

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

NJ DIRECT

MEMBER HANDBOOK

FOR EMPLOYEES AND RETIREES

ENROLLED IN THE

**STATE HEALTH BENEFITS PROGRAM OR
SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM**

PLAN YEAR 2009

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

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An online version of this handbook containing current updates is available for viewing at: www.state.nj.us/treasury/pensions/shbp.htm Be sure to check the Division of Pensions and Benefits Internet home page at: www.state.nj.us/treasury/pensions 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 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 *NJ DIRECT Member Handbook*; which describes the benefits provided in the contract with Horizon BCBSNJ. 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: pensions.nj@treas.state.nj.us

NJ DIRECT

Except where identified, the NJ DIRECT benefits described in this member handbook are identical for SHBP and SEHBP members.

NJ DIRECT is administered for the Division of Pensions and Benefits by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ).

NJ DIRECT provides both in-network and out-of-network benefits.

- **In-network** care is provided through a network of providers which includes internists, general practitioners, pediatricians, specialists, 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. Most in-network hospital admissions are covered in full. For in-patient mental health hospitalization information see page 33.
- **Out-of-network** benefits provide reimbursement for expenses for eligible services rendered for the treatment of illness and injury. Most out-of-network care is usually reimbursed at a percentage of the reasonable and customary allowance after an annual member deductible is met, see page 20. Under the SHBP, out-of-network hospital admissions are subject to a separate \$200.00 deductible per admission.

NJ DIRECT 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 79 for additional information on contacting NJ DIRECT, 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: pensions.nj@treas.state.nj.us

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 normally requires 35 hours per week.

The following categories of State employees are also eligible for coverage in NJ DIRECT15.

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 NJ DIRECT15 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 by NJ DIRECT15 up to the date of retirement. See [Fact Sheet #66](#), *Health Benefits Coverage for Part-Time Employees*, for more information.

State Intermittent Employees — Certain intermittent State employees who have worked 750 hours in a Fiscal Year (July 1 - June 30) are eligible for coverage under NJ DIRECT15. 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 in NJ DIRECT15 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 under NJ DIRECT15.

LOCAL EMPLOYEES

To be eligible for local employer coverage, you must be a full-time employee as determined by your employer or an appointed or elected officer as defined by [N.J.S.A. 40A:9](#) receiving a salary from a local government employer (county, municipality, county or municipal authority, etc.) that participates in the SHBP or a local education employer (board of education, county college, etc.) that participates in the SEHBP. Each participating local employer defines the minimum number of hours necessary to be considered full-time. It can be no less than an average of 20 hours per week. The employer is required to file a resolution with the Health Benefits Bureau of the Division of Pensions and Benefits

indicating the minimum hour requirement. 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 categories of local employees are also eligible for coverage in NJ DIRECT15.

Local Part-Time Employees — A part-time faculty member employed by a county or community college that participates in the SEHBP is eligible for NJ DIRECT15 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 by NJ DIRECT15 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 [NJ Health Benefits 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 unmarried children.

Spouse — A member of the opposite sex to whom you are legally married. A photocopy of the marriage certificate is 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 is 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) is 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 — Refers to your unmarried children under age 23 who:

- live with you in a regular parent-child relationship;
- are away at school; or
- are divorced children living at home provided that they are dependent upon you for support and maintenance.

A photocopy of your child's birth certificate is required for enrollment.

If you are a single parent, divorced, or legally separated, your children who do not live with you are eligible if you are legally required to support those children — [Affidavits of Dependency](#) and legal documentation are required with enrollment forms for these cases. If a *Qualified Medical Child Support Order* (QMCSO) is issued for your child, the health plan of the parent required to provide coverage according to the terms of the QMCSO will be the primary plan for that child. The employer must be notified of the QMCSO and a [NJ Health Benefits Application](#) submitted electing coverage for the child within 60 days of the date the order was issued.

Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you, are under the age of 23 and are substantially dependent upon you for support and maintenance. [Affidavits of Dependency](#) and legal documentation are required with enrollment forms for these cases.

Coverage for an enrolled child will end when the child marries, enters into a civil union or domestic partnership, moves out of the household, turns age 23, or is no longer dependent on you for support and maintenance. Coverage for children age 23 ends on December 31 of the year in which they turn age 23 (see the "COBRA" section on page 53, "Dependent Children with Disabilities" and "Over Age Children Until Age 31" below for continuation of coverage provisions).

Dependent Children with Disabilities — If a covered child is not capable of self-support when he or she reaches age 23 due to mental illness or incapacity, or a physical disability, the child 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 23, 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 or does not enter into a civil union or domestic partnership, 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 over age children 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;
- unmarried or not a partner in a civil union or domestic partnership;
- 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 under Chapter 375, however, vision and dental benefits may be available through COBRA (see page 53).

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 more details.

