Product:	**HORIZON HMO**
Company Name:	**NJ TRANSIT-RAIL-ACTIVE**
Group Number:	**76105-1121,1124,1221,1224**

Introduction

This booklet describes the benefits and other important features of Your group's coverage with Horizon Healthcare of New Jersey, Inc. (Horizon HMO).

You should read this booklet carefully so that You know the health care benefits available to You and Your family.

Your benefits are self-insured through NJ TRANSIT. Benefits under this Plan are offered to you in accordance with your collective bargaining agreement.

NJ TRANSIT pays most of the cost of your Health Care Plan. You are required to contribute toward the cost of the coverage for you and your eligible dependents. Contribution amounts will be announced annually.

If You have questions, contact Your Plan's Member Services representative at the number shown on Your identification card.

This Evidence of Coverage replaces any booklet You may have received previously.

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Schedule of Covered Services and Supplies

COVERED SERVICES AND SUPPLIES UNDER YOUR GROUP'S PROGRAM ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE AND ARE DETERMINED PER BENEFIT PERIOD BASED ON THE PLAN'S ALLOWANCE, UNLESS OTHERWISE STATED.

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

The Plan will provide coverage for the Covered Services and Supplies listed in Your group's program subject to the terms, conditions, limitations and exclusions stated within the program.

Services and supplies are covered when provided by the PCP You selected to coordinate overall health care, or through a Referral by the PCP. With respect to certain Illnesses or conditions as Determined by the Plan, a Special Referral may be provided.

No services and supplies are covered under Your group's program unless the PCP or Referred Specialist has provided them or coordinated them before the Covered Service or Supply was provided, except for services or supplies provided during a Medical Emergency.

All treatment for Mental or Nervous Disorders and Chemical Dependency, and as otherwise designated by the Plan, must be Certified and coordinated by Magellan Behavioral Health, except as otherwise provided in Your group's program.

A. BASIC COVERED SERVICES AND SUPPLIES

LIFETIME MAXIMUM	Unlimited.
FACILITY BENEFIT DAYS	365 Benefit Days of Inpatient care per Benefit Period and 365 Benefit Days of Outpatient care per Benefit Period.
COINSURANCE	No Coinsurance applies to basic services and supplies.
EMERGENCY ROOM COPAYMENT	$**35.00** per Visit to the Outpatient department of a Hospital, an Ambulatory Surgery Center, or other eligible Facility for an Injury or a Medical Emergency (waived if Admitted directly).
OUTPATIENT SERVICES	**$35.00** Copayment per Visit to the Outpatient department of a Hospital, an Ambulatory Surgery Center, or other eligible Facility.

AMBULANCE SERVICES	Subject to Certification except in a Medical Emergency situation.
PREVENTIVE CARE SERVICES	**$0.00** Copayment
PRIMARY CARE PHYSICIAN SERVICES	**$5.00** Copayment per Out-of-Hospital Visit
– **HOUSE CALLS**	**$25** Copayment applies if the house call is made between 7:00 a.m. and 9:00 p.m. **$35** Copayment applies if the house call is made between 9:00 p.m. and 7:00 a.m.
– **MATERNITY CARE**	**$5.00** Copayment for the initial Visit only.

NOTE: These Copayments apply to all Visits to or by a PCP unless otherwise specified in this Section.

SPECIALIST SERVICES	**$5.00** Copayment per Out-of-Hospital Visit for services performed by a Specialist to whom the Member was Referred by his PCP.
– **MATERNITY CARE**	**$5.00** Copayment for the initial Visit only.
ELECTIVE ABORTIONS	2 per Benefit Period and 4 Per Lifetime.
HOME HEALTH AGENCY SERVICES	100 Visits per Benefit Period.
HOSPICE CARE PROGRAM MAXIMUM	Unlimited Per Lifetime.
INFERTILITY SERVICES	**$5,000** Per Lifetime maximum for all Covered Services and Supplies. This is a combined Per Lifetime maximum for both the Member and his Spouse.

MENTAL OR NERVOUS DISORDERS OR CHEMICAL DEPENDENCY:

Benefits are based on the type and place of service and are provided on the same basis as for other conditions.

NUTRITIONAL SERVICES	3 Visits to a nutritionist per Benefit Period.

THERAPY SERVICES:	**$5.00** Copayment per Visit. Payment will be made for a maximum of up to **25 Visits** per Benefit Period.
OCCUPATIONAL THERAPY **PHYSICAL THERAPY** **RESPIRATION THERAPY** **SPEECH THERAPY**	
CHIROPRACTIC CARE	**$5.00** Copayment per Visit. Payment will be made for a maximum up to 12 visits per Benefit Period. Payment will be 50% of the Allowance for the first 6 Visits and 25% of the Allowance for the remaining Eligible Visits. These Visits are Eligible without a Referral from the Member's PCP.
SKILLED NURSING FACILITY SERVICES MAXIMUM	60 Benefit Days of Inpatient care at an Eligible Facility.
VISION SERVICES	**$0.00** Specialist Copayment applies. Payment of **$50** per Member for eyeglasses or contact lenses every **24** months. **NOTE:** When this Contract provides benefits for either eyeglasses or contact lenses in a given Benefit Period to a Member, that Member is not entitled to benefits for these supplies during the next Benefit Period.

B. SUPPLEMENTAL COVERED SERVICES AND SUPPLIES

COINSURANCE	**80%** of the Allowance for Covered Services and Supplies Eligible under supplemental coverage, unless otherwise specified in this section.
DEDUCTIBLE	**$0.00** per Member per Benefit Period.
COINSURANCE CAP	Once the Member has contributed **$400** of Coinsurance toward Covered Services and Supplies in a Benefit Period, coverage for Eligible expenses for Covered Services and Supplies incurred during the remainder of that Benefit Period will increase from 80% to 100% of the Allowance.
COINSURANCE CHARGE LIMIT	Once the Member has incurred **$2,000** of expenses for Covered Services and Supplies in a Benefit Period, coverage for Eligible expenses for Covered Services and Supplies during the remainder of that Benefit Period will increase from **80%** to **100%** of the Allowance.
FAMILY COINSURANCE CAP	If 2 members of the same family enrolled under the same Coverage Type under this Contract each meet the Coinsurance Cap in the same Benefit Period, coverage for expenses incurred thereafter for Covered Services and Supplies in that Benefit Period by all enrolled Eligible family members will increase from **80%** to **100%** of the Allowance.
LIFETIME MAXIMUM	**Unlimited** per Member. Applies to Eligible supplemental Covered Services and Supplies.

LIMITATIONS ON PAYMENT:

FOOT ORTHOTICS	**80%** of the Allowance, up to **$100,000** Per Lifetime maximum for all Covered Services and Supplies. Subject to 1 pair per Benefit Period.
INPATIENT PHYSICAL REHABILITATION SERVICES MAXIMUM	60 Benefit Days of Inpatient care per Benefit Period per Member.

OUT-OF-HOSPITAL PRIVATE-DUTY NURSING SERVICES	Maximum 60 8-hour shifts per Benefit Period per Member. Subject to **$100,000** Lifetime Maximum.
WIG BENEFIT	Subject to Deductible and **80%** Coinsurance.

Definitions

The words shown below have special meanings when used in this Evidence of Coverage. Please read these definitions carefully. These defined terms appear throughout with their initial letter capitalized.

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

Admission – Benefit Days of Inpatient services provided to a Member.

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

Affidavit of Domestic Partnership: an affidavit that sets forth each party's name and age, the parties' common mailing address, and a statement that, at the time the affidavit is signed, both parties meet the requirements of New Jersey law for entering into a Domestic Partnership and wish to enter into a Domestic Partnership with each other.

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

Allowance – a dollar amount Determined by the Plan as reasonable, customary and appropriate for Covered Services and Supplies, unless otherwise required by law.

Alternate Payee:

a. A custodial parent, who is not an Employee under the terms of the Plan, of a Child Dependent; or

b. The Division of Medical Assistance and Health Services in the New Jersey Department of Human Services which administers the State Medicaid Program.

Ambulance – a Certified transportation vehicle for transporting Ill or Injured people, or people with other conditions, that contains all life-saving equipment and staff as required by state and local law.

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

a. It must:

   1. be staffed by Practitioners and Nurses under the supervision of a physician;

   2. have permanent operating and recovery rooms;

3. be staffed and equipped to give Medical Emergency care; and

4. have written back-up arrangements with a local Hospital for Medical Emergency care.

b. The Plan will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

1. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or

2. approved for its stated purpose by Medicare.

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

Benefit Day: Each of the following:

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

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

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

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

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

a. It must:

1. provide full-time Skilled Nursing Care by or under the supervision of Nurses;

2. be staffed and equipped to give Medical Emergency care; and

3. have written back-up arrangements with a local Hospital for Medical Emergency care.

b. The Plan will recognize it if:

1. it carries out its stated purpose under all relevant state and local laws; or

2. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or

3. it is approved for its stated purposes by Medicare.

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

Chemical Dependency – abuse of or addiction to drugs or controlled substances, including alcoholism.

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

- Proof of Dependent eligibility, such as birth certificate, Dependent's social security number and a marriage certificate, will be required when your Dependents enroll for coverage;

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

- You, your Spouse's or Same Sex Domestic/Civil Union Partner's legal ward. But, proof of guardianship satisfactory to the Plan must be furnished to us when we ask.

- Foster children are not included.

A Child Dependent is covered, regardless of the child's:

(1) financial dependency on a Covered Person;

(2) marital status or Domestic Partner;

(3) residency with a Covered Person;

(4) student status;

(5) employment;

(6) eligibility for other coverage.

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

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 (HMO CMA App (10/97)) at the end of the Booklet for information about Civil Unions.

Coinsurance – the percentage applied to the Allowance for certain Covered Services and Supplies in order to calculate benefits under Your group's contract.

Coinsurance Cap – the maximum amount of Coinsurance a Member must pay before no further Coinsurance is required.

Coinsurance Charge Limit – the amount of expenses for Covered Services or Supplies a Member must incur before no Coinsurance is required.

Copayment – a specified dollar amount a Member must pay for specified Covered Services and Supplies or per specified period of time, as indicated in the Schedule of Covered Services and Supplies.

