STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS

Horizon HMO

MEMBER HANDBOOK

FOR EMPLOYEES AND RETIREES

ENROLLED IN THE

STATE HEALTH BENEFITS PROGRAM OR
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

PLAN YEAR 2014

ADMINISTERED FOR THE DIVISION OF PENSIONS AND BENEFITS BY
HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY

WELCOME

Welcome to Horizon HMO.

Your Horizon HMO plan provides you with access to safe and effective care through many programs and services and a large network of participating physicians, facilities and other health care professionals. Other Horizon HMO features include:

- Preventive health care benefits.
- An easy-to-use referral system.
- Direct access to your participating Ob/Gyn.
- Emergency medical care coverage.
- Discounts on health products and services.

To get the most from your Horizon HMO plan, please refer to this Member Handbook. It will help you understand your coverage and how your Horizon HMO plan works.

If you have questions about your Horizon HMO benefits, we are here to help you. Visit *www.HorizonBlue.com/shbp* or call Member Services at **1-800-414-7427 (SHBP).**

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An online version of this handbook containing current updates is available for viewing at: *www.state.nj.us/treasury/pensions/health-benefits.shtml*

Be sure to check the Division of Pensions and Benefits Internet home page at: *http://www.state.nj.us/treasury/pensions/index.shtml* for forms, fact sheets, and news of any new developments affecting your health benefits.

INTRODUCTION

The State Health Benefits Program (SHBP) was established in 1961. It offers medical and prescription drug coverage to qualified State and local government public employees, retirees, and eligible dependents; and dental coverage to qualified State and local government/education public employees, retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP.

The State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the SHBP. The SHBC includes the State Treasurer as the chairperson, the Commissioner of the Department of Banking and Insurance, the Chairman of the Civil Service Commission, a State employee representative chosen by the Public Employees' Committee of the AFL-CIO, and a local employee representative chosen by the Public Employees' Committee of the AFL-CIO. The Director of the Division of Pensions and Benefits is the Secretary to the SHBC.

The State Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The School Employees' Health Benefits Program (SEHBP) was established in 2007. It offers medical and prescription drug coverage to qualified local education public employees, retirees, and eligible dependents. Local education employers must adopt a resolution to participate in the SEHBP.

The School Employees' Health Benefits Commission (SEHBC) is the executive organization responsible for overseeing the SEHBP. The SEHBC includes the State Treasurer, the Commissioner of the Department of Banking and Insurance, an appointee of the Governor, an appointee from New Jersey School Board Association, three appointees from New Jersey Education Association, an appointee from New Jersey State AFL-CIO, and a chairperson appointed by the Governor from nominations submitted by the other members of the commission. The Director of the Division of Pensions and Benefits is the Secretary to the SEHBC.

The School Employees' Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.46 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, is responsible for the daily administrative activities of the SHBP and the SEHBP.

Every effort has been made to ensure the accuracy of the Horizon HMO*;* which describes the benefits provided in the contract with Horizon Healthcare of New Jersey. However, State law and the New Jersey Administrative Code govern the SHBP and SEHBP. If there are any discrepancies between the information presented in this booklet and/or plan documents and the law, regulations, or contracts, the law, regulations, and contracts will govern. **Furthermore, if you are unsure whether a procedure is covered, contact your plan before you receive services to avoid any denial of coverage issues that could result.**

If, after reading this booklet, you have any questions, comments, or suggestions regarding this material, please write to the Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295, call us at (609) 292-7524, or send an e-mail to: *https://www.state.nj.us/treas/pensions/pensionmail.shtml*

HORIZON BCBSNJ MEMBER ONLINE SERVICES

Horizon Blue Cross Blue Shield of New Jersey offers members an easy, secure and quick way to track your health plan benefits and health information online through Member Online Services at HorizonBlue.com/Members. Member Online Services saves you time by allowing immediate access to important information about your Horizon BCBSNJ health plan.

Accessing health plan benefits and health information online, Members can:

- View benefits.
- Check claims status and payments.
- View authorizations and referrals.
- Request ID cards.
- Tell Horizon if they have other health insurance coverage.
- Find a participating doctor or hospital.
- Change a doctor or dentist.
- Manage Member Online Services account and preferences.

Accessing Member Online Services

To become a registered user of Member Online Services, members should visit HorizonBlue.com and click Register in the upper right-hand corner. If members are having difficulty accessing Horizon BCBSNJ's Member Online Services, members should e-mail Member_Portal@HorizonBlue.com. Representatives are available Monday through Friday, between 7 a.m. and 6 p.m., ET.

My Health Manager, powered by WebMD®

You are your own best health advocate. But to get and stay healthy, it helps to have some guidance. That's why we offer *My Health Manager*, powered by WebMD®.

My Health Manager is your personalized health guide. You can customize it to include news feeds, articles and reminders, plus take advantage of an online health record that gives you and your family the ability to store, manage and maintain health information in a centralized location.

My Health Manager also features these powerful tools:

- **WebMD's Symptom Checker:** Answer a few simple questions and get information on potential causes and treatments to discuss with your physician.
- **Hospital Quality Comparison Tool:** Review diagnosis and procedure specific quality rankings of hospitals.
- **Treatment Cost Advisor:** Determine the approximate cost of treatment for specific illnesses and disorders, based on your geographical region, age and gender.
- **Health Assessment Tool:** Take an assessment that covers your current health conditions, family health history, vital statistics, lifestyle and life events, among other factors.
- **Condition Centers:** Tap into enhanced risk; identification and management tools for conditions ranging from allergies and asthma to depression and diabetes.
- **And much more:** From health measurement trackers to tailored health improvement programs, we provide all the tools you need.

For more details, try our **My Health Manager Demo**.

Sign in or ***register*** to get started

My Health Manager is only available to registered members, so register or sign in to Member Online Services to see what tools are available to you. **Register** or **Sign in.**

HORIZON HMO

Except where identified, Horizon HMO benefits described in this member handbook are identical for SHBP and SEHBP members.

Horizon HMO is administered for the Division of Pensions and Benefits by Horizon Healthcare of New Jersey, Inc., a subsidiary of Horizon Blue Cross Blue Shield of New Jersey. Both companies are independent licensees of the Blue Cross and Blue Shield Association.

Horizon HMO covers in-network benefits only.

Care is provided through a network of providers which includes internists, general practitioners, pediatricians, specialists, pharmacies and hospitals. Network providers offer a full range of services that include well-care and preventive services such as annual physicals, well-baby/well-child care, immunizations, mammograms, annual gynecological examinations, and prostate examinations. In-network services are generally covered in full after a member copayment, and, depending on the plan, may be subject to a copay or in-network deductible and coinsurance. See page 22 for additional in-network benefit information.

Horizon HMO is self-funded. Funds for the payment of claims and services come from funds supplied by the State, participating local employers, and members.

Refer to page 93 for additional information on contacting Horizon HMO, the Division of Pensions and Benefits, and related health services.

HEALTH BENEFITS PROGRAM ELIGIBILITY

ACTIVE EMPLOYEE ELIGIBILITY

Eligibility for coverage is determined by the State Health Benefits Program (SHBP) or School Employees' Health Benefits Program (SEHBP). Enrollments, terminations, changes to coverage, etc. must be presented through your employer to the Division of Pensions and Benefits. If you have any questions concerning eligibility provisions, you should contact the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524. Or send e-mail to: *https://www.state.nj.us/treas/pensions/pensionmail.shtml*

STATE EMPLOYEES

To be eligible for State employee coverage, you must work full-time for the State of New Jersey or be an appointed or an elected officer of the State of New Jersey (this includes employees of a State agency or authority and employees of a State college or university). For State employees, full-time requires at least 35 hours per week or more if required by contract or resolution.

The following State employees are also eligible for coverage in Horizon HMO.

State Part-Time Employees — Part-time employees of the State and part-time faculty at institutions of higher education that participate in the SHBP are eligible for HMO coverage if they are members of a State-administered pension system. The employee or faculty member must pay the full cost of the coverage. Part-time employees will not qualify for employer or State-paid post-retirement health care benefits, but may enroll in retired group coverage at their own expense provided they were covered up to the date of retirement. See Fact Sheet #66, *Health Benefits Coverage for Part-Time Employees,* for more information.

The following State employees are eligible for coverage in Horizon HMO.

State Intermittent Employees — Certain intermittent State employees who have worked 750 hours in a Fiscal Year (July 1 - June 30) are eligible for coverage. Intermittent employees who maintain 750 hours of work per year continue to qualify for coverage in subsequent years. See Fact Sheet #69, *SHBP Coverage for State Intermittent Employees,* for more information.

New Jersey National Guard — A member of the New Jersey National Guard who is called to State active duty for 30 days or more is eligible to enroll at the State's expense. Upon enrollment, the member may also enroll eligible dependents. The Department of Military and Veteran's Affairs is responsible for notifying eligible members and the Division of Pensions and Benefits of members who are eligible for coverage.

LOCAL EMPLOYEES

To be eligible for local employer coverage, you must be a full-time employee or an appointed or elected officer receiving a salary from a local employer (county, municipality, county or municipal authority, board of education, etc.) that participates in the SHBP or SEHBP. Each participating local employer defines the minimum hours required for full-time by a resolution filed with the Division of Pensions and Benefits, but it can be no less than 25 hours per week or more if required by contract or resolution. Employment must also be for

12 months per year except for employees whose usual work schedule is 10 months per year (the standard school year).

The following local employees are also eligible for coverage in Horizon HMO.

Local Part-Time Employees — A part-time faculty member employed by a county or community college that participates in the SEHBP is eligible for coverage if they are members of a State-administered pension system. The faculty member must pay the full cost of the coverage. Part-time faculty members will not qualify for employer or State-paid post-retirement health care benefits, but may enroll in retired group coverage at their own expense provided they were covered up to the date of retirement. See Fact Sheet #66, *Health Benefits Coverage for Part-Time Employees,* for more information.

ENROLLMENT

You are not covered until you enroll in the SHBP or SEHBP. You must fill out a *Health Benefits Program Application* and provide all the information requested. If you do not enroll all eligible members of your family within 60 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so. Open Enrollment periods generally occur once a year usually during the month of October. Information about the dates of the Open Enrollment period and effective dates for coverage is announced by the Division of Pensions and Benefits.

ELIGIBLE DEPENDENTS

Your eligible dependents are your spouse, civil union partner or eligible same-sex domestic partner, and your eligible children (as defined below).

Spouse — A person of the opposite sex to whom you are legally married. A photocopy of the marriage certificate and additional supporting documentation are required for enrollment.

Civil Union Partner — A person of the same sex with whom you have entered into a civil union. A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions and additional supporting documentation are required for enrollment. The cost of a civil union partner's coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions,* for details).

Domestic Partner — A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity that adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage. A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners) and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

Children — In compliance with the federal Patient Protection and Affordable Care Act (PPACA) coverage is extended for children until the end of the year in which he/she turns age 26. This includes natural children under age 26 regardless of the child's marital, student, or financial dependency status. A photocopy of the child's birth certificate that includes the covered parent's name is required for enrollment (non-custodial parents, see page 87).

For a stepchild provide a photocopy of the child's birth certificate showing the spouse/partner's name as a parent **and** a photocopy of marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.

Foster children and children in a guardian-ward relationship under age 26 and under are also eligible. A photocopy of the child's birth certificate **and** additional supporting legal documentation are required with enrollment forms for these cases. Documents must attest to the legal guardianship by the covered employee (see page 87).

Coverage for an enrolled child ends on December 31 of the year in which he or she turns age 26 (see the "COBRA" section on page 67, "Dependent Children with Disabilities" and "Over Age Children Until Age 31" below for continuation of coverage provisions).

Dependent Children with Disabilities — If a child is not capable of self-support when he or she reaches age 26 due to mental illness, mental retardation, or a physical disability, he or she may be eligible for a continuance of coverage.

To request continued coverage, contact the Office of Client Services at (609) 292-7524 or write to the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end.

Since coverage for children ends on December 31 of the year they turn 26, you have until January 31 to file the *Continuance for Dependent with Disabilities* form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP or SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.

Over Age Children Until Age 31 — Certain children over age 26 may be eligible for coverage until age 31 under the provisions of Chapter 375, P.L. 2005, as amended by Chapter 38, P.L. 2008. This includes a child by blood or law who is under the age of 31; is unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.

Under Chapter 375, an over age child does not have any choice in the selection of benefits but is enrolled for coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. The covered parent or child is responsible for the entire cost of coverage. There is no provision for dental or vision benefits.

Coverage for an enrolled over age child will end when the child no longer meets any one of the eligibility requirements or if the required payment is not received. Coverage will also end when the covered parent's coverage ends. Coverage ends on the first of the month following the event that makes the dependent ineligible or up until the paid through date in the case of non-payment.

See Fact Sheet #74, *Health Benefits Coverage of Children until Age 31 under Chapter 375*, for details.

SUPPORTING DOCUMENTATION REQUIRED FOR ENROLLMENT OF DEPENDENT

The SHBP and SEHBP are required to ensure that only eligible employees and retirees, and their dependents, are receiving health care coverage under the program. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents, and over age children continuing coverage) must submit supporting documentation in addition to the enrollment application. See page 87 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

AUDIT OF DEPENDENT COVERAGE

Periodically, the Division of Pensions and Benefits performs an audit using a random sample of members to determine if enrolled dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union, or birth certificates, or tax returns are required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of ALL coverage and may include financial restitution for claims paid. Members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law.

MULTIPLE COVERAGE UNDER THE SHBP/SEHBP IS PROHIBITED

State statute specifically prohibits two members who are each enrolled in SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent.

Eligible children may only be covered by one participating subscriber.

For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose Family coverage, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

MEDICARE COVERAGE WHILE EMPLOYED

In general, it is not necessary for a Medicare-eligible employee, spouse, civil union or domestic partner, or dependent child(ren) to be covered by Medicare while the employee remains actively at work. However, if you or your dependents become eligible for Medicare due to End Stage Renal Disease (ESRD), and the 30-month coordination of benefits period has ended, you and/or your dependents must enroll in Medicare Parts A and B even though you are actively at work. For more information, see “Medicare Coverage” beginning on page 12 in the “Retiree Eligibility” section.

RETIREE ELIGIBILITY

The following individuals will be offered SHBP Retired Group coverage for themselves and their eligible dependents:

- Full-time State employees, employees of State colleges/universities, autonomous State agencies and commissions, or local employees who were covered by, or eligible for, the SHBP at the time of retirement and begin receiving a monthly retirement benefit or lifetime annuity immediately following termination of employment.
- Part-time State employees and part-time faculty at institutions of higher education that participate in the SHBP if enrolled in the SHBP at the time of retirement.
- Participants in the Alternate Benefit Program (ABP) eligible for the SHBP who retire with at least 25 years of credited ABP service or those who are on a long-term disability and begin receiving a monthly lifetime annuity immediately following termination of employment.
- Certain local policemen or firemen with 25 years or more of service credit in the retirement system or retiring on a disability retirement if the employer does not provide any payment or compensation toward the cost of the retiree's health benefits. A qualified retiree may enroll at the time of retirement or when he or she becomes eligible for Medicare. See Fact Sheet #47, *Retired Health Benefits Coverage under Chapter 330,* for more information.
- Surviving spouses, civil union partners, eligible same-sex domestic partners, and children of Police and Firemen's Retirement System (PFRS) members or State Police Retirement System (SPRS) members killed in the line of duty.

The following individuals will be offered SEHBP Retired Group coverage for themselves and their eligible dependents:

- Full-time members of the Teachers' Pension and Annuity Fund (TPAF) and school board or county college employees enrolled in the Public Employees' Retirement System (PERS) who retire with less than 25 years of service credit from an employer that participates in the SEHBP.
- Full-time members of the TPAF and school board or county college employees enrolled in the PERS who retire with 25 years or more of service credit in one or more State or locally-administered retirement systems or who retire on a disability retirement, even if their employer did not cover its employees under the SEHBP. This includes those who elect to defer retirement with 25 or more years of service credit in one or more State or locally-administered retirement systems (see "Aggregate of Pension Membership Service Credit" on page 10).
- Full-time members of the TPAF or PERS who retire from a board of education, vocational/ technical school, or special services commission; maintain participation in the health benefits plan of their former employer; and are eligible for and enrolled in Medicare Parts A and B. A qualified retiree may enroll when he or she becomes eligible for Medicare.
- Participants in the Alternate Benefits Program (ABP) eligible for the SEHBP who retire with at least 25 years of credited ABP service or those who are on a long-term disability and begin receiving a monthly lifetime annuity immediately following termination of employment.

- Part-time faculty at institutions of higher education that participate in the SEHBP if enrolled in the SEHBP at the time of retirement.

Eligibility for SHBP or SEHBP membership for the individuals listed in this section is contingent upon meeting two conditions:

1. You must be immediately eligible for a retirement allowance from a State- or locally-administered retirement system (except certain employees retiring from a school board or community college); and
2. You were a full-time employee and eligible for employer-paid medical coverage immediately preceding the effective date of your retirement (if you are an employee retiring from a school board or community college under a deferred retirement with 25 or more years of service, you must have been eligible at the time you terminated your employment), or a part-time State employee or part-time faculty member who is enrolled in the SHBP or SEHBP immediately preceding the effective date of your retirement.

This means that if you allow your active coverage to lapse (i.e. because of a leave of absence, reduction in hours, or termination of employment) prior to your retirement or you defer your retirement for any length of time after leaving employment; you will lose your eligibility for Retired Group health coverage. (This does not include former full-time employees enrolled in TPAF and PERS board of education or county college who retire with 25 or more years of service).

Note: If you continue group coverage through COBRA (see the "COBRA" section on page 67) — or as a dependent under other coverage through a public employer — until your retirement becomes effective, you will be eligible for retired coverage under the SHBP or SEHBP.

Otherwise qualified employees whose coverage is terminated prior to retirement **but who are later approved for a *disability retirement*** will be eligible for Retired Group coverage beginning on the employee's retirement date. If the approval of the disability retirement is delayed, coverage shall not be retroactive for more than one year.

Aggregate of Pension Membership Service Credit

Upon retirement, a full-time State employee, board of education, or county college employee who has 25 years or more of service credit, is eligible for State-paid health benefits under the SHBP or SEHBP; subject to the applicable retiree contribution, if any.

A full-time employee of a local government who has 25 years or more of service credit whose employer participates in the SHBP **and** has chosen to provide post-retirement medical coverage to its retirees is eligible for employer-paid health benefits under the SHBP.

A retiree eligible for the SHBP or SEHBP may receive this benefit if the 25 years of service credit is from one or more State or locally-administered retirement systems and the time credited is nonconcurrent.

For PERS or TPAF members, Out-of-State Service, U.S. Government Service, or service with a bi-state or multi-state agency, requested for purchase after November 1, 2008, cannot be used to qualify for any State-paid or employer-paid health benefits in retirement.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage except for Chapter 334 domestic partners (described below) and the Medicare requirements (see page 12).

Chapter 334, P.L. 2005, provides that retirees from local entities (municipalities, counties, boards of education, and county colleges) whose employers do not participate in the SHBP or SEHBP, but who become eligible for SHBP or SEHBP coverage at retirement (see page 11), may also enroll a registered same-sex domestic partner as a covered dependent provided that the former employer's plan includes domestic partner coverage for employees.

Multiple Coverage under the SHBP/SEHBP is Prohibited

State statute specifically prohibits two members who are each enrolled in SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent.

Eligible children may only be covered by one participating subscriber.

For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose Family coverage, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

Enrolling in Retired Group Coverage

The Health Benefits Bureau is notified when you file an application for retirement with the Division of Pensions and Benefits. If eligible, you will receive a letter inviting you to enroll in Retired Group coverage. Early filing for retirement is recommended to prevent any lapse of coverage or delay of eligibility.