DEPENDENT ELIGIBILITY VERIFICATION AUDIT

During 2009 and 2010, a Dependent Eligibility Verification Audit of all members will be performed by Aon Consulting on behalf of the Division of Pensions and Benefits to determine if covered dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union, and/or birth certificates, and tax returns are required. Coverage for ineligible dependents will be terminated. An amnesty period will be permitted during which employees and retirees will have the opportunity to voluntarily identify and remove any ineligible dependents from coverage and therefore avoid any penalties or other legal action. After the close of the amnesty period, members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law. Failure to respond to the audit will result in the termination of dependent 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) 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 9 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 pension fund 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 8).
- 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 at retirement or when he or she becomes eligible for Medicare.
- Participants in the Alternate Benefit 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 53) — 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.

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 and the Medicare requirements (described below).

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 7), 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.

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: pensions.nj@treas.state.nj.us.

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 NJ DIRECT is supplemental to the Medicare payment. NJ DIRECT will consider the remaining Medicare coinsurance and deductible as the allowable expense and apply

the applicable copayments, coinsurance, 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

The prescription drug benefits provided through the SHBP and SEHBP Retired Group medical plans are equal to or better than the benefits provided by the standard Medicare Part D plan. Therefore, most Medicare eligible retirees and/or their Medicare eligible dependents **need not enroll** in Medicare Part D prescription drug coverage. Some SHBP or SEHBP members who qualify for low income subsidy programs may find it beneficial to enroll in Medicare Part D. However, once you and/or your dependents enroll in Medicare Part D, your SHBP or SEHBP retired group prescription drug benefits will be terminated for **both** you and your dependents.

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.**

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.

How to File a Claim If You Are Eligible for Medicare

When filing your claim, follow the procedure listed below that applies to you.

New Jersey Physicians or Providers:

- You should provide the physician or provider with your identification number. This number should be written on the *Medicare Request for Payment* (claim form) under "Other Health Insurance."
- The physician or provider will then submit the *Medicare Request for Payment* to the Medicare Part B carrier.
- After Medicare has taken action, you will receive an *Explanation of Benefits* statement from Medicare.

- If the remarks section of the *Explanation of Benefits* contains the following statement, you need not take any action: "This information has been forwarded to the Plan for their consideration in processing supplementary coverage benefits."
- If the statement shown above does not appear on the *Explanation of Benefits*, you should indicate your NJ DIRECT identification number and the name and address of the physician or provider in the remarks section of the *Explanation of Benefits* with a completed NJ DIRECT claim form and send it to the address on the claim form.

Out-Of-State Physicians or Providers:

- The *Medicare Request for Payment* form should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information.
- When you receive the *Explanation of Benefits*, indicate your identification number and the name and address of the physician or provider in the *Explanation of Benefits* with a completed claim form to the address on the claim form.

Retirees Enrolled in Medicare Who Move Outside the United States

Members who reside outside the United States must still maintain their Medicare coverage (Part A and Part B) in order to be covered under Retired Group coverage; however, Medicare does not cover services outside the United States. For members who reside outside the United States, NJ DIRECT covers services as if NJ DIRECT were primary.

Members, who reside outside the United States, even if they reside in a country with a national health plan, should consider that if they travel outside their country of residence they will still need coverage. In order to have coverage at any time in the future, the member must stay enrolled in the SHBP or SEHBP, since once a member terminates coverage they will not be reinstated.

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 NJ DIRECT.

NJ DIRECT 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 BCBSNJ.)
- Are listed in the “Eligible Services and Supplies” section on page 59.
- Are ordered by an eligible provider for treatment of illness or injury.
- Were provided while you or your eligible covered dependents were covered by NJ DIRECT.
- Are not specifically excluded (listed in the “Charges Not Covered by NJ DIRECT” section on page 38).

When you use an out-of-network provider, all services, supplies, tests, etc. prescribed by the out-of-network provider, including hospitalization, are reimbursed at a percentage of the reasonable and customary allowance after deductibles and coinsurance have been met. The member is responsible for any amount charged by the physician that is above and beyond the reasonable and customary allowance in addition to deductibles and coinsurance.

Medical Need and Appropriate Level of Care

The medical need and appropriate level of care for any service or supply is determined by Horizon BCBSNJ 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 17.

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.

PRECERTIFICATION OF BENEFITS IN-NETWORK AND OUT-OF-NETWORK

A precertification is required for certain services and all inpatient admissions. Failure to obtain a precertification may result in benefits being denied. Participating physicians and hospitals will obtain precertification on your behalf. Horizon BCBSNJ will conduct a review of any services that were not precertified to determine eligibility. If you do not obtain precertification, payment will not be made for services that are determined to be not medically appropriate.

NJ DIRECT SERVICES REQUIRING PRECERTIFICATION

Accidental Dental Injuries

Air Ambulance

Cancer Clinical Trials

Cochlear Implants

Durable Medical Equipment (DME) (see examples below)

- Electric, customized or motorized wheelchairs and scooters, and powered accessories
- Electric beds/Clinitron/power hospital beds/air mattresses/power accessories
- Enteral formula
- Bone stimulators
- Neurostimulators
- Lymphadema pumps
- External defibrillators
- All rentals

Inpatient Admissions:

- All acute care confinements, exclusive of maternities, including:
 1. Surgical admissions
 2. Medical admissions
 3. Hospice admission
 4. All Skilled Nursing Facility (SNF) confinements
- All Rehabilitation Facility confinements
- All Sub-Acute confinements
- Mental health and substance abuse confinements (including Residential, Partial Hospitalizations, and Intensive Out-Patient Admissions.)