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

a. Surgery to correct the result of an Injury;

b. Surgery to treat a condition, including a birth defect, which impairs the function of a body organ;

c. Surgery to reconstruct a breast after a mastectomy is performed.

d. Treatment of newborns to correct congenital defects and abnormalities.

e. Treatment of cleft lip.

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

a. Surgery to correct gynecomastia;

b. Breast augmentation procedures, including their reversal for women who are asymptomatic;

c. Reversal of breast augmentation procedures for asymptomatic women who had reconstructive Surgery or who previously had breast implants for cosmetic purposes;

d. Rhinoplasty, except when performed to treat an Injury;

e. Lipectomy;

f. Ear or other body piercing.

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

Coverage Type – any of the different forms of coverage combinations listed in Section 5, under the heading "Types of Coverage Available."

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

supplies must be:

a. Furnished or ordered by a Provider; and

b. For Preventive Care, or Medically Necessary and Appropriate to diagnose or treat an Illness (including Mental or Nervous Disorders) or Injury.

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

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

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

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

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

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

Day Programs: Outpatient personalized or packaged programs that: (a) are designed primarily for patients who are medically stable enough to live at home, but who may require certain therapies; (b) offer multiple therapies in a day setting; and (c) are usually scheduled for three to five days a week and five to nine and a half hours per day. Some examples of the therapies offered are: cognitive therapy; recreation therapy; work hardening programs; vocational therapy; group cognitive/interpersonal therapy; remedial treatments; and treatments to improve interpersonal communication and social skills. "Day Programs" do not include outpatient programs for the treatment of mental illnesses.

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

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

a. radiology, ultrasound and nuclear medicine;

b. laboratory and pathology; and

c. EKGs, EEGs and other electronic diagnostic tests.

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 the State in which he or she resides or a member of another Domestic Partnership;

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

(5) Both persons are of the same sex and therefore unable to enter into a marriage with each other that

is recognized by the State law in which he or she resides, 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;

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

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

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

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

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

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

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

d. It is suitable for use in the home.

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

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

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

Employer: Collectively, all employers included under the Plan.

Enrollment Date – with respect to a Covered person, the effective date of his coverage or, if earlier, the first day of any applicable waiting period.

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

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

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

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

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

b. There must be sufficient proof, published in peer-reviewed scientific literature, that confirms the effectiveness of the Technology. That proof must consist of well-designed and well-documented investigations. But, if such proof is not sufficient or is questionable, the Plan may consider opinions about and evaluations of the Technology from appropriate specialty advisory committees and/or specialty consultants.

c. The Technology must result in measurable improvement in health outcomes, and the therapeutic benefits must outweigh the risks, as shown in scientific studies. "Improvement" means progress toward a normal or functional state of health.

d. The Technology must be as safe and effective as any established modality. (If an alternative to the Technology is not available, the Plan may, to determine the safety and effectiveness of a Technology, consider opinions about and evaluations of the Technology from appropriate specialty advisory committees and/or specialty consultants.)

e. The Technology must demonstrate effectiveness when applied outside of the investigative research setting.

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

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

Even if such an "off-label" use of a drug is not supported in one or more of the above compendia, the Plan

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

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

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

Explanation of Benefits (EOB) – the statement sent to Members by the Plan listing services provided, amount billed and Payment made.

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

Family or Medical Leave of Absence – a period of time of predetermined length, approved by the Employer, during which the Employee does not work, but after which the Employee is expected to return to Active service. Any Employee who has been granted an approved Leave of Absence in accordance with the Family and Medical Leave Act of 1993 shall be considered to be Active for purposes of eligibility for Covered Services and Supplies under Your group’s contract.

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

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

Group Health Plan: An Employee welfare benefit plan to the extent that the Plan provides medical care and includes items and services paid for as medical care to Employees and/or their dependents directly or through insurance, reimbursement or otherwise.

HIPAA – the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191.

Home Health Agency: A Provider which mainly provides care for an ill or injured person in the person's home under a home health care program designed to eliminate Hospital stays. The Plan will recognize it

if it: (a) is licensed by the state in which it operates; or (b) is certified to take part in Medicare as a Home Health Agency.

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

a. The care must be given on a part-time or intermittent basis, except if full-time or 24-hour services are Medically Necessary and Appropriate on a short-term basis.

b. Continuing Inpatient stay in a Hospital would be needed in the absence of Home Health Care.

c. The care is furnished under a physician's order and under a plan of care that: (a) is established by that physician and the Home Health Care Provider; (b) is established within 14 days after Home Health Care starts; and (c) is periodically reviewed and approved by the physician.

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

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

Horizon HMO – Horizon Healthcare of New Jersey, Inc., d/b/a Horizon HMO.

Hospice: A Provider which mainly provides palliative and supportive care for terminally ill or terminally injured people under a Hospice Care Program. The Plan will recognize a Hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. approved for its stated purpose by Medicare; or

b. accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

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

Hospital: A Facility which mainly provides Inpatient care for ill or injured people. The Plan will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited as a hospital by the Joint Commission: or

b. approved as a hospital by Medicare.

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

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

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

Illness: A sickness or disease suffered by a Covered Person.

Infertility: a disease or condition that results in the abnormal function of the reproductive system such that: (i) a male is unable to impregnate a female; (ii) a female under 35 years of age is unable to conceive after two years of unprotected sexual intercourse; (iii) a female 35 years of age and over is unable to conceive after one year of unprotected sexual intercourse; (iv) the male or female is medically sterile, or (v) the female is unable to carry a pregnancy to live birth. Infertility shall not mean a person who has been voluntarily sterilized regardless of whether the person has attempted to reverse the sterilization. But, it shall mean a partner of such person if the person has successfully reversed sterilization and the partner meets the other conditions of this section.

Artificial insemination: the introduction of sperm into a woman’s vagina or uterus by noncoital methods for the purpose of conception, and includes intrauterine insemination.

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

Carrier: a health service corporation; a hospital service corporation; a medical service corporation; an insurance company; and, a health maintenance organization.

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

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

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

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

Embryo: a fertilized egg that has begun cell division and has completed the pre-embryonic stage.

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

Fertilization: the penetration of the egg by the sperm.

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

Gamete Intrafallopian tube transfer (GIFT): the direct transfer of a sperm/egg mixture into the fallopian tube by laparoscopy, where fertilization takes place inside the fallopian tube.

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

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

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

In vitro fertilization (IVF): an Assisted reproductive technologies procedure whereby eggs are removed from a woman's ovaries and fertilized outside her body. The resulting embryo is then transferred into a woman's uterus.

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

Oocyte: the female egg or ovum.

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

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

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

Zygote: a fertilized egg before cell division begins.

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

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

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

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

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

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

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

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

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

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

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

- credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
- physician and health care Provider specialty society recommendations;
- the views of physicians and health care Providers practicing in relevant clinical areas; and
- 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 – Parts A and B of the health care program for the aged and disabled provided by Title XVII of the United States Social Security Act, as amended from time to time.

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

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

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

(2) Conditions related to behavior problems or learning disabilities, except with respect to the treatment of Mental or Nervous Disorders.

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

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

Network – the Horizon Managed Care Network.

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

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

a. is properly licensed or certified to provide medical care under the laws of the state where he/she practices; and

b. provides medical services which are: (a) within the scope of his/her license or certificate; and (b) are covered by this Plan.

Optical Services – services or supplies provided to a person for eyeglass lenses and/or frames and contact lenses. Optical Services are limited to:

a. facial measurements,

b. assistance in frame selection,

c. acquiring proper lenses and frames,

d. fitting and adjustments, and

e. after-care for verification of fitting and lens adjustment, and for maintenance of comfort and efficiency.

Out-of-Area Urgent Care – Outpatient or Out-of-Hospital medical care which, as Determined by the Plan or an entity designated by the Plan, is (1) rendered outside the Service Area, and (2) required by an unexpected Illness or Injury or other condition that is not life threatening, but should be treated before the Member returns to the Service Area.

Out-of-Hospital – services or supplies provided to a Member other than as an Inpatient or Outpatient.

Out-of-/Non-Network – a Provider, or the services and supplies provided by a Provider, who does not have an agreement with the Plan to provide Covered Services or Supplies.

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

Partial Hospitalization: Intensive short-term non-residential day treatment services that are: (a) for Mental or Nervous Disorders; chemical dependency; or Alcoholism; and (b) rendered for any part of a day for a minimum of four consecutive hours per day.

Per Lifetime: During the lifetime of a person.

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

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

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

b. approved for its stated purpose by Medicare.

Plan: The **NJ TRANSIT** Medical Plan.

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

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

a. is properly licensed or certified to provide medical care under the laws of the state where he/she practices; and

b. provides medical services which are: (a) within the scope of the license or certificate; and (b) are covered by this Plan.

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

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

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

Primary Care Provider (PCP): A duly licensed family practitioner, internist or pediatrician who has entered into an agreement with us to participate in the Horizon Managed Care Network and is responsible for coordinating all aspects of medical care for those members who have selected him or her. These responsibilities include personally providing medical care or referring members to the appropriate source for medical care, whether that source is a specialist physician, ancillary physician or inpatient facility. In addition, other specialists or health care professionals with appropriate qualifications may serve as a member's Primary Care Physician where Horizon BCBSNJ so agrees.

For information on how to select a PCP, and for a list of In-Network PCPs or Practitioners who specialize

in obstetrics or gynecology, access Horizon BCBSNJ's website at www.horizonblue.com.

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

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

Referral (or Referred) – a written recommendation by the Member's PCP or Specialist as Determined by the Plan for the Member to receive services from another Provider.

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

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

b. approved for its stated purpose by Medicare.

Residential Treatment – residential and non-residential treatment for Mental or Nervous Disorders or Chemical Dependency provided by or in a Facility. The Plan will recognize it if it carries out its stated purpose under all relevant state and local laws.

Routine Eye Examination:

a. A comprehensive medical examination of the eye (with or without definitive refraction) performed by an ophthalmologist. Covered Services include, but are not limited to: a diagnostic ophthalmic exam with medical diagnosis, prescription of lenses, post-cycloplegic exam, and verification of lenses; or

b. Vision survey and analysis performed by an optometrist. Covered Services include, but are not limited to: case history, complete refraction, coordination measurements and tests, visual field charting and prescription of lenses.

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

Service Area – the geographic area defined by the zip codes in the State of New Jersey.