If you do not submit a *Retired Coverage Enrollment Application* at the time of retirement, you will not generally be permitted to enroll for coverage at a later date. See Fact Sheet #11, *Enrolling for Health Benefits Coverage When You Retire,* for more information.

If you believe you are eligible for Retired Group coverage and do not receive an offering letter by the date of your retirement, please contact the Division of Pensions and Benefits, Office of Client Services at (609) 292-7524 or send an e-mail to: *https://www.state.nj.us/treas/pensions/pensionmail.shtml*

Additional restrictions and/or requirements may apply when enrolling for Retired Group coverage. Be sure to carefully read the "Retiree Enrollment" section of the *Summary Program Description*.

MEDICARE COVERAGE

Medicare Parts A and B

IMPORTANT: A Retired Group member and/or dependent spouse, civil union partner, eligible same-sex domestic partner, or child who is eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in SHBP or SEHBP Retired Group coverage.

You will be required to submit documented evidence of enrollment in Medicare Part A and Part B when you or your dependent becomes eligible for that coverage. Acceptable documentation includes a photocopy of the Medicare card showing both Part A and Part B enrollment, or a letter from Medicare indicating the effective dates of both Part A and Part B coverage. Send your evidence of enrollment to the Health Benefits Bureau, Division of Pensions and Benefits, PO Box 299, Trenton, New Jersey 08625-0299 or fax it to (609) 341-3407. If you do not submit evidence of Medicare coverage under both Part A and Part B, you and/or your dependents will be terminated from coverage. Upon submission of proof of full Medicare coverage, your Retired Group coverage will be reinstated by the Health Benefits Bureau on a prospective basis.

IMPORTANT: When coordinating benefits with Medicare, the secondary benefit under Horizon HMO is supplemental to the Medicare payment. Horizon HMO will consider the remaining Medicare coinsurance and deductible as the allowable expense and apply the applicable copayments or deductible when appropriate. If a provider is not registered with or opts out of Medicare, no benefits are payable under the SHBP or SEHBP for the provider's services, the charges would not be considered under the medical plan, and the member will be responsible for the charges.

Medicare Part D

If you are enrolled in the Retired Group of the SHBP/SEHBP and eligible for Medicare, you will be automatically enrolled in Medicare Part D and the Express Scripts Medicare Prescription Plan.

Important: If you decide not to be enrolled in the Express Scripts Medicare Prescription Plan, you will lose your prescription drug benefits provided by the SEHBP/SHBP. However, your medical benefits will continue. In order to waive the Express Scripts Medicare Prescription Plan, you **must** enroll in another Medicare Part D plan. To request that you not be enrolled, you must submit a *Retired Change of Status Application* waiving your prescription drug coverage.

Medicare Eligibility

A member may be eligible for Medicare for the following reasons:

- ***Medicare Eligibility by Reason of Turning Age 65***

  A member (the retiree or covered spouse/partner) is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if he or she is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his/her 65th birthday.

  The retired group health plan is the secondary plan.

- ***Medicare Eligibility by Reason of Disability***

  A member (the retiree or covered spouse/partner or dependent) who is under age 65 is considered to be eligible for Medicare by reason of disability if they have been receiving Social Security Disability benefits for 24 months.

  The retired group health plan is the secondary plan.

- ***Medicare Eligibility by Reasons of End Stage Renal Disease***

  A member usually becomes eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. A member (the retiree or covered spouse/partner or dependent) who is not eligible for Medicare because of age or disability may qualify because of treatment for End Stage Renal Disease (ESRD). When a person is eligible for Medicare due to ESRD, Medicare is the secondary payer when:

  - ✓ The individual has group health coverage of their own or through a family member (including a spouse/partner).
  - ✓ The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

  The rules listed above, known as the Medicare Secondary Payer (MSP) rules are federal regulations that determine whether Medicare pays first or second to the group health plan. These rules have changed over time.

  As of January 1, 2000, where the member becomes eligible for Medicare solely on the basis of ESRD, the Medicare eligibility can be segmented into three parts: (1) an initial three-month waiting period; (2) a "coordination of benefits" period; and (3) a period where Medicare is primary.

  Three-month waiting period

  Once a person has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Parts A and B benefits. During the initial three-month period, **the group health plan is primary.**

  Coordination of benefits period

  During the "coordination of benefits" period, **Medicare is secondary to the group health plan coverage.** Claims are processed first under the health plan. Medicare considers the claims as a secondary carrier. For members who became eligible for Medicare due solely to ESRD, the coordination of benefits period is 30 months.

  When Medicare is primary

  After the coordination of benefits period ends, **Medicare is considered the primary payer and the group health plan is secondary.** If you are eligible for Medicare by reason of ESRD and Medicare is primary, you must enroll in Medicare A and B and submit proof of enrollment to the SHBP/SEHBP. If you do not enroll in Medicare A and B before the end of the coordination of benefits period, your SHBP/SEHBP coverage will be terminated. It is your responsibility to ensure that you file your application for Medicare so that the Medicare effective date is on or before the date that the coordination of benefits period ends.

Dual Medicare Eligibility

When the member is eligible for Medicare because of age or disability and then becomes eligible for Medicare because of ESRD:

- ✓ If the health plan is primary because the member has active employment status, then **the group health plan continues to be primary** for 30 months from the date of dual Medicare entitlement.
- ✓ If the health plan is secondary because the member is not actively employed, then **the health plan continues to be the secondary payer.** There is no 30-month coordination period.

GENERAL CONDITIONS OF THE PLAN

All benefits listed in this handbook may be subject to limitations and exclusions as described in subsequent sections. All pertinent parts of this handbook should be consulted regarding a specific benefit.

Even though a service or supply may not be described or listed in this handbook, that does not mean the service or supply is eligible for benefits under the Horizon HMO

Horizon HMO will pay only for eligible services or supplies that meet the following conditions:

- Are medically needed at the appropriate level of care (see below) for the medical condition. (When there is a question as to medical need, the decision on whether the treatment is eligible for coverage will be made by Horizon HMO.)
- Are listed in the "Eligible Services and Supplies" section on page 73.
- Are ordered by an eligible provider for treatment of illness or injury.
- Were provided while you or your eligible covered dependents were covered by the HMO.
- Are not specifically excluded (listed in the "Charges Not Covered by Horizon HMO" section on page 42.

Medical Need and Appropriate Level of Care

The medical need and appropriate level of care for any service or supply is determined by Horizon HMO and must meet each of these requirements:

- It is ordered by an eligible provider for the diagnosis or the treatment of an illness or injury.
- The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use.
- That it is the most appropriate level of service or supply considering the potential benefits and possible harm to the patient.

See also "Experimental or Investigational Treatments" on page 20.

Health Care Fraud

Health care fraud is an intentional deception or misrepresentation that results in an unauthorized benefit to a member or to some other person. Any individual who willfully and knowingly engages in an activity intended to defraud the SHBP or SEHBP will face disciplinary action that could include termination of employment and may result in prosecution. Any member who receives monies fraudulently from a health plan will be required to fully reimburse the plan.

Your Primary Care Physician (PCP)

When you enroll with the Horizon HMO, you must select a Primary Care Physician (PCP). PCP's are licensed family practitioners, general practitioners, internists or pediatricians who have passed the Horizon Managed Care Network credentialing process. They have agreements with Horizon Managed Care Network to participate in their network.

As your personally selected physician, your PCP provides medical care or refers you to the appropriate source for medical care, whether that source is a specialty physician or other health care professional or facility. Your PCP also coordinates your health care services.

Your PCP:

- Handles most of your medical care in his/her office.
- Performs annual well care and preventive health exams or refers you to a specialty care physician or facility, as applicable.
- Coordinates your specialty care and helps you with prior authorizations for medically necessary services.
- Is on call or has an appointed, covering physician available 24 hours a day, seven days a week.

To verify that the PCP you select is participating in the Horizon Managed Care Network, visit the Provider Directory at *www.HorizonBlue.com/SHBP* You may also call the SHBP/SEHBP Member Services at 1-800-414-7427 (SHBP).

Changing Your PCP

You may change your PCP at any time. To do so, follow these simple steps.

1. Visit the online provider directory at *www.HorizonBlue.com/SHBP* to find a new participating PCP. By answering a few short questions, you can create a list of participating physicians near you, or check to see if a specific physician is participating in the Horizon BCBSNJ network.
2. There are three ways to notify the Horizon HMO of your request to change your PCP.
   - If you're registered for Member Online Services, you may change your PCP online. Just visit *www.HorizonBlue.com/SHBP*, log in to Member Online Services and click *Change Your Doctor.*
   - You may call Horizon HMO at 1-800-414-7427 (SHBP) to change your PCP through the interactive voice response (IVR) system.
   - You may call the SHBP/SEHBP member services at 1-800-414-7427 (SHBP) and speak with a Member Services Representative.

   Horizon BCBSNJ will send a letter to you confirming your new PCP selection. You may see your new PCP in 14 days after notifying Horizon HMO.
3. Have your medical records transferred to your newly selected PCP. There may be a nominal cost from your physician to transfer your records.

Making Appointments

Call your PCP when you need an appointment for periodic physical exams. This helps ensure that you receive proper preventive care services. Contact your PCP whenever you have medical concerns or questions.

Physician Access Standards

It is important for you to receive a timely appointment. To help make sure you have access to the medical care you need, when you need it, Horizon HMO developed Physician Access Standards when scheduling appointments with you.

If you need an appointment for:	You must be offered:
Routine Care — includes any condition or illness that does not require urgent attention or is not life-threatening, as well as routine gynecological care.	An appointment as soon as possible not to exceed **two weeks** from your call.
Routine Physical Exam — includes an annual health assessment, as well as routine gynecological exams, for new and established patients.	An appointment within **four months** of your call.
Urgent Care — includes medically necessary care for an unexpected illness or injury.	An appointment within **24 hours** of your call.
Emergency Care — includes a medical condition of such severity that a prudent layperson would call for immediate medical attention and care. For a complete definition please refer to the Glossary.	To be seen **immediately or directed to an emergency care facility.**

Physician Compensation

You have a right to know how Horizon HMO pays the physicians and facilities in their managed care network so you will know if there are any financial incentives or disincentives tied to medical decisions. You also have the right to ask physicians and other health care professionals how they are compensated for their services.

Physicians and other health care professionals in the Horizon HMO network have agreed to be paid in different ways. Your participating physician may be paid each time he/she treats you (fee for service), or he/she may be paid a set fee each month for each member whether or not the member actually receives services (capitation).

These payment methods may include financial incentive agreements to pay some physicians more (bonuses) or less (withholds) based on many factors, including member satisfaction, quality of care and the control of costs and use of services.

The laws of the state of New Jersey at N.J.S.A. 45.9-22.4 et seq., require that a physician, chiropractor, or podiatrist, who is permitted to make referrals to other health care professionals or facilities in which he/she has a significant interest, inform his/her patients of that financial interest when making such a referral.

For 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, call the New Jersey Division of Consumer Affairs at 1-800-242-5846 or 1-973-504-6200.

Specialty Care

At times your PCP may feel it is appropriate to refer you for specialty care services. If specialty care services are required, your PCP will give you a referral. Your PCP will find the appropriate specialist to provide the specialty care you need. You do not need a referral for routine obstetrical or gynecological-related visits to participating Ob/Gyns.

Referrals

Your PCP will give you a referral if he/she determines that you need specialty medical care or services. Take this referral confirmation and your Horizon HMO ID card to the participating specialty care physician at the time of service.

If you are referred for specialty care, please review your referral with your PCP. It is a good idea to write down any questions you have about your condition and your need for specialty care and discuss these questions with your PCP.

How Long are Referrals Valid?

Referrals are valid for the number of visits and type(s) of services specified by your PCP. Your PCP can refer you for as many as 12 visits within 180 days if it is medically necessary and appropriate.

Extended Referrals

If you have a chronic condition, your PCP may contact Horizon HMO to request an extended referral. Extended referrals may also be called special referrals.

What to do if Referred for Care

If you need specialty care services, call the participating specialist your PCP has referred you to and schedule an appointment. You may also access your referral by visiting *www.horizonblue.com/shbp* and selecting the Member Portal. Take our referral confirmation and your ID card to your visit. If you do not have these items, the specialist may not be able to see you.

Hospitalization

The Horizon Hospital Network includes many hospitals throughout New Jersey and nearby in Pennsylvania, Delaware and New York. For eligible charges to be covered:

You must receive care, or be admitted to, a network hospital. Your PCP or participating health care professional must follow the Horizon HMO prior authorization procedures.

To find a participating hospital or facility, use our *Provider Directory* at *www.HorizonBlue.com/shbp* or call Member Services at 1-800-414-7427. You can also use a web-enabled device to access the *Provider Directory* from *Mobile.HorizonBlue.com*

Hospital Stays and Prior Authorization

If you need to be hospitalized, your PCP or other participating health care professional must contact the Horizon HMO for prior authorization. Once your hospital stay has been authorized, they will give your physician a prior authorization number. If you need emergency care, go directly to the nearest hospital or emergency facility without worrying about finding a participating facility. If you are admitted into the hospital, you or the hospital's admitting staff need to call Horizon HMO to let them know.

Behavioral Health and Substance Abuse Care

Horizon Behavioral Health[SM] is responsible for the management of your behavioral health benefit. This benefit includes treatment for mental health conditions and alcohol/ substance abuse. An extensive network of participating providers will provide behavioral health and substance abuse services (including treatment of alcoholism). A referral is not required to access behavioral health and substance abuse treatment. Please refer to page 26 for details.

Accessing Behavioral Health and Substance Abuse Care

For assistance with behavioral health or alcohol/substance abuse care, please call Horizon Behavioral Health at 1-800-991-5579. The phone number is on the back of your Horizon HMO ID card. Behavioral health and substance abuse care is available 24 hours a day, seven days a week. All calls are confidential.

Due to the confidential nature of these services, an authorization form may be needed during or after your course of treatment for the disclosure of treatment information. The authorization form might also be required for any individual (including family members) to get information about a member's behavioral health/substance abuse treatment.

For more information about Horizon Behavioral Health, visit *www.HorizonBlue.com/shbp* or call the Behavioral Health Services number on the back of your Horizon HMO ID card.

Prior Authorization

Prior authorization is the approval Horizon HMO gives you and your participating physician prior to receiving certain specialty services. With the proper prior authorization, your specialty services will be covered under your Horizon HMO plan. Prior authorization is also known as pre-approval.

When You Need Prior Authorization

Prior authorization may be required for some hospital-related care, some outpatient services and some durable medical equipment (DME). If you have questions about which services need prior authorization under your Horizon HMO, please speak with your physician or other health care professional. If you still have questions regarding prior authorization, please contact your dedicated SHBP/SEHBP customer service area at 1-800-414-7427 (SHBP).

When Your Physician Requests Prior Authorization

When you need hospital care or services, your participating physician will coordinate your prior authorization with Horizon HMO. Once your physician authorizes your care with Horizon HMO, he/she will be given a prior authorization number.

Utilization Management (Medical Management and Review)

Treatment is subject to Utilization Management (UM), a process used to ensure that treatment is medically needed and provided at the appropriate level of care. Your network provider is responsible for the UM contact. Benefits are payable for treatment when they are provided by an in-network provider, the UM organization has been notified to review the treatment, and the UM organization has approved the treatment.

The Horizon HMO adheres to the following UM principles. The Horizon HMO:

1. Makes UM decisions based solely on the necessity and appropriateness of care and services within the parameters of the member's benefit package.

2. Does not compensate those responsible for making UM decisions in a manner that incents them to deny coverage for medically necessary and appropriate covered services.
3. Does not offer incentives to those responsible for UM determinations to encourage denials of coverage or services and does not provide financial incentives to physicians to withhold covered health care services that are medically necessary and appropriate.
4. Emphasizes the provisions of medically necessary, appropriate and cost-effective delivery of health care services to members and encourages the reporting, investigation and elimination of underutilization.

Experimental or Investigational Treatments

Horizon HMO **does not** cover treatment that is considered experimental or investigational. Charges in connection with such a service or supply are also not covered. For the purpose of this exclusion, a service or supply will be considered experimental or investigational if Horizon HMO determines that one or more of the following is true.

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety, or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to phase I, II, and III clinical trials, with the exception of approved cancer trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for a particular diagnosis or set of indications before it is used outside clinical trials or other research settings. Horizon HMO will determine this based on:
   - Published reports in authoritative medical literature; and
   - Regulations, reports, publications, and evaluations issued by US government agencies such as the Agency for Health Care Research and Quality, the National Institutes of Health, and the federal Food and Drug Administration (FDA).
3. The provider's institutional review board acknowledges that the use of the service or supply is experimental or investigational and subject to that board's approval.
4. The provider's institutional review board requires that the patient, parent, or guardian give an informed consent stating that the service or supply is experimental or investigational, part of a research project or study, or federal law requires such consent.
5. Research protocols indicate that the service or supply is experimental or investigational. This item applies for protocols used by the patient's provider as well as for protocols used by other providers studying substantially the same service or supply.
6. The service or supply is not recognized by the prevailing opinion within the appropriate medical specialty as an effective treatment for the particular diagnosis or set of indications.
7. Additionally, if it is a drug, device, or other supply that is subject to FDA approval it will be considered experimental and investigational if it:
   - Does not have FDA approval for sale and use in the United States (that is, for introduction into and distribution in interstate commerce); or

- Has FDA approval only under the Treatment Investigational New Drug regulation or a similar regulation; or
- Has FDA approval, but is being used for an indication or at a dosage that is not an acceptable off-label use. Horizon HMO will determine if a certain use is an accepted off-label use based on published reports in peer-reviewed, authoritative medical literature and entries in the following drug compendia: The American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United States Pharmacopoeia Dispensing Information.

Chronic Care Program

The Horizon HMO Chronic Care Program helps members with chronic conditions take better care of their health, understand their care choices and improve their health. This program is available at no added cost to eligible members with:

- Asthma.
- Chronic Kidney Disease (CKD).
- Chronic Obstructive Pulmonary Disease (COPD).
- Coronary Artery Disease (CAD).
- Diabetes.
- Heart Failure.

For more information:

- Visit *www.HorizonBlue.com/shbp* and click *Health and Wellness* and *Health Programs.*
- Or, call **1-888-345-1150**, Monday through Friday, between 8 a.m. and 7 p.m., Eastern Time. If you are hearing-impaired, please call **1-800-855-2881** during the same hours.

Case Management Program

If you have a serious health problem or need major surgery, you may be able to sign up for Horizon HMO's Case Management program. A case manager, who is a registered nurse, can help you understand your treatment choices and find out about available specialists; hospitals and care, while making sure you get the most out of your Horizon HMO benefits. Your case manager can work with you and your physician(s) to make sure you get the most appropriate and effective treatment.

He/she will also:

- Work with your physician to make sure you know your health problem and treatment choices.
- Handle prior authorization requests for special services, equipment and other supplies as asked for by your physician and other health care professionals.
- Give you information about local services for you and your family.
- Help you get the right care while you are in the hospital and after you leave.

For more information or to sign up, call **1-888-621-5894**, option **2**, Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.

This program is available at no added cost to eligible members.

HORIZON HMO PLAN BENEFITS

Under the Horizon HMO, care is provided through a network of providers that includes internists, general practitioners, specialists, pediatricians, pharmacies and hospitals. Care under Horizon HMO must be provided by in-network providers to be covered. Well-care and preventive services are covered in addition to services for the treatment of illness or injury. Your PCP will coordinate your care and obtain referrals for any specialty care you may require. Referrals are required for visits to a specialist. To find current participating physicians in New Jersey contact Horizon HMO directly at 1-800-414-SHBP or visit*: www.horizonblue.com/shbp*

Copayments

Horizon HMO will pay, in most cases, the full cost after the copayment for covered physician office visits. Copayments apply to in-network, provider office visits unless otherwise indicated and vary by plan option as outlined below:

Horizon HMO Plan Option	Primary Care Office Visit Copay	Specialist Office Visit Copay
HMO10	$10	$10
HMO15	$15	$15
HMO1525	$15	$25
HMO2030	$20	$30 for adults; $20 for children up to the end of year the child turns 26
HMO2035	$20	$35

Depending on the HMO option selected, some services may be subject to deductible and or coinsurance. In-network hospital admissions are covered in full in most cases. Inpatient admissions and outpatient services, however, are subject to the deductible and coinsurance under HMO2035.