Home Health Care Services

Home Hospice Services

Hospital Based Weight Loss Programs

Hyperbaric Oxygen Therapy

Infertility Services

- Gamete intrafallopian transfer
- In vitro fertilization
- Zygote intrafallopian transfer
- Artificial insemination
- Hysterosalpingography

Home Infusion (IV) Therapy

Mental Health and Alcohol and Substance Abuse Services

Specific Medications administered in a physician's office or dialysis facility (review performed by Care Core National)

- Aranesp
- Epogen
- Procrit

Pain Management

Private Duty Nursing in the Home (Inpatient PDN is ineligible)

Radiology (review services performed by Care Core National)

- CT/CTA Scans
- MRI/MRA
- Nuclear Medicine/Nuclear Cardiology
- PET and PET/CT Scans
- Echo Stress Tests
- Diagnostic Left Heart Catheterization.

Reconstructive Procedures that may be considered Cosmetic:

- Blepharoplasty/Canthopexy/Canthoplasty
- Excision of excessive skin due to weight loss
- Rhinoplasty/rhytidectomy
- Pectus excavatum repair
- Breast reconstruction/enlargement
- Breast reduction/mammoplasty
- Lipectomy or excess fat removal
- Sclerotherapy or surgery for varicose veins
- Facial reconstruction or repair including:
 - ✓ Orthognathic surgery
 - ✓ Bone grafts
 - ✓ Osteotomies
 - ✓ Surgical management of temporomandibular joint

- Any other potentially cosmetic procedure

Specialty Pharmaceuticals

Spinal Disk Surgeries (including but not limited to):

- Percutaneous Laser Discectomy
- Nucleoplasty
- Spinal Fusion

Surgery for Morbid Obesity (including but not limited to):

- Gastroplasty
- Gastric Bypass
- Bariatric Procedures

Therapy Services:

- Cognitive Therapy
- Occupational Therapy
- Physical Therapy
- Speech Therapy

Transplants

- Lung
- Liver
- Heart
- Pancreas
- Autologous Bone Marrow
- Cornea
- Kidney
- Autologous Chondrocyte Transplants
- Uvulopalatopharyngoplasty (UPPP)

Predetermination of Benefits

A predetermination for any service may be obtained *in writing* in advance of services being rendered. The written request will need to include the provider's name, address, and phone number, the diagnosis, a description of the services to be rendered, and the anticipated charges. Telephone contact with Horizon BCBSNJ or the Division of Pensions and Benefits about coverage does not constitute a predetermination of benefits. If the actual services rendered differ from those described in the written request, the predetermination of benefits will have no effect. A predetermination is valid for one year from the date issued. All requests for written predeterminations must include all necessary medical documentation and must be presented to Horizon BCBSNJ three to four weeks prior to the services being rendered. If Horizon BCBSNJ requires additional medical information, the written response may be delayed.

UTILIZATION MANAGEMENT (Medical Management and Review)

Both in-network and out-of-network 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. When the treatment is proposed by an in-network provider, the provider is responsible for the UM contact. Benefits are payable for in-network 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.

Out-of-network benefits that are actually payable will also depend on whether the patient or patient's provider has or has not contacted the UM organization in regard to proposed medical treatment and whether the UM organization agrees that the treatment is needed and at the appropriate level of care. If the member is utilizing a non-participating physician, they should request their non-participating physician to contact Utilization Management at the number listed on their ID card (1-800-664-2583). If a member calls this number to request precertification, the UM organization's Precertification Department will request the phone number of the physician and will contact the physician to obtain the clinical information needed in order to review the services requested.

For out-of-network benefits when the patient has failed to contact the UM organization at Horizon BCBSNJ, treatment will be considered not certified and expenses will not be applied to the annual out-of-pocket maximum. However, if the treatment is eligible, reimbursement will be made at appropriate 70/80 percent of reasonable and customary allowances after any deductible has been met.

Reasonable and Customary Allowances (for Out-of-Network Services)

NJ DIRECT covers only reasonable and customary allowances, which are determined by the Prevailing Healthcare Charges System (PHCS) fee schedule. This schedule is based on actual charges by physicians in a specific geographic area for a specific service. If your physician charges more than the reasonable and customary allowance, you will be responsible for the full amount above the reasonable and customary allowance in addition to any deductible and coinsurance you may be required to pay.

Experimental or Investigational Treatments

NJ DIRECT **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 BCBSNJ 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 BCBSNJ 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 BCBSNJ 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.

PLAN BENEFITS

Unless otherwise indicated, NJ DIRECT refers to both NJ DIRECT10 and NJ DIRECT15.

IN-NETWORK BENEFITS

You can benefit most from NJ DIRECT when you obtain your care from in-network providers. When you are treated in-network, you are covered for treatment of illness or injury in addition to well-care and preventive services. NJ DIRECT will pay, in most cases, the full cost after an appropriate member copayment per visit. **If you do not contact NJ DIRECT for prior precertification for selected services (see page 14) your claims will be paid at the out-of-network level of benefits and the amount that you are required to pay will not apply to the out-of-pocket maximums.**

Copayments

Copayments apply to in-network services unless otherwise indicated.