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

Skilled Nursing Facility: A Facility which mainly provides full-time Skilled Nursing Care for ill or injured people who do not need to be in a Hospital. The Plan will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or

b. approved for its stated purpose by Medicare. In some places, a Skilled Nursing Facility may be called an "Extended Care Center" or a "Skilled Nursing Center."

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

Specialist Physician: A fully licensed physician who:

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

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

(c) is currently admissible to take the exam administered by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association; or has evidence of completion of an appropriate qualifying residency approved by the American Medical Association or American Osteopathic Association; or

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

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

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

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

Substance Abuse Centers: Facilities that mainly provide treatment for people with Substance Abuse problems or Alcoholism. The Plan will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or

b. approved for its stated purpose by Medicare.

Surgery/Surgical:

a. The performance of generally accepted operative and cutting procedures, including: surgical diagnostic procedures; specialized instrumentations; endoscopic exams; and other invasive procedures;

b. The correction of fractures and dislocations;

c. Pre-operative and post-operative care; or

d. Any of the procedures designated by C.P.T. codes as Surgery.

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

a. ordered by a Practitioner;

b. performed by a Provider;

c. Medically Necessary and Appropriate for the treatment of a Covered Person's Illness or Accidental Injury.

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

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

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

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

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

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

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

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

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

Speech Therapy: Therapy that is by a qualified speech therapist and is described below:

a. Speech therapy to restore speech after a loss or impairment of a demonstrated, previous ability to speak. Two examples of speech therapy that will not be covered are: (a) therapy to correct pre-speech deficiencies; and (b) therapy to improve speech skills that have not fully developed.

b. Speech therapy to develop or improve speech after Surgery to correct a defect that both: (a)

existed at birth; and (b) impaired or would have impaired the ability to speak.

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

Urgent Care Claim: An Urgent Care Claim is any claim for medical care which, if denied, in the opinion of the Covered Person or his/her Provider, will cause serious medical consequences in the near future, or subject the Covered Person to severe pain that cannot be managed without the medical services that have been denied.

Visit – an occasion during which treatment or consultation services are rendered in a Practitioner's office, in the Outpatient department of an eligible Facility, or by a Practitioner on the staff of (or under contract or arrangement with) a Home Health Agency to provide Covered home health care Services or Supplies.

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

We, Us, and Our – the Plan.

You, Your and Yours – the Employee.

How To Enroll

How To Enroll

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

Your Identification (ID) Card

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

Always carry this card and use your ID number when you or a Dependent receive 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 Same Sex Domestic/Civil Union Partner and your Child Dependents.
- **Husband and Wife/Two Adults** – provides coverage for you and your Spouse or Same Sex Domestic/Civil Union Partner only.
- **Parent and Child(ren)** – provides coverage for you and your Child Dependents, but not your Spouse or Same Sex Domestic/Civil Union Partner.

Changing Coverage Type

If you need to change your type of coverage, you must contact your Benefits Representative. If you marry, you **must** arrange for enrollment changes within 31 days following your marriage.

To add or delete Dependents or make other changes, you must complete a new enrollment form, which is available from the Employee Benefits Department. **Changes are not made automatically; you are**

responsible for initiating the process. If you cancel coverage and then want to reinstate it, you must wait until the next annual open enrollment period unless you have a Change in Family Status.

For example:

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

- If you have Single coverage and marry, or acquire a Same Sex Domestic/Civil Union Partner, your new Spouse or Same Sex Domestic/Civil Union Partner will be covered from the date you marry or meet the rules for covering Same Sex Domestic/Civil Union Partner if you apply for Husband and Wife/Two Adults 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 period.

Eligible Employees

Full-time active Rail Employees are eligible to participate in this Medical Plan on the first day of the calendar month following your date of hire.

Non-Duplication of Coverage

Remember, a NJ TRANSIT Employee cannot be covered under more than one NJ TRANSIT sponsored Plan; you may be covered as an Employee or as a Dependent of another NJ TRANSIT Employee, but not both. Dependent children are eligible for benefits under only one NJ TRANSIT Employee's coverage.

Eligible Dependents

Your eligible Dependents are your Spouse or Same Sex Domestic/Civil Union Partner, and your Child Dependents.

To enroll a Same Sex Domestic/Civil Union Partner, you must provide proof that a Same Sex Domestic/Civil Union Partner exists by providing us with an Affidavit of Domestic Partnership or Civil Union Certification.

Coverage for your Spouse or Same Sex Domestic/Civil Union Partner will end: (A) at the end of the month in which you tell us to delete your Spouse or Same Sex Domestic/Civil Union Partner from coverage following legal separation or (B) at the end of the month in which you divorce.

Coverage for a Child Dependent ends the end of the Benefit Month in which the Child Dependent reaches age 26.

Handicapped Children Over Age 26

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

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

Enrollment of Dependents

Proof of dependent eligibility, such as birth certificate, dependent's social security number and a marriage certificate, will be required when your dependents enroll for coverage. Newly eligible dependents must be enrolled within 31 days of the event or at the next open enrollment period.

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

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

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

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

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

- Permit you to enroll your Child Dependent, without any enrollment restrictions;

- Permit: (a) the Child Dependent's other parent; (b) the Division of Medical Assistance and Health Services; or (c) the Division of Family Development as the State IV-D agency, in the Department of Human Services, to enroll the Child Dependent in this Plan, if the parent who is the Covered Person fails to enroll the Child Dependent; and

- Not terminate coverage of the Child Dependent unless the parent who is the Covered Person provides Horizon BCBSNJ or the Plan with satisfactory written proof that:

    - the court or administrative order is no longer in effect: or

    - the Child Dependent is or will be enrolled in a comparable health benefits plan which will be effective on the date coverage under this Plan ends.

Special Enrollment Periods

As a result of recent federal legislation, the Health Insurance Portability and Accountability Act of 1996, the following applies:

Individual Losing Other Coverage

A self-insured plan must offer group health coverage and shall permit an Employee (or Dependent) who is eligible for coverage, but not enrolled, to enroll for coverage under the terms of the Plan if all of the following conditions are met:

- The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered;

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

- The Employee or Dependent coverage described in the first bullet above:

    (i) was under a COBRA continuation provision and the COBRA coverage was exhausted; or

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

- The Employee requests enrollment not later than 31 days after the date of exhaustion of coverage described in (i) above or termination of coverage or employer contribution described in (ii) above, and

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

New Dependents

If the following conditions are met, the group health plan shall provide for a Dependent special enrollment period during which the person (or, if not otherwise enrolled, the Employee) may be enrolled under the Plan as a Dependent of the Employee:

- A group health plan makes coverage available with respect to a Dependent of an Employee,
- The Employee is a participant under the Plan (or has met any waiting period applicable to becoming a participant under the Plan and is eligible to be enrolled under the Plan but for a failure to enroll during a previous enrollment period), and
- A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

Dependent Special Enrollment Period-a period of no less than 31 days which begins on the later of the date Dependent coverage is made available, or the date of the marriage, birth, adoption or placement for adoption.

Special Enrollment Due to Marriage Same Sex Domestic/Civil Union Partner

- An employer must allow an Employee to enroll a new Spouse or Same Sex Domestic/Civil Union Partner in the Plan.
- An Employee who is eligible, but who previously declined coverage under the Plan, is also eligible to enroll in the Plan at the same time that the Employee's Spouse or Same Sex Domestic/Civil Union Partner is enrolled.
- The Employee must request enrollment of his or her Spouse or Same Sex Domestic/Civil Union Partner within 31 days of their marriage or partnership.
- The coverage becomes effective on the date of marriage or partnership.
- The Plan may apply Pre-Existing Condition exclusions to both the Employee and the Spouse or Same Sex Domestic/Civil Union Partner, subject to the requirements that apply to Pre-Existing Conditions exclusions for timely enrollees.

Special Enrollment Due to Newborn/Adopted Children

- An employer must allow an Employee to enroll a newly born or newly adopted Dependent Child in the Plan.
- A Spouse or Same Sex Domestic/Civil Union Partner of a participant can be enrolled separately when a child is born.
- An Employee who is eligible, but who previously declined coverage under the Plan, is also eligible to enroll in the Plan at the same time that the Employee's Dependent is enrolled.

- These requirements apply only if an employer offers coverage for Dependents.
- The Employee must request enrollment of the new Dependent within 31 days of birth, adoption or placement for adoption.
- The coverage must be effective on the date of birth or adoption, or placement for adoption.
- The Plan cannot apply a Pre-Existing Condition exclusion to a child who is enrolled within 31 days of birth, adoption or placement for adoption.

If an individual seeks to enroll a Dependent during the first 31 days of the Dependent special enrollment period, the coverage of the Dependent shall become effective:

- in the case of a Dependent's birth, as of the date of birth
- in the case of a Dependent's adoption or placement for adoption, the date of adoption or placement for adoption.

Important Notes

- When an Employee is currently enrolled at the time of the life event and is adding his/her dependent during a Dependent Special Enrollment Period, the Employee may change to another offering of the employer without having to wait until the group's next open enrollment period. However, a retiree does **not** have this same right and must wait until the group's next open enrollment period to change to another offering.
- An employer is not required to provide for late enrollment. However, if late enrollment is allowed, eligibility for late enrollment cannot be based on any factor related to health status.
- The Employee must have declined coverage (including coverage solely for a Dependent) under his or her employer's plan during the initial period of eligibility.
- The Plan is required to provide the Employee with a notice describing the Plan's special enrollment rules.
- Employees are not required to accept COBRA benefits for which they may have been eligible under their former plan.

Multiple Employment

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

When Coverage Ends

Coverage will terminate on the earliest of the following:

- When you are no longer a member of an eligible class of Employees;

- When the group Health Care Plan terminates;
- When you are no longer working for NJ TRANSIT;
- On the last day of the month your dependent(s) ceasesto qualify as eligible unless otherwise noted;
- On the last date you cease to make the required contributions.

Under certain circumstances, it may be possible to continue part or all of your coverage.

