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NEW JERSEY

STATE HEALTH BENEFITS PROGRAM

NJ PLUS

MEMBER HANDBOOK

FOR EMPLOYEES AND RETIREES

Department of the Treasury
Division of Pensions and Benefits

Administered by
Horizon Blue Cross Blue Shield of New Jersey

Plan Year 2007

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TABLE OF CONTENTS

INTRODUCTION 1

SPECIAL PLAN PROVISIONS UNDER THE SHBP 2

Women's Health and Cancer Rights Act 2

Automobile-Related Injuries 2

Work-Related Injury or Disease 3

Health Insurance Portability and Accountability Act 3

Mental Health Parity Act Requirements 3

Certification of Coverage 3

HIPAA Privacy 4

Notice of Provider Termination 4

Purchase of Individual Insurance Coverage 4

Medical Plan Extension of Benefits 4

Audit of Dependent Coverage 5

Termination for Cause 5

STATE HEALTH BENEFITS PROGRAM ELIGIBILITY 6

ACTIVE EMPLOYEE ELIGIBILITY 6

State Employees 6

Local Employees 6

Eligible Dependents 7

Medicare Coverage While Employed 8

RETIREE ELIGIBILITY 9

Aggregate of Service Credit 10

Eligible Dependents of Retirees 10

Enrolling in the Retired Group of the SHBP 10

Medicare Coverage 11

Medicare Parts A and B 11

Medicare Part D 11

Medicare Eligibility 11

How to File a Claim if You are Medicare Eligible 13

Retirees with Medicare Who Move Outside the United States 13

COBRA COVERAGE 14

Continuing Coverage When It Would Normally End 14

COBRA Events 14

Cost of COBRA Coverage 15

Duration of COBRA Coverage 15

Employer Responsibilities Under COBRA 15
Employee Responsibilities Under COBRA 15
Failure to Elect COBRA Coverage 16
Termination of COBRA Coverage 16

NJ PLUS 17
GENERAL CONDITIONS OF THE PLAN 17
Medical Need and Appropriate Level of Care 17
Reasonable and Customary Allowances 18
Experimental or Investigational Treatments 18
Educational or Developmental Services or Supplies, or Educational Testing 19
Predetermination of Benefits 19
Custodial, Maintenance, and Supportive Care 19
PRESCRIPTION DRUG BENEFITS 20
Employee Prescription Drug Plan 20
Plan Benefits 20
Prescription Drug Benefits Provided Through SHBP Health Plans 21
Employee Prescription Drug Reimbursement Plan for NJ PLUS Members 21
Retiree Prescription Drug Coverage 22
Medicare Part D 22
Prescription Drug Coverage Through NJ PLUS 22
COORDINATION OF BENEFITS 23
PLAN BENEFITS 25
In-Network Benefits 25
Selecting a Primary Care Physician (PCP) 25
How to Access Information That Will Help You Choose a PCP 25
Out-of-Network Benefits 26
Deductibles 26
Coinsurance 26
Utilization Management 27
Overall Benefit Maximums 27
Mental Health Maximums 28
SUMMARY OF COVERED SERVICES AND SUPPLIES 29
Specific Coverage Areas 29
Acupuncture 29
Alcoholism and Substance Abuse 29
Allergy Testing and Treatment 29

Ambulance 30
Audiology Services 30
Automobile-Related injuries 30
Biofeedback 31
Birthing Centers 31
Blood 31
Breast Reconstruction 31
Chiropractic Services 31
Congenital Defects 31
Dental Care 31
Diabetic Self-Management Education 32
Dialysis 33
Durable Medical Equipment and Supplies 33
Emergency Medical Services 33
Emergency Room 35
Federal Government Hospitals 35
Home Health Care 35
Home Hemophilia Treatment 36
Hospice Care Benefits 36
Hospital-Based Weight Loss Programs 37
Immunizations 37
Infertility Treatment 37
Lithotripsy Centers 37
Lyme Disease Intravenous Antibiotic Therapy 37
Mastectomy Benefit 38
Maternity/Obstetrical Care 38
Maternity/Obstetrical Care for Child Dependents 38
Mental or Nervous Conditions and Substance Abuse 38
Nutritional Counseling 39
Organ Transplant Benefits 39
Pain Management 39
Pap Smears 40
Patient Controlled Analgesia (PCA) 40
Physical Therapy 40
Pre-Admission Hospital Review 40
Pre-Admission Testing Charges 40
Preventive Care 40
Private Duty Nursing 41