- **NJ DIRECT10** has a **\$10.00** copayment.
- **NJ DIRECT15** has a **\$15.00** copayment.

In-network care is provided through a network of providers that includes internists, general practitioners, specialists, pediatricians, and hospitals. No referrals are needed for visits to a specialist. If the physician participates in the Horizon BCBSNJ Managed Care Network, the member only pays the appropriate copayment. Members living outside of New Jersey can utilize physicians participating in the national Blue Cross Blue Shield Network. In-network hospital admissions are also covered in full in most cases. If the physician does not participate in the Horizon BCBSNJ Managed Care Network or the national network, the services will be considered out-of-network. Contact your doctor to see if he or she participates in the Horizon BCBSNJ Managed Care or national network. To find current participating physicians in New Jersey, use the Unified Provider Directory. To find a participating physician outside of New Jersey, contact Horizon BCBSNJ directly.

Coinsurance (In-Network)

Select in-network services require the member to pay coinsurance instead of a copayment. Examples of the types of service requiring the coinsurance are durable medical equipment, ambulance services, and prosthetic devices. Once the member reaches the in-network out-of-pocket annual maximum of \$400, NJ DIRECT will pay 100 percent of the cost of these types of covered services.

OUT-OF-NETWORK BENEFITS

NJ DIRECT includes an option for using out-of-network providers. When you exercise this out-of-network option, you will be responsible for deductibles and a percentage of coinsurance based on a reasonable and customary fee schedule, and any amount exceeding the reasonable and customary allowances for all services. NJ DIRECT's out-of-network benefits do not cover most well-care or preventive care.

The out-of-network determination is based on the participating status of the provider such as the physician, specialist, therapist, hospital/facility rendering the service. For example, if you utilize a non-participating doctor and services are provided at an in-network hospital, the

doctor will be paid at the out-of-network level as indicated above and the hospital will be paid at the in-network level.

Deductible

NJ DIRECT has one annual deductible for out-of-network benefits that the individual or family must meet before an out-of-network charge is paid. The annual deductible for out-of-network services is \$100 per individual and \$250 per family. The actual maximum deductible applied varies with the level of coverage you elect:

- **Single** – \$100
- **Member and Spouse/Partner** – \$100 per person
- **Family or Parent and Child(ren)** – \$250 in aggregate for all family members, but no more than \$100 per person

For SHBP members, an out-of-network hospital admission has a separate \$200 deductible per hospital stay.

The benefit year in which the deductible is measured runs from January 1 to December 31. However, if treatment for an illness or injury is provided during the last three months of the year, the allowable expenses that were applied toward the deductible may be allowed to 'carry over' toward meeting the deductible for the following year.

Deductible Examples:

Single Coverage — You incur an out-of-network doctor's office visit in April 2009 and the allowable expense is \$100. This is your first claim of the year and no other calendar year deductible has been met; therefore the \$100 allowable expense is applied to and satisfies the deductible for 2009.

Family Coverage/Aggregate — You and two covered family members incur an out-of-network doctor's office visit in May 2009. The allowable expense is \$85 per visit or \$255 for all three visits. These are your family's first claims of the year and no other calendar year deductible has been met; therefore \$85 for the first two visits is applied toward the family deductible (\$170) along with \$80 from the third visit (\$250.) The \$250 family deductible is met for 2009.

Family Coverage/Individual — You or a family member incur an out-of-network doctor's office visit in May 2009 and the allowable expense is \$100. This is the first claim of the year and no other calendar year deductible has been met, therefore the \$100 allowable expense is applied to and satisfies the individual deductible for 2009. The \$100 allowable expense is also applied toward the \$250 family deductible for 2009.

Deductible Carryover — You incur an out-of-network doctor's office visit in October 2009 and the allowable expense is \$90. This is your first claim of the year and no other calendar year deductible has been met; therefore the full \$90 allowable expense is applied to the deductible for 2009. Since this amount was applied in the last three months of 2009, the full \$90 will carry over and be applied toward meeting the 2010 deductible as well.

Coinsurance (Out-of-Network)

NJ DIRECT will pay a percentage of the reasonable and customary allowance for eligible out-of-network charges. You are required to pay the remaining percentage of the reasonable and customary allowance as well as the difference between the allowance and the provider's charges. When your out-of-pocket amount for the year totals \$2,000 per individual

or \$5,000 per family, the plan will pay 100 percent of the reasonable and customary allowance for eligible services.

For SEHBP members, in-network out-of-pocket expenses apply to the out-of-network out-of-pocket maximum under NJ DIRECT10. Only coinsurance goes toward in-network out-of-pocket expenses under NJ DIRECT15.

The member is responsible for any amount above the reasonable and customary allowance in addition to deductible and coinsurance liability. Expenses for ineligible services and charges in excess of the reasonable and customary allowance do not count toward your out-of-pocket maximum. Eligible services and precertified treatment count toward the NJ DIRECT maximum out-of-pocket expense level. Expenses for ineligible services and charges in excess of reasonable and customary allowances do not count toward your out-of-pocket maximums and are your financial responsibility.