Date Coverage Ends

Your coverage for medical benefits for all conditions will terminate according to the following schedule:

Reason for Ceasing	**Benefit**
Employment	**Termination Date**
1. Resignation	End of the month in which active service ends.
2. Furlough (with less than one (1) full year of service)	End of month furlough occurs.
3. Furlough (with one (1) or more years of service) or suspension	End of 3rd month following the month in which the leave of absence/dismissal occurs.
4. Leave of Absence/Dismissal	End of 3rd month fillowing the month in which the leave of absence/dismissal occurs.
5. Military Leave	End of month following 31 consecutive days of military leave.
6. Retirement	End of month following the month in which retirement occurs.
7. Death	Coverage for your eligible dependents will terminate according to the terms of your union contract.
8. Disabled Employees (with less than one (1) year of service)	End of month disability ends but not beyond the end of the 3rd month following date of disability.

9. Disabled Employees (with one (1) or more years of service)	End of month disability ends but not beyond the end of the calendar year following 24 months of total disability.

Coverage For Your Eligible Dependents After Your Death

If you die while actively employed by NJ TRANSIT, coverage for your eligible Dependents will continue at no cost to them as specified in your union contract. Coverage can be extended if your Dependent applies for continuation and agrees to pay the full cost, as described in the section "Continuation of Coverage under COBRA".

Benefits After Termination

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

Continued Coverage Under The Federal Family And Medical Leave Act

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

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

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

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

Consult your Benefits Representative for further details.

Continued Coverage For Surviving Dependents

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

- The date which is 180 days after the Employee's death.
- The date the Dependent fails to pay any required Cobra premium after the initial 180 days after the

Employee's death.

- The date on which the Dependent is no longer an eligible Dependent.
- The date the Plan's coverage for the deceased Employee's class ends.

Consult your Benefits Representative for further details.

Continuation of Coverage under COBRA

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

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

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

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

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

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

If you and/or your Dependents elect to continue coverage, it will be identical to the health care coverage

for other members of your class. It will continue as follows:

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

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

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

- This Plan ends for the class you belong to.

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

- The person becomes covered under any other group health plan. But, coverage will not end due to this rule until the end of any period for which pre-existing conditions are excluded, or benefits for them are limited, under the other plan.

- The person becomes entitled to Medicare benefits.

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

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

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

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

- The end of the 24-month period starting on the date the Employee was first absent from work due to the service.

- The date on which the Employee fails to return to work after completing service in the uniformed

services, or fails to apply for reemployment after completing service in the uniformed services.

- The date on which this Plan ends.

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

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

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

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

Uniformed services: The following:

1. The Armed Services.

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

3. The commissioned corps of the Public Health Service.

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

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

1. Active duty.

2. Active and inactive duty for training.

3. National Guard duty under federal statute.

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

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

How The Horizon HMO Program Works

Payment for Services from Participating Providers

Different providers in our network have agreed to be paid in different ways. Your provider may be paid each time he or she treats you ("fee for service"), or may be paid a set fee each month for each member whether or not the member actually receives services ("capitation"), or may receive a salary. These payment methods may include financial incentive agreements to pay some providers more (bonuses) or less (withholds), based on many factors: member satisfaction, quality of care, and control of costs and use of services among them. If a member desires additional information about how PCPs or any other providers in our network are compensated, she/he can call us at 1-800-355-BLUE or the number on his/her ID card or write: Horizon Healthcare of New Jersey, Inc., P.O. Box 820, Newark, NJ 07101.

The laws of the State of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make referrals to other health care providers in which s/he has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care provider or facility when making a referral to that health care provider or facility. If you want more information about this, contact your physician, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 or (800) 242-5846.

Referral Forms

When Your PCP feels it is necessary, he or she will refer You for Specialist services. You will always need a Referral form (unless a Referral is forwarded electronically, as explained below) for medical care or services provided by any doctor other than Your PCP. Exceptions include the annual gynecological and vision exams, and Visits to an OB/GYN for services that fall within the scope of an OB/GYN as Determined by the Plan.

Your PCP will give You a Referral form to bring to the Specialist's office. However, Your PCP's office may be automated and will send Your Referral electronically. In this case, You will not be given a Referral form.

Referral forms are only valid for the number of Visits and types of services specified on the form by Your PCP. Your first Visit must take place within 60 days of the date of the Referral. Any remaining Visits must be used with 180 days of the date on the Referral form.

Because it is so important that Your PCP be advised of Your condition, each Referral form is only valid for 180 days. At the end of the 180 days, You will have to return to Your PCP for another Referral, except in the case of a Special Referral.

A Special Referral is a Referral provided by a PCP that will allow You to obtain Covered Services and Supplies directly through a Specialist without the need for additional Referrals from the PCP. The Special Referral may be limited in scope, duration and other factors as Determined by the Plan.

Call the Specialist to make an appointment. Remember to take the Referral form with You. Requests for a Referral form after You have received care will not be approved. You will be responsible for all costs related to Your Visit if You do not bring the Referral form.

Certification

Certification is approval needed for certain services before a doctor provides treatment to a Member. It is important that You make sure Your doctor calls for Certification. Some examples of services that require Certification before You receive care are all Hospital activity and home nursing services.

Coinsurance Cap

Coinsurance amounts are limited for each Member and each enrolled family per Benefit Period except as stated below. The Coinsurance Cap cannot be met with:

a. Non-Covered Services and Supplies;

b. Deductibles;

c. Copayments.

The Coinsurance Caps are shown in Section 3, Schedule of Covered Services and Supplies.

Each Member's Coinsurance amounts are used to meet his own Coinsurance Cap and are combined with Coinsurance amounts from other enrolled family members to meet the family's Coinsurance Cap.

Once the Member's Coinsurance amounts in a Benefit Period exceed the individual Coinsurance Cap, the Plan will waive his Coinsurance for the rest of that Benefit Period.

Once 2 Members in a family meet their individual Coinsurance amounts, the Plan will waive the family's Coinsurance for the rest of that Benefit Period.

Payment Limits

The Plan limits the amount We will cover for certain types of Covered Services and Supplies. See Section 3 Schedule of Covered Services and Supplies for these limits.

Claims Procedure

The Plan will make Payment based on Our Allowance for certain Covered Services and Supplies, according to the terms, conditions and limitations of Your group's contract.

Claims forms and instructions for filing claims should be provided to You by Your employer. Completed claim forms and any other required materials must be submitted to the Plan for processing.

Submission of Claims

If You receive a bill, You must follow the following instructions:

a. Notice of claim must be made not later than 24 months following the date the Covered Services were performed or Covered Supplies purchased.

b. Itemized bills must accompany each claim form. A separate claim form is needed for each claim submitted. The itemized bills must contain enough data to identify the patient, the Provider, type of service and charge for each service and the Provider's license number. Bills for Prescription Drugs must contain the prescription number, name and quantity of the drug dispensed. Bills for Private Duty Nursing must state that the Nurse is a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) and must contain the Nurse's license number. Along with the bill, You must submit a letter from the attending Practitioner certifying that the Private Duty Nursing services of the Nurse were Medically Necessary and Appropriate.

c. If a claim is wholly or partially denied for reasons other than plan limitations, the claimant will be notified of the decision within 30 days after the Plan received the completed notice of claim.

   The Plan will provide to You (or Your agent or assignee) a notice that will set forth:

   1. the reasons for the denial;

   2. a statement as to what substantiating documentation or other documentation is needed to complete the claim;

   3. a statement that the claim is disputed, if applicable; and

   4. a statement of the special needs to which the claim is subject, if applicable.

   All Clean Claims shall be paid no later than 30 calendar days of receipt of the completed claim of notice if the claim is submitted to Us by electronic means, or within 40 calendar days of receipt of the completed notice of claim if the claim is submitted by other than electronic means. In addition, any portion of a claim that is complete and proper shall be paid according to the above time limits.

d. If You are the non-custodial parent of a Child Dependent, the Plan will provide such information to the custodial parent as may be necessary for the Child Dependent to obtain coverage, and will permit the custodial parent, or the Provider with the authorization of the custodial parent, to submit claims for Covered Services without the need for Your approval.

Payment of Claims

The Plan will provide Payment for all Covered Services and Supplies to which You are entitled within 60 days of the Plan's receipt of the claim. All claims will be paid as they are received by the Plan. Any claims unpaid at Your death will be paid, as soon as practicable after the Plan receives due proof of the death, to one of the following:

a. Your estate;

b. Your Spouse or Same-Sex Domestic Partner;

c. Your parents;

d. Your child(ren);

e. Your brothers and sisters; or

f. any unpaid Provider.

If You are the non-custodial parent of a Child Dependent, the Plan will make Payments on claims submitted in accordance with paragraph e. of the above subsection Submission of Claims directly to the Provider or custodial parent, or certain state agencies as specified in Your group's contract, as appropriate.

When You file a claim, You may direct the Plan, in writing, to pay claims to the Provider who provided the Covered Service or Supply which became payable. The Plan may Determine to honor such direction.

You may not assign Your right to take legal action to any Provider. The Covered Services and Supplies provided in Your group's contract may not be assigned by You without the Plan's permission. The Plan may Determine to pay claims directly to a Provider if it chooses to do so.

Physical Exams

The Plan, at its expense, has the right to physically examine a Member. This may be done as often as reasonably needed to process a claim. The Plan also has the right to have an autopsy performed, at its expense.

Limitation of Actions

A Member cannot bring a legal action against the Plan until 60 days from the date he files a claim. He cannot bring legal action against Your group's contract after 3 years from the date he files a claim.

Your Horizon HMO Benefits

This Section lists the Covered Services and Supplies the Plan will provide Payment for up to its Allowance subject to all the terms of Your group's program including, but not limited to, Certification, Referral or approval by the Member's PCP, Medical Necessity and Appropriateness, and utilization review features. PLEASE CHECK THE SCHEDULE OF COVERED SERVICES AND SUPPLIES, AND OTHER SECTIONS OF YOUR GROUP'S PROGRAM DESCRIBING COVERAGE LIMITATIONS AND EXCLUSIONS.

A. Eligible Basic Services And Supplies

Hospital Covered Services and Supplies

You are covered for Inpatient Hospital care, including room and board, routine nursing care, and ancillary services and supplies when provided to You by a Hospital on an Inpatient basis.

NOTE: If You or Your Dependent occupies a Private Room, You will be responsible for expenses incurred beyond those for which the Plan has provided coverage, except when the Plan Determines it to be Medically Necessary and Appropriate.