Scalp Hair Prostheses 42
Second Surgical Opinion 42
Shock Therapy Benefits 42
Skilled Nursing Facility Charges 42
Speech Therapy Benefit 42
Surgical Services 43
Temporomandibular Joint Disorder (TMJ) and Mouth Conditions 43
Vision Care Benefits 43
CHARGES NOT COVERED BY THE PLAN 44
THIRD PARTY LIABILITY 49
Repayment Agreement 49
Recovery Right 49
WHEN YOU HAVE A CLAIM 50
SUBMITTING A CLAIM 50
In-Network 50
Out-of-Network 50
Filing Deadline - Proof of Loss 51
Itemized Bills are Necessary 51
Foreign Claims 51
Filling Out the Claim Form 51
Medicare Claim Submission 52
Authorization to Pay Provider 52
Questions About Claims 52
APPENDIX I 53
SUMMARY SCHEDULE OF SERVICES AND SUPPLIES 53
Your Share of Costs 53
Copayments 53
Coinsurance 53
Maximum Out-of-Pocket 54
Deductible/Out-of-Network 54
Hospital Admission Deductible 54
Maximum Plan Benefits 54
Mental Health Maximums 54
For Non-Biologically-Based Mental Illnesses 54
Eligible Services and Supplies 55
Covered Services 55

APPENDIX II 60
UTILIZATION REVIEW APPEAL PROCEDURE 60
First Level Appeal 60
Second Level Appeal 60
External Appeal 61
APPENDIX III 62
CLAIM APPEAL PROCEDURES 62
APPENDIX IV 64
SHBP MEDICAL TREATMENT POLICIES 64
Infertility Treatment 64
Eligible Services 64
Ineligible Services 66
Lyme Disease Intravenous Antibiotic Therapy 67
Diagnosis 67
Early Localized Lyme Disease 67
Early Disseminated Lyme Disease 68
Late/Chronic Disease Lyme Arthritis and Late/Chronic Disease Neuroborreliosis 68
APPENDIX V 71
GLOSSARY 71
APPENDIX VI 81
SHBP NOTICE OF PRIVACY PRACTICES 81
Protected Health Information 81
SHBP Uses and Disclosures of PHI 81
Member Rights 82
Questions and Complaints 83
STATE HEALTH BENEFITS PROGRAM CONTACT INFORMATION 85
Addresses 85
Telephone Numbers 85
STATE HEALTH BENEFITS PROGRAM PUBLICATIONS 86
General Publications 86
SHBP Fact Sheets 86
SHBP Member Handbooks 86

INTRODUCTION

The State Health Benefits Program (SHBP) was originally established in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. 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 State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the State Health Benefits Program (SHBP). The SHBC includes the State Treasurer as the chairperson, the Commissioner of the Department of Banking and Insurance, the Commissioner of the Department of Personnel, a State employee representative chosen by the Public Employees' Committee of the AFL-CIO, and a representative chosen by the New Jersey Education Association (NJEA), or their designated representatives. The Director of the Division of Pensions and Benefits is the Secretary to the SHBC. 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.

NJ PLUS is a point-of-service plan that provides both **in-network** managed care similar to an HMO plan and **out-of-network** care similar to a traditional indemnity plan.

In-network care is provided through the NJ PLUS network of providers which includes primary care physicians (PCP) 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 small copayment. In-network hospital admissions are covered in full.