No benefits are available for non-network services. Members accessing urgent care services outside of New Jersey can utilize physicians participating in the national BlueCard® PPO Network.

In-Network Deductible (Horizon HMO2035)

Horizon HMO2035 members must meet a $200 individual or $500 family annual, in-network deductible before in-network charges are paid by the plan. The in-network deductible does not apply to physician office visits that are subject to an office visit copay or emergency room services that are subject to the emergency room copay.

In-Network Coinsurance (Horizon HMO2035)

With the exception of physician office visits that are subject to a copayment, HMO2035 members are responsible for twenty percent coinsurance for all in-network services after the in-network deductible has been met. In-network coinsurance paid by the member is applied toward the in-network out-of-pocket maximum.

In-Network Coinsurance Out-of-Pocket Maximum (Horizon HMO2035)

Horizon HMO2035 includes a $2,000 individual and $5,000 family in-network coinsurance out-of-pocket maximum. During the plan year, coinsurance paid by the member accumulates toward the out-of-pocket maximum. If the member's out-of-pocket expenses reach the maximum, the member will be in benefit and eligible services will be covered at 100% for the balance of the plan year.

Total Out-of-Pocket Maximum

For all Horizon HMO options, out-of-pocket expenses paid by the member including copayments, deductible and coinsurance apply toward the total out-of-pocket maximum. Once the total out-of-pocket maximum of $6,350 per individual or $12,700 per family is met, the Plan will pay 100 percent of the cost of covered in-network services for the balance of the plan year.

Limits / Deductibles

Coverage for certain services are subject to limitations. Unless noted otherwise, these limits apply to all HMO options.

- Coverage for physical therapy, speech therapy and occupational therapy is limited to 60 visits per calendar year for all three therapies combined.
- Coverage for chiropractor visits is limited to 20 per calendar year.
- Private duty nursing coverage is limited to 60 eight-hour shifts. Prior authorization is required. Inpatient private duty nursing is not covered.
- Skilled nursing facility care is limited to 120 days per benefit period.

Some services require the payment of a deductible before eligible charges are covered.

- Horizon HMO, Horizon HMO1525, Horizon HMO2030 members must meet a $100.00 per person per calendar year deductible for Durable Medical Equipment and Medical Appliances/Equipment.

COORDINATION OF BENEFITS

For group plans that have a Coordination of Benefits provision, the following rules determine which plan is primary.

- If you, the active employee, are the patient, Horizon HMO is primary for you. If your spouse/partner is the patient, and covered under a health plan provided through his or her employer as an active employee, that plan is the primary plan for them.
- If a member has coverage as an active employee and additional coverage as a retiree the coverage through active employment is primary to retiree coverage.

- When Medicare is involved (except for ESRD; see page 13), the benefits of the plan that covers an active employee and/or his or her dependents will be considered primary before the benefits of a plan that covers a laid-off or a retired employee and his or her dependents.
- If a dependent child is the patient and is covered under both parents' plans, the following birthday rule will apply.

  Under the birthday rule, the plan covering the parent whose birthday falls earlier in the year will have primary responsibility for the coverage of the dependent children. For example, if the father's birthday is July 16 and the mother's birthday is May 17, the mother's plan would be the primary plan for the couple's dependent children because the mother's birthday falls earlier in the year. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary.

  This birthday rule regulation affects all carriers and all contracts which contain Coordination of Benefits provisions. It applies only if both contracts being coordinated have the birthday rule provision. If only one contract has the birthday rule and the other has the gender rule (father's contract is always primary), the contract with the gender rule will prevail in determining primary coverage.
- If two or more plans cover a person as a dependent child of separated or divorced parents, benefits for the dependent child will be determined in the following order.
  - ✓ The plan of the parent with custody is primary; followed by
  - ✓ The plan of the spouse/partner of the parent with custody of the child; then
  - ✓ The plan of the parent not having custody of the child.
- If it has been established by a court decree — Qualified Medical Child Support Order (QMCSO) — that one parent has responsibility for the child's health care expenses, then the plan of that parent is primary.
- If none of the rules listed above determine the order of benefits, the plan that has covered the patient for the longer period is the primary plan.
- Horizon HMO will provide its *regular* benefits in full when it is the primary plan.
- As a secondary plan, Horizon HMO, Horizon HMO 1525 and Horizon HMO 2030 will provide reimbursement up to its regular benefit which when added to the benefits under other group plans will not exceed 100 percent of the member's liability.
- As a secondary plan, Horizon HMO 2035 uses a non-duplication of benefits approach to coordination of benefits (COB.) When Horizon HMO 2035 is secondary to another health plan Horizon HMO 2035 will only provide reimbursement up to the normal liability if we had been primary. The secondary benefit payment under non-duplication COB is determined by calculating the Horizon HMO 2035 normal liability then subtracting the other (primary) health plan payment, and paying the remaining amount, if any. If the primary health plan benefit is the same as or higher than the Horizon HMO 2035 benefit, no secondary payment will be made..

Please note: The Coordination of Benefits rules described above may change if Medicare is involved. Please refer to the Medicare sections on page 8 and page 12 for more information.

GENERAL BENEFITS

This section lists the general treatments, services, and supplies that Horizon HMO will consider. Expenses for these services or supplies are subject to medical need and appropriate level of care; utilization review; the Schedule of Services and Supplies; and benefit limitations and exclusions. A "Summary Schedule of Services and Supplies" is on page 73 for your reference. Select services require prior authorization (see page 19 for details).

Allergy Testing and Treatment

Most commonly used methods of allergy testing are covered. However, some methods are subject to medical need at the appropriate level of care and will be reviewed before eligibility can be determined.

Ambulance

Ambulance use for local **emergency** transport to the nearest facility equipped to treat the emergency condition is covered subject to medical need at the appropriate level of care. If emergency air transport is needed, it must be medically necessary and approved by having your physician call Horizon HMO at 1-800-664-2583.

Chartered air flights, non-emergency air ambulance, invalid coach, transportation services, or other travel, lodging, or communication expenses of patients, providers, nurses, or family members are not covered.

Audiology Services

Audiology services are covered when rendered by a physician or a licensed audiologist, when such services are determined to be medically necessary and at the appropriate level of care. See exclusions for hearing aids and hearing examinations.

Autism or Another Developmental Disability

Chapter 115, P.L. 2009, requires that the SHBP/SEHBP provide:

- Coverage for expenses incurred in screening and diagnosing autism or another developmental disability;
- Coverage for expenses incurred for medically necessary physical therapy, occupational therapy and speech therapy services for the treatment of autism or another developmental disability;
- Coverage for expenses incurred for medically necessary behavioral interventions (ABA therapy) for individuals under 21 years of age diagnosed with autism;
- A benefit for the Family Cost Share portion of expenses incurred for certain health care services obtained through the New Jersey Early Intervention System (NJEIS).

ABA therapy is not eligible for children with developmental diagnoses.

Horizon Behavioral Health must be contacted to precertify ABA services for autistic children.

Horizon HMO Utilization Management must be contacted for precertification by the provider requesting occupational therapy, speech, and physical therapy services.

Automobile-Related Injuries

Horizon HMO will provide secondary coverage to your mandatory New Jersey Personal Injury Protection (PIP) unless Horizon HMO has been elected as the primary coverage by or for the employee covered under Horizon HMO. This election is made by the named insured under the PIP program and affects that member's family members who are not themselves the named insured under another auto policy. Horizon HMO may be primary for one member, but not for another if the individuals have separate auto policies and have made different selections regarding primacy of health coverage.

If Horizon HMO is primary to PIP or other automobile insurance coverage, benefits are paid in accordance with the terms, conditions, and limits set forth in your contract and only for those services normally covered under the HMO.

Please note: If you elect to have the Horizon HMO as primary to PIP, prior notification to Horizon HMO is not required. Upon receipt of an auto related claim, the Horizon HMO will request the submission of written documentation, such as a copy of your policy declaration page, for verification of your selection.

The Horizon HMO is one of several health insurance plans which provides benefits for automobile related injuries. If the covered employee has elected health coverage as primary, these plans may coordinate benefits as they normally would in the absence of this provision.

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

- The remaining uncovered allowable expenses after PIP has provided coverage, subject to medical need at the appropriate level of care and other provisions, after application of deductibles and coinsurance, or

The actual benefits that would have been payable had Horizon HMO been primary.

Behavioral Health and Substance Abuse Care

Horizon Behavioral Health is responsible for the management of your behavioral health benefit. No referral is required to access treatment. This benefit includes treatment for both mental health conditions and alcohol/substance abuse provided by an eligible behavioral health provider and include in-patient, partial hospital, residential, intensive out-patient, out-patient, and group treatment. Eligible providers of behavioral health are Psychiatrists (MD), Licensed Psychologists (PhD), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC), and Certified (Psychiatric), Nurse Practitioners working within the scope of their practice.

Precertification (prior to treatment) is required by Horizon Behavioral Health for all admissions. The Precertification process will determine if the treatment to be provided is medically appropriate and if it will be provided at the most appropriate level of care to fit your behavioral health needs. Horizon Behavioral Health medical necessity determinations for mental health services are supported by Horizon Behavioral Health Medical Necessity criteria. Substance abuse determinations are supported by the American Society of Addictions Medicine (ASAM) guidelines. The precertification process through Horizon Behavioral Health is available 24 hours a day, 7 days a week.

To receive mental health or substance abuse treatment benefits, a participating provider must provide your care. Outpatient mental health and substance abuse care will generally be covered without the need for authorization by Horizon Behavioral Health; for coverage of electroconvulsive therapy, biofeedback, psychological testing, and intensive outpatient treatment, you will need to follow the precertification process outlined above. In addition, authorization is required for coverage of any treatment that Horizon Behavioral Health

determines is not consistent with usual treatment practice for your condition (for example, frequency of sessions, duration of treatment, and other factors). Horizon Behavioral Health will contact your provider to discuss your treatment and the authorization requirement that will be applied.

If the Services that require precertification are provided before precertification is received, this may result in the denial of payment for services.

In addition to the precertification process, Horizon Behavioral Health will support your treatment and manage the services you are receiving to ensure that they are the most appropriate for your behavioral health needs and ensure that your treatment is supported by Horizon Behavioral Health Medical Necessity criteria and/or the American Society of Addictions Medicine (ASAM) criteria.

Call Horizon Behavioral Health at 1-800-991-5579 and get assistance from a Member Advocate when you need help understanding your Behavioral Health benefits or navigating the range of services available. The Member Advocate will help you prioritize appropriate use of such services according to your need. Educational materials including information packets, articles, and screening tools are also available to you and providers online at *www.HorizonBlue.com/shbp*

Birthing Centers

As an alternative to conventional hospital delivery room care for low-risk maternity patients, Horizon HMO allows benefits for care in participating birthing centers. Services routinely provided by the birthing centers including prenatal, delivery, and postnatal care will be covered in full if the delivery takes place at the center. If complications occur and delivery occurs in an approved hospital because of the need for emergency or inpatient care, this care will also be covered in full.

Blood

Blood, blood products, blood transfusions, and the cost of testing and processing blood are covered. Horizon HMO does not pay for blood which has been donated or replaced on behalf of the patient.

Breast Reconstruction

If you are receiving benefits in connection with a mastectomy and elect to have breast reconstruction along with that mastectomy, Horizon HMO will provide coverage for the following:

- Reconstruction of the breast on which the mastectomy was performed.
- Prosthesis(es).
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Physical complications at all stages of the mastectomy, including lymphedemas.

Chiropractic Services

There is a 20-visit per calendar year benefit maximum for chiropractic services. The chiropractor must be licensed, the services must be appropriate for the diagnosed condition(s), and must fall within the scope of practice of a chiropractor in the state in which he or she is practicing. No referral is needed to use the services of a chiropractor. Chiropractic services are subject to a medical necessity review process.

Dental Care

Horizon HMO provides benefits for the removal of bony impacted molars, and will pay for the treatment of accidental injuries, and treatment for mouth tumors if medically necessary.

Horizon HMO may provide coverage for the treatment of accidental dental injuries. You must have been covered by Horizon HMO at the time the injury occurred. An accidental dental injury is considered an injury to teeth (must be sound natural teeth) which is caused by an external factor such as damage caused by being hit by a hockey puck or having teeth broken in a fall on the ice.

The treatment and replacement must occur within 12 months of the accident. A treatment plan must be submitted. If it is determined that treatment cannot be reasonably completed within 12 months, this time limit **may be** extended. Breaking a tooth while chewing on food is not considered an accidental dental injury. Stress fractures in teeth are very common and generally undetectable by X-ray. Stress fractures are often the cause of tooth breakage. Treatment for this type of tooth breakage is considered a dental service and not eligible for reimbursement.

Dental services required as the result of medical conditions or medical services rendered such as: radiation, chemotherapy and long term use of prescription drugs are not eligible. These dental services should be submitted to your Dental Plan.

Hospital and anesthesia charges incurred for dental services that are medically needed and at the appropriate level of care are covered for severely disabled members and children when convincing documentation is submitted in advance for the medical need for the hospitalization/anesthesia services. Charges for the actual dental procedures would not be eligible for benefits.

Orthodontia is not covered.

Diabetic Self-Management Education

Benefits, limited to four visits per year, are included 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 the member's condition.

Benefits for self-management education and education relating to diet shall be limited to medically necessary visits upon:

- The diagnosis of diabetes;
- The diagnosis by a physician or nurse provider/clinical nurse specialist of a significant change in your symptoms or conditions which necessitate changes in your self-management; and
- Determination by a physician or nurse provider/clinical nurse specialist that reeducation or refresher education is necessary.

Diabetes self-management education is covered when provided by:

- A physician, nurse provider, or clinical nurse specialist;
- A health care professional such as a registered dietician that is recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators; or
- 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.

Benefits are provided for expenses incurred for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or nurse provider/clinical nurse specialist:

- Blood glucose monitors
- Test strips for glucose monitors and visual reading and urine testing strips
- Insulin
- Injection aid cartridges
- Syringes
- Insulin pumps
- Insulin infusion devices
- Alcohol wipes

Dialysis

Dialysis is covered when the services are provided and billed by an eligible hospital, by a freestanding dialysis center, or by an eligible home health care agency. The facility must make arrangements for training, equipment rental, and supplies on behalf of the patient. Home dialysis will be considered when there is documented evidence that the services cannot be performed in an outpatient facility. Ambulance transportation/invalid coach service to and from dialysis sessions is not eligible for coverage.

Durable Medical Equipment and Supplies

Charges for the rental of durable medical equipment needed for therapeutic use are covered. Horizon HMO may cover the purchase of such items when it is less costly and more practical than renting such items. The rental or purchase of any items that do not fully meet the definition of durable medical equipment is not covered. It is recommended that costly durable medical equipment be approved by Horizon HMO prior to purchase.

Horizon HMO, Horizon HMO 1525, Horizon HMO 2030 members must satisfy a $100.00 per person per calendar year deductible for Durable Medical Equipment and Medical Appliances/Equipment (DME). A separate deductible for DME does not apply for HMO2035 members, however, these services are subject to the in-network deductible under this plan.

Horizon HMO also covers eligible supplies including surgical dressings, blood and blood plasma, artificial - limbs, larynx and eyes, casts, Inherited Metabolic Disease medical food, certain non-standard infant formula (under one year of age), splints, trusses, braces, crutches, respirator oxygen and rental of equipment for its use.

Deluxe models of durable medical equipment items such as, but not limited to, wheelchairs are not eligible for benefits.

Emergency Medical Services

Horizon HMO covers you for medical emergency care, 24 hours-a-day, seven days-a-week. Emergency care is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual in (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of bodily organ or part.

Less severe medical problems and chronic conditions may be more appropriately handled by your PCP in his/her office.

Medical Emergency Screening Exam

Sometimes you may not be sure if your condition requires emergency care. The Horizon HMO covers a medical emergency screening exam, which is an evaluation performed in a hospital Emergency Room (ER) by qualified health care personnel, to determine if a medical emergency exists. The cost of the medical emergency screening exam will be covered. However, if it is determined that an emergency does not exist, please follow up with your PCP for instructions.

Medical Emergency Procedures

If you reasonably believe that your medical condition is a medical emergency, please follow the steps below:

1. Go directly to the nearest ER or call 911 or your local emergency response number:
2. Call your PCP, if possible. In some situations, you may be able to call before you go to the ER. If you can't, call your PCP as soon as reasonably possible. If you are unable to make the call, please have a family member or friend call on your behalf. It is important that your PCP be kept aware of your condition. Without this information, your PCP cannot coordinate your care.

You do not need to call member services to notify them of a medical emergency.

If it is determined that your visit was not a medical emergency, you may be responsible for all expenses with the exception of the cost of the medical emergency screening exam.

Each time the member uses the hospital emergency room, the member must pay a copayment. If the member is admitted within 24 hours, the copayment amount is waived. There may also be additional medical charges for out-of-network emergency rooms that may not be reimbursed in full.

Urgent and After Hours Care

Urgent care is medically necessary care for an unexpected illness or injury that should be treated within 24 hours but is not life-threatening. It is medical care you can safely postpone until you can call your PCP. Examples of urgent care include fever, earache, cuts, sprains, and minor burns. In instances like these, call your PCP first for instructions. If your PCP determines your situation is a medical emergency, he or she will refer you directly to an emergency facility. If it is not a medical emergency, your PCP will tell you how to treat the problem yourself or make an appointment to see you. Your physician or a covering physician should be available 24 hours a day, every day.

Contact your PCP for after-hours care or care that is required at night or on a weekend or holiday. Your PCP will provide instructions on how to treat your problem.

Federal Government Hospitals

Horizon HMO will pay for eligible charges in hospitals operated by the United States government (Veterans Administration) as if they were member hospitals, regardless of their location, for eligible charges for nonmilitary conditions.

Horizon HMO will pay hospitals operated by the United States government for nonmilitary patients (i.e., patients other than military retirees and their dependents and dependents of active duty military personnel) for eligible charges only if:

- Services are for treatment on an emergency basis for accidental injury from an external cause; or
- Services are provided in a hospital located outside of the United States and Puerto Rico.

Gynecological Care and Examinations

Gynecological care and examinations are eligible. Horizon HMO provides coverage for one routine gynecological examination per year which may include one routine Pap smear, when provided by a gynecologist. No referral is required for one routine gynecological examination per year.

Hearing Aids

Coverage will be provided for medically necessary expenses incurred in the purchase of a hearing aid for covered members who are 15 years old or younger. Coverage is provided for the purchase of a hearing aid for each hearing impaired ear once in a 24 month period, when it is medically necessary and prescribed by a licensed physician or audiologist. Benefits during each 24 month period are limited to the cost of the hearing aid up to $1,000 for each hearing impaired ear. If a higher priced hearing aid is selected, the member is responsible for the amount that is greater than $1,000.

Hemophilia Treatment

Hemophilia treatment is covered in an inpatient facility or outpatient facility. Home hemophilia treatment will be considered when there is documented medical evidence that these services cannot be performed in an outpatient facility.

Home Health Care

Home health care services and supplies are covered only if furnished by providers on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis. Precertification is required for these services. Home health care will be covered up to a maximum of 120 days.

The home health care plan must be established in writing by the member's provider within 14 days after home health care starts and it must be reviewed by the member's provider at least once every 30 days.

Eligible home health services (subject to exclusions) provided by a home health care agency include:

- Part-time skilled nursing services provided by or under the supervision of a registered professional nurse (R.N.).
- Physical therapy.
- Occupational therapy.