You are also covered for care received as an Inpatient in a Special Care Unit, in the same way You are covered for any Illness or Injury or other condition, and, excluding room and board, for Outpatient Hospital services, and services provided by a Hospital Outpatient clinic. You are also covered for emergency room treatment, subject to the emergency room Copayment.

Office Visits

Office Visits and services are covered when provided by Your PCP. Specialist services are covered upon prior Referral by Your PCP except as otherwise noted.

Non-Surgical Care and Treatment

The Program provides coverage for the Medically Necessary and Appropriate non-Surgical care and treatment of an Illness or Injury.

Surgery

Coverage is provided for Surgery, including a Hospital stay for at least 72 hours following a modified radical mastectomy and a Hospital stay for at least 48 hours following a simple mastectomy, unless You, in consultation with Your physician, determine that a shorter length of stay is medically appropriate. While there is no requirement that Your Provider obtain Certification from the Plan for prescribing 72 or 48 hours, as appropriate, of Inpatient care as stated in this subsection, any notification requirements remain in full force and effect. Surgical procedures following a mastectomy on one breast or both breasts, including, but not limited to, reconstructive breast Surgery and Surgery to achieve symmetry between the two breasts are also covered.

If You receive benefits in connection with a mastectomy and elect to have breast reconstruction Surgery along with the mastectomy, the following will be covered in a manner determined in consultation with the attending physician:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.
- Outpatient x-ray, radiation therapy, or outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer.

Cosmetic Surgery is not covered.

Medical Emergency and Medical Screening Examinations

You are covered for Medical Emergencies including diagnostic X-ray and lab, and Urgent Care for medical and Mental or Nervous Disorders on a 24-hour, 7-day-a-week basis.

The Plan will provide coverage for eligible Covered Services and Supplies provided by an eligible Hospital as stated in this Section for Medical Screening Examinations, as required under Federal law and as specified in N.J.A.C. 8:43G-12, as necessary to determine whether a Medical Emergency exists, whether or not the services or supplies were arranged for or provided by an eligible Provider.

The Plan will not cover Services and Supplies beyond the time when Your condition, in the judgment of the attending physician, is medically stable, no longer requires critical care, and You can be safely transferred to another eligible Facility or the care of Your PCP. The Plan will Determine the most cost effective and medically beneficial place for follow-up care.

Urgent Care Services

a. Urgent Care Services in the Service Area
   1. When You are inside the Service Area and need Urgent Care for a General Condition, the care must be arranged through Your PCP.
   2. When a Member is inside the Service Area and needs Urgent Care for a Mental or Nervous Disorders or Chemical Dependency, the care must be arranged through Magellan Behavioral Health. Magellan Behavioral Health should be contacted by calling 1-800-626-2212.

b. Out-Of-Area Urgent Care Services

1. When a Member is outside the Service Area and needs Urgent Care for a General Condition, the care must be arranged through HMO BLUE USA. HMO BLUE USA should be contacted by calling the number provided by the Plan.

   However, if the Member is not in an area serviced by HMO BLUE USA, The Plan must be notified within 48 hours or as soon as reasonably possible after care has commenced. Payment will not be made when the Plan has not been notified within this time period.

   Services and supplies for Urgent Care for a General Condition are not eligible beyond the time when the patient's condition reasonably permits him to be transferred to the care of his PCP. The Plan will Determine the most cost effective and medically beneficial place for follow-up care.

2. When a Member is outside the Service Area and needs Urgent Care for a Mental or Nervous Disorders or Chemical Dependency, the care must be arranged through Magellan Behavioral Health. Magellan Behavioral Health should be contacted by calling 1-800-626-2212.

3. When a Member is planning to be outside the Service Area for a period of not less than 30 and not more than 180 consecutive days, a Member can apply for "guest membership" and receive medical care through a "host" HMO.

Allergy Testing and Treatment

Coverage is provided for allergy testing and treatment.

Ambulance Services

Ambulance services when ordered by a Provider or an officer of the law are covered, including coverage for transportation to:

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

b. the nearest Hospital capable of providing needed and appropriate care and treatment, if a local Hospital cannot provide it. It must be connected with an Inpatient Admission; or

c. transporting You to another Inpatient Facility.

d. Ambulance service or invalid coach service (as defined by N.J.A.C. 8:40-1.1) when Certified by the Plan for non-Medical Emergency medical transport.

Ambulance services must be provided by professional Ambulance service; ground only, for a Medical Emergency as Determined by the Plan. Chartered air flights and other travel or communication expenses

of patients, Practitioners or family members are not covered. Air transport will be covered for Medical Emergencies as Determined by the Plan.

Ambulatory Surgical Centers

Coverage is provided for services and supplies provided by an Ambulatory Surgical Center in connection with covered Surgery.

Anesthesia

Anesthetics and their administration are covered.

NOTE: Anesthesia in connection with obstetrical procedures is covered if You have coverage for obstetrical care.

Birthing Centers

Coverage is provided for services and supplies provided by a Birthing Center for pre-natal care, delivery, and post partum care in connection with a Member's pregnancy, up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Member by a Birthing Center.

Breast Prostheses

Breast prostheses are covered following eligible reconstructive breast Surgery, regardless of when the mastectomy was performed. Breast prostheses following a mastectomy on one breast or both breasts is covered.

Chiropractic Care

Therapeutic Manipulations are covered, limited to no more than three modalities per Visit. Therapeutic Manipulation is eligible without a Referral from Your PCP.

Dental Care and Treatment

Coverage for dental care and treatment includes:

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

b. the surgical removal of bony or partial bony impacted teeth.

Coverage is also provided for treatment of an Injury to natural teeth or the jaw, but only if:

a. the Injury occurs while You are covered under Your group's Contract;

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

c. all treatment is completed within 6 months of the date of the Injury.

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

Eligible Inpatient dental expenses include the Covered Services and Supplies of an:

a. Eligible Practitioner and Facility when You are an Inpatient due to:
   1. an Injury and You are Admitted by Your PCP;
   2. a malignancy of the mouth; or
   3. during an otherwise eligible Inpatient Admission, either to relieve Your discomfort from a diagnosed non-dental condition, or as part of the prescribed treatment for a non-dental Illness or Injury.

b. Eligible Facility, when You are an Inpatient due to the extraction of one or more teeth when You have a specified complicating organic non-dental disease or Illness.

NOTE: In this circumstance, the Plan will not provide coverage for the services of a Practitioner.

Diabetes Benefits

a. Coverage is provided for expenses incurred for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by an Participating physician or a Participating Nurse Practitioner/clinical Nurse Specialist:

   1. blood glucose monitors and blood glucose monitors for the legally blind;
   2. test strips for glucose monitors and visual reading and urine testing strips;
   3. insulin;
   4. injection aids;
   5. cartridges for the legally blind;
   6. syringes;
   7. insulin pumps and appurtenances thereto;
   8. insulin infusion devices; and
   9. oral agents for controlling blood sugar.

b. We will also provide benefits for expenses incurred for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of his condition, including information on proper diet. Benefits for self-management education and education relating to diet shall be limited to Visits Medically Necessary and Appropriate upon:

1. the diagnosis of diabetes;
2. the diagnosis by a Participating physician or a Participating Nurse Practitioner/clinical Nurse Specialist of a significant change in the Member's symptoms or conditions which necessitate changes in the Member's self-management; and
3. determination of a Participating physician or a Participating Nurse Practitioner/clinical Nurse Specialist that reeducation or refresher education is necessary.

c. Diabetes self-management education is covered when provided by a Participating Provider who is:

1. a dietitian registered by a nationally recognized professional association of dietitians,
2. a health care professional recognized as a certified Diabetes Educator by the American Association of Diabetes Educators, or
3. a registered pharmacist in New Jersey qualified with regard to management education for diabetes by any institution recognized by the Board of Pharmacy of the State of New Jersey.

Dialysis Centers

Services and supplies provided by a dialysis center for dialysis services are covered.

Elective abortions

Elective abortions are covered when performed in the first trimester only. See Section 3 Schedule of Covered Services and Supplies for additional limitations and benefit levels.

Home Health Agency Services

Services and supplies provided by a Home Health Agency on a part-time or intermittent basis, are covered, except when full-time or 24 hour service on a short-term basis is Medically Necessary and Appropriate.

Subject to the conditions above, the following Home Health Agency services are included:

a. Skilled Nursing Care Visits;

b. Physical Therapy by a registered physical therapist;

c. Such other Therapy Services and supplies furnished by the Home Health Agency as would be routinely available to Hospital Inpatients under this section;

d. Services of a home health aide but only as long as the patient is receiving one of the eligible services stated in a., b., or c. above.

The Plan will not provide coverage for Home Health Agency services for:

a. homemaker or housekeeping services;

b. maintenance therapy;

c. administration of hemodialysis;

d. food or home-delivered meals;

e. bed;

f. dietary service;

g. drugs;

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

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

Home Infusion Therapy Services

These services must be provided by a Home Health Agency or other eligible Provider as Determined by the Plan. Coverage will be limited to the following services and supplies when billed by and payable to an eligible Provider: Prescription Drugs, Durable Medical Equipment, administration services, and Skilled Nursing Care.

Home Treatment of Hemophilia

a. Blood products when used as other than blood substitutes or replacements;

b. Blood infusion equipment (syringes and needles); and

c. Self-administration training for the home treatment of hemophilia.

Hospice Care Program

The following services and supplies listed below are eligible under the Hospice Care Program for Members whose life expectancy is 6 months or less as Determined and certified by the Member's PCP or Specialist and who would otherwise require an Inpatient Admission at an acute care Facility or Skilled Nursing Facility:

a. Inpatient Hospice Acute Care – When the condition necessitating hospitalization is related to the condition for which the Member is in the Hospice, these days will be billed for by and payable to the Hospice. These Inpatient Benefit Days are not charged against the Inpatient Benefit Days stated in the Schedule of Covered Services and Supplies. When hospitalization is necessitated by a

condition unrelated to the condition for which the Member is in the Hospice, the Inpatient Benefit Days stated in the Schedule of Covered Services and Supplies will be utilized.

b. Respite Care – Up to a maximum of 7 Benefit Days Per Lifetime;

c. Interim professional nursing services of an RN, LPN or LVN for assessment servicing;

d. Interim home health aide services provided under the supervision of an RN;

e. Medical care rendered by a Hospice Care Program physician and/or the Member's PCP;

f. Diagnostic services related to the Hospice Member's condition;

g. Medical/surgical supplies and Durable Medical Equipment (with Certification above $200);

h. Prescription Drugs related to the Hospice Member's condition;

i. Dietician services related to the Hospice Member's condition;

j. Oxygen and its administration;

k. Medical social services;

l. Short term Inpatient acute care for pain management assessment;

m. Inpatient Hospice room, board and Routine Nursing Care;

n. Psychological support services to the terminally Ill Member and family as defined in the Hospice Care Program;

o. Family counseling related to the Hospice Member's terminal Illness;

p. Dialysis treatment used solely for the purpose of pain management (with Certification).