Out-of-network benefits provide reimbursement for expenses for services rendered for the treatment of illness and injury. Most out-of-network care is usually reimbursed at 70 percent of the reasonable and customary allowance after an annual deductible is met.

NJ PLUS is self-funded. Funds for the payment of claims and services come from funds supplied by the State, participating local employers, and members. NJ PLUS is administered for the SHBP by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ).

An online version of this handbook containing current updates is available for viewing over the Internet 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 SHBP related forms, fact sheets, and news of any new developments affecting the benefits provided under the SHBP.

Every effort has been made to ensure the accuracy of the *NJ PLUS Member Handbook,* which describes the benefits provided and is an amendment to the contract with Horizon BCBSNJ. However, State law and the New Jersey Administrative Code govern the SHBP. **If there are discrepancies between the information presented in this handbook, and the law, regulations, or contract, the latter will govern.**

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 e-mail to: *pensions.nj@treas.state.nj.us*
Refer to page 85 for information on contacting the SHBP and its related health services.

SPECIAL PLAN PROVISIONS UNDER THE SHBP

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Effective October 21, 1998, the State Health Benefits Commission adopted as policy, the federal mandate "Women's Health and Cancer Rights Act of 1998." The mandate requires that plans which cover mastectomies, must provide coverage for breast reconstruction surgery to produce a symmetrical appearance, prostheses, and treatment of any physical complications.

AUTOMOBILE-RELATED INJURIES

The SHBP will provide secondary coverage to Personal Injury Protection (PIP) unless you choose your SHBP plan as your primary insurer on your automobile policy. In addition, if your automobile policy contains provisions that make PIP secondary or as excess coverage to your health plan, then the SHBP will automatically be primary to your PIP policy. If you elect your SHBP plan as primary, this election may affect each of your family members differently.

When the SHBP is primary to your PIP policy, benefits are paid in accordance with the terms, conditions, and limits set forth by the SHBP health plan you have chosen. Your PIP policy would be a secondary payer to whom you would submit any bills unpaid by your SHBP plan. Any portions of unpaid bills would be eligible for payment under the terms and conditions of your PIP policy.

Please note: If you are covered by the retiree group and Medicare is primary for you and/or your spouse or eligible partner, you do not have the option to select the SHBP as primary to your PIP policy.

If your SHBP plan is secondary to the PIP policy, when applicable, the actual benefits payable will be the lesser of:

- The remaining uncovered allowable expenses after the PIP policy has provided coverage. The expenses will be subject to medical appropriateness and any other provisions of your SHBP plan, after application of any deductibles and coinsurance; or
- The actual benefits that would have been payable had your SHBP plan been primary to your PIP policy.

If you are enrolled in several health plans regardless of whether you have selected PIP as your primary or secondary coverage, the plans will coordinate benefits as dictated by each plan's coordination of benefits terms and conditions. You should consult the coordination of benefits provisions in your plan’s handbook and your PIP policy to assist you in making this decision.

Please note: There is no coordination of benefits for prescription drug expenses.

WORK-RELATED INJURY OR DISEASE

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

- Injuries arising out of or in the course of work for wage or profit, whether or not your injuries are covered by a Workers' Compensation policy.
- Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.
- Work-related tests, examinations, or immunizations of any kind required by your work.

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires group health plans to implement several provisions contained within the law or notify its membership each plan year of any provisions from which they may file an exemption. Self-funded, non-federal governmental plans may elect certain exemptions from compliance with HIPAA provisions on a year-to-year basis.

Mental Health Parity Act Requirements

The State Health Benefits Commission has filed an exemption from the mental health parity requirement with the federal Centers for Medicare and Medicaid Services for calendar year 2007. As a result, maximum annual and lifetime dollar limits apply to mental health benefits under NJ PLUS, except for *biologically-based* mental illness. Maximum annual and lifetime dollar limits for mental health benefits are outlined for NJ PLUS in this handbook and are also described in the *SHBP Comparison Summary Chart* (see page 86 for information on how to obtain this publication).