OVERALL BENEFIT MAXIMUMS

For **in-network** services there is **no lifetime benefit maximum**.

For **out-of-network** services, there is a lifetime maximum benefit of **\$1,000,000** for diagnosis and treatment of illness and injuries, with an automatic limited restoration feature. If your coverage under the plan ends and begins again at a later date, your individual lifetime maximum benefit resumes at the same level it was when your coverage ended. In addition, if you transferred to NJ DIRECT from NJ PLUS or the Traditional Plan, your lifetime maximum level transfers with you. The \$1,000,000 maximum applies to all covered services and supplies incurred under any NJ DIRECT option.

Mental Health Benefit Maximums

There is a \$15,000 annual mental health benefit maximum for non-biologically based mental health conditions as well as a \$50,000 lifetime mental health benefit maximum. There is a restoration benefit that restores up to \$2,000 per year up to a lifetime maximum of \$50,000.

Services rendered for the treatment of a **biologically based mental health conditions** are treated like any other illness and are not subject to the mental health maximums. Biologically based mental illness includes, but is not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

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, NJ DIRECT 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 10), 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.

NJ DIRECT will provide its regular benefits in full when it is the primary plan. As a secondary plan, NJ DIRECT 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.

Please note: The Coordination of Benefits rules described above may change if Medicare is involved. Please refer to the Medicare sections on page 6 and page 9 for more information.

Please note: There is **no** coordination of benefits between two freestanding prescription drug plans.

GENERAL BENEFITS

This section lists the general treatments, services, and supplies that NJ DIRECT will consider. Expenses for these services or supplies are subject to reasonable and customary allowances; 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 59 for your reference. Select services require precertification (see page 14 for details). If a service is not listed, please contact Horizon BCBSNJ directly to find out if it is covered.

The fact that an item or service is not listed below, does not automatically make the service or item covered under NJ DIRECT.

Acupuncture

Acupuncture treatment is covered when the services are for **a diagnosis related to pain management** and are rendered by a Licensed Acupuncturist or Licensed Medical Doctor (M.D., D.O.). Acupuncture treatment is subject to maintenance and supportive care provisions.

Examples of acupuncture services that are **not** eligible under NJ DIRECT include weight loss and smoking cessation.

Alcoholism and Substance Abuse

NJ DIRECT covers the treatment of Alcoholism and Substance Abuse the same way it would any other illness, if such treatment is prescribed by an eligible provider and it is deemed to be medically needed and at the appropriate level of care. For scheduled or emergency treatment relating to substance abuse, or alcoholism, you or your provider **MUST** call 1-800-991-5579. You **must** obtain a precertification for all admissions.

Inpatient or outpatient treatment may be furnished as follows:

- Care provided in a state licensed health care facility.
- Care provided in a licensed detoxification facility.
- Care provided at a licensed and state approved residential treatment facility, under a plan which meets minimum standards of care.

Psychotherapy to treat alcohol or substance abuse is covered under mental health and is subject to the annual and lifetime mental health maximum benefits.

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 review before eligibility can be determined. This includes, but is not limited to, the following tests:

- RAST (Radioallergosorbent Testing)
- MAST (Multiple Radioallergosorbent Testing)
- FAST (Fluorescent Allergosorbent Testing)
- ELISA (Enzyme-Linked Immunosorbent Assay)

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 BCBSNJ at 1-800-664-2583.

NJ DIRECT **does not cover** 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.

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. Pre-approval is required for these services. See exclusions for hearing aids and hearing examinations.

Automobile-Related Injuries

NJ DIRECT will provide secondary coverage to your mandatory New Jersey Personal Injury Protection (PIP) unless NJ DIRECT has been elected as the primary coverage by or for the employee covered under NJ DIRECT. 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. NJ DIRECT 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 NJ DIRECT 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 NJ DIRECT.

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

If NJ DIRECT is one of several health insurance plans which provide benefits for automobile related injuries and 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 NJ DIRECT 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 NJ DIRECT been primary.

Biofeedback

Biofeedback to treat a medical or **biologically-based mental illness** diagnosis is covered the same as any other general condition. All mental health diagnoses, other than for biologically-based mental illness, are subject to mental health annual and lifetime maximums.

Birthing Centers

As an alternative to conventional hospital delivery room care for low-risk maternity patients, NJ DIRECT pays 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 during labor, and delivery occurs in an approved hospital because of the need for emergency or inpatient care, this care will also be covered in full. Contact Horizon BCBSNJ at 1-800-414-7427 to identify eligible birthing centers near you.

Blood

Blood, blood products, blood transfusions, and the cost of testing and processing blood are covered. NJ DIRECT 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, NJ DIRECT 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 30-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.

Congenital Defects

Surgical procedures that are necessary to correct a congenital birth defect which significantly impairs function are covered.

Dental Care

NJ DIRECT 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.

NJ DIRECT may provide coverage for the treatment of accidental dental injuries. You must have been covered by NJ DIRECT 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.

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. NJ DIRECT may cover the purchase of such items when it is less costly and more practical than renting such items. NJ DIRECT does not cover the rental or purchase of any items that do not fully meet the definition of durable medical equipment. For in and out-of-network services it is recommended that costly durable medical equipment be approved by Horizon BCBSNJ prior to purchase.