The following services are not covered as Hospice services even if performed by or in a Hospice:

a. Bereavement counseling;

b. Dialysis treatment not utilized for pain management;

c. Food or home delivered meals;

d. Homemaker services;

e. Medical care by a Provider other than the Hospice or the Member's PCP without Certification;

f. Pastoral services;

g. Private-duty nursing services;

h. Volunteer services;

i. Legal and/or financial counseling or services;

j. Treatment not included in the Hospice Care Program.

Infertility Services

This Plan covers charges for artificial and surgical procedures designed to enhance fertility, including, but not limited to, artificial insemination, in-vitro fertilization, in-vivo fertilization, gamete-intra-fallopian-transfer (GIFT), Zygote Intra-fallopian-transfer (ZIFT), sperm, egg, and/or inseminated eggs procurement and processing and freezing, and storage and thawing of sperm and/or embryos. Storage is limited to 6 months.

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

Injected Chemotherapy Treatments

Eligible services must be administered and provided by the Outpatient department of an eligible Facility, in a physician's office, or by a Participating Home Health Care Agency. Services include both the administration and the chemotherapy drugs.

Maternity/Obstetrical Coverage

Maternity care provided to Employees and Spouse is covered. This includes the Hospital delivery and Hospital stay for at least 48 hours after a vaginal delivery or 96 hours after a cesarean section if the attending Practitioner determines that Inpatient care is medically necessary and appropriate or if requested by the eligible mother notwithstanding medical necessity and appropriateness. Complications of pregnancy may be considered eligible for Child Dependents.

NOTE: Refer to Newborn Children in Section 5, How to Enroll.

Maternity care includes these services:
- obstetrical;
- pre-natal;
- delivery
- nursery;
- postnatal and post partum care for at least 31 Benefit Days following the date of birth; and
- treatment of complications of pregnancy.

Precious Additions, a new mothers program, is available to eligible mothers and includes these services with the payment of the first office Visit Copayment:

- a pregnancy diary with information on nutrition and weight control;
- a maternity classes booklet, listing classes at the Plan's Select Hospital network;
- up to $50 reimbursement for attending a maternity class;
- home care services after delivery if the eligible mother leaves the Hospital after one overnight for a vaginal delivery or after two overnights for a cesarean section;
- a gift for the newborn after completion of the program.

Mental or Nervous Disorders and Chemical Dependency

The Contract provides coverage for the treatment of Mental or Nervous Disorders and Chemical Dependency. Coverage for the treatment of Mental or Nervous Disorders or Chemical Dependency is provided on the same basis and subject to the same terms and rules as for other conditions.

Services and supplies for these conditions will be covered when the Care Manager manages, assesses, coordinates, directs and gives Certification for a Member's care. Services and supplies will be provided at a reduced level if the Care Manager does not manage, assess, coordinate, direct and give Certification for the Member's Inpatient care before expenses are incurred, unless otherwise provided in the Contract. The Care Manager will review and Determine, on behalf of the Plan, if services rendered were Medically Necessary and Appropriate. No benefits are payable for care that is not Determined to be Medically Necessary and Appropriate.

A Member may receive treatment as an Inpatient in a Hospital, or a Substance Abuse Center, or may receive Residential Treatment. He/she may also receive treatment at a Hospital Outpatient Substance Abuse Center, or by any Practitioner, psychologist or social worker.

NOTE: The Plan will provide Payment for Outpatient and Partial Hospitalization care if, based on Medical Necessity, the Plan or the Care Manager Determines that the Member would otherwise require an Inpatient Admission.

Pre-Admission Testing

Coverage is provided for Pre-Admission Testing if provided within 7 days of an Admission.

Preventive Care

Coverage for Preventive Care includes:

a. Obstetrical/Gynecological (OB/GYN) Coverage

Coverage is provided, up to the Allowance, for 1 routine gynecological examination and 1 routine Pap smear per Benefit Period. This examination will be eligible without a Referral from Your PCP. Certification for OB/GYN coverage must be obtained from the PCP for any services beyond the

routine exam and tests; except with respect to services or supplies provided or coordinated by a Specialist under a Special Referral. Non-Surgical services performed by a Participating OB/GYN, except fertility related services, are eligible without Referral from Your PCP if they fall within the scope of services typically performed by an OB/GYN as Determined by the Plan. Any Certification requirements for Surgery or Inpatient Admissions still apply.

Pap Confirmatory

Coverage shall be provided for any confirmatory test when medically necessary and ordered by the woman's physician.

b. Mammography

Coverage for mammograms provided to a female Member is as follows:

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

Horizon BCBSNJ will cover charges for:

a. one baseline mammogram for female Covered Persons who are at least 35 but less than 40 years of age. (However, if the woman is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, Horizon BCBSNJ will cover a mammogram at such age and intervals as deemed needed by the woman's Practitioner.)

b. one mammogram each year for female Covered Persons age 40 and older.

A Referral can be obtained for a covered mammogram from a Specialist.

c. Medical Social Services

Coverage for Medical social services and preventive health services includes health education and information services, voluntary family planning services and nutritional services.

d. Prostate Cancer Screening

Coverage is provided for one routine office Visit per Benefit Period for adult Members, including a digital rectal examination and a prostate-specific antigen test for adult male Members.

e. Well-Child Care

Routine Out-of-Hospital well-child care, Immunizations and lead poisoning screening and treatment are covered through the end of the day before the Child Dependent's **20th** birthday. In order to be covered under this section:

a. childhood immunizations must be as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health pursuant to Section 7. of P.L. 1995, Ch 316.
b. screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing, must be as specified by the Department of Health pursuant to Section 7. of P.L. 1995, Ch 316. Medical evaluation and any necessary follow-up and treatment for lead-poisoned children are also covered.

Coverage is provided for regular pediatric care including newborn care and immunizations as set forth at N.J.A.C. 8:57-8, Childhood Immunization Insurance Coverage.

f. Additional Preventive Services

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

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

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

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

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

Horizon HMO shall administratively update new recommendations to the preventive services listed above at the schedule established by the Secretary of Health and Human Services.

Second Opinion Consultations

Second opinion consultations by another Plan Participating Provider are covered when authorized by Your PCP.

Skilled Nursing Facilities

Coverage is provided for bed and board, including diets, drugs, medicines, dressings and Routine Nursing Care in a Skilled Nursing Facility. You must be Admitted to the Skilled Nursing Facility within 14 days of discharge from a Hospital, for continuing medical care and treatment prescribed by a Practitioner.

If you are a resident of a Skilled Nursing Facility, a continuing care retirement community or a retirement community that operates a Skilled Nursing Facility on its premises, your PCP must refer you to the Skilled Nursing Facility or the community's Medicare-certified nursing unit separate from the facility if:

a. the facility has the capacity to provide the services required by you;

b. the PCP, in consultation with you (or a representative from their family) determines that a referral is in your best interest;

c. the facility agrees to be reimbursed at the same contract rate negotiated for similar providers for the same services and supplies in the same geographic area; and

d. the facility meets all applicable State licensing and certification requirements.

Therapy Services

Therapy services, as defined in the Definitions section, are covered.

NOTE: Speech Therapy for the treatment of speech loss or impairment due to congenital defect or psychiatric condition is eligible only if such therapy would preclude further pathological degeneration.

Therapeutic Radiology

Coverage is provided for therapeutic radiology.

Transplant Coverage

Services and supplies related to certain human organ and bone marrow transplant procedures are eligible as Determined by the Plan.

No coverage will be provided for transplant procedures except as listed below, even if the transplant procedure becomes accepted medical practice and no longer is considered Experimental or Investigative.

The following types of transplants are covered:

a. Cornea

b. Kidney

c. Lung

d. Liver

e. Heart

f. Heart-valve

g. Heart-lung

h. Pancreas

i. Allogeneic bone marrow

Vision Services

Vision services include:

a. One routine eye examination per Benefit Period when performed by a Participating ophthalmologist or Participating optometrist for a Member.

b. Eyeglasses or contact lenses (excluding those referenced in Section 7. B. Eligible Supplemental Services and Supplies) – eyeglass frames with at least one prescription lens. The lens(es) can be clear, tinted, or sunglasses. As an alternative, prescription contact lenses will be covered.

   The lens(es) must be prescribed by a Participating ophthalmologist or optometrist. You can go directly to a Participating ophthalmologist or optometrist without a Referral from Your PCP.

Voluntary Sterilization

Voluntary sterilization is covered.

X-Rays and Laboratory Tests

Coverage is provided for x-rays and laboratory tests. Except as provided under the Preventive Care section, the Plan does not provide coverage for x-rays and tests done as part of routine physical examinations. Certification for x-rays and laboratory tests coverage must be obtained from the PCP for

any services beyond the routine exam and tests; except with respect to services or supplies provided or coordinated by a Specialist under a Special Referral.

B. Eligible Supplemental Services And Supplies

Blood

Coverage includes blood, blood products, blood transfusions and the cost of testing and processing blood. We do not cover blood which has been donated or replaced on behalf of the Member. Autologous blood services are covered if the blood is drawn, processed and stored for transfusion for a scheduled Surgery.

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

Durable Medical Equipment

The rental of Durable Medical Equipment needed for therapeutic use is covered. The Plan may Determine to provide coverage for the purchase of such items when it is less costly and more practical than their rental. Coverage does not include:

a. replacements or repairs; or

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

Foot Orthotics

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

Physical Rehabilitation

a. Physician services

   Services of a physician when provided to an Inpatient in a Physical Rehabilitation Facility. Such services must be provided by a Practitioner who does not accept payment for such services from any Facility.

b. Facility services

   Inpatient rehabilitation therapy and related services and supplies when provided by a licensed Physical Rehabilitation Facility.