- Speech therapy.
- Related treatment and services eligible for hospital benefits, except drugs and administration of hemodialysis.
- Medical social services or part-time services by a home health care aide during the period when you are receiving eligible skilled nursing care, physical therapy, or speech therapy services.

A prior inpatient hospital stay is not required to qualify for home health care agency benefits but the patient must be homebound and require skilled nursing care under a plan prescribed by an attending physician.

- Horizon HMO **does not** cover:
- Services furnished to family members, other than the patient.
- Services provided by a companion.
- Services and supplies not included in the home health care plan.
- Nursing home care or care that is **maintenance care,** supportive care, care to treat deficiencies that are developmental in nature or are primarily **custodial care** in nature.

Hospice Care Benefits

Benefits for hospice care must be provided according to a physician prescribed course of treatment approved by Horizon HMO with a confirmed diagnosis of terminal illness and a life expectancy of six (6) months or less.

The following hospice services are covered:

- Interim professional nursing services of an R.N. or L.P.N.
- Home health care aide services provided under the supervision of an R.N.
- Medical care rendered by a hospice care program physician and/or the patient's PCP.
- Therapy services (including speech, physical and occupational therapies).
- Diagnostic services related to the Hospice member's condition.
- Medical and surgical supplies.
- Durable medical equipment.
- Prescribed drugs.
- Oxygen and its administration.
- Up to 7 days for respite care.
- Inpatient acute care for related conditions.
- Medical social services.
- Psychological support services to the terminally ill patient.
- Family counseling related to the Eligible Person's terminal condition.
- Dietician services related to the Hospice member's condition.
- Inpatient room, board and general nursing services for related conditions.

No benefit consideration will be given for any of the following hospice care benefits:

- Medical care rendered by a provider other than the Hospice or the member's PCP without certification.
- Volunteer services.
- Pastoral services.
- Homemaker services.
- Food or home-delivered meals.
- Non-authorized private-duty nursing services.
- Dialysis treatment not utilized for pain management.
- Bereavement counseling.
- Private duty nursing services
- Legal or financial counseling or services.
- Treatment not included in the Hospice Care Program.

Inpatient benefits for hospice patients are provided at the same level as those provided for non-hospice patients. For more information on hospice care, please call Horizon HMO at 1-800-414-7427.

Immunizations

Immunizations provided by in-network physicians or contracted, New Jersey pharmacies are covered under Horizon HMO unless they are for travel outside the country or work-related.

Infertility Treatment

Horizon HMO will follow the New Jersey State Mandate for Infertility.

Charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy (including microsurgical sperm aspiration); laboratory tests; sperm washing or preparation; diagnostic evaluations; assisted hatching; fresh and frozen embryo transfer; ovulation induction; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF), including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate; zygote intrafallopian transfer (ZIFT); artificial insemination; intracytoplasmic sperm injection (ICSI); and the services of an embryologist. This benefit includes diagnosis and treatment of both male and female infertility.

Eligibility Requirements

Infertility services are covered for any abnormal function of the reproductive systems such that you are not able to:

- Impregnate another person;
- Conceive after two years if the female partner is under 35 years old, or after one year if the female partner is 35 years old or older, or if one partner is considered medically sterile; or
- Carry a pregnancy to live birth.

In vitro fertilization, gamete transfer and zygote transfer services are covered only:

- If you have used all reasonable, less expensive and medically appropriate treatment and are still unable to become pregnant or carry a pregnancy;
- Up to four completed egg retrievals combined, per lifetime (including those covered under prior plans, but not those provided at your expense); and
- If you are 45 years old or younger.

Covered Expenses

- Where a live donor is used in the egg retrieval, the medical costs of the donor shall be covered until the donor is released from treatment by the reproductive endocrinologist.
- Egg retrievals where the cost was not covered by any carrier shall not count in determining whether the four completed egg retrieval limit has been met.
- Intracytoplasmic sperm injections.
- In vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate.
- Prescription medications, including injectable infertility medications, are covered under the SHBP/SEHBP's Prescription Drug Plans. Private freestanding prescription drug plans arranged by local employer groups are required to be comparable to the SHBP/SEHBP Prescription Drug Plans and must provide coverage for infertility medications for covered members and donors.
- Ovulation induction.
- Surgery, including microsurgical sperm aspiration.
- Artificial Insemination.
- Assisted Hatching.
- Diagnosis and diagnostic testing.
- Fresh and frozen embryo transfers

Exclusions

The following are specifically ***excluded*** infertility services:

- Reversal of male and female voluntary sterilization.
- Infertility services when the infertility is caused by or related to voluntary sterilization.
- Non-medical costs of an egg or sperm donor. Medical costs of donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist.
- Cryopreservation is not a covered benefit.
- Any experimental, investigational, or unproven infertility procedures or therapies.
- Payment for medical services rendered to a surrogate for purposes of childbearing where the surrogate is not covered by the carrier's policy or contract.

- Ovulation kits and sperm testing kits and supplies.
- In vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer for persons who have not used all reasonable less expensive and medically appropriate treatments for infertility, who have exceeded the limit of four covered completed egg retrievals, or are 46 years of age or older.
- Costs associated with egg or sperm retrieval not related to an authorized IVF procedure.

Laboratory Testing

You must use LabCorp or AtlantiCare Clinical Laboratories for laboratory work. Your PCP may draw blood for the test in his/her office or send you to a participating laboratory for testing.

Your PCP may refer you directly to a LabCorp Patient Service Center. If so, he/she will give you a LabCorp Requisition Form to take with you. You may also use this form at AtlantiCare Clinical Laboratories. Please present the requisition form and your Horizon HMO ID card at the participating laboratory facility

To find a LabCorp Patient Service Center near you, visit *www.labcorp.com/psc* or call 1-888-LAB-CORP (522-2677). You may also use the website to schedule an appointment.

AtlantiCare Clinical Laboratories has a special relationship with Horizon HMO and LabCorp. Horizon HMO members may use AtlantiCare Clinical Laboratories to draw laboratory specimens on behalf of LabCorp on an in-network basis. For more information and to locate the most convenient AtlantiCare testing center, visit our online Provider Directory at *www.HorizonBlue.com* or visit *www.AtlantiCare.org* — click Locations and then click Clinical Laboratories. Remember, if you do not use LabCorp or AtlantiCare Clinical Labs, you will not be covered. If you receive a bill for lab work from LabCorp or AtlantiCare Clinical Labs, please call Member Services at 1-800-414-7427 (SHBP).

Lead Poisoning Screening and Treatment

Lead poisoning screening no copayment applies to in-network screenings.

Lithotripsy Centers

Lithotripsy services are covered when they are performed in an approved hospital or lithotripsy center.

Lyme Disease Intravenous Antibiotic Therapy

All intravenous antibiotic therapy for the treatment of Lyme Disease require precertification. When intravenous therapy is determined to be medically appropriate, the supplies, cost of the drug, and skilled nursing visits will be covered services. If services are not precertified and are determined not to be medically necessary, the services will not be covered.

Mammography

Covers mammograms provided to a female member. Coverage is provided as follows:

- One baseline mammography at any age.
- Age forty and older, one screening mammography per year.

Mastectomy Benefits

A hospital stay of at least 72 hours following a modified radical mastectomy and a hospital stay of at least 48 hours is covered following a simple mastectomy unless the patient, in consultation with his physician, determines that a shorter length of stay is medically needed and at the appropriate level of care.

Maternity/Obstetrical Care

Medical care related to childbirth 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 provider determines that inpatient care is medically needed and at the appropriate level of care.

Services and supplies provided by a hospital to a newborn child during the initial covered hospital stay of the mother and child are covered as part of the obstetrical care benefits.

Horizon HMO also covers birthing center charges made by a provider for pre-natal care, delivery, and post-partum care in connection with a member's pregnancy.

Professional charges, billed by an eligible provider, related to the prenatal care, delivery and postnatal care for home birth are covered.

Note: Providers do not routinely perform home births. The availability of a provider who performs home births is not guaranteed.

Maternity/Obstetrical Care for Child Dependents

In some instances, Horizon HMO will pay bills related to the birth of a grandchild. In order for benefits to be available, the mother must be enrolled as a covered child.

Coverage for the grandchild ends when the mother is discharged from the hospital. The grandparent may apply for dependent coverage of the grandchild only if he or she obtains legal custody of the child.

Nutritional Counseling

The HMO allows three visits per year for nutritional counseling that is medically needed and at the appropriate level of care.

Occupational Therapy **(See Therapy Services)**

Organ Transplant Benefits

Pre-approved services and supplies for the following types of transplants are covered:

- Bone marrow/stem cell (autologous and allogeneic)
- Lung
- Liver

- Combination liver/kidney
- Heart
- Combination heart/bilateral lung
- Pancreas
- Cornea
- Kidney

If you need a transplant Horizon HMO dedicated case management team is available to assist you and your physician. For more information on Horizon HMO's participating local and national transplant facilities, call 1-888-621-5894 extension 46404.

Benefits only include surgical, storage and transportation services of the organ which are directly related to the donation and billed for by the hospital.

Pain Management

Pain management services are subject to current medical guidelines and policies. Pain management therapy administered by a licensed physician must be supported by a comprehensive evaluation of the patient and documentation of the rationale for treatment. The treatment of pain is multifaceted and may include therapeutic exercises, activity modification, physical therapy, occupational therapy, pharmacological interventions, behavioral health interventions, therapeutic and/or surgical interventions. Treatment may not achieve complete elimination of a patient's pain. In such cases, an increase in a patients' level of function and teaching the patient strategies to cope with residual pain will be the goal. If treatment offers no appreciable improvement in the patient's condition further services may be considered maintenance and/or supportive care and will not be eligible for reimbursement.

Horizon HMO contracts with CareCore National LLC to review and authorize pain management services. Monitored anesthesia rendered as part of pain management services must also be authorized. Your network physician will obtain prior authorization on your behalf. Your physician can contact CareCore at 1-866-241-6603 to request authorization. If you or your physician do not obtain prior authorization for pain management services, those services will not be eligible for reimbursement. If services are rendered without the proper authorization, benefits will be denied. A retroactive benefit review will not be conducted.

Pap Smears

Annual Pap smears provided by your participating OB/GYN are covered at the in-network level of benefits. This benefit is limited to one Pap smear per year unless additional tests are medically needed and at the appropriate level of care for diagnostic purposes.

Patient Controlled Analgesia (PCA)

Patient Controlled Analgesia (PCA) is covered when it is medically appropriate, prescribed by a medical doctor, and provided under the guidance of one of the following:

- Doctor;
- Anesthesiologist; or
- Approved home care agency.

Physical Therapy (See Therapy Services)

Physicals

One routine physical examination for you and your eligible dependents is covered per year. No copayment applies if the sole reason for the visit is to receive preventive services as noted by the procedure and diagnosis code reported by the provider.

Physicals for work related purposes — ***other than*** *employer mandated physical examinations that are a prerequisite for participation in an employer mandated physical fitness test required as a condition of continuing employment* — sports, or other similar reasons are **not** covered.

Pre-Admission Hospital Review

All non-emergency hospital and other facility admissions must be reviewed by Horizon HMO before they occur. You or the network hospital or your provider must notify Horizon HMO and request a Pre-Admission Review by phone or facsimile. Horizon HMO must receive the notice and request at least 5 business days or as soon as reasonably possible before the admission is scheduled to occur. For a maternity admission, such notice must be given to Horizon HMO at least 60 days before the expected date of delivery, or as soon as reasonably possible, to obtain in-network benefits.

Pre-Admission Testing Charges

Pre-admission diagnostic X-ray and laboratory tests needed for a planned hospital admission or surgery are covered. Horizon HMO only covers these tests if the tests are done on an outpatient or out-of-hospital basis within seven days of the planned admission or surgery.

However, Horizon HMO does not cover tests that are repeated after admission or before surgery, unless the admission or surgery is deferred solely due to a change in the member's health.

Prostate Cancer Screening

One routine office visit per year is covered for adult members, including a digital rectal examination and a prostate-specific antigen test for adult male members over the age of 40.

Radiology/Diagnostic Imaging Services

CareCore National, LLC provides you with access to nonemergency outpatient radiology/ diagnostic imaging services. CareCore, a physician-owned radiology management service company, will help schedule and manage your outpatient radiology/diagnostic imaging services, including determining whether a service is medically necessary. Your ordering physician must call CareCore at **1-866-496-6200**, before you receive any of the Advanced Imaging Services listed below:

- CT/CTA scans
- Diagnostic left heart catheterization
- Echocardiogram
- Echo stress
- MRIs/MRAs

- PET scans
- Nuclear medicine studies (including Nuclear Cardiology)

Once the test is approved, CareCore will contact you to schedule the procedure at a participating rendering location. When possible, CareCore will conduct a three-way call with you and the rendering location to coordinate the scheduling process. You may call CareCore directly at **1-866-969-1234** to schedule the approved procedure. You will also receive a letter from CareCore confirming the scheduled appointment.

You may schedule all other radiology services through CareCore's easy-to-use Scheduling Line. The Scheduling Line replaces the referral process. The scheduling staff will coordinate with the participating radiology/diagnostic imaging center of your choice to schedule your exam and provide you with a confirmation number. To make an appointment and get a confirmation number, please call the Scheduling Line toll free at **1-866-969-1234**, Monday through Friday, between 7 a.m. and 7 p.m., Eastern Time (ET). For more information, please call your dedicated SHBP/SEHBP customer service area Member Services at 1-800-414-7427.

Scalp Hair Prostheses

A benefit maximum of $500 in a 24 month period subject to the annual $100 deductible, per person, is covered for scalp hair prostheses (wig) prescribed by a doctor, only if they are furnished in connection with hair loss resulting from the treatment of disease by radiation or chemicals.

Second Surgical Opinion

Horizon HMO provides coverage for a second physician's personal examination of a patient following a recommendation for any eligible surgical procedure. Horizon HMO will pay for one consultation by a qualified specialist physician.

If the second opinion specialist does not confirm the need for surgery, Horizon HMO will provide coverage for one additional consultation if requested by the patient. Horizon HMO also will provide coverage for any diagnostic X-rays, laboratory tests, or diagnostic surgical procedures required by the physicians performing the consultations.

Shock Therapy Benefits

Horizon HMO provides benefits for electroshock treatments, insulin shock treatments, and other similar treatments. Benefits are also payable for anesthesia in connection with the shock treatment and for all other eligible services performed on that day for the disorder.

Skilled Nursing Facility Charges

Room and board, including diets, drugs, medicines and dressings, and general nursing services in a skilled nursing facility are covered.

For Medicare Primary Members — the eligible benefit days run concurrently with Medicare eligible days. Once Medicare days are exhausted and Horizon HMO becomes primary, Horizon HMO will review continuing services for medical appropriateness and eligibility. Precertification is required after Medicare benefits are exhausted or if Medicare does not allow benefits.

Speech Therapy Benefit (see Therapy Services)

Surgery

Surgical procedures performed by a network physician with the appropriate referral from your PCP are covered under the Horizon HMO.

Therapy Services

Therapy Services are covered when ordered by a network provider and performed by a network practitioner. The services must be medically necessary and appropriate for the treatment of the member's illness or injury.

Therapy Services means the following services and supplies:

- **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 which 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*** —- treatment to 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, restore maximum function, and prevent disability following disease; injury or loss of limb

  See note on next page.
- **Radiation Therapy** — the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes 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 rendered by a qualified speech therapist and is described used to:

  ✓ 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.

  ✓ Speech therapy to develop or improve speech to correct a defect that both (a) existed at birth and (b) impaired or would have impaired the ability to speak.

  Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed are not covered <u>except for</u> Autism and Pervasive Development Disorder (PDD).

  ***Note:** Coverage for physical, occupational, and speech therapy is limited to 60 visits per calendar year for the three therapies combined.

Vision Care Benefits

Horizon HMO covers an annual routine eye examination by a network ophthalmologist or optometrist. There are no benefits available for frames, lenses, or contact lenses. Contact lens fitting examinations are also not covered. No referral is needed for an annual routine vision examination.

CHARGES NOT COVERED BY HORIZON HMO

Even though a service or supply may not be described or listed in this handbook, that **does not** make the service or supply eligible for a benefit under this plan.

The following services and supplies **are not covered:**

- Acupuncture.
- Automobile accident-related injuries or conditions: Unless Horizon HMO has been chosen by the member as primary, Horizon HMO does not pay for the treatment of injuries or conditions related to an automobile accident if automobile insurance could have or should have covered the treatment. This exclusion applies to, but is not limited to:
  - ✓ Existing motor vehicle insurance contracts;
  - ✓ Motor vehicle contracts that were purchased but have since lapsed;
  - ✓ Motor vehicle insurance coverage that should have been purchased; and
  - ✓ Failure to make timely claims under a motor vehicle insurance policy.
- Any therapy not included in the definition of Therapy Services.
- Autopsy.
- Blood or blood plasma or other blood derivatives or components which are replaced by a Member.
- Broken appointments.
- Car Seats.
- Chair and stair lifts.
- Charges that exceed the Plan allowance.
- Charges billed by an Assisted Living Facility.
- Charges for services or supplies not specifically covered under the Plan.
- Charges for services rendered by a member of the patient's immediate family (including you, your spouse/domestic partner, your child, brother, sister, or parent or grandparent of you or your spouse/domestic partner).
- Charges for services rendered by a Birth Doula.
- Charges for the completion of a claim form, photocopies of pertinent medical information, medical records or report preparation.
- Charges the Member or his Dependent is not legally obligated to pay.
- Charges in connection with an external review of an appeal or complaint.
- Charges incurred prior to or in the course of a legal adoption.
- Charges that should have been paid by Medicare, if Medicare coverage had been in effect.
- Christian Science.

- 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.
- Cosmetic procedures — charges connected with curing a condition by cosmetic procedures. This provision does not apply if the condition is due to an accidental injury that occurred while the injured person is enrolled in Horizon HMO. Among the services that are not covered are:
  - ✓ Removal of warts, with the exception of plantar warts;
  - ✓ Spider vein treatment; and
  - ✓ Plastic surgery when performed primarily to improve the person's appearance.
- Costs beyond the embryo transfer for a surrogate are not eligible.
- Court ordered services or treatments.
- Custodial Care or domiciliary care.
- Deluxe models of wheelchairs and other durable medical equipment.
- Dental care or treatment and appliances (other than accidental injury as described on page 28), including but not limited to the following:
  - ✓ Dental prosthesis;
  - ✓ Orthodontia;
  - ✓ Operative restorations;
  - ✓ Fillings;
  - ✓ Medical or surgical treatment of dental caries;
  - ✓ Gingivitis;
  - ✓ Outpatient and Out-of-Hospital dental treatment;
  - ✓ Radicular or dentigerous cysts;
  - ✓ Extractions of teeth; and
  - ✓ Dental implants.
- Durable medical equipment or supplies which are specifically excluded from coverage.
- Education or training while a Member is confined in an institution that is primarily an institution for learning or training.
- Educational or developmental services or supplies, or educational testing. This includes services or supplies that are rendered with the primary purpose being to provide the person with any of the following:
  - ✓ Training in the activities of daily living. This does not include training directly related to the treatment of an illness or injury that resulted in a loss of a previously demonstrated ability to perform those activities.
  - ✓ Instruction in scholastic skills such as reading and writing.
  - ✓ Preparation for an occupation.

- ✓ Treatment for learning disabilities.
- ✓ To promote development beyond any level of function previously demonstrated.
- ✓ Assessments/testing of academic function.
- ✓ Services and supplies are not covered to the extent that they are determined to be allocated to the scholastic education or vocational training of the patient regardless of where services are rendered. Rehabilitation programs that are primarily educational or behavioral in nature.