NJ DIRECT 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

A medical emergency 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.

With respect to emergency services furnished in a hospital emergency department, Horizon BCBSNJ shall not require prior authorization for the provision of such services if the member arrived at the emergency medical department with symptoms that reasonably suggested an emergency condition based on the judgment of a prudent layperson. All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered.

If you find yourself in an emergency situation and notification prior to treatment is not reasonably possible, go directly to the nearest emergency facility. All such treatment received during the first 48 hours after the onset of the medical emergency will be eligible for in-network benefits, regardless of whether such treatment is received in or out of the service area or whether such treatment is furnished by a network provider.

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 a physician. Examples of urgent care include fever, earache, cuts, sprains, and minor burns. In instances like these, call your physician first for instructions. If your physician 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 physician 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 physician for after hours care or care that is required at night or on a weekend or holiday. Again, your physician will provide instructions on how to treat your problem.

Emergency Room

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.

Federal Government Hospitals

NJ DIRECT 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.

NJ DIRECT 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. NJ DIRECT provides coverage for one routine gynecological examination per year which may include one routine Pap smear, when provided by a gynecologist.

Hearing Aids

Effective March 30, 2009, 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.

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.

NJ DIRECT **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 NJ DIRECT with a confirmed diagnosis of terminal illness and a life expectancy of six (6) months or less.

The following hospice services are covered:

- Part-time 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.
- Therapy services (including speech, physical and occupational therapies).
- Diagnostic services.

- Medical and surgical supplies.
- Durable medical equipment.
- Prescribed drugs.
- Oxygen and its administration.
- Up to 10 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.
- 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 the patient's private physician (would be paid separately under the plan).
- Volunteer services.
- Pastoral services.
- Homemaker services.
- Food or home-delivered meals.
- Non-authorized private-duty nursing services.
- Dialysis treatment.
- Bereavement counseling.

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 BCBSNJ at 1-800-414-7427.

Hospital-Based Weight Loss Programs

Hospital-based weight loss programs may be eligible for a patient diagnosed with morbid obesity. For in-network level benefits, the provider must obtain authorization from the plan. For out-of-network services, the member or provider should call Horizon BCBSNJ at 1-800-664-2583 to verify eligibility prior to enrolling in a hospital-based weight loss program.

Immunizations

Immunizations provided by an in-network physician are covered under NJ DIRECT unless they are for travel outside the country or work-related. Well-child immunizations for children less than 12 months of age are the only immunizations allowed out-of-network.

Infertility Treatment

NJ DIRECT 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.

Lead Poisoning Screening and Treatment

Lead poisoning screening (in-network only). Treatment is eligible In-Network and Out-of-Network.

Lithotripsy Centers

Lithotripsy services are covered when they are performed in an approved hospital or lithotripsy center. For information regarding the eligibility of certain centers, please call Horizon BCBSNJ at 1-800-414-7427.

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 is covered as part of the obstetrical care benefits.

NJ DIRECT 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.

Maternity/Obstetrical Care for Child Dependents

In some instances, NJ DIRECT will pay bills related to the birth of a grandchild. In order for benefits to be available, **all** of the following must apply:

- The mother must be enrolled as a dependent;
- The mother resides with the member and must be substantially dependent on the member for support and maintenance; and
- The mother is under the age of 23 and unmarried (and not in a civil union or domestic partnership).

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 (s)he obtains legal custody of the child.

Mental or Nervous Conditions and Substance Abuse

Magellan Behavioral Health is responsible for the management of your behavioral health benefit. This benefit includes treatment for both mental health 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.

Your benefit may allow treatment for mental health and alcohol and substance abuse however; precertification (prior to treatment) is required by Magellan Behavioral Health for all admissions (in-network and out-of-network). 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. Magellan Behavioral Health medical necessity determinations for mental health services are supported by Magellan Medical Necessity criteria. Substance abuse determinations are supported by the American Society of Addictions Medicine (ASAM) guidelines. The precertification process through Magellan Behavioral Health is available 24 hours a day, 7 days a week. In addition to the

precertification process, Magellan 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 Magellan Behavioral Health Medical Necessity criteria and/or the American Society of Addictions Medicine (ASAM) criteria.

Before initiating mental health and substance abuse services you must contact Magellan Behavioral Health at 1-800-991-5579. Magellan Behavioral Health will be able to assist you in finding a provider and navigating the precertification process. These services require precertification before services are provided and may result in the denial of payment for services if precertification is not obtained and the amount that you are required to pay will not be applied to the out-of-pocket maximums.

Nutritional Counseling (In-Network Only)

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

Occupational Therapy (See Physical Therapy.)

Organ Transplant Benefits

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

- Lung.
- Liver.
- Heart.
- Pancreas.
- Certain autologous bone marrow.
- Cornea (pre-approval is not required in or out-of-network).
- Kidney (pre-approval is not required in or out-of-network).