All SHBP health plans meet or exceed the federal requirements with the exception of mental health parity for the Traditional Plan and NJ PLUS. Parity would require that the dollar limitations on mental health benefits are not lower than those of medical or surgical benefits.

Certification of Coverage

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

HIPAA Privacy

The State Health Benefits Program makes every effort to safeguard the health information of its members and complies with the privacy provisions of HIPAA, which requires that health plans maintain the privacy of any personal information relating to its members' physical or mental health. See page 81 for the State Health Benefits Program's *Notice of Privacy Practices*.

NOTICE OF PROVIDER TERMINATION

Any person enrolled in a managed care plan (HMO or NJ PLUS) must be provided with 90-days notice if that person's Primary Care Physician (PCP) will be terminated from the provider network. If 90-day notice cannot be provided, the managed care plan must notify the member as soon as possible. The covered person may then choose another PCP or may change coverage to another participating health benefits plan. This provision does not apply if your PCP voluntarily terminates participation with the plan.

PURCHASE OF INDIVIDUAL INSURANCE COVERAGE

Employees, retirees, and their dependents may purchase individual, direct payment coverage from their State Health Benefits Program (SHBP) health plan carrier if their loss of group health coverage is due to any reason other than voluntary termination. Note: failure to pay required premiums is considered voluntary termination.

Before considering a policy, New Jersey residents who are not Medicare eligible, should first investigate coverage available under the provisions of the New Jersey Individual Health Coverage Program. Information about available policies can be obtained from the New Jersey Individual Health Coverage Board at the Department of Banking and Insurance. Carrier and rate information can be obtained by calling 1-800-838-0935 or at *www.njdobi.org*

If you are Medicare eligible you may qualify for a Medigap policy. For more information, contact the State Health Insurance Assistance Program (SHIP) at 1-800-792-8820.

You will have 31 days from the end of your SHBP coverage to exercise your right to a direct payment policy.

MEDICAL PLAN EXTENSION OF BENEFITS

If you or a dependent are totally disabled with a condition or illness at the time of your termination from the SHBP and you have no other group medical coverage, you may qualify for an extension of benefits for this specific condition or illness. To obtain more informatiom about total disability and an extension of benefits please contact Horizon BCBSNJ for assistance.

If the extension applies, it is only for expenses relating to the disabling condition or illness. An extension under any SHBP plan will be for the time you remain totally disabled from any such condition or illness, but not beyond the end of the calendar year after the one in which your coverage ends. During an extension there will be no automatic restoration of part or all of a lifetime benefit maximum.

AUDIT OF DEPENDENT COVERAGE

Periodically, the SHBP performs an audit using a random sample of members to determine if dependents are eligible under plan provisions. Proof of dependency such as a marriage certificate or birth certificate is required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of coverage for dependents.

TERMINATION FOR CAUSE

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

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

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

If the State Health Benefits Commission sustains the termination by NJ PLUS, no further benefits are available from the day a completed application for a change of coverage to enroll in another health plan offered through the SHBP is received and processed by the Division of Pensions and Benefits, Health Benefits Bureau.

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

STATE HEALTH BENEFITS PROGRAM ELIGIBILITY

ACTIVE EMPLOYEE ELIGIBILITY

Eligibility for coverage is determined by the State Health Benefits Program (SHBP). Enrollments, terminations, changes to coverage, etc. must be presented through your employer to the SHBP. If you have any questions concerning eligibility provisions, you should call the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524.

STATE EMPLOYEES

To be eligible for NJ PLUS State employee coverage, you must work full-time 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 NJ PLUS coverage.