- Expenses for wilderness rehabilitation programs, diabetic camps, or other similar camps or programs.
- Experimental or investigational treatments, procedures, hospitalizations, Drugs, Biological Products or Medical Devices and charges in connection with such treatment, services or supplies (see page 20).
- Eye care including:
  - ✓ Lenses of any type except initial lens replacement for loss of the natural lens after cataract surgery.
  - ✓ Eyeglasses and contact lenses regardless of the diagnosis, including but not limited to Kerataconus.
  - ✓ Low vision aids
- Eye surgery, such as radial keratotomy, Lasik procedures, or other refractive procedures performed for any reason.
- 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). 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 treatment of Inherited Metabolic Diseases and Specialized Non-Standard Infant Formulas.
- Routine Foot Care including treatment for bunions, 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. This exclusion does not apply to capsular or bone surgery.
- Government plan charges including a charge for a service or supplies:
  - ✓ Furnished by or for the United States government.
  - ✓ Furnished by or for any government, unless payment is required by law; or
  - ✓ To the extent that the service or supply, or any benefit for the charge, is provided by any law or government under which the member is or could be covered. This applies to Medicare and “no-fault” medical and dental coverage when required in contracts by a motor vehicle or similar law.
- Health Clubs and Gym Memberships.
- Hearing aids of any type (except as described under “Hearing Aids” on page 31).

- Hearing examinations - 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 Grace's Law / Hearing Aids and Related Service and Newborn Hearing Screening.
- Herbal, Alternative or Complementary medicine and treatments.
- Hypnosis.
- Incidental Procedures — certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is considered part of the primary procedure in order to successfully complete service.
- Infertility enhancement treatments, except as stated on page 33.
- Legal fees.
- Local anesthesia charges billed separately by a Practitioner for Surgery he performed on an Outpatient basis.
- Maintenance care — care that has reached a level where additional services will not appreciably improve the condition.
- Maintenance therapy for:
  - ✓ Physical Therapy;
  - ✓ Therapeutic Manipulation;
  - ✓ Occupational Therapy; and
  - ✓ Speech Therapy.
- Marriage, career or financial counseling, and sex therapy.
- Medical Emergency services when not rendered by a physician, and related supplies.
- Medicare services rendered by providers who are not registered with or opt-out of Medicare.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Methadone maintenance treatment or programs.
- Milieu Therapy: Inpatient services and supplies which are primarily for milieu therapy, even though eligible treatment may also be provided. This means that Horizon HMO has determined that the purpose of an entire or portion of an Inpatient stay is chiefly to change or control a patient's environment; and an Inpatient setting is not Medically Necessary and Appropriate for the treatment provided, if any.
- Modifications to an auto to make it accessible and/or drivable.
- Modifications to a home to make it accessible for a disabled/injured person.
- Mouth conditions — charges for doctor's services or X-ray examinations for a mouth condition. This exclusion applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of Temporomandibular Joint disorders (TMJ) or malocclusion involving joints or

muscles by methods including, but not limited to, crowning, wiring, or repositioning of teeth. See page 77 of the "Glossary" for the definition of a mouth condition.

- 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.
- Nursing home care.
- Out-of-Area Urgent Care not arranged for through HMO BLUE USA which was provided while the person was in an area serviced by HMO BLUE USA, or when Horizon HMO was not contacted within the notification time.
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies purchased over the counter such as syringes, incontinence pads and reagent strips.
- Over-the-counter supplies, supplements, vitamins, medications, or drugs that do not require a prescription order under Federal law, even if the prescription is written by a physician. These include, but are not limited to, aspirin, vitamins, lotions, creams, oils, formulas, liquid diets, and dietary supplements.
- Personal comfort or convenience items including telephone or television service, haircuts, guest trays, or a private room during an inpatient stay.
- Prescription drug charges or copayments. If your prescription drug plan does not provide benefits for a particular drug, it does not mean that it will be eligible under Horizon HMO.
- Postage, handling and shipping fees.
- Private rooms in a hospital. If you occupy a private room in a hospital or facility, you must pay the difference between the private room rate and the average semiprivate room rate.
- Repatriation (Returning a traveler to his/her home when unable to continue with travel due to medical reasons).
- Room and board charges for any period of time during which the Member was not physically present in the room.
- Self-administered services such as: self or home-testing kits, self-care and self-help training whether prescribed by a doctor or not.
- Services or supplies:
  - ✓ for breast prosthesis implants except when following a mastectomy on one breast or both breasts;
  - ✓ 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 Horizon HMO, demonstrable and significant improvement from psychiatric treatment is unlikely.
- ✓ 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, Jacuzzis, pools, and hot tubs of any type.
- ✓ provided by or in a government hospital unless the services are for treatment:
  - of a non-service related medical emergency;
  - 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 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.
- ✓ which are specifically limited or excluded;
- ✓ which are not provided or arranged for by the individual's PCP or Horizon HMO, unless otherwise stated.

- Services for cosmetic surgery (or complications that result from such surgery) on any part of the body **except** for reconstruction surgery following a mastectomy or when medically necessary to correct damage caused by an accident, an injury, therapeutic surgery or to correct a congenital defect.
- Services or supplies that are not medically needed and/or not at the appropriate level of care and charges in connection with such services or supplies. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically needed for the treatment and diagnosis of an illness or injury or make it a covered medical expense.
- Services that are commonly or customarily provided without charge to the patient. Even when the services are billed, Horizon HMO will not pay if they are usually not billed when there is no coverage available.
- Services and supplies prescribed or provided by an ineligible provider.
- Services or supplies that require prior authorization that are <u>not</u> authorized before services are rendered.

- Services rendered before the effective date of coverage or after the termination of coverage date. However if the covered patient is hospitalized as an inpatient and coverage terminates during the stay, that inpatient stay (as long as otherwise eligible) will be covered through to discharge.
- Services rendered or billed by an Assisted Living Facility.
- Shoes that are not custom molded, are not attached to a brace, or can be purchased without a prescription.
- Special medical reports not directly related to treatment of the Member (e.g. employment physicals and reports prepared in connection with litigation.)
- Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed (Exceptions: Autism and Pervasive Developmental Disorder).
- Sports physicals.
- 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.
- Supportive care — supportive care is defined as treatment for patients having reached maximum therapeutic benefit in which periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains. In some instances therapy may be clinically appropriate (such as treatment of a chronic condition that requires supportive care) yet it would not be eligible for reimbursement under Horizon HMO.
- Taxes on services/supplies.
- Telephone consultations or provider charges for telephone calls.
- TMJ Syndrome — medical treatment of TMJ Syndrome, except as otherwise stated, including but not limited to:
  - ✓ Biofeedback;
  - ✓ Intraoral prosthetic devices;
  - ✓ Nonsurgical intervention;
  - ✓ Office Visits; or
  - ✓ Physical Therapy.
- Transplants, unless otherwise specified in this contract, and non-human organ transplants.
- Transportation (non-emergency), other than ambulance/invalid coach service when certified by Horizon HMO; travel.
- Treatment of injuries sustained while the Member engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- Vitamins and dietary supplements.
- Vocational and educational training and services.

- Weight reduction or control, special foods; food supplements; liquid diets; diet plans; or any related products, except as otherwise stated.
- Weight loss programs such as Jenny Craig, Weight Watchers, and the cost of food associated with them.
- Wigs; toupees; hair transplants; hair weaving; or any drug used to eliminate baldness, unless otherwise stated.
- Work-related injury or disease including injuries arising out of or in course of work for wage or profit, whether or not the member is covered by a Workers' Compensation policy; Disease caused by reason of its relation to Workers Compensation law, occupational disease laws or similar laws; Work-related tests, examinations or immunizations of any kind required by the member's work (with the exception of one (1) annual physical exam per year used to satisfy an employment requirement.)
- Work-related injury or disease. This includes the following:
  - ✓ Injuries arising out of or in the course of work for wage or profit, whether or not you are covered by a Workers' Compensation policy.
  - ✓ Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.
  - ✓ Work-related tests, examinations, or immunizations of any kind required by your work.
  - ✓ Work related injuries will not be eligible for benefits under Horizon HMO before or after your Worker's Compensation carrier has settled or closed your case.

  This exclusion does not apply to employer-mandated physical examinations that are a prerequisite for participation in an employer mandated physical fitness test required as a condition of continuing employment. However, such employer mandated physical examinations are covered in-network only.

  Please note: If you collect benefits for the same injury or disease from both Workers' Compensation and Horizon HMO, you may be subject to prosecution for insurance fraud.

Examples of Non-Covered Services:

Example 1: A physician orders inpatient private duty nursing for a surgery patient. Since, while confined in a hospital, nursing services are provided by the hospital, any charges for private duty nursing will not be paid.

Example 2: A person is studying to become a therapist and is required by the school to enter therapy. The treatment is intended to ensure that the new therapist is well-equipped to work with patients. The treatment is not covered because it is primarily educational.

Example 3: A physician orders a drug that is FDA-approved but is not commonly used to treat the particular condition. If Horizon BCBSNJ determines that the use is experimental, the plan will not pay for the drug.

Example 4: A hospital routinely requires an assistant surgeon or Registered Nurse First Assistant (RNFA) to be present at certain operations. Horizon BCBSNJ will only pay for assistant surgeons/RNFA's that are determined to be medically necessary.

THIRD PARTY LIABILITY

Repayment Agreement

If you have received benefits from Horizon HMO for medical services that are either auto-related or work-related, Horizon HMO has the right to recover those payments. This means that if you are reimbursed through a settlement, satisfied by a judgment, or other means, you are required to return any benefits paid for illness or injury to Horizon HMO. The repayment will only be equal to the amount paid by Horizon HMO.

This provision is binding whether the payment received from the third party is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, whether or not the third party has admitted liability for the payment.

Recovery Right

You are required to cooperate with Horizon BCBSNJ in recovering any amounts payable. Horizon HMO may:

- Assume your right to receive payment for benefits from the third party;
- Require you to provide all information and sign and return all documents necessary to exercise Horizon HMO's rights under this provision, before any benefits are provided under your group's policy;
- Require you to give testimony, answer interrogatories, attend depositions, and comply with all legal actions which Horizon HMO may find necessary to recover money from all sources when a third party may be responsible for damages or injuries.

SUBROGATION AND REIMBURSEMENT

Benefits payable as a result of any injuries claimed against any person or entity other than this Health Plan are excluded from coverage under this Plan. If benefits are provided by this Plan that are otherwise payable or become payable by any third party action against any person or entity, this Plan is entitled to reimbursement only on the following terms and conditions:

- In the event that benefits are provided under this Plan, the Plan shall be subrogated to all of the Member's rights of recovery against any person or organization to the extent of the benefits provided ("Member" includes any person receiving benefits hereunder including all dependents). The Member shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Member shall do nothing after loss to prejudice such rights. The Member must cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any accident as the Plan or its representatives deem necessary to fully investigate the incident.
- The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with, and not exclusive of, the subrogation right granted in the preceding paragraph, but only to the extent of the benefits provided by the Plan.

- The subrogation and reimbursement rights and liens apply to any recoveries made by the Member as a result of the injuries sustained, including but not limited to the following:
  - ✓ Payments made directly by a third party, or any insurance company on behalf of a third party, or any other payments on behalf of the third party.
  - ✓ Any payments or settlements, judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Member or other person.
  - ✓ Any other payments from any source designed or intended to compensate a Member for injuries sustained as the result of negligence or alleged negligence of a third party.
  - ✓ Any worker's compensation award or settlement.
  - ✓ Any recovery made pursuant to no-fault insurance.
  - ✓ Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Member, whether under comparative negligence or otherwise.

WHEN YOU HAVE A CLAIM

Submitting a Claim

Generally you will not have to submit any claim forms to Horizon HMO for reimbursement for treatment from a network provider. You will simply pay the provider the required copayment amount and the provider will submit claims directly to Horizon HMO for the appropriate reimbursement.

If you receive emergency treatment out-of-network, claims must be submitted for reimbursement to:

Horizon BCBSNJ
P.O. Box 820
Newark, NJ 07101-0820

All mental health and substance abuse claims should be mailed to:

Horizon Behavioral Health
Horizon BCBSNJ
PO Box 10191
Newark NJ 07101-3189

Filing Deadline (Proof of Loss)

Horizon HMO must be given written proof of a loss for which a claim is made under Horizon HMO. This proof must cover the occurrence, character, and extent of the loss. It must be furnished **within one year and 90 days of the end of the calendar year in which the services were incurred.** For example, if a service were incurred in the year 2013, you would have until March 31, 2014, to file the claim.

A claim will not be considered valid unless proof is furnished within the time limit shown above. If it is not possible for you to provide proof within the time limit, the claim may be considered valid upon appeal if the reason the proof was not provided in a timely basis was reasonable.

Itemized Bills are Necessary

You must obtain itemized bills from the providers of services for all medical expenses. The itemized bills must include the following:

- Name and address of provider;
- Provider's tax identification number;
- Name of patient;
- Date of service;
- Diagnosis;
- Type of service;
- CPT 4 code; and
- Charge for each service.

Foreign Claims

Bills for emergency services that are incurred outside of the United States must include an English translation and the charge for each service performed. The exchange rate at the time of service should also be indicated on the bill that is submitted for reimbursement.

Filling Out the Claim Form

Be sure to fill out the claim form completely. Include the identification number that appears on your Horizon HMO identification card. Fill out all applicable portions of the claim form and sign it. A separate claim form must be submitted for each individual and each time you file a claim.

MEDICARE CLAIM SUBMISSION

If a member is a New Jersey resident, has Medicare primary coverage, and receives care within New Jersey, claims will be transmitted automatically from the Medicare carrier to the Horizon HMO.

QUESTIONS ABOUT CLAIMS

If you have questions about a hospital claim, hospital benefits, a medical claim, or medical benefits or if you need a claim form, call Horizon HMO member services at 1-800-414-SHBP (7427).

If for any reason the claim is not eligible, you will be notified of its ineligibility within 90 days of receipt of your claim. To request a review of the claim, you should follow the instructions described in the “Appeal Procedures” section.

APPEAL PROCEDURES

SHBP/SEHBP MEDICAL APPEAL PROCEDURE

Member appeals that involve medical judgment made by Horizon BCBSNJ are considered medical appeals. An adverse benefit determination involving medical judgment is (a) a denial; or (b) a reduction from the application of clinical or medical necessity criteria; or (c) a failure to cover an item or service for which benefits are otherwise provided because Horizon HMO determines the item or service to be experimental or investigational, cosmetic, or dental, rather than medical. Adverse benefit determinations involving medical judgment may usually be appealed up to three (3) times as outlined below:

- **First Level Medical Appeal** – The First Level Medical Appeal of an adverse benefit determination.
- **Second Level Medical Appeal** – The Second Level Medical Appeal of an adverse benefit determination available to you after completing a First Level Medical Appeal.
- **External Appeal** – The third Level Medical Appeal of an adverse benefit determination, which, at your request, would generally follow a Second Level Medical Appeal. An External Appeal provides you the right to appeal to an Independent Review Organization (IRO).

An overview of the medical appeal procedure is provided below. A Horizon HMO Medical Appeals Procedure brochure will be provided with every adverse benefit determination involving medical judgment. The brochure provides a comprehensive description of the procedures.

First Level Medical Appeal

First Level Medical Appeals may be submitted in writing or verbally. Verbal appeals may be directed to Horizon HMO Utilization Management at 1-888-221-6392. Written appeals may be sent to:

Horizon HMO
Medical Appeals
P.O. Box 420
Mail Station PP 14E
Newark, NJ 07101-0420

The member, physician, or authorized representative has one (1) year following your receipt of the initial adverse benefit determination letter to request a Medical Appeal.

To initiate a First Level Medical Appeal, the following information must be provided:

- Name and address of the member or provider(s) involved.
- Member's identification number.
- Date(s) of service.
- Nature and reason behind your appeal.
- Remedy sought.
- Clinical documentation to support your appeal.

First Level Medical Appeals will be reviewed and decided in the following time frames:

- Standard First Level Medical Appeals are reviewed and decided within 15 calendar days of receipt.
- First Level Expedited (urgent and emergent) Medical Appeals are decided as soon as possible in accordance with the medical urgency of the case, but will not exceed 72 hours from Horizon HMO's receipt of the appeal request.

The member will receive a letter documenting Horizon HMO's First Level Medical Appeal decision. The letter will include the specific reasons for the determination.

Expedited Review

Horizon HMO Medical Appeal procedures may be expedited in circumstances involving urgent or emergent care.

First and Second Level Medical Appeals are automatically handled in an expedited manner for all determinations regarding urgent or emergent care, an admission, availability of care, continued stay, or health care services for which the claimant received emergency services but has not been discharged from the facility. Furthermore, if you feel that the Horizon HMO decision will cause serious medical consequences in the near future, you have the right to an Expedited Medical Appeal. You also have the right to an Expedited Medical Appeal if in the opinion of a physician with knowledge of your medical condition, your condition is as described above or that you will be subject to severe pain that cannot be adequately managed without receiving the denied medical services. Expedited Medical Appeals are initiated by calling a Horizon HMO Appeals Coordinator at **1-888-221-6392**.

Second Level Medical Appeals

If you disagree with the First Level Medical Appeal decision, you have one (1) year following receipt of Horizon HMO's original determination letter to request a Second Level Medical Appeal. If you wish to make a Second Level Medical Appeal, you may do so by sending your appeal in writing to the following address:

Horizon HMO Appeals Department
Mail Station PP-14E
P.O. Box 420
Newark, NJ 07101-0420

You may also initiate a Second Level Medical Appeal by calling a Horizon HMO Appeals Coordinator at **1-888-221-6392.**

To initiate a Second Level Medical Appeal, the following information must be provided:

- Name and address of the member or provider(s) involved.
- Member's identification number.
- Date(s) of service.
- Nature and reason behind your appeal.
- Remedy sought.
- Clinical documentation to support your appeal.

If a Second Level Medical Appeal is received, it is submitted to the Horizon HMO Appeals Committee. The Appeals Committee is made up of Horizon Medical Directors and staff, physicians from the community, and consumer advocates. A smaller subcommittee reviews Expedited Second Level Medical Appeals. The Appeals Coordinator will advise you of the date of your hearing. You have the option of attending the hearing in person or via telephone conference. You may also elect to have the Appeals Committee review and decide your Second Level Medical Appeal without your appearance.

Second Level Medical Appeals will be reviewed and decided in the following time frames:

- Standard Second Level Medical Appeals are reviewed and decided within 15 calendar days of Horizon HMO's receipt.
- Second Level Expedited (urgent and emergent circumstances, as previously described) Medical Appeals are decided as soon as possible in accordance with the medical urgency of the case, but will not exceed 72 hours from Horizon HMO's receipt of your First Level Medical Appeal request.

If you participate in the hearing, you will be notified of the Appeals Committee's decision verbally by telephone on the day of the hearing whenever possible. Written confirmation of the decision is sent to you and/or your physician or other authorized representative who pursued the Second Level Medical Appeal on your behalf. If you choose not to appear at the hearing you will be notified of the Appeals Committee's decisions in writing within five (5) business days of the decision. Horizon HMO's letter will include the specific reasons for the determination. If Horizon HMO's decision is not in your favor, you have the right to pursue an External Appeal through an Independent Review Organization (IRO).

Expedited Review of Second Level Medical Appeals

If the circumstances previously described in the "Expedited Review" section apply in your case (see page 55), you have the same right to an expedited review of your Second Level Medical Appeal.

EXTERNAL APPEAL RIGHTS

Standard External Appeals

If you are dissatisfied with the results of Horizon HMO's internal appeals process, and you wish to pursue an External Appeal with an Independent Review Organization (IRO), you must submit a written request within four (4) months from your receipt of Horizon HMO's final adverse benefit determination of your Appeal. To initiate a Standard External Appeal, you should submit a written request to the following address:

Horizon HMO Appeals Department
Mail Station PP-14E
P.O. Box 420
Newark, NJ 07101-0420

Upon receipt of your written request, a preliminary review will be conducted by Horizon HMO and completed within five (5) business days to determine:

- Your eligibility under your group health plan at the time the service was requested or provided.