Private Duty Nursing Care

Out-of-Hospital private duty nursing care is covered when Certified by the Plan.

Prosthetic Devices

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

Vision Care

a. Special eyeglasses and contact lenses following cataract removal.

b. Contact lenses which perform the function of a human lens lost as a result of intra-ocular Surgery, Injury or congenital disease.

Coverage will be provided for replacement of such contact or eyeglass lenses only (I) when required due to a change in prescription; and (ii) if the lenses are needed to correct conditions caused by an Injury or Illness which occurred after Your Coverage Date or while You were covered under a prior group or non-group major medical contract with Horizon Blue Cross Blue Shield of New Jersey, if coverage was transferred to Your group's contract without interruption.

Wigs Benefit

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

Exclusions

The following are Non-Covered Services and Supplies. The Plan will not provide coverage for any services or supplies provided for or in connection with:

Acupuncture.

Ambulance; air, water, and rail, except as otherwise provided.

Any charge to the extent it exceeds the Allowance.

Any therapy not included in the definition of Therapy Services.

Aviation – Illnesses or Injuries or other conditions resulting from aviation, other than when the individual is a fare paying passenger on a regularly scheduled airline.

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

Blood, plasma, or other blood derivatives or components when used as blood substitutes or replacements.

Broken appointments.

Christian Science.

Completion of claim forms.

Copayments, deductibles, the Member's portion of any Coinsurance, and expenses incurred after any Payment maximum is or would be reached.

Cosmetic surgery, unless it is required as a result of an Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of Cosmetic surgery; drugs prescribed for Cosmetic purposes.

Court ordered treatment which is not Medically Necessary and Appropriate.

Custodial Care or domiciliary care.

Dental care or treatment and appliances, including but not limited to the following, except as otherwise stated in the group's contract:

a. dental prosthesis;

b. orthodontia;

c. operative restorations;

d. fillings;

e. medical or surgical treatment of dental caries;

f. gingivitis;

g. Outpatient and Out-of-Hospital dental treatment;

h. radicular or dentigerous cysts;

i. extractions of teeth including, but not limited to, impacted teeth; and

j. dental implants.

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

Elective abortions after the first trimester.

Experimental or Investigational Treatments, Procedures, Hospitalizations, Drugs, Biological Products or Medical Devices.

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

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

Food products (including enterally administered food products, except when used as the sole source of nutrition). But, this exclusion does not apply to the foods, food products and specialized non-standard infant formulas that are eligible for coverage in accordance with the subsections "Treatment of Inherited Metabolic Diseases" and "Specialized Non-Standard Infant Formulas" in "Section 7-Summary of Covered Services and Supplies.

Herbal medicine.

High-dose chemotherapy, except as otherwise stated.

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

Hypnosis.

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

Infertility enhancement treatments, except as otherwise stated in this Evidence of Coverage.

Inpatient Admission or any part of an Inpatient Admission primarily for Physical Therapy and/or rehabilitation therapy.

Needles and syringes, except as otherwise stated.

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

Maintenance therapy for:

a. Physical Therapy;

b. Therapeutic Manipulation;

c. Occupational Therapy; and

d. Speech Therapy.

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

Marriage, career or financial counseling, and sex therapy.

Medical Emergency services when not rendered by a physician, and related supplies.

Methadone maintenance.

Milieu Therapy:

> Inpatient services and supplies which are primarily for milieu therapy, even though Eligible treatment may also be provided. This means that the Plan has Determined: a. the purpose of an entire or portion of an Inpatient stay is chiefly to change or control a patient's environment; and b. an Inpatient setting is not Medically Necessary and Appropriate for the treatment provided, if any.

Non-medical equipment which is primarily for personal hygiene or for comfort or convenience rather than for a medical purpose, including air conditioners, dehumidifiers, purifiers, heating pads and similar supplies which are useful to a person in the absence of Illness or Injury or other condition.

Non-prescription drugs or supplies, except as otherwise stated in this Evidence of Coverage.

Out-of-Area Urgent Care: (a) not arranged for through HMO BLUE USA which was provided while the person was in an area serviced by HMO BLUE USA, or (b) when the Plan was not contacted within the notification time stated.

Prescription Drugs purchased from a Pharmacy

Private-duty nursing care, except as otherwise stated.

Prosthetic devices, except when following a mastectomy on one breast or both breasts.

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

Psychological testing for educational purposes.

Rest or convalescent cures.

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

Routine examinations or Preventive Care, including related x-rays and laboratory tests, except as otherwise stated; pre-marital or similar examinations or tests not required to diagnose or treat an Illness or Injury or other condition; screening, research studies, education or experimentation, mandatory consultations required by Hospital regulations, routine pre-operative consultations.

Routine Foot Care including treatment for bunions, except capsular or bone Surgery, corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, subluxations of the foot, symptomatic complaints of the feet, orthopedic shoes, the casting for orthotics and any appliances except orthotics.

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

Services or supplies:

- eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Member asserts his rights to obtain this coverage or payment for these services;
- for breast prosthesis implants except when following a mastectomy on one breast or both breasts;
- for, or in connection with, Cosmetic surgery, procedures, treatment, drugs or biological products;
- for ptosis of the eyelids, except as Medically Necessary and Appropriate;
- for reduction mammoplasty, except as Medically Necessary and Appropriate;
- for septoplasty, except as Medically Necessary and Appropriate;
- for the treatment of Mental or Nervous Disorders or Chemical Dependency when the patient is not involved;

- for the treatment of organic brain disorders when, as Determined by the Plan, demonstrable and significant improvement from psychiatric treatment is unlikely.

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

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

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

- for the personal convenience or comfort of the Member, including, but not limited to, such items as televisions, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;

- for vision therapy, vision or visual acuity training, orthoptics, pleoptics, and other vision care;

- furnished by one of the following members of the Member's family, unless otherwise stated: Spouse or Same-Sex Domestic Partner, child, parent, grand parent, in-law, brother or sister;

- in an amount greater than the Plan's Allowance;

- in connection with the pregnancy of a Child Dependent;

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

- not listed as eligible, unless otherwise stated;

- not directly related to the care of the patient, such as guest meals and accommodations, telephone charges, take-home drugs and supplies, and similar costs;

- provided after the Member's coverage ends except for eyeglass lenses, frames, or contact lenses ordered prior to termination and delivered within 60 day after the termination date;

- provided by a Facility while the Member is not receiving eligible physician's services for treatment of the same condition;

- provided by a health care Provider who is paid by a Hospital or other institution or who is not permitted to charge for services;

- provided by Non-Participating Providers, unless otherwise stated or the care has been arranged for by the Member's PCP and Certified by the Plan;

– provided by or in a government Hospital unless the services are for treatment:

  a. of a non-service related Medical Emergency;

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

– provided by or in any locale outside the United States, except in the case of a Medical Emergency;

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

– provided by a social worker, except as otherwise stated;

– provided for any Illness, disease, Injury or other condition occurring while an individual is on active duty during military service;

– provided to the newborn child of a male or female Child Dependent,

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

– related to hearing exams to determine the need for hearing aids, the purchase, repair and maintenance of hearing aids, and the need to adjust them, except as otherwise provided in "Hearing Aids and Related Services" and "Newborn Hearing Screening" in the EOC's Summary of Covered Services and Supplies".

- rendered prior to the Member's Coverage Date or after his termination of coverage under the group's contract, unless otherwise stated;

- required by the Employer as a condition of employment or rendered through a medical department, clinic, or other similar facility provided or maintained by the Employer; and

– which a Member is not legally obligated to pay;

– which are specifically limited or excluded elsewhere;

– which are not Medically Necessary and Appropriate; or

– which are not provided or arranged for by the individual's PCP or the Plan, unless otherwise stated.

Smoking cessation aids of all kinds and any services related to smoking cessation.

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

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

Sterilization reversal.

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

Surrogate motherhood.

Telephone consultations, except as the Plan may request.

TMJ syndrome – medical treatment of TMJ Syndrome, except as otherwise stated, including but not limited to:

a. biofeedback;

b. intraoral prosthetic devices;

c. nonsurgical intervention;

d. office Visits; or

e. Physical Therapy.

Transplants, unless otherwise specified, and non-human organ transplants.

Transportation, other than Ambulance/invalid coach service when Certified by the Plan; travel.

Treatment for intentionally self-inflicted Injury while sane.

Vitamins and dietary supplements.

Vocational and educational training and services.

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

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness, unless otherwise stated in this Evidence of Coverage.

Other Terms of Your Coverage

Coordination of Benefits and Services

Purpose of this provision

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

Definitions

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

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

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

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

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

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

a. Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;

b. Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;

c. Group or group-type coverage through a Health Maintenance Organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant

to a Federal or State continuation law;

d. Group hospital indemnity benefit amounts that exceed $150.00 per day;

e. Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

a. Individual or family insurance contracts or subscriber contracts;

b. Individual or family coverage through an Health Maintenance Organization HMO or under any other prepayment, group practice and individual practice plans;

c. Group or group-type coverage where the cost of coverage is paid solely by the Covered Person except when coverage is being continued pursuant to a Federal or State continuation law;

d. Group hospital indemnity benefit amounts of $150.00 per day or less;

e. School accident-type coverage;

f. A State plan under Medicaid.

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

a. The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or

b. All Plans which cover the Covered Person use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the Plan determines its benefit first.

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

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

Primary and Secondary Plan

The Plan considers each Plan separately when coordinating payments.