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 coverage under NJ PLUS and the Employee Prescription Drug Plan 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 the SHBP retired group at their own expense provided they were covered by the SHBP up to the date of retirement. See Fact Sheet #66, *SHBP Coverage for State 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) will be eligible for NJ PLUS and/or the Employee Prescription Drug Plan. Intermittent employees who maintain 750 hours of work per year continue to qualify for health benefits 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 PLUS and the Employee Prescription Drug Plan 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 for notifying the Division of Pensions and Benefits of members who are eligible.

LOCAL EMPLOYEES

To be eligible for NJ PLUS local employer coverage, you must be a full-time employee or an appointed or elected officer receiving a salary from a local employer (county, municipality, county or municipal authority, board of education, etc.) that participates in the SHBP. Each participating local employer defines the minimum hours required for full-time by a resolution filed with the SHBP, but it can be no less than an average of 20 hours per week. 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 NJ PLUS coverage.

Local Part-Time Employees — A part-time faculty member employed by a county or community college that participates in the SHBP is eligible for coverage under NJ PLUS — and if provided by the employer the Employee Prescription Drug Plan — 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 the SHBP retired group at their own expense provided they were covered by the SHBP up to the date of retirement. See Fact Sheet #66, *SHBP Coverage for State Part-Time Employees,* for more information.

ELIGIBLE DEPENDENTS

Your eligible dependents are your spouse, civil union partner, or eligible same-sex domestic partner and/or your eligible unmarried children (see definitions below).

Spouse — This is 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 — This is a member 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 — This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another 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 — This includes your unmarried children under age 23 who live with you in a regular parent-child relationship, your children who are away at school, as well as divorced children living at home provided that they are dependent upon you for support and maintenance. 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 named in the QMCSO will be the primary plan for that child. The employer must be notified of the QMCSO and a *NJ State Health Benefits Program 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 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 14, and the continuation of coverage provisions described below).

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, mental retardation, or a physical disability, he or she may be eligible for a continuance of coverage. To request continued coverage, contact the Office of Client Services at (609) 292-7524 or write to the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 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, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.

Over Age Children to Age 30 — Certain over age children may be eligible for coverage until age 30 under the provisions of Chapter 375, P.L. 2005. This includes a child by blood or law who is under the age of 30; is unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.

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

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

MEDICARE COVERAGE WHILE EMPLOYED

In general, it is not necessary for a Medicare-eligible employee, spouse, civil union partner, eligible same-sex 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 the "Medicare Coverage" section on page 11.

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.
- 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.
- 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 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 SHBP. 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 Service Credit" on page 10).
- Full-time members of the TPAF and school board or county college employees enrolled in the PERS who retire with less than 25 years of service credit from an employer that participates in the SHBP.
- Full-time members of the TPAF and 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.
- Participants in the Alternate Benefit Program (ABP) who retire with at least 25 years of credited ABP service or those who are on a long-term disability.
- 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, *SHBP Retired 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.

Eligibility for membership in the SHBP 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 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 health coverage under the Retired Group of the SHBP. (This does not include full-time TPAF retirees and PERS board of education or county college retirees with 25 or more years of service).

Note: If you continue group coverage through COBRA (see page 14 for an explanation of COBRA) — or as a dependent under other group coverage through a public or private employer — until your retirement becomes effective, you will be eligible for retired coverage under the SHBP.

Otherwise qualified employees whose coverage is terminated prior to retirement **but who are later approved for a *disability retirement*** will be eligible for coverage under the Retired Group of the SHBP 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 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. A full-time employee of a local government who has 25 years or more of service credit whose employer is enrolled 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. Effective August 15, 2001, instead of having to meet the 25-year service credit requirement from a single State or locally-administered retirement system, a retiree under the SHBP 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.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage (see page 7) except for the Medicare requirements (see page 11).

Enrolling in the Retired Group of the SHBP

The SHBP 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 the SHBP's Retired Group coverage. Early filing for retirement is recommended to prevent any lapse of SHBP coverage or delay of eligibility.

Additional restrictions and/or requirements may apply when enrolling in the Retired Group of the SHBP. Be sure to carefully read the "Retiree Enrollment" section of the *SHBP Summary Program Description* (see page 86 for information on how to obtain this publication).