- That the adverse benefit determination does not relate to your failure to meet eligibility requirements under the terms of your group health plan (e.g. worker classification or similar).
- The internal appeals process has been exhausted (if required).
- You have provided all the information and forms required to process the external review.

After the completion of this preliminary review, written notification will be issued informing you of Horizon HMO's determination regarding the eligibility of your request for external review. If your request for an external review meets the eligibility requirements, your appeal will be assigned to an IRO by Horizon HMO. The IRO will notify you in writing of your request's eligibility and acceptance for external review. The IRO will review all of the information and documents received and will provide its written final external review decision to the claimant and Horizon HMO within 45 days after the IRO first received the request for the external review. Upon receipt of a final external review decision reversing an adverse benefit determination, Horizon HMO will provide coverage or payment for the claim(s) or service(s) involved. If the final external review decision upholds the adverse benefit determination, no further action is taken and the Horizon HMO Medical Appeals Process is complete.

The Standard External Appeal rights described may be expedited in the following circumstances:

The initial adverse benefit determination involving medical judgment concerns a medical condition such that the completion of a Standard Internal Appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function, and the member has filed a request for an Expedited Internal Appeal,

OR

The final adverse benefit determination (decision upon appeal) involving medical judgment concerns a medical condition such that the completion of a Standard External Appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function, or if final adverse benefit determination involving medical judgment concerns an admission, availability of care, continued stay or a health care item or service for which the member received emergency services, but has not been discharged from the facility.

In instances of an expedited request, your request can be made by calling a Horizon BCBSNJ Appeals Coordinator at **1-888-221-6392**. For Expedited External Review requests, the final notice of the decision must be provided as expeditiously as the member's medical condition or circumstances require, but in no event shall exceed 72 hours from the IRO's receipt of the request for Expedited External Review.

SHBP/SEHBP ADMINISTRATIVE APPEAL PROCEDURE

The member or the member's authorized representative may appeal and request that Horizon HMO reconsider any claim or any portion(s) of a claim for which they believe benefits have been erroneously denied based on Plan limitations and/or exclusions. This appeal may be of an administrative nature. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Examples of Administrative Appeals include:

- Visits beyond the 30 visit chiropractic limit
- Benefits beyond the reasonable and customary allowance
- Routine Vision Services rendered out-of-network
- Benefits for a wig that exceed the $500/24 month limit
- Hearing Aid for a 60 year old member

Adverse benefit determinations involving the application of plan benefits may usually be appealed up to three (3) times as outlined below:

- **First Level Administrative Appeal** – The First Level Administrative Appeal of an adverse benefit determination.
- **Second Level Administrative Appeal** – The Second Level Administrative Appeal of an adverse benefit determination available to you after completing a First Level Administrative Appeal.
- **Commission Appeal** – The Third Level Administrative Appeal of an adverse benefit determination, which, at your request, would generally follow a Second Level Administrative Appeal. A Commission Appeal provides you the right to appeal to the State Health Benefits Commission/School Employees' Health Benefits Commission.

An overview of the administrative appeal process is provided below. An SHBP/SEHBP Administrative Appeals Procedure brochure will be provided with every administrative adverse benefit determination. The brochure provides a comprehensive description of the procedures.

First Level Administrative Appeal

The member may request an administrative appeal by calling **1-800-414-SHBP (7427)** or submitting a written appeal to:

Horizon BCBSNJ
SHBP/SEHBP Appeals
P.O. Box 820
Newark, NJ 07101

The member has one (1) year following your receipt of the initial adverse benefit determination letter to request an Administrative Appeal.

The First Level Administrative Appeal should include the following information:

- Name and address of the patient and the member;
- Member's identification number;

- Date(s) of service(s);
- Provider's name and identification number;
- Physician's name and identification number;
- The reason you think the claim/service should be reconsidered;
- All documentation supporting your appeal.

You will receive a written response to your First Level Administrative Appeal within 30 days. If you are not satisfied with this written determination, a Second Level Administrative Appeal may be requested.

Second Level Administrative Appeal

The member may request a Second Level Administrative Appeal within one (1) year following receipt of the initial adverse benefit determination letter by calling **1-800-414-SHBP (7427)**, or by writing to the address noted earlier. The member may also send an appeal via fax to **1-973-274-4599**.

During the Second Level Administrative Appeal, Horizon HMO will review any additional evidence the member wished to supply in support of the appeal. The member will receive a written determination of the final decision within 30 days. This will complete the Horizon HMO appeal options.

Commission Appeal

Once all appeal options have been exhausted through Horizon HMO the member may appeal to the State Health Benefits Commission/School Employees' Health Benefits Commission (Commission). If dissatisfied with a final Horizon HMO decision on an administrative appeal, you have one (1) year following receipt of the initial adverse benefit determination letter to request a Commission Appeal. Only the member or the member's legal representative may appeal, in writing, to the Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf.

Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to:

Appeals Coordinator
State Health Benefits Commission/
School Employees' Health Benefits Commission
P.O. Box 299
Trenton, NJ 08625-0299

The member will be advised by the Commission how to arrange a hearing date, the date of the hearing and the option to attend and appear before the Commission.

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps he or she may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request in writing to the Commission, within 45 days, that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so, the case will be forwarded to the Office of Administrative Law. An Administrative Law Judge (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify or reject.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. The member will be responsible for any expenses involved in gathering evidence or material that will support the grounds for appeal. The member will be responsible for any court filing fees or related costs that may be necessary during the appeal process. If an attorney or expert medical testimony is required, the member will be responsible for any fees or costs incurred.

If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals may be made to the Superior Court of New Jersey, Appellate Division.

PRESCRIPTION DRUG BENEFITS

The State Health Benefits Commission and School Employees' Health Benefits Commission require that all covered employees and retirees have access to prescription drug coverage.

The Commissions reserve the right to establish dispensing limits on any medication based on Food and Drug Administration (FDA) recommendations and medical appropriateness. Prior Authorization, Drug Utilization Review, Dose Optimization, Step Therapy, Preferred Drug Step Therapy (PDST)* and the Specialty Pharmacy Program are employed to ensure that the medications that are reimbursed under the plan are the most clinically appropriate and cost effective. Volume restrictions also apply to certain drugs such as sexual dysfunction drugs (Viagra, Muse, etc.). Certain drugs that require administration in a physician's office may be covered through your medical plan.

*PDST does not apply to certain State employees and their dependents.

EMPLOYEE PRESCRIPTION DRUG COVERAGE

State Employees

State employees enrolled in Horizon HMO medical plans have access to the SHBP/SEHBP Employee Prescription Drug Plans. Plan benefits are available through retail pharmacies, by mail order through Express Scripts, and from specialty pharmacy services provided through Accredo, Express Scripts' specialty pharmacy.

The plans feature a three tier copayment design, except for high deductible health plans. Retail pharmacy services require a copayment for up to a 30-day supply of prescription drugs. Mail order participants can receive up to a 90-day supply of prescription drugs for one mail order copayment. Specialty pharmacy services are only provided via mail through Accredo. If your doctor prescribes a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy.

See the SHBP/SEHBP *Prescription Drug Plans Member Handbook* for additional information on prescription drug benefits and limitations.

The amount that State employees and their eligible dependents pay for prescription drugs is determined by the medical plan the employee selects.

> **Note:** In the past, regardless of which medical plan you were enrolled, the Employee Prescription Drug Plan copayments were the same. As a result of the SHBP/SEHBP Plan Design Committees' actions, the copayments for prescription drugs are now determined by the medical plan you select.

The State Health Benefit Plan Design Committee establishes the copayment amounts on an annual basis. In Plan Year 2014 a State employee or dependent will pay the following copayments amounts.

EMPLOYEE PRESCRIPTION DRUG PLAN COPAYMENTS
STATE EMPLOYEES

Member Copayment up to 30 day supply retail and up to 90 days mail	Horizon HMO	Horizon HMO1525	Horizon HMO2030	Horizon HMO2035
Retail Generic	$3	$7	$3	$7
Retail Brand *without* generic equivalent	$10	$16	$18	$21
Retail Brand *with* generic equivalent	$25	$35	$46	Member pays the difference*
Mail Order Generic	$5	$18	$5	$18
Mail Order Brand *without* generic equivalent	$15	$40	$36	$52
Mail Order Brand *with* generic equivalent	$40	$88	$92	Member pays the difference*

**You pay the applicable generic copayment as listed above, plus the cost difference between the brand drug and the generic drug.*

Note: The following **preventive medications** are covered with a doctor's prescription with a zero dollar copayment for certain members meeting specific criteria (see the *Prescription Drug Plans Member Handbook* for specific limits related to age, gender, and medical condition): Aspirin, Fluoride, Folic Acid, Iron supplements, and certain drugs that assist with Smoking Cessation.

Local Government and Local Education Employees

The amount that local government/education employees and their eligible dependents pay for prescription drugs is determined by the prescription drug plan option provided by the employer and the medical plan the employee selects. Local government and local education employers may elect one of the following three options to provide prescription drug benefits to their employees: The SHBP/SEHBP Employee Prescription Drug Plans, HMO Prescription Drug Plan, or a private (non-SHBP/SEHBP) prescription drug plan.

1. **The SHBP/SEHBP Employee Prescription Drug Plans:** Benefits are available through retail pharmacies, by mail order through Express Scripts, and from specialty pharmacy services provided through Accredo, Express Scripts' specialty pharmacy. The plans feature a three tier copayment design, except for the high deductible health plans. Retail pharmacy services require a copayment for up to a 30-day supply of prescription drugs. Mail order participants can receive up to a 90-day supply of prescription drugs for one mail order copayment. Specialty pharmacy services are only provided via mail through Accredo. If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy.

See the SHBP/SEHBP *Prescription Drug Plans Member Handbook* for additional information on prescription drug benefits and limitations.

The State Health Benefit and School Employees' Health Benefit Plan Design Committees establish the copayment amounts on an annual basis.

Note: In the past, regardless of which medical plan you were enrolled, the Employee Prescription Drug Plan copayments were the same. As a result of the SHBP/SEHBP Plan Design Committees' actions, the copayments for prescription drugs are now determined by the medical plan you select.

In Plan Year 2014 a local government/education employee or dependent will pay the following copayments amounts.

EMPLOYEE PRESCRIPTION DRUG PLAN COPAYMENTS
LOCAL GOVERNMENT AND LOCAL EDUCATION EMPLOYEES

Member Copayment up to 30 day supply retail and up to 90 days mail	Horizon HMO	Horizon HMO1525	Horizon HMO2030	Horizon HMO2035
Retail Generic	$3	$7	$3	$7
Retail Brand *without* generic equivalent	$10	$16	$18	$21
Retail Brand *with* generic equivalent	$10	$35	$46	Member pays the difference*
Mail Order Generic	$5	$18	$5	$18
Mail Order Brand *without* generic equivalent	$15	$40	$36	$52
Mail Order Brand *with* generic equivalent	$15	$88	$92	Member pays the difference*

**You pay the applicable generic copayment as listed above, plus the cost difference between the brand drug and the generic drug.*

Note: The following **preventive medications** are covered with a doctor's prescription with a zero dollar copayment for certain members meeting specific criteria (see the *Prescription Drug Plans Member Handbook* for specific limits related to age, gender, and medical condition): Aspirin, Fluoride, Folic Acid, Iron supplements, and certain drugs that assist with Smoking Cessation.

2. **The HMO Prescription Drug Plan:** Available to employees enrolled in Horizon HMO, Horizon HMO1525, Horizon HMO2030, or Horizon HMO 2035 when the local public employer does not provide either the Employee Prescription Drug Plans or a private prescription drug plan. Plan benefits are available through participating retail pharmacies, by mail order through Express Scripts, or online at:

www.medco.com/statenj and from specialty pharmacy services provided through Accredo, Express Scripts' specialty pharmacy.

The HMO Prescription Drug Plan features a three-tier copayment design for prescription drugs that are prescribed by your Primary Care Physician (PCP) or a provider to whom your PCP has referred you.

See the SHBP/SEHBP *Prescription Drug Plans Member Handbook* for additional information on prescription drug benefits and limitations.

In Plan Year 2014 a local government/education employee or dependent will pay the following copayments amounts.

HMO PRESCRIPTION DRUG PLAN COPAYMENTS
LOCAL GOVERNMENT AND LOCAL EDUCATION EMPLOYEES

Member Copayment up to 30 day supply retail and up to 90 days mail	**Horizon HMO**	**Horizon HMO1525**	**Horizon HMO2030**	**Horizon HMO2035**
Retail Generic	$5	$7	$3	$7
Retail Brand *without* generic equivalent	$10	$16	$18	$21
Retail Brand *with* generic equivalent	$20	$35	$46	Member pays the difference*
Mail Order Generic	$5	$18	$5	$18
Mail Order Brand *without* generic equivalent	$15	$40	$36	$52
Mail Order Brand *with* generic equivalent	$25	$88	$92	Member pays the difference*

**You pay the applicable generic copayment as listed above, plus the cost difference between the brand drug and the generic drug.*

Note: The following **preventive medications** are covered with a doctor's prescription with a zero dollar copayment for certain members meeting specific criteria (see the *Prescription Drug Plans Member Handbook* for specific limits related to age, gender, and medical condition): Aspirin, Fluoride, Folic Acid, Iron supplements, and certain drugs that assist with Smoking Cessation.

3. **A private (non-SHBP/SEHBP) prescription drug plan** that is at least equal to the Employee Prescription Drug Plan.

RETIREE PRESCRIPTION DRUG COVERAGE

Retirees enrolled in a SHBP or SEHBP medical plan have access to the **Retiree Prescription Drug Plan.** Plan benefits are available through participating retail pharmacies, by mail order through Express Scripts, and from specialty pharmacy services provided through Accredo, Express Scripts' specialty pharmacy.

The plan features a three-tier copayment design except for high deductible health plans. Retail pharmacy services require a copayment for up to a 30-day supply of prescription drugs. Mail order participants can receive up to a 90-day supply of prescription drugs for one mail order copayment. Specialty pharmacy services are only provided via mail through Accredo. If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy.

Medicare Part D

If you are enrolled in the Retired Group of the SHBP/SEHBP and eligible for Medicare, you will be automatically enrolled in the Express Scripts Medicare Prescription Plan, a Medicare Part D plan.

Important: If you decide not to be enrolled in the Express Scripts Medicare Prescription Plan, you will lose your prescription drug benefits provided by the SEHBP/SHBP. However, your medical benefits will continue. In order to waive the Express Scripts Medicare Prescription Plan, you must enroll in another Medicare Part D plan. To request that you not be enrolled, you must submit a Retired Change of Status Application waiving your prescription drug coverage.

RETIREE PRESCRIPTION DRUG COPAYMENTS

The amount that retired members and their eligible dependents pay for prescription drugs is determined by the medical plan the retiree selects.

Effective January 1, 2014, copayments for retiree prescription drug coverage are as follows.

State Retirees and Local Government Retirees

Member Copayment up to 30 day supply retail and up to 90 days mail	Horizon HMO	Horizon HMO1525	Horizon HMO2030
Retail Generic	$7	$7	$3
Retail Brand *without* generic equivalent	$14	$17	$19
Retail Brand *with* generic equivalent	$27	$37	$49
Mail Order Generic	$7	$5	$5
Mail Order Brand *without* generic equivalent	$21	$43	$38
Mail Order Brand *with* generic equivalent	$34	$94	$98

- If enrolled in Horizon HMO10 or Horizon HMO15, the annual out-of-pocket maximum is $1,446 per person. If enrolled in Horizon HMO 1525 or Horizon HMO 2030, there is no out-of-pocket maximum for covered prescription drugs.

Local Education Retirees

Member Copayment up to 30 day supply retail and up to 90 days mail	**Horizon HMO**	**Horizon HMO1525**	**Horizon HMO2030**
Retail Generic	$6	$7	$3
Retail Brand *without* generic equivalent	$13	$17	$19
Retail Brand *with* generic equivalent	$26	$36	$49
Mail Order Generic	$5	$5	$5
Mail Order Brand *without* generic equivalent	$19	$41	$37
Mail Order Brand *with* generic equivalent	$31	$91	$95

- The annual out-of-pocket maximum for Local Education Retirees is $1,411 per person for all Horizon HMO Prescription plans.

Note: Horizon HMO2035 is not currently available to SHBP/SEHBP retirees.

COBRA COVERAGE

CONTINUING COVERAGE WHEN IT WOULD NORMALLY END

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage. COBRA coverage is available for limited time periods (see “Duration of COBRA Coverage” on page 68), and the member must pay the full cost of the coverage plus an administrative fee.

Leave taken under the federal and/or State Family Leave Act is not subtracted from your COBRA eligibility period.

Under COBRA, you may elect to enroll in any or all of the coverages you had as an active employee or dependent (health, prescription drug, dental, and vision). You may also change your health or dental plan when enrolling in COBRA. You may elect to cover the same dependents that you covered while an active employee, or delete dependents from coverage — however, you cannot add dependents who were not covered while an employee except during the annual Open Enrollment period (see below) or unless a "qualifying event" (marriage, birth or adoption of a child, etc.) occurred within 60 days of the COBRA event.

Open Enrollment — COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll, if eligible, in any medical, dental, or prescription drug coverage during the Annual Open Enrollment Period regardless of whether you elected to enroll for the coverage when you went into COBRA. This affords a COBRA enrollee the same opportunity to enroll for benefits during the Annual Open Enrollment Period as an active employee. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If the State Health Benefits Commission or School Employees’ Health Benefits Commission make changes to any benefit plan available to active employees and/or retirees, those changes apply equally to COBRA participants.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents who would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct).
- Death of the member/retiree.
- Reduction in work hours.
- Leave of absence.
- Divorce, legal separation, dissolution of a civil union or domestic partnership (makes spouse/ partner ineligible for further dependent coverage).

- Loss of a dependent child's eligibility through the attainment of age 26.The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

Note: Employees who at retirement are eligible to enroll in SHBP or SEHBP Retired Group coverage cannot enroll for health benefits coverage under COBRA.

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Cost of COBRA Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

Duration of COBRA Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of **termination of employment, a reduction in hours, or a leave of absence.**

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Proof of Social Security Administration determination must be submitted to the Health Benefits Bureau of the Division of Pensions and Benefits within 60 days of the award or within 60 days of COBRA enrollment. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of your **death, divorce, dissolution of a civil union or domestic partnership,** or a child becomes ineligible for continued group coverage because of **attaining age 26, or** because you **elected Medicare as your primary coverage.**

If a second qualifying event — such as a divorce — occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- Notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled;
- Notify you and your dependents of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the *COBRA Notification Letter* and a *COBRA Application* within 14 days of receiving notice that a COBRA qualifying event has occurred;

- Notify the Health Benefits Bureau of the Division of Pensions and Benefits within 30 days of the loss of an employee's coverage; and
- Maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and/or your dependents:

- You or your eligible dependents must notify your employer (if you are retired, you must notify the Health Benefits Bureau of the Division of Pensions and Benefits) that a divorce, legal separation, dissolution of a civil union or domestic partnership, or your death has occurred or that your child has reached age 26 — notification must be given within 60 days of the date the event occurred;
- File a *COBRA Application* (obtained from your employer or the Health Benefits Bureau) within 60 days of the loss of coverage or the date of the *COBRA Notice* provided by your employer, whichever is later;
- Pay the required monthly premiums in a timely manner; and
- Pay premiums, when billed, retroactive to the date of group coverage termination.

Failure to Elect COBRA Coverage

In considering whether to elect continuation of coverage under COBRA, an eligible employee, retiree, or dependent (also known as a "qualified beneficiary" under COBRA law) should take into account that a failure to continue group health coverage will affect future rights under federal law.

- First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. The election of continuation of coverage under COBRA may help you to bridge such a gap. (If, after enrolling in COBRA you obtain new coverage which has a pre-existing condition clause, you may continue your COBRA enrollment to cover the condition excluded by the pre-existing condition clause.)
- Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if you do not continue coverage under COBRA for the maximum time available to you.
- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days of the date your group coverage ends. You will also have the same special enrollment right at the end of the COBRA coverage period if you get the continuation of coverage under COBRA for the maximum time available to you.