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 covered subject to medical guidelines. Pain management therapy must be supported by a comprehensive evaluation of the patient, the rationale for treatment must be well documented, and treatment must include a comprehensive program that is multifaceted and may include therapeutic exercises, activity modification, physical therapy, occupational therapy, pharmacological interventions, mental health and behavioral interventions, therapeutic and injection interventions, and surgical interventions, if needed. Treatment will not always achieve complete elimination of a patient's pain. In such cases, an increase in a patient's level of function and teaching the patient strategies to cope with residual pain will be the aim. If treatment reaches a point at which no appreciable improvement in the patient's condition is anticipated, services will be considered maintenance and/or supportive care and will not be eligible for reimbursement.

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. An annual Pap smear provided out-of-network is covered, subject to any deductible and coinsurance.

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/Occupational Therapy

Therapy that is medically needed and at the appropriate level of care is covered based on one session per day. A session of therapy is defined as up to one hour of therapy (treatment and/or evaluation) or up to three therapy modalities provided on any given day.

Physicals (In-Network Only)

Routine physical examination(s) for you and your eligible dependents are covered in-network only.

Physicals for work related purposes, sports, or other similar reasons are **not** covered.

Pre-Admission Hospital Review (In-Network and Out-of-Network)

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

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.

Scalp Hair Protheses

A benefit maximum of **\$500** in a **24** month period, per person, is covered for scalp hair protheses (wig) prescribed by a doctor, only if they are furnished in connection with hair loss resulting from:

- Treatment of disease by radiation or chemicals;

- Alopecia Universalis (totalis); or
- Alopecia Areata.

Second Surgical Opinion

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

If the second opinion specialist does not confirm the need for surgery, NJ DIRECT will provide coverage for one additional consultation if requested by the patient. NJ DIRECT 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

NJ DIRECT provides benefits for electroshock treatments, insulin shock treatments, and other similar treatments. All treatment provided will be counted towards the annual and lifetime mental health visit maximums. 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.

Speech Therapy Benefit

Speech therapy services provided by a qualified speech therapist are covered only as follows:

- **To restore speech** after a loss of a demonstrated previous ability to speak or impairment of a demonstrated previous ability to speak.
- To develop or improve speech after surgery to correct a defect that existed at birth and impaired the ability to speak 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 except for Autism and Pervasive Development Disorder (PDD).

Speech therapy services will be considered eligible for a period of one year for children with a documented medical history of multiple cases of Otitis Media and one or more myringotomy(ies).

Surgical Services (Out-of-Network)

- **Multiple Procedures**

If multiple procedures are performed during the same operative session, the procedure with the highest Relative Value Unit (RVU) will be considered the primary procedure and the full reasonable and customary allowance will be allowed for that primary procedure minus any applicable member deductible and coinsurance liability. The RVU associated with the procedure codes represents the time and skill involved in the performance of the procedure. All eligible additional procedures performed in the same operative session will be

considered secondary procedures that are paid at 50 percent of the reasonable and customary allowance.

- **Bilateral Procedures**

Bilateral procedures will be paid at 150 percent of the reasonable and customary allowance. Services qualify as bilateral when anatomically there are two specific body parts which are being operated upon during the same surgery such as ears, eyes, knees, breasts, and kidneys. A lesion on the right arm and a lesion on the left arm would not qualify as bilateral since the skin is one body organ.

- **Reasonable and Customary Allowances (for Out-of-Network Services)**

The Plan covers only reasonable and customary allowances, which are determined by the Prevailing Healthcare Charges System (PHCS) fee schedule. This schedule is based on actual charges by physicians in a specific geographic area for a specific service. If your physician charges more than the reasonable and customary allowance, you will be responsible for the full amount above the reasonable and customary allowance in addition to any deductible and coinsurance you may be required to pay.

Temporomandibular Joint Disorder (TMJ) and Mouth Conditions

Medical and surgical services performed for the treatment of the jaw are covered. Services in relation to the teeth in any manner are excluded. Charges for doctor's services or X-ray examinations for a **mouth condition** are not eligible.

Charges for dental or orthodontic services for a TMJ diagnosis are not eligible. 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 TMJ or malocclusion involving joints or muscles by methods including but not limited to crowning, wiring or repositioning of teeth and dental implants.

Vision Care Benefits

NJ DIRECT covers an annual eye examination by an in-network ophthalmologist or optometrist. There are no benefits available for frames, lenses, or contact lenses. Contact lens fitting examinations are also not covered. There is no out-of-network preventive vision care benefit.

Any visits to an ophthalmologist or optometrist for the diagnosis and treatment of a condition will be eligible at the in-network and out-of-network level of benefits.

CHARGES NOT COVERED BY NJ DIRECT

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**:

- Automobile accident-related injuries or conditions: Unless NJ DIRECT has been chosen by the member as primary, NJ DIRECT 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.
- Autopsy.
- Car Seats.
- Care that is primarily custodial in nature.
- Chair and stair lifts.
- Charges above the reasonable and customary 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 of you or your spouse/domestic partner).
- Charges for the completion of a claim form, photocopies of pertinent medical information, or medical records.
- 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.
- 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 NJ DIRECT. 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.
- Deluxe models of wheelchairs and other durable medical equipment.
- Dental Care – other than accidental injury.
- Durable medical equipment or supplies which are specifically excluded from coverage. To determine which equipment or supplies are eligible for coverage, call 1-800-414-SHBP (7427).
- 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 services or supplies and charges in connection with such services or supplies (see page 17).
- Eye care including:
 - ✓ Out-of-network examinations to determine the need for glasses or lenses of any type, typically known as refraction examinations regardless of the diagnosis.
 - ✓ 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.
- Foot conditions — charges for doctor's services for:
 - ✓ A weak, strained, flat, unstable, or imbalanced foot, metatarsalgia, or a bunion. However, this exclusion does not apply to an open cutting operation.