MEDICARE COVERAGE

Medicare Parts A and B

IMPORTANT: A Retired Group subscriber and/or dependent(s) who are 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 Retired Group coverage.

You will be required to submit documentation of enrollment in Medicare Parts A and B when you become eligible for that coverage. Acceptable documentation includes a photocopy of your Medicare card showing both your Part A and B enrollment or a letter from Medicare indicating the effective dates of both your Parts A and 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 Parts A and B, you and/or your dependents will be terminated from the SHBP. Upon submission of proof of full Medicare coverage, your coverage will be reinstated by the SHBP on a prospective basis.

IMPORTANT: If a provider is not registered with or opts out of Medicare, no benefits are payable under the SHBP for the provider's services and, therefore, the charges would not be considered under the medical plan and the member will be responsible for the charges.

Medicare Part D

Most Medicare eligible SHBP members and/or their Medicare eligible dependents need not enroll in Medicare Part D prescription drug coverage. Some SHBP 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 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 Age***

  A member 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 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 to Medicare when the member is the subscriber, is under age 65, and is retired, or when the dependent is covered under Medicare and not covered under any active employer group 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 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, civil union partner, or eligible same-sex domestic 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 after 1996, 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** to 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 is indicated 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 NJ PLUS 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 Social Security number and the name and address of the physician or provider in the remarks section of the *Explanation of Benefits* with a completed claim form and send it to the address on the claim form of your SHBP plan.

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 remarks section and send the *Explanation of Benefits* with a completed claim form to the address on the claim form.

Retirees With Medicare Who Move Outside the United States

Medicare does not cover services outside the United States. For SHBP members who reside outside the United States, the Traditional Plan covers services as if the plan were primary.

Members who reside outside the United States must still maintain their Medicare coverage (Parts A and B) in order to be covered under the SHBP.

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

COBRA COVERAGE

CONTINUING COVERAGE WHEN IT WOULD NORMALLY END

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage. COBRA coverage is available for limited time periods (see “Duration of COBRA Coverage” on page 15), and the member must pay the full cost of the coverage plus an administrative fee.

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

Open Enrollment — COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll in any SHBP health plan and, if offered by your employer, SHBP prescription drug coverage during the SHBP Open Enrollment period regardless of whether you elected to enroll for the coverage when you went into COBRA. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If the State Health Benefits Commission makes changes to the health insurance package available to active employees and retirees, those changes apply equally to COBRA participants.

COBRA Events

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

- Termination of employment (except for gross misconduct).
- Death of the member/retiree.
- Reduction in work hours.
- Leave of absence.
- Divorce, legal separation, dissolution of civil union or same-sex domestic partnership (makes spouse, civil union partner, or same-sex domestic partner ineligible for further dependent coverage).
- Loss of a dependent child's eligibility through independence (moving out of household), the attainment of age 23, marriage, civil union, or domestic partnership.
- The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

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

Cost of COBRA Coverage

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

Duration of COBRA Coverage

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

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

COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of your **death, divorce, dissolution of a civil union or domestic partnership,** or he or she becomes ineligible for continued group coverage because of **marriage, entering into a civil union or domestic partnership, attaining age 23, or moving out of the household**, or because you **elected Medicare as your primary coverage.**

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

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

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- Notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled;
- Notify you, your spouse, civil union partner, or eligible same-sex domestic partner, and your children of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the *COBRA Notification Letter* and a *COBRA Application* within 14 days of receiving notice that a COBRA qualifying event has occurred;
- Notify the SHBP within 30 days of the loss of an employee’s coverage; and
- Maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and/or your dependents:

- Notify your employer (if you are retired, you must notify the Health Benefits

Bureau of the Division of Pensions and Benefits) that a divorce, legal separation, dissolution of a civil union or domestic partnership, or your death has occurred or that your child has married, entered into a civil union or domestic partnership, moved out of your household, or reached age 23 — notification must be given within 60 days of the date the event occurred;

- File a *COBRA Application* within 60 days of the loss of coverage or the date of the COBRA Notice provided by your employer, whichever is later;
- Pay the required monthly premiums in a timely manner; and
- Pay premiums, when billed, retroactive to the date of group coverage termination.