Termination of COBRA Coverage

Your COBRA coverage will end when any of the following situations occur:

- Your eligibility period expires;
- You fail to pay your premiums in a timely manner;
- After the COBRA event, you become covered under another group insurance program (unless a pre-existing clause applies);
- You voluntarily cancel your coverage;
- Your employer drops out of the SHBP or SEHBP;
- You become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

APPENDIX I

SPECIAL PLAN PROVISIONS UNDER HORIZON HMO

WORK-RELATED INJURY OR DISEASE

Work-related injuries or disease are not covered under Horizon HMO. This includes the following:

- Injuries arising out of or in the course of work for wage or profit, whether or not your injuries are covered by a Workers' Compensation policy.
- Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.
- Work related tests, examinations or immunizations of any kind required by your work except employer mandated examinations that are a prerequisite for participation in an employer mandated physical fitness test required as a condition of continuing employment.
- Work related injuries will not be eligible for benefits under your medical plan before or after your Worker's Compensation carrier has settled or closed your case.

Please note: If you collect benefits for the same injury or disease from both Workers' Compensation and Horizon HMO, you may be subject to prosecution for insurance fraud.

MEDICAL PLAN EXTENSION OF BENEFITS

If you or a dependent are disabled with a condition or illness at the time of your termination from the SHBP or SEHBP, you may qualify for an extension of benefits for this specific condition or illness. You do not qualify for an extension of benefits if you currently have or are eligible for any other type of medical coverage including but not limited to Medicare. If you feel that you may qualify for an extension of benefits please contact Horizon HMO at 1-800-414-SHBP (7427) for assistance.

If the extension applies, it is only for eligible expenses relating to the disabling condition or illness. An extension under Horizon HMO will be for the time you or your dependent remains disabled from any such condition or illness, but not beyond the end of the calendar year after the one in which your coverage ends.

TERMINATION FOR CAUSE

If any of the following conditions exist, you may receive written notice that you will no longer be covered under Horizon HMO.

- If, after reasonable efforts, Horizon HMO and/or participating providers are unable to establish and maintain a satisfactory, provider/patient relationship with you or you repeatedly act in a manner which is verbally or physically abusive.
- If you permit any person who is not authorized to use the identification card(s) issued to you. You may be liable for the cost of any claims paid for services for an ineligible individual.
- If you willfully furnish incorrect or incomplete information in a statement made for the purpose of effecting coverage.
- If you abuse the system, including, but not limited to theft, damage to a participating providers' property, or forgery of prescriptions.

Any action by Horizon HMO under these provisions is subject to review in accordance with the established appeals procedures. If an appeal is denied and the decision upheld, this action is subject to appeal to either the State Health Benefits Commission or School Employees' Health Benefits Commission. No benefits, other than for emergencies, will be provided to the member and to any family members under the coverage as of 31 days after such written notice is given by Horizon HMO.

If the State Health Benefits Commission or School Employees' Health Benefits Commission overrules the decision to terminate, benefits will be restored.

APPENDIX II

SUMMARY SCHEDULE OF SERVICES AND SUPPLIES

New Jersey statutes, administrative code, and agreements between the SHBP or SEHBP and Horizon HMO govern this plan. The following schedule of benefits is a summary description of plan benefits. It is not a complete listing. The schedule does not describe all the limitations or conditions associated with the coverage as described in other sections of this handbook. All pertinent parts of this handbook should be consulted regarding a specific benefit. Health decisions should not be made on the basis of the information provided in the schedule. Horizon HMO will administer the coverage listed in the Schedule of Covered Services and Supplies, subject to the terms, conditions, limitations, and exclusions stated within this handbook.

Please note: The fact that a doctor may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically needed for the treatment and/or diagnosis of an illness or injury or make it a covered medical expense. Certain services are subject to precertification.

HORIZON HMO ELIGIBLE SERVICES AND SUPPLIES

The following copayments apply to covered office based and emergency room services unless otherwise indicated;

Horizon HMO Plan Option	Primary Care Office Visit Copayment	Specialty Care Office Visit Copayment	Emergency Room Copayment
HMO 10	$10	$10	$35
HMO 15	$15	$15	$50
HMO 1525	$15	$25	$75
HMO 2030	$20	$30 for adults; $20 for children up to end of year the child turns 26	$125
HMO 2035	$20	$35	$300

HORIZON HMO COVERED SERVICES

Only eligible services provided by network providers are covered under Horizon HMO. Some services require referrals which must be arranged through your PCP.

As detailed below, the **Horizon HMO, HMO1525 and HMO 2030** plan benefit is **100 percent** for most eligible in-network services. Office and therapy visits are subject to a copayment unless otherwise noted.

For **Horizon HMO2035**, the plan benefit is **80 percent** for all in-network services except as noted. Before benefits are paid, the Horizon HMO2035 annual in-network deductible must be satisfied.

Allergy Testing ..... **100/100 percent coverage**

Ambulance Services ..... **100/80 percent coverage**

Ambulatory Surgery ..... **100/80 percent coverage**

Anesthesia ..... **100/80 percent coverage**

Behavioral Health/Substance Abuse

- **Alcohol or Substance Abuse (Inpatient)** ..... **100/80 percent** coverage
- **Alcohol or Substance Abuse (Outpatient)** ..... **100/80 percent** coverage
- **Mental or Nervous Conditions**

  Inpatient ..... **100/80 percent** coverage

  Outpatient ..... **100/80 percent** coverage

Biofeedback ..... **100/80 percent** coverage

Chiropractic Services (No Referral Required) ....**100/100 percent** coverage

(20 visits per calendar year)

Diagnostic Laboratory.....**100/80 percent** coverage

Diagnostic X-Ray ..... **100/80 percent** coverage

Dialysis Center Charges ..... **100/80 percent** coverage

Durable Medical Equipment ..... **100/80 percent** coverage

(Horizon HMO, Horizon HMO1525, Horizon HMO2030: $100 annual deductible per individual)

Emergency Room.....**100/100 percent** coverage, after the Emergency Room copayment (*The emergency room copayment is waived if admitted)*

Hospital Charges..... **100/80 percent** coverage

Home Health Care ..... **100/80 percent** coverage

Hospice Care ..... **100/80 percent** coverage

Inpatient Hospice Care ..... **100/80 percent** coverage

Inherited Metabolic Disease Medical Foods..... **100/80 percent** coverage

Inpatient Physician Services..... **100/80 percent** coverage

Maternity/Obstetrical Care .....**100/80 percent** coverage after a copayment for the initial visit

Nutritional Counseling..... **100/100 percent** coverage (3 visits per year)

Pre-Admission Testing..... **100/80 percent** coverage

Preventive Care

Under the Patient Protection and Affordable Care Act, some preventive care services are covered with no out-of-pocket cost (no copayment), when you receive the services from an in-network health care professional and the sole reason for the visit is to receive the preventive care services. If your health care professional provides a preventive service as part of an office visit, you may be responsible for cost sharing for the office visit if the preventive service is not the primary purpose of your visit or if the provider bills you for the office visit separately from the preventive care.

- **Annual Routine Gynecological Care and Examinations (limited to one per year)** **100/100 percent** coverage (no copayment) No referral is required for one routine gynecological exam per year.

- **Annual Wellness Visit** ..... **100/100 percent** coverage (no copayment)
- **Immunizations** ..... **100/100 percent** coverage (no copayment)
- **Mammography** ..... **100/100 percent** coverage (no copayment)
- **Pap Smears** ..... **100/100 percent** coverage (no copayment)
- **Prostate Cancer Screening** ..... **100/100 percent** coverage (no copayment)
- **Well Child** ..... **100/100 percent** coverage (no copayment)
- **Well Child Immunizations** ..... **100/100 percent** coverage (no copayment)

Private Duty Nursing (Outpatient) ..... **100/80 percent** coverage
(60 eight-hour shifts. Prior authorization required.
Inpatient private duty nursing not covered.)

Second Surgical Opinion Charges (Voluntary) ..... **100/80 percent** coverage

Skilled Nursing Facility Charges ..... **100/80 percent** coverage
(up to 120 days per benefit period)

Specialist Office Visits ..... **100/100 percent** coverage

Specialized Non-Standard Infant Formula ..... **100/80 percent** coverage
(subject to deductible)

Surgical Services ..... **100/80 percent** coverage

Therapy Services, office based ..... **100/80 percent** coverage

(Speech, Physical and Occupational) (60 visits combined for physical, occupational and speech therapy per calendar year.)

Transplant Benefits ..... **100/80 percent** coverage

APPENDIX III

GLOSSARY

Accidental Injury — Physical harms or damage done to a person as a result of a chance or unexpected occurrence.

Active Group Member (subscriber) — An employee who has met the requirements for participation and has completed a form constituting written notice of election to enroll for coverage for him or herself and, if applicable, any eligible dependents. Also includes eligible employees or dependents who continue coverage as a subscriber in the COBRA program.

Activities of Daily Living — Day-to-day activities, such as dressing, feeding, toileting, transferring, ambulating, meal preparation, and laundry functions.

Ambulatory Surgical Center — An accredited ambulatory care facility licensed as such by the state in which it operates to provide same-day surgical services.

Appeal — A request made by a member, doctor, or facility that a carrier review a decision concerning a claim. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of need or appropriateness of treatment or whether treatment is considered experimental or educational in nature. Appeals to the Health Benefits Commission may only be filed by a member or the member's legal representative.

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 your coverage date. The last Benefit Period ends when you are no longer covered.

Calendar Year — A year starting January 1 and ending on December 31.

Case Manager — A person or entity designated by the plan to manage, assess, coordinate, direct, and authorize the appropriate level of health care treatment.

Civil Union Partner — A person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey Civil Union Certificate or a valid certification from another jurisdiction that recognizes same-sex civil unions and additional supporting documentation are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions,* for details).

COBRA — Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law requires private employers with more than 20 employees and all public employers to allow covered employees and their dependents to remain on group insurance plans for limited time periods at their own expense under certain conditions.

Coordination of Benefits — The practice of correlating the payments a plan makes with payments provided by other insurance covering the same charges or expenses, so that (1) the plan with primary responsibility pays first, (2) reimbursement does not exceed 100 percent of the actual expense, and (3) the plan does not pay more than it would if no other insurance existed.

Copayment — The fee charged to a member or patient to be paid directly to the participating provider or network specialist at the time treatment is rendered for certain covered services.

Cosmetic Services — Services rendered to refine or reshape body structures or surfaces that are not functionally impaired. They are to improve appearance or self-esteem, or for other psychological, psychiatric or emotional reasons.

Covered Person (member) — An employee, retiree, or COBRA participant or a dependent of an employee, retiree, or COBRA participant who is enrolled.

Coverage — The plan design of payment for medical expenses under the program.

Custodial Care — Services that do not require the skill level of a nurse to perform. These services include but are not limited to assisting with activities of daily living, meal preparation, ambulation, cleaning, and laundry functions. Custodial care services are not eligible for coverage under the plan, including those that are considered to be medically needed.

Deductible — The portion of the first eligible charges submitted for payment in each calendar year that HORIZON HMO2035 requires the member or covered dependent to pay. This does not apply to preventive services or services that require a copayment.

Dependent — A member's spouse, civil union partner, or same-sex domestic partner (as defined by Chapter 246, P.L. 2003); and unmarried child(ren) under the age of 26 who lives with and is substantially dependent upon the member for support. Children include natural, adopted, foster, and stepchildren. If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness, mental retardation, or a physical disability, coverage may be continued subject to approval.

Detoxification Facility — A health care facility licensed by the state it is in as a detoxification facility for the treatment of alcoholism and/or substance abuse.

Domestic Partner — A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity that adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage. A photocopy of the New Jersey Certificate of Domestic Partnership dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners) and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

Durable Medical Equipment — Equipment determined to be:

- Designed and able to withstand repeated use;
- Made for and used primarily in the treatment of a disease or injury;
- Generally not useful in the absence of an illness or injury;
- Suitable for use while not confined in a hospital;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Eligible Services and Supplies — These are the charges that may be used as the basis for a claim. They are the charges for certain services and supplies to the extent the charges meet the terms as outlined below:

- Medically needed at the appropriate level of care for the medical condition.
- Listed in covered services and supplies.

- Ordered by a doctor for treatment of illness or injury.
- Not specifically excluded (listed in the "Charges Not Covered by the Horizon HMO" section on page 42).
- Provided while you or your eligible family members were covered by Horizon HMO.

Emergency — A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or a guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of bodily organ or part.

Claims will be paid for emergency services furnished in a hospital emergency department if the presenting symptoms reasonably suggested an emergency condition as would be interpreted by a prudent layperson. All procedures performed during the evaluation (triage) and treatment of an emergency condition will be covered.

Employer — The State, or a local government public employer that participates in the State Health Benefits Program, or a local education public employer that participates in the School Employees' Health Benefits Program.

Facility Charges — Charges from an eligible medical institution such as a hospital, residential treatment center, detoxification center, ambulatory or separate surgical center, dialysis center, or a skilled nursing center.

Family or Medical Leave of Absence — A period of time of pre-determined 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 program.

Full Medicare Coverage — Enrollment in both Part A (Hospital Insurance) and Part B (Medical Insurance) of the federal Medicare Program. ***State law requires that anyone who is enrolled in the Retired Group and is eligible for Medicare must enroll in both Parts A and B of the Medicare Program in order to be covered in the State Health Benefits Program or School Employees' Health Benefits Program.***

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.

Government Hospital — A hospital which is operated by a government or any of its subdivisions or agencies. This includes any federal, military, state, county, or city hospital.

Home Health Care Agency — A provider which mainly provides skilled nursing care and therapeutic services for an ill or injured person in the home under a home health care program designed to eliminate hospital stays. To be eligible for reimbursement it must be licensed by the state in which it operates, or be certified to participate in Medicare as a home health care agency.

Hospice — A provider that renders a health care program which provides an integrated set of services designed to provide comfort, pain relief and supportive care for terminally ill or terminally injured people under a hospice care program.

Hospital — An approved institution that meets the tests of 1, 2, 3, 4, or 5, listed below:

1. It is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals and Medicare approved.
2. It (a) is legally operated, (b) is supervised by a staff of doctors, (c) has 24-hour-a-day nursing service by registered graduate nurses, and (d) mainly provides general inpatient medical care and treatment of sick and injured persons by the use of the medical, diagnostic, and major surgical facilities in it.
3. It is licensed as an ambulatory or separate surgical center. The center must mainly provide outpatient surgical care and treatment.
4. It is an institution for the treatment of alcoholism not meeting all the tests of (1) or (2) but which is:
    - A licensed hospital; or
    - A licensed detoxification facility; or
    - A residential treatment facility which is approved by a state under a program that meets standards of care equivalent to those of the Joint Commission on Accreditation of Hospitals. (Educational services provided while at an approved treatment facility is not eligible).
5. It is a birth center that is licensed, certified, or approved by a department of health or other regulatory authority in the state where it operates or meets all of the following tests:
    - It is equipped and operated mainly to provide an alternative method of childbirth.
    - It is under the direction of a doctor.
    - It allows only doctors to perform surgery.
    - It requires an exam by an obstetrician at least once before delivery.
    - It offers prenatal and postpartum care.
    - It has at least two birthing rooms.
    - It has the necessary equipment and trained people to handle foreseeable emergencies. The equipment must include a fetal monitor, incubator, and resuscitator.
    - It has the services of registered graduate nurses.
    - It does not allow patients to stay more than 24 hours.
    - It has written agreements with one or more hospitals in the area that meet the tests listed above in (1) or (2) and will immediately accept patients who develop complications or require post-delivery confinement.
    - It provides for periodic review by an outside agency.
    - It maintains proper medical records for each patient. **"Hospital"** does not include a nursing home. Neither does it include an institution, or part of one, that:

- Is used mainly as a place for convalescence, rest, nursing care, or for the aged or drug addicts.
- Is used mainly as a center for the treatment and education of children with mental disorders or learning disabilities.
- Provides home-like or custodial care.

Illness — Any disorder of the body or mind.

Independent Review Organization (IRO) — An independent organization commissioned by the New Jersey Department of Banking and Insurance to review utilization management appeals that have already gone through the internal Horizon HMO appeals process.

In network — The physicians, other health care professionals and facilities that the Horizon HMO has selected and contracted with to care for it members. In-network care occurs when: your receive care from your Primary Care Physician (PCP), you received care from a participating Ob/Gyn, you received care at a participating facility; or your specialty care is coordinated by your PCP.

Injury — Damage to the body.

Local Employee — For purposes of health benefits coverage, a local employee is a full-time employee receiving a salary and working for a Participating Local Employer. Full-time shall mean employment of an eligible employee who appears on a regular payroll and who receives salary or wages for an average number of hours specified by the employer, but not to be less than 25 hours per week. It also means employment in all 12 months of the year except in the case of those employees engaged in activities where the normal work schedule is 10 months. In addition, for local coverage, employee shall also mean an appointed or elected officer of the local employer, including an employee who is compensated on a fee basis as a convenient method of payment of wages or salary but who is not a self-employed independent contractor compensated in a like manner. To qualify for coverage as an appointed officer, a person must be appointed to an office specifically established by law, ordinance, resolution, or such other official action required by law for establishment of a public office by an appointing authority. A person appointed under a general authorization, such as to appoint officers or to appoint such other officers or similar language is not eligible to participate in the program as an appointed officer. An officer appointed under a general authorization must qualify for participation as a full-time employee.

Local Employer — Government employers in New Jersey, including counties, municipalities, townships, school districts, community colleges, and various public agencies or organizations.

Maintenance Care — Care that does not substantially improve the condition. When care is provided for a condition that has reached maximum improvement and further services will not appreciably improve the condition, care will be deemed to be maintenance care and no longer eligible for reimbursement. Maintenance care services, even those that are considered to be medically needed, are not eligible for coverage under Horizon HMO.

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 medical attention to result in:

- placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of a bodily organ or part.

With respect to a pregnant woman who is having contractions, an emergency exists where there is not adequate time to affect a safe transfer to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or the unborn child.

Medical Emergency Screening Examination — An examination and evaluation within the capability of the hospital's emergency department including ancillary services routinely available to the emergency department, and performed by qualified personnel.

Medical Need and Appropriate Level of Care — A service or supply that Horizon HMO determines meets **each** of these requirements:

- It is ordered by a doctor for the diagnosis or the treatment of an illness or injury.
- The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the person's medical condition.
- That it is the most appropriate level of service or supply considering the potential benefits and harm to the patient.
- It is known to be effective in improving health outcomes (for new interventions, effectiveness is determined by scientific evidence; then, if necessary, by professional standards; then, if necessary, by expert opinion).

Medicare — The federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. Medical coverage consists of two parts: Part A is Hospital Insurance Benefits and Part B is Medical Insurance Benefits. A Retired Group member and/or spouse who are eligible for Medicare coverage by reason of age or disability must be enrolled in Parts A and B to enroll or remain in SHBP or SEHBP Retired Group coverage.

Member — An employee, retiree, COBRA enrollee or dependent who is enrolled under Horizon HMO.

Mental or Nervous Condition — A condition which manifests symptoms which are primarily mental or nervous, whether organic or non-organic, biological or non-biological, chemical or non-chemical in origin and regardless of cause, basis or inducement, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication. Mental or nervous conditions 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. Mental or nervous condition does not include substance abuse or alcoholism.

Morbid Obesity — A body mass index (BMI) greater than 40kg/m2, or a BMI greater than 35kg/m2 with associated life-threatening or disabling co-morbidities including, but not limited to, coronary heart disease, diabetes, hypertension, or obstructive sleep apnea.

Mouth Condition — A condition involving one or more teeth, the tissue or structure around them, or the alveolar process of the gums.

