal depends on the Covered Person's full compliance with both stages of Horizon BCBSNJ's internal appeal process.

To start an external appeal, the Covered Person or Provider must submit a written request within four months from receipt of Horizon BCBSNJ's Final Internal Adverse Benefit Determination (or within four months from the date of an occurrence described in (a), (b) or (c) under "Right to Waive Horizon BCBSNJ's Internal Appeals Process", above).

The Covered Person or Provider must use the required forms and include both: (a) a **\$25.00** check made payable to "New Jersey Department of Banking and Insurance"; and (b) an executed release to enable the IURO to obtain all medical records pertinent to the appeal, to:

**New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
P.O. Box 329
Trenton, New Jersey 08625-0329
(888) 393-1062**

The **\$25.00** fee will be refunded to the Covered Person or Provider if the IURO reverses Horizon BCBSNJ's ABD-Medical decision.

If the Covered Person cannot afford to pay the fee, the fee will be waived if the Covered Person can show proof of financial hardship. Proof of financial hardship can be demonstrated through evidence that one or more members of the household are receiving aid or benefits under: Pharmaceutical Assistance to the Aged and Disabled; Medicaid; General Assistance; Social Security Insurance; NJ FamilyCare; or the New Jersey Unemployment Assistance program. Annual filing fees for any one Covered Person shall not exceed **\$75.00**.

Upon receipt of the request for the appeal, together with the executed release and the appropriate fee, if any, the DOBI shall immediately assign the appeal to an IURO to conduct a preliminary review and accept it for processing. But this will happen only if the IURO finds that:

1. the person is or was a Covered Person of Horizon BCBSNJ;
2. the service or supply which is the subject of the appeal reasonably appears to be a Covered Service or Supply under the Covered Person's Program; and
3. the Covered Person has furnished all information needed by the IURO and the DOBI to make the preliminary determination. This includes: the appeal form; a copy of any information furnished

by Horizon BCBSNJ regarding its Final Adverse Benefit Determination; and the fully executed release.

Upon completion of this review, the IURO will immediately inform the Covered Person or Provider, in writing, as to whether or not the appeal has been accepted for review. If it is not accepted, the IURO will give the reasons.

If the appeal is accepted, the IURO will notify the Covered Person and/or his/her Provider of the right to submit in writing, within five business days, any further information to be considered in the review. The IURO will provide Horizon BCBSNJ with any such information within one business day after its receipt.

The IURO will complete its review and issue its decision in writing within 45 calendar days from its receipt of the request for the review. But that time frame will be reduced to 48 hours if the appeal involves any of the following:

- (a) An Urgent Care Claim or a Medical Emergency.
- (b) An Inpatient admission.
- (c) The availability of medical care.
- (d) The continuation of an Inpatient Facility stay.
- (e) A Claim for medical services for a Covered Person who has received emergency care, but who has not been discharged from a Facility.
- (f) A medical condition for which the standard time frame would seriously jeopardize the life or health of the Covered Person or his/her ability to regain normal function.

When the IURO completes its review, it will state its findings in writing and make a determination of whether Horizon BCBSNJ's denial, reduction, or termination of benefits deprived the Covered Person of Medically Necessary and Appropriate treatment. If a decision made within 48 hours was not in writing, the IURO will provide a written confirmation within 48 hours after the verbal decision.

If the IURO determines that the denial, reduction, or termination of benefits deprived the Covered Person of Medically Necessary and Appropriate treatment, this will be conveyed to the Covered Person and/or Provider and Horizon BCBSNJ. The IURO will also describe the Medically Necessary and Appropriate services that should be received. This determination is binding upon Horizon BCBSNJ and the Covered Person, except to the extent that other remedies are available to either party under state or federal law.

If all or part of the IURO's decision is in favor of the Covered Person, Horizon BCBSNJ will provide coverage for those Covered Services and Supplies that are determined to be Medically Necessary and Appropriate. Unless there is a judicial decision stating otherwise, this will be done without delay even if Horizon BCBSNJ intends to seek a judicial review or other remedies.

And within ten business days of its receipt of a decision in favor of the Covered Person, (or sooner, if the medical facts of the case indicate a more rapid response), Horizon BCBSNJ will send a written report to: the IURO; the Covered Person and/or Provider; and the DOBI that describes how Horizon BCBSNJ will implement the IURO's determination.

Appeals Process for ABD-Medical - Exclusive to Substance Use Disorders

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) may appeal an ABD-Medical with respect to Substance Use Disorders.