Failure to Elect COBRA Coverage

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

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

Termination of COBRA Coverage

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

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

NJ PLUS

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 make the service or supply eligible for a benefit under this plan.

Your Primary Care Physician (PCP) will ensure that your treatment is within the general conditions of the plan. However, if you go **out-of-network** you should know what will or will not be covered. The plan 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 NJ PLUS.)
- Are listed in the "Eligible Services and Supplies" section of this handbook.
- Are ordered by a doctor (as defined by the plan) for treatment of illness or injury.
- Were provided while you or your eligible family members were covered by the plan.
- Are not specifically excluded (listed in the "Charges Not Covered by the Plan" section on page 44).

When you go out-of-network, all services, supplies, tests, etc. prescribed by the out-of-network provider, including hospitalization, are reimbursed at 70 percent of the reasonable and customary allowance (see page 18).

Medical Need and Appropriate Level of Care

The medical need and appropriate level of care for any service or supply as recommended by the treating physician is determined by NJ PLUS and must meet **each** of these requirements:

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

When there is a question as to medical need, the decision on whether the treatment is eligible for coverage will be made by NJ PLUS.

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.

Experimental or Investigational Treatments

The plan 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 the claims administrator determines that one or more of the following is true.

- 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.
- 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. The claims administrator will determine this based on:
  - Published reports in authoritative medical literature; and
  - Regulations, reports, publications, and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the federal Food and Drug Administration (FDA).
- It is a drug, device, or other supply that is subject to FDA approval but:
  - 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; or
  - Is an FDA-regulated product, service, supply, or drug under any FDA program other than FDA approval for introduction and distribution into interstate commerce.

- 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.
- 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 a consent.
- 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.
- 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.

Educational or Developmental Services or Supplies, or Educational Testing

The plan does not cover 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 services directly related to 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.
- Services rendered at Alternative Educational Facilities.
- To promote development beyond any level of function previously demonstrated.

In the case of a hospital stay, the stay, 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.

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.

Custodial, Maintenance, and Supportive Care

NJ PLUS does not provide coverage for services that are determined to be for custodial, maintenance, and/or supportive care. Custodial care relates to services that do not require the skill level of a nurse to perform. These services include, but are not limited to, assisting with activities of daily living, meal preparation, ambulation, cleaning, and laundry functions. Maintenance

care is care that when provided does not substantially improve the condition. When care is provided for a condition that has reached maximum improvement and further services will not appreciably improve the condition, care will be deemed to be maintenance care and no longer eligible for reimbursement. Supportive care is treatment for patients having reached maximum therapeutic benefit in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains.

Regardless of whether they are medically necessary, custodial, maintenance, and/or supportive care are ineligible for reimbursement under NJ PLUS.

PRESCRIPTION DRUG BENEFITS

EMPLOYEE PRESCRIPTION DRUG PLAN

The Employee Prescription Drug Plan is offered to active State employees and their eligible dependents as a separate prescription drug plan. Local employers may also elect to provide the SHBP Employee Prescription Drug Plan to their employees as a separate prescription drug benefit.

The Employee Prescription Drug Plan is currently administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) through Caremark.