Nonparticipating — Physicians, health care professionals or facilities that do not contract with the Horizon HMO to provide care to Horizon HMO members. Nonparticipating may also be referred to as out-of-network or non-network.

Off-Label Use — A drug not approved by the FDA for treatment of the condition in question or prescribed at a different dosage than the approved dosage.

Participating Provider — A Primary Care Physician, specialty care physician or other medical services professional or organization (hospitals, laboratory facilities etc.) that contracts with the Horizon HMO: or a behavioral health and substance abuse care participating facility or participating practitioner. Participating may also be referred to as in-network.

Precertification — A process by which the eligibility and medical appropriateness of services or supplies is determined before services are rendered.

Primary Care Physician (PCP) — A duly licensed family practitioner, general practitioner, internist or pediatrician who has entered into an agreement with the Horizon HMO 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 PCP where Horizon HMO so agrees.

Primary Health Plan — A plan which pays benefits for a member's covered charge first, ignoring what the member's secondary plan pays. A secondary health plan then pays the remaining unpaid expenses in accordance with the provisions of the member's secondary health plan.

Prior authorization/preapproval — Written approval by the Horizon HMO prior to the date of service for a physician or other health care professional or facility to provide specific services or supplies.

Provider — The term is used to define a participating provider and includes medical doctors, dentists, podiatrists, acupuncturists, psychologists, psychiatrists, physician assistants, nurse midwives, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, board certified behavior analysts – doctoral (BCBA – D), board certified behavior analysts (BCBA), ABA therapist credentialed by the National Behavior Analyst Certification Board (BACB) or working under the direct supervision of a BCBA or BCBBA-D, chiropractors, certified nurse practitioners, clinical nurse specialists, Registered Nurse First Assistants (RNFA), physical therapists, occupational therapists, optometrists, and audiologists who are properly licensed and are working within the scope of their practice.

Referral — The recommendation by your PCP for you to receive care from a participating physician or facility.

Residential Treatment Facility — A health care facility licensed, by the State of New Jersey for treatment of alcoholism or substance abuse or meeting the same standards, if out-of-state.

Respite Care — Short-term or temporary care provided for the hospice patient in order to provide relief, or respite to the family caregiver.

Retired Group Member — An eligible retiree of a state-administered or local public pension fund who has met the requirements for participation and has completed a form constituting written notice of election to enroll for Retired Group coverage in the SHBP or SEHBP for

him/herself and, if applicable, any eligible dependents. Also includes a surviving spouse of a deceased Retired Group member who has met the requirements for and has completed a form constituting written notice of election to enroll in Retired Group coverage for him/herself and, if applicable, any eligible dependents. Also includes a surviving dependent child of a deceased Retired Group member who had parent-child(ren) coverage, providing he or she has completed a form constituting written notice of election to enroll in Retired Group coverage.

School Employees' Health Benefits Commission — The entity created by N.J.S.A. 52:14-17.46 and charged with the responsibility of overseeing the School Employee's Health Benefits Program.

School Employees' Health Benefits Program (SEHBP) — The SEHBP was established by Chapter 103, P.L. 2007. It offers medical and prescription drug coverage to qualified school employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SEHBP. The School Employees' Health Benefits Program Act is found in the N.J.S.A. 52:14-17.46 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

SEHBP Member — An individual who is either a School Employees' Health Benefits Program Active Group, Retired Group, or COBRA participant and their dependents.

SHBP Member — An individual who is either a State Health Benefits Program Active Group, Retired Group, or COBRA participant and their dependents.

Skilled Nursing Facility — A facility which is approved by either the Joint Commission on Accreditation of Health Care Organizations or the Secretary of Health and Human Services and provides skilled nursing care and services to eligible persons. The skilled nursing facility provides a specific type of treatment that falls midway between a hospital that provides care for acute illness and a nursing home that primarily provides custodial, maintenance or supportive care as well as assistance with daily living.

Specialty care — Services provided by a health care professional whose practice is limited to a specific area of medicine (i.e. orthopedics, dermatology, physical therapy, chiropractic manipulation, etc.).

State Biweekly Employee — For health benefits purposes, state biweekly employee means a full-time employee of the State, or an appointed or elected officer, paid by the State's centralized payroll system whose benefits are based on a biweekly cycle. Full-time normally requires 35 hours per week.

State Health Benefits Commission — The entity created by N.J.S.A. 52:14-17.27 and charged with the responsibility of overseeing the State Health Benefits Program.

State Health Benefits Program (SHBP) — The SHBP was originally established by statute in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP and its plans. The State Health Benefits Program Act is found in the N.J.S.A. 52:14-17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

State Monthly Employee — For health benefit purposes, state monthly employee means a full-time employee of the State, or an appointed or elected officer, whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's

centralized payroll system). Full-time shall mean the usual full-time weekly schedule for the particular title, which normally requires 35 hours per week.

State Monthly Employer — Employers whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). This includes state colleges and universities and participating independent state commissions, authorities, and agencies such as:

- Rutgers, the State University of New Jersey
- Palisades Interstate Park Commission
- New Jersey Institute of Technology
- University of Medicine & Dentistry of NJ
- Thomas Edison State College
- William Paterson University
- Ramapo College of NJ
- Rowan University
- The College of New Jersey
- Montclair State University
- New Jersey City University
- Kean University
- Stockton State College
- New Jersey State Library
- New Jersey State Legislature and Legislative Offices
- New Jersey Building Authority
- New Jersey Commerce and Economic Growth Commission
- Waterfront Commission of New York Harbor
- Agencies or special projects that are supported from, or whose employees are paid from, sources of revenue other than general funds, which other funds shall bear the cost of benefits under this program

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

Supportive Care — Care for patients that have reached the maximum therapeutic benefit in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains. Supportive care services, even those that are considered to be medically appropriate are not eligible for coverage under Horizon HMO.

Surgical Center — Also called a surgicenter. An ambulatory-care facility licensed by a state to provide same-day surgical services.

Surgical Procedure — This includes cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, application

of plaster casts, electrocauterization, tapping (paracentesis), administration of pneumothorax, endoscopy, or injection of sclerosing solution.

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

Urgent Care — Outpatient or out-of-hospital medical care which, as determined by the Horizon HMO or an entity designated by the Horizon HMO, is required by an unexpected illness or injury that is not life-threatening or a medical emergency, but should be treated by a physician within 24 hours.

Waiting Period — The period of time between enrollment in the health benefits program and the date when you become eligible for benefits.

APPENDIX IV

REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, and eligible dependents receive coverage under the programs. Employees or Retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children) must submit supporting documentation in addition to the appropriate health benefits application.

Required Documentation for Dependent Eligibility and Enrollment

Dependent	Eligibility Definition	Required Documentation
Spouse	A person of the opposite sex to whom you are legally married.	A photocopy of the Marriage Certificate **and** a photocopy of the front page of the employee/retiree's most recently filed tax return* (*Form 1040*) that includes the spouse. If filing separately, submit a copy of both spouses' tax returns.
Civil Union Partner	A person of the same sex with whom you have entered into a civil union.	A photocopy of the *New Jersey Civil Union Certificate* **or** a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the front page of the employee/ retiree's most recently filed NJ tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partner's and is received at the same address.
Domestic Partner	A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or any eligible employee/retiree of a SHBP/SEHBP participating local public entity, who adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage.	A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 **or** a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the front page of the employee/retiree's most recently filed NJ tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partner's and is received at the same address.

Continued on next page

***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.*

Required Documentation for Dependent Eligibility and Enrollment

Dependent	Eligibility Definition	Required Documentation
Children	A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	**Natural or Adopted Child** – A photocopy of the child's birth certificate** showing the name of the employee/retiree as a parent. **Step Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse **or** partner as a parent **and** a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child** – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.
Dependent Children With Disabilities	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. See "Dependent Children with Disabilities" on page 7 for additional information. You will be contacted periodically to verify that the child remains eligible for continued coverage.	Documentation for the appropriate "Child" type (as noted above) **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* *(Form 1040)* that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. **Please note** that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
Continued Coverage for Over Age Children	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. See "Over Age Children until Age 31" on page 7 for additional information.	Documentation for the appropriate "Child" type (as noted above), **and** a photocopy of the front page of the child's most recently filed federal tax return* (*Form 1040*), and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

New Jersey residents can obtain records from the State Bureau of Vital Statistics and Registration Web site: *www.state.nj.us/health/vital/index.shtml* To obtain copies of other documents listed on this chart, contact the office of the Town Clerk in the city of the birth marriage, etc., or visit these Web sites: *www.vitalrec.com* or *www.studentclearinghouse.org*

***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.*

***Or a National Medical Support Notice (NMSN) if you are the non-custodial parent and are legally required to provide coverage for the child as a result of the NMSN.*

APPENDIX V

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Horizon HMO meets the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requirements.

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. This includes any prior group plan coverage that was in effect 90 days prior to the individual's effective date under the new plan. A *Certification of Coverage* form, which verifies your SHBP or SEHBP group health plan enrollment and termination dates, is available through your payroll or human resources office, should you terminate your coverage.

HIPAA Privacy

The SHBP and SEHBP make every effort to safeguard the health information of its members and comply with the privacy provisions of HIPAA, which requires that health plans maintain the privacy of any personal information relating to its members' physical or mental health. See page 89 for the *Notice of Privacy Practices*.

APPENDIX VI

NOTICE OF PRIVACY PRACTICES TO ENROLLEES IN THE NEW JERSEY STATE HEALTH BENEFITS PROGRAM AND SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE DATE: APRIL 30, 2013

Protected Health Information

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required by the federal Health Insurance Portability and Accountability Act (HIPAA) and State laws to maintain the privacy of any information that is created or maintained and relates to your past, present, or future physical or mental health. This Protected Health Information (PHI) includes information communicated or maintained in any form. Examples of PHI are your name, address, Social Security number, birth date, telephone number, fax number, dates of health care service, diagnosis codes, and procedure codes. PHI is collected through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The SHBP and SEHBP are required by law to abide by the terms of this Notice. The SHBP and SEHBP reserve the right to change the terms of this Notice. If the SHBP or SEHBP make material change to this Notice, a revised Notice will be sent.

Uses and Disclosures of PHI

The SHBP and SEHBP are permitted to use and to disclose PHI in order for our members to obtain payment for health care services and to conduct the administrative activities needed to run programs without specific member authorization. Under limited circumstances, we may be able to provide PHI for the health care operations of providers and health plans. Specific examples of the ways in which PHI may be used and disclosed are provided below. This list is illustrative only and not every use and disclosure in a category is listed.

- The SHBP or SEHBP may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The SHBP or SEHBP may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The SHBP or SEHBP receives PHI from employers, including the member's name, address, Social Security number, and birth date. This enrollment information is provided to our Business Associates so that they may provide coverage for health care benefits to eligible members.
- The SHBP or SEHBP and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.
- The SHBP or SEHBP may provide PHI to a provider, a health care facility, or a health plan that is not our Business Associate that contacts us with questions regarding the member's health care coverage.

- The SHBP or SEHBP may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The SHBP or SEHBP may use and disclose PHI for fraud and abuse detection.
- The SHBP or SEHBP may allow use of PHI by our Business Associates to identify and contact our members for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services or about treatment alternatives that may be of interest to them.
- In the event that a member is involved in a lawsuit or other judicial proceeding, the SHBP or SEHBP may use and disclose PHI in response to a court or administrative order as provided by law.
- The SHBP or SEHBP may use or disclose PHI to help evaluate the performance of our health plans. Any such disclosure would include restrictions for any other use of the information other than for the intended purpose.
- The SHBP or SEHBP may use PHI in order to conduct an analysis of our claims data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

Except as described above, unless a member specifically authorizes us to do so, the SHBP and SEHBP will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid in the conduct of business (our "Business Associates"). An authorization form may be obtained over the Internet at: *www.state.nj.us/treasury/pensions* or by sending an e-mail to: *hipaaform@treas.state.nj.us*

A member may revoke an authorization at any time.

Restricted Uses

- PHI that contains genetic information is prohibited from use or disclosure by the Programs for underwriting purposes.
- The use or disclosure of PHI that includes psychotherapy notes requires authorization from the member.

When using or disclosing PHI, the SHBP and SEHBP will make every reasonable effort to limit the use or disclosure of that information to the minimum extent necessary to accomplish the intended purpose. The SHBP and SEHBP maintain physical, technical, and procedural safeguards that comply with federal law regarding PHI. In the event of a breach of unsecured PHI the member will be notified.

Member Rights

Members of the SHBP or SEHBP have the following rights regarding their PHI.

Right to Inspect and Copy: With limited exceptions, members have the right to inspect and/or obtain a copy of their PHI that the SHBP or SEHBP maintains in a designated record set which consists of all documentation relating to member enrollment and the use of this PHI for claims resolution. The member must make a request in writing to obtain access to their PHI. The member may use the contact information found at the end of this Notice to obtain a form to request access.

Right to Amend: Members have the right to request that the SHBP or SEHBP amend the PHI that we have created and that is maintained in our designated record set.

We cannot amend demographic information, treatment records or any other information created by others. If members would like to amend any of their demographic information, please contact your personnel office. To amend treatment records, a member must contact the treating physician, facility, or other provider that created and/or maintains these records.

The SHBP or SEHBP may deny the member's request if: 1) we did not create the information requested on the amendment; 2) the information is not part of the designated record set maintained by the SHBP or SEHBP; 3) the member does not have access rights to the information; or 4) we believe the information is accurate and complete. If we deny the member's request, we will provide a written explanation for the denial and the member's rights regarding the denial.

Right to an Accounting of Disclosures: Members have the right to receive an accounting of the instances in which the SHBP, SEHBP, or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years. We will provide the member with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those made for treatment, payment or health benefits operation purposes or made in accordance with an authorization) and will not appear on the accounting.

Right to Request Restrictions: The member has the right to request that the SHBP or SEHBP place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The SHBP and SEHBP are not required to agree to any restrictions and in some cases will be prohibited from agreeing to them. However, if we do agree to a restriction, our agreement will always be in writing and signed by the Privacy Officer. The member request for restrictions must be in writing. A form can be obtained by using the contact information found at the end of this Notice.

Right to Restrict Disclosure: The member has the right to request that a provider restrict disclosure of PHI to the Programs or Business Associates if the PHI relates to services or a health care item for which the individual has paid the provider in full. If payment involves a flexible spending account or health savings account, the individual cannot restrict disclosure of information necessary to make the payment but may request that disclosure not be made to another program or health plan.

Right to Receive Notification of a Breach: The member has the right to receive notification in the event that the Programs or a Business Associate discover unauthorized access or release of PHI through a security breach.

Right to Request Confidential Communications: The member has the right to request that the SHBP or SEHBP communicate with them in confidence about their PHI by using alternative means or an alternative location if the disclosure of all or part of that information to another person could endanger them. We will accommodate such a request if it is reasonable, if the request specifies the alternative means or locations, and if it continues to permit the SHBP or SEHBP to collect premiums and pay claims under the health plan.

To request changes to confidential communications, the member must make their request in writing, and must clearly state that the information could endanger them if it is not communicated in confidence as they requested.

Right to Receive a Paper Copy of the Notice: Members are entitled to receive a paper copy of this Notice. Please contact us using the information at the end of this Notice.

Questions and Complaints

If you have questions or concerns, please contact the SHBP or SEHBP using the information listed at the end of this Notice.

If members think the SHBP or SEHBP may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the use or disclosure of their information, or to have the SHBP or SEHBP communicate with them in confidence by alternative means or at an alternative location, they must submit their complaint in writing. To obtain a form for submitting a complaint, use the contact information found at the end of this Notice.

Members also may submit a written complaint to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The SHBP and SEHBP support member rights to protect the privacy of PHI. It is your right to file a complaint with the SHBP, SEHBP, or with the US Department of Health and Human Services.

Contact Office:

Division of Pensions and Benefits — HIPAA Privacy Officer

Address:

State of New Jersey
Department of the Treasury
Division of Pensions and Benefits
PO Box 295
Trenton, NJ 08625-0295

E-mail: *hipaaform@treas.state.nj.us*

APPENDIX VII

HEALTH BENEFITS PROGRAM CONTACT INFORMATION

Addresses

SHBP/SEHBP Horizon Blue Cross Blue Shield of New Jersey

Mailing Address:

Horizon HMO
PO Box 820
Newark, NJ 07101-0820

Internet Address: *www.horizonblue.com/shbp*

Division of Pensions and Benefits — Health Benefits Bureau

Mailing Address:

Health Benefits Bureau
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299

Internet Address: *www.state.nj.us/treasury/pensions/health-benefits.shtml*

E-mail Address: *https://www.state.nj.us/treas/pensions/pensionmail.shtml*

Please indicate on all correspondence whether you are a SHBP or SEHBP member.

Telephone Numbers

Horizon Blue Cross Blue Shield of New Jersey ..... 1-800-414-7427 (SHBP)

Division of Pensions and Benefits:

Office of Client Services and Automated Information System .....(609) 292-7524

TDD Phone (Hearing Impaired) .....(609) 292-7718

State Employee Advisory Service (EAS) 24 hours a day.....1-866-327-9133

New Jersey State Police

Employee Advisory Program (EAP).....1-800-FOR-NJSP

Rutgers University Personnel Counseling Service

Employee Advisory Program (EAP).....(732) 932-7539

University of Medicine and Dentistry of New Jersey

Employee Advisory Program (EAP).....(973) 972-5429

New Jersey Department of Banking and Insurance

Individual Health Coverage Program Board.....1-800-838-0935

Consumer Assistance for Health Insurance..... (609) 292-5316 (Press 2)

New Jersey Department of Human Services

Pharmaceutical Assistance to the Aged and Disabled (PAAD).....1-800-792-9745

New Jersey Department of Health and Senior Services

Division of Aging and Community Services 1-800-792-8820

Insurance Counseling 1-800-792-8820

Independent Health Care Appeals Program .....(609) 633-0660

Centers for Medicare and Medicaid Services

New Jersey Medicare — Part A and Part B 1-800-Medicare

HEALTH BENEFITS PROGRAM PUBLICATIONS

Fact sheets, handbooks, and other publications are available for viewing or printing over the Internet at: *http://www.state.nj.us/treasury/pensions/pubslist.shtml*

General Publications

Summary Program Description booklet — an overview of the SHBP and SEHBP

Plan Comparison Summary — Out-of-pocket cost comparison charts for State employees, local government employees, local education employees, and all retirees.

Fact Sheet #11, *Enrolling in Health Benefits Coverage When You Retire*

Fact Sheet #23, *Health Benefits Coverage and Medicare Parts A & B for Retirees*

Fact Sheet #25, *Employer Responsibilities under COBRA*

Fact Sheet #26, *Health Benefits Options upon Termination of Employment*

Fact Sheet #30, *Continuation of Health Benefits Insurance under COBRA*

Fact Sheet #31, *Benefits at Termination of Employment*

Fact Sheet #37, *Employee Dental Plans*

Fact Sheet #47, *Retired Health Benefits Coverage under Chapter 330 (PFRS, LEO)*

Fact Sheet #51, *Continuing Coverage for Over Age Children with Disabilities*

Fact Sheet #60, *Voluntary Furlough Program*

Fact Sheet #66, *Health Benefits Coverage for Part-Time Employees*

Fact Sheet #69, *SHBP Coverage for State Intermittent Employees*

Fact Sheet #71, *Benefits under the Domestic Partnership Act*

Fact Sheet #73, *Retiree Dental Expense Plan*

Fact Sheet #74, *Health Benefit Coverage of Children until Age 31 under Chapter 375*

Fact Sheet #75, *Civil Unions*

Member Handbooks

NJ DIRECT Member Handbook

Horizon HMO Member Handbook

NJ DIRECT HDHP Member Handbook

Aetna Freedom and Value HD Plans Member Handbook

Aetna HMO Member Handbook

Prescription Drug Plans Member Handbook

Employee Dental Plans Member Handbook

Retiree Dental Expense Plan Member Handbook

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