The appeal process for Adverse Benefit Determinations involving medical judgment with respect to Substance Use Disorders consists of the following:

- (a) an expedited internal review by Horizon BCBSNJ (a "Substance Use Disorders Stage One Appeal"); and
- (b) a formal expedited external review with the Independent Health Care Appeals Program at DOBI (a "Substance Use Disorders Stage 2 Appeal").

Substance Use Disorders Stage 1 Appeal

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) can file a Substance Use Disorders Stage 1 Appeal by calling or writing Horizon BCBSNJ at the telephone number and address on the Covered Person's ID card. At the Substance Use Disorders Stage 1 Appeal, a Covered Person may discuss the ABD-Medical directly with the Horizon BCBSNJ physician who made it, or with the medical director designated by Horizon BCBSNJ.

To submit a Substance Use Disorders Stage 1 Appeal, the Covered Person must include the following information:

1. the name(s) and address(es) of the Covered Person(s) or Provider(s) involved;
2. the Covered Person's ID number;
3. the date(s) of service;
4. the details regarding the actions in question;
5. the nature of and reason behind the appeal;
6. the remedy sought; and
7. the documentation to support the appeal.

Horizon BCBSNJ will decide Substance Use Disorders Stage 1 Appeals within 24 hours. Horizon BCBSNJ will provide the Covered Person and/or the Provider with: (a) written notice of the outcome; (b) the reasons for the decision; and (c) if the initial ABD-Medical is upheld, instructions for filing a Substance Use Disorders Stage 2 Appeal.

Substance Use Disorders Stage 2 Appeal

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) who is dissatisfied with the results of Horizon BCBSNJ's internal appeal process with respect to a ABD-Medical can pursue a Substance Use Disorders Stage 2 Appeal, an expedited external appeal with an IURO assigned by the DOBI. The procedures for filing a Substance Use Disorders Stage 2 Appeal are the same as in those set forth above in "External Appeal".

When the IURO completes its review, it will state its findings in writing and make a determination of whether Horizon BCBSNJ's denial, reduction, or termination of benefits deprived the Covered Person of Medically Necessary and Appropriate treatment. The IURO will provide its decision within 48 hours from its receipt of the request for the review.

COVERED PERSONS' RIGHTS

A Covered Person has the right to:

- Formulate and have advance directives implemented in accordance with applicable law;
- Receive prompt written notice of benefit changes or the termination of benefits or services, no later than 30 days following the date of any such change or termination;
- File a complaint with New Jersey's Department of Banking and Insurance;

**New Jersey Department of Banking and Insurance
20 West State Street
(P.O. Box 325)
Trenton, NJ 08625-0325
(609) 292-5360**

- Access Covered Services and Supplies, and receive the Program's benefits for them, and have care available 24 hours a day, seven days a week, for Medical Emergencies and Urgent Care;
- Appeal a denial, reduction or termination of health care services or benefits pursuant to a utilization management decision by or on behalf of Horizon BCBSNJ;
- Be treated with courtesy, consideration, and with respect to his/her dignity and need for privacy;
- Be provided with information concerning our policies and procedures regarding products, services, providers, appeals procedures, and with other information about the organization and the care provided;
- Obtain a current directory of Network Providers upon request, including addresses and telephone numbers, and a listing of Providers who accept Covered Persons who speak languages other than English.

SERVICE CENTERS

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

Telephone personnel are available twenty-four hours a day, seven days a week.

For Prescription Drug coverage, please call **Prime Therapeutics LLC (Prime) Service Centers** at:

1-800-370-5088

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

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

The company office or enrollment official to contact about coverage:

The identification number shown on my identification card:

The effective date when my coverage begins:

My group number is:

CIVIL UNION RIDER

I. The following terms shall have the meanings set forth below:

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.

II. Pursuant to New Jersey law, your Booklet is changed in the following respects:

- (a) Except as otherwise provided in (c), below, all of the rights, benefits, obligations and privileges granted under the Policy to an Employee with respect to a Spouse and their Child Dependents shall also apply equally with respect to: (i) an Employee and a person with whom he/she has established a Civil Union; and (ii) the Child Dependents of the Employee and his/her Civil Union Partner.
- (b) Except as otherwise provided in (c), below, any provision of the Policy that affects a Spouse upon his/her divorce or legal separation from the Employee shall, subject to the Policy's terms and conditions, also equally affect an Employee's Civil Union Partner upon dissolution of the Civil Union. Such provisions include, but are not limited to, the following:
 - (i) Termination of the Civil Union Partner's coverage.
 - (ii) The right of the Civil Union Partner to convert to an individual health policy.
- (c) Regardless of anything above to the contrary, any right to continue the Policy's coverage that is granted to an Employee's Spouse pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, shall not apply with respect to an Employee's Civil Union Partner.