- ✓ One or more corns, calluses, or toenails. This exclusion does not apply to a charge for the removal of part or all of a nail root and services connected with treating metabolic or peripheral vascular disease.
- 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 plan 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 law or similar law.
- Hearing aids of any type (except as described under "Hearing Aids" on page 28).
- Hearing examinations to determine the need for hearing aids or the need to adjust a hearing aid, no matter what the cause of the hearing loss, except for members who are 15 years old or younger (see page 28).
- Herbal, Alternative or Complementary medicine treatments.
- Hot tubs, saunas, Jacuzzis or pools of any type.
- Hypnosis.
- Immunizations and preventive vaccines when out-of-network (see exceptions under "Immunizations" on page 30).
- Legal fees.
- Maintenance care — care that has reached a level where additional services will not appreciably improve the condition.
- Marriage counseling.
- Medicare services rendered by providers who opt-out of Medicare.
- 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 70 of the "Glossary" for the definition of a mouth condition.
- Nursing home care.
- 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, unless your participating employer does not provide prescription drug coverage. If your prescription drug plan does not provide benefits for a particular drug, it does not mean that it will be eligible under NJ DIRECT benefits.
- Private Duty Nursing (Inpatient).
- 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.
- Preventive care/routine screening — unless otherwise indicated, NJ DIRECT's out-of-network coverage does not provide benefits for services or supplies that are considered to be performed for any of the following:
 - ✓ Routine well-care as part of a routine examination.
 - ✓ Services and supplies that are provided for a diagnosis that does not indicate an illness present at the time the service are rendered.
 - ✓ Services that are considered preventive or screening in nature.

The following services are examples of out-of-network routine services that are **not** covered:

- ✓ All immunizations/vaccinations including well-child immunizations/vaccinations (except for children under 12 months of age).
 - ✓ Flu shots/pneumonia vaccines.
 - ✓ Well-care annual physicals.
 - ✓ Cancer antigen tests that are performed because of a family history. Specific guidelines apply to the eligibility of cancer antigen tests. Therefore, you may wish to request a pre-determination of benefits prior to having services rendered.
 - ✓ PSA (Prostate Specific Antigen) as part of a routine examination or recommended due to a family history of disease. Specific guidelines apply to the eligibility of PSA for non-routine reasons.
- Self- or home-testing kits whether prescribed by a doctor or not.
 - 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, NJ DIRECT 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 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.
- 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.
- Supportive care — supportive care is defined as treatment for patients having reached maximum therapeutic benefit in whom 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 NJ DIRECT.
- Taxes on services/supplies.
- Telephone consultations or provider charges for telephone calls.
- Transport — Non-emergency transport via ambulance or transport by coach of any kind (by land, air, or water).
- Treatment of injuries sustained while committing a felony.
- War — charges for illness or injury due to an act of war. War means either declared or undeclared, including resistance or armed aggression.
- 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 NJ DIRECT 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 NJ DIRECT, 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 NJ DIRECT 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. Other hospitals do not have that requirement. NJ DIRECT will not pay for assistant surgeons/RNFAs that are determined to be not medically necessary. Only in-network RNFAs are eligible.

THIRD PARTY LIABILITY

Repayment Agreement

If you have received benefits from NJ DIRECT for medical services that are either auto-related or work-related, Horizon BCBSNJ has the right to recover those payments. This means that if your medical expenses 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 NJ DIRECT. The repayment will only be equal to the amount paid by NJ DIRECT.

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 BCBSNJ 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 NJ DIRECT'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 BCBSNJ 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:

1. In the event that benefits are provided under this Plan, the Plan shall be subrogated to all of the Member's (the term Member includes any person receiving benefits hereunder including all dependents) rights of recovery against any person or organization to the extent of the benefits provided. 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.
2. The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with, and not exclusive of, the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.
3. 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:

- a. 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 ..
 - b. 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.
 - c. 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.
 - d. Any worker's compensation award or settlement.
 - e. Any recovery made pursuant to no-fault insurance.
 - f. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.
4. 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 (In-Network)

Generally you will not have to submit any claim forms to Horizon BCBSNJ 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 BCBSNJ for the appropriate reimbursement.

Submitting a Claim (Out-of-Network)

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

**Horizon BCBSNJ,
P.O. Box 820,
Newark NJ 07101-0820
(Phone: 1-800-414-SHBP).**

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

**Magellan/NJ DIRECT
P.O. Box 5172,
Columbia, MD 21045-5172**

Filing Deadline (Proof of Loss)

Horizon BCBSNJ must be given written proof of a loss for which a claim is made under NJ DIRECT. 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 2009, you would have until March 31, 2011, 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.