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

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

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

Rules For The Order Of Benefit Determination

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

The benefits of the Plan that covers the Covered Person as an Employee who is neither laid off nor retired, or as a Dependent of such person, shall be determined before those of the Plan that covers the Covered Person as a laid off or retired Employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the Covered Person as an Employee, Member, subscriber, or as the Dependent of such person, shall be determined before those of the Plan that covers the Covered Person under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a Child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

a. The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.

b. If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the Plan covering the parent for a shorter period of time.

c. Birthday, as used above, refers only to month and day in a Calendar Year, not the year in which the parent was born.

d. If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a Child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

a. The benefits of the Plan of the parent with custody of the Child shall be determined first.

b. The benefits of the Plan of the spouse of the parent with custody shall be determined second.

c. The benefits of the Plan of the parent without custody shall be determined last.

d. If the terms of a court decree state that one of the parents is responsible for the health care expenses for the Child, and if the entity providing coverage under that Plan has knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which Plan is the Primary Plan, the benefits of the Plan that covers the Employee, Member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures To Be Followed By The Secondary Plan To Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

a. The basis on which the Primary Plan and the Secondary Plan pay benefits; and

b. Whether the Provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the Provider bills a charge and the Covered Person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a Reasonable and Customary Charge is called a "Reasonable and Customary Charge Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a Provider, called an In- Network Provider, bills a charge, the Covered Person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Covered Person uses the services of an Out-of-Network Provider, the Plan will be treated as a Reasonable and Customary Charge Plan even though the Plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means that the carrier pays the Provider a fixed amount per member. The Covered Person is liable only for the applicable Deductible, Coinsurance and/or Copayment. In this section, a Plan that pays Providers based upon capitation is called a "Capitation Plan."

In the rules below, "Provider" refers to the provider who provides or arranges the services or supplies.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the Provider is an In-Network Provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a. The amount of any Deductible, Coinsurance and/or Copayment required by the Primary Plan; or

b. The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the Provider receives from the Primary Plan, the Secondary Plan and the Covered Person shall not exceed the fee schedule of the Primary Plan. In no event shall the Covered Person be responsible for any payment in excess of the Copayment, Coinsurance and/or Deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Reasonable & Customary Plan

If the Provider is an In-Network Provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a. The amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or

b. The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Reasonable & Customary Plan or Fee Schedule Plan

If the Primary Plan is an HMO Plan that does not allow for the use of Out-of-Network Providers except in the event of Urgent Care or a Medical Emergency and the service or supply the Covered Person receives from an Out-of-Network Provider is not considered as Urgent Care or a Medical Emergency, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or Reasonable & Customary Plan

If the Covered Person receives services or supplies from a Provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

a. The amount of any Deductible, Coinsurance and/or Copayment required by the Primary Plan; or

b. The amount the Secondary plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or Reasonable & Customary Plan and Secondary Plan is Capitation Plan

If the Covered Person receives services or supplies from a Provider who is in the network of the

Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the Provider and shall not be liable to pay the Deductible, Coinsurance and/or Copayment imposed by the Primary Plan. The Covered Person shall not be liable to pay any Deductible, Coinsurance and/or Copayment of either the Primary Plan or the Secondary Plan.

Effect of Medicare on Benefits

Important Notice

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

For the purpose of this section:

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

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

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

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

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

Medicare Eligibility by Reason of Age

This part applies to a Covered Person who:

a. is the Employee or covered Spouse;and

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

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

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

This part does **not** apply to:

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

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

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

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

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

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

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

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

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

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

Medicare Eligibility by Reason of Disability

This part applies to a Covered Person who:

a. is under age 65;

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

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

This part does **not** apply to:

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

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

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

Medicare Eligibility by Reason of End Stage Renal Disease

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

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

a. eligible for Medicare by reason of age ; or

b. eligible for Medicare by reason of disability.

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

The coordination period starts on the earlier of:

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

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

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

Dual Medicare Eligibility

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

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

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

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

How To File A Claim If You Are Eligible For Medicare

Follow the procedure that applies to you or the Covered Person from the categories listed below when

filing a claim.

New Jersey Providers:

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

Out-of-State Providers:

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

Coverage For Automobile Related Injuries

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

Definitions

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

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

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

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

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

Application of this Provision

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

Determination of Primary or Secondary Coverage

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

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

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

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

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

Benefits This Plan Will Pay if it is Secondary to PIP

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

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

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

Medicare

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

Subrogation and Reimbursement

1. In the event that benefits are provided under this Plan to or on behalf of any participant, beneficiary (including all dependents), hereinafter individually and collectively referred to as "Covered Person", as the result of an injury or illness caused by a third party or organization, the Plan shall be subrogated to all of the Covered Person's rights of recovery against any such person or organization causing the injury or illness to the extent of the benefits provided. The Covered Person shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights.

2. The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise.

3. The Plan, by providing benefits hereunder, is hereby granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to, or received by the Covered Person or his/her representatives, and the Covered Person hereby consents to said lien and agrees to take whatever steps are necessary to help the company secure said lien. By the acceptance of benefits under the Plan, the Covered Person and his/her representatives agree to hold the proceeds of any settlement in trust for the benefit of the Plan to the extent of 100% of all benefits paid on behalf of the Covered Person.

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

    a. Payments made directly by the third party tortfeasor, or any insurance company on behalf of the third party tortfeasor, or any other payments on behalf of the third party tortfeasor, or payments made from any other source intended to compensate a Covered Person for injuries sustained.

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

    c. Any worker's compensation award or settlement.

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

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

5. The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Covered Person, which right shall not be defeated nor reduced by the application of any doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

6. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically, no court costs nor attorneys fees may be deducted from the Plan's recovery without the prior express written consent of the Plan.

7. The Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

General Provisions

Cost-Saving Alternatives

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

Member Services

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

Miscellaneous Provisions

a. This Plan is intended to pay for Covered Services and Supplies as described in this Booklet. The Plan does not provide the services or supplies themselves, which may, or may not, be available.

b. The Plan is only required to provide its Allowance for Covered Services and Supplies, to the extent stated in the Plan. The Plan has no other liability.

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

Referral Forms

A Member can be referred for Specialist services by a Member's PCP.

Member will be responsible for the cost of all services provided by anyone other than a Member's Primary Care Physician (including but not limited to Specialist Services) if a Member has not been referred by his or her Primary Care Physician, except in the case of a Special Referral.

Selecting or Changing a Primary Care Physician

When You first obtain this coverage, You must select a Primary Care Physician.

Members select a Primary Care Physician from Our Provider Directory. We cannot guarantee the availability of a particular doctor. If the Primary Care Physician initially selected cannot accept additional patients, a Member will be notified and given an opportunity to make another Primary Care Physician selection. After initially selecting a Primary Care Physician, a Member can transfer to a different Primary Care Physician listed in Our Provider Directory upon notification to and approval by Us.

The selection of a new PCP is effective no later than 14 days following the date of the selection when such change is discretionary, and is immediately effective when change of the PCP is necessitated by termination of the PCP from the network.

Termination for Fraud

Subject to 30 days advance written notice, this Contract will be cancelled if the Contractholder commits fraudulent acts or makes misrepresentations with respect to coverage of Eligible Members. Any act or omission by a Member which indicates intent to defraud the Plan, such as the intentional and/or repetitive misuse of the Plan's services or the omission or misrepresentation of a material fact on a Member's application for enrollment, health statement or similar document, will result, subject to 30 days advance written notice, in the termination of the Member's coverage under this Contract. The termination will be retroactive to the Coverage Date. The Plan retains the right to recoup from any individual all Payments made and to retain charges paid.

Out-of-Area Services

Horizon HMO covers only limited healthcare services received outside of Horizon HMO's Service Area. For example, emergency or urgent care obtained out of Horizon HMO's geographic Service Area is always covered. Any other services will be covered only if authorized by the Covered Person's Primary Care Physician.

For those out-of-area healthcare services that Horizon HMO does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Horizon HMO has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through the Inter-Plan Program. If so, the claim will be presented to Horizon HMO for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

Your Rights and Responsibilities

Appeals Process

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

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

Appeals Process for Adverse Administrative Decisions

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

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

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

Your Explanation of Benefits will include detailed information regarding how to file an appeal.

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

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

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

Appeals Process for Adverse Utilization Management Decisions

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

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

Your appeal must include the following information:

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

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

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

External Appeal Rights

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

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

are completed, the IRO will review all of the information in your case as if it were new. The IRO is not bound by any decisions or conclusions that were reached during the internal appeals process.

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

PRIVACY OF MEDICAL AND PERSONAL INFORMATION

The Plan is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. This section summarizes the Plan's official Notice of Privacy Practices, which is available from the Plan's Privacy Official.

The main idea of HIPAA is to make sure that private health information that identifies (or could be used to identify) you is kept completely private. This individually identifiable health information is known as "Protected Health Information" (PHI). The Plan will not use or disclose your protected health information without your written authorization except as necessary for treatment, payment, health Plan operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any Plan benefit.

This Plan also hires professionals and other companies to advise the Plan and help administer and provide health care benefits. The Plan requires these individuals and organizations, called "Business Associates", to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates (for example, Horizon Blue Cross Blue Shield of New Jersey). That notice will describe your rights with respect to benefits provided by that individual/organization.

Under federal law, you have certain rights where your protected health information is concerned, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, change or correct the information. You have the right to request reasonable restrictions on disclosure of information about you and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

If you have questions about the privacy of your health information, please contact NJ TRANSIT's Privacy Official. To file a complaint about a privacy issue, please contact:

Privacy Official
Senior Director of HR Operations
NJ TRANSIT
180 Boyden Avenue
Maplewood, NJ 07040

THE NJ TRANSIT HEALTH CARE PLAN

This booklet describes the Plan.

Type of Plan:	Horizon HMO
Plan Year:	July 1 through June 30.
Employer (Plan Sponsor):	NJ TRANSIT 180 Boyden Avenue Maplewood, NJ 07040 (973) 378-6142
Employer Identification Number:	22-2281352
Plan Administrator:	Horizon Blue Cross Blue Shield of New Jersey
Agent for Service of Legal Process	NJ TRANSIT 180 Boyden Avenue Maplewood, NJ 07040 (973) 378-6142 Attn: Director of Employee Benefits Attn: Deputy Attorney General of New Jersey

Type of Administration: Contract Administration. Benefits are provided in accordance with the provisions of the Plan maintained by the Plan Administrator. Horizon Blue Cross Blue Shield of New Jersey provides administrative services only.

The cost of coverage is shared by NJ TRANSIT and plan participants for employee and dependent coverage.

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

FUTURE OF THE HEALTH CARE PLAN

NJ TRANSIT hopes to continue this Plan, but reserves the right to terminate, suspend, withdraw, amend or modify the Plan at any time. Any change or termination of benefits will be based solely on the decision of NJ TRANSIT and may apply to active employees, future retirees and current retirees either as separate groups, or as one group. If this should happen, you will be notified.

NJ TRANSIT also reserves the right, in its complete and sole discretion, to interpret and administer this Plan.