Plan Benefits

Employee Prescription Drug Plan benefits are available through a participating **retail pharmacy** or through the Caremark **mail order** and **specialty pharmacy services.**

- **Retail pharmacy** services require a copayment for each 30-day supply. Employee Prescription Drug Plan participants may obtain up to a 90-day supply of prescription drugs at participating retail pharmacies. You are required to pay two copayments for a 31 to 60-day supply or three copayments for a 61 to 90-day supply.
- **Mail order** participants can receive up to a 90-day supply of prescription drugs for one mail order copayment.
- **Specialty pharmacy services** are provided through Caremark Specialty Pharmacy which is the exclusive provider for specialty pharmaceuticals for the SHBP's prescription drug plans. Specialty pharmaceuticals are a class of medications that are typically produced through biotechnology, administered by injection, and/or require special patient monitoring and handling. If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy. If you try to fill a specialty prescription at a retail pharmacy, the pharmacy representative will advise you to contact CaremarkConnect at 1-800-237-2767. When calling, identify yourself as a State Health Benefits Program member. Caremark will contact your doctor and take care of the appropriate paperwork. Your medication will be shipped directly to your home, office, or doctor's office.

For more information about the Employee Prescription Drug Plan, copayment amounts, and specific benefits, see the *Employee Prescription Drug Plan Member Handbook* which is available from your employer, from the Division of Pensions and Benefits, or at the SHBP home page at: *www.state.nj.us/treasury/pensions/shbp.htm*

PRESCRIPTION DRUG BENEFITS PROVIDED THROUGH SHBP HEALTH PLANS

The State Health Benefits Commission requires that all participating employees and retirees have access to prescription drug coverage.

- **If you are employed by a county, municipality, board of education, or other local public employer that does not provide a separate prescription drug plan,** your SHBP health plan will include prescription drug benefits.
- **If you are eligible for prescription drug coverage through a separate drug plan provided by your employer,** your SHBP medical plan will not include prescription drug coverage and any prescription drug copayments from other group plans will not be reimbursed through the Traditional Plan, NJ PLUS, or any SHBP HMO.

Employee Prescription Drug Reimbursement Plan for NJ PLUS Members

Active employees whose employer does not offer a separate prescription drug plan have prescription drug coverage through the Employee Prescription Drug Reimbursement Plan for NJ PLUS. The Employee Prescription Drug Reimbursement Plan is accepted at most pharmacies nationwide. These pharmacies have agreed to provide prescription drugs at a discounted price to plan members. When you use a participating pharmacy, most claims can be submitted electronically to the plan for consideration.

Prescriptions will be reimbursed at 90 percent of the allowed amount.

After your NJ PLUS out-of-pocket maximum has been reached (see “Coinsurance” on page 26), you will be reimbursed 100 percent of the eligible pharmacy price under the Employee Prescription Drug Reimbursement Plan.

Mail order service is available through the Employee Prescription Drug Reimbursement Plan for NJ PLUS for active employees (including COBRA participants) who do not have a separate prescription drug plan through their employer. The mail order service is administered by Horizon Blue Cross Blue Shield of New Jersey through Caremark. Members may order maintenance prescriptions by mail or online from *caremark.com,* the mail service pharmacy owned and operated by Caremark.

Specialty pharmacy services also apply — for details see “Specialty Pharmacy Services“ on page 20.

Using a pharmacy that does not participate in the plan may result in higher out-of-pocket costs. If you have a prescription filled at a non-participating pharmacy or forget to present your Employee Prescription Drug Reimbursement Plan identification card, you will need to submit a completed claim for reimbursement.

Some prescription drugs are covered by the Employee Prescription Drug Reimbursement Plan only in certain quantities.

RETIREE PRESCRIPTION DRUG COVERAGE

Medicare Part D

Most Medicare eligible retirees and/or their Medicare eligible dependents need not enroll in Medicare Part D prescription drug coverage. Some SHBP 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 retired group prescription drug benefits will be terminated for both you and your dependents.

Prescription Drug Coverage Through NJ PLUS

Retirees enrolled in NJ PLUS have access to a separate Retiree Prescription Drug Plan that includes retail pharmacy, mail order, and specialty pharmacy services. The plan is administered by Horizon Blue Cross Blue Shield of New Jersey through Caremark, and features a three-tiered design.

Based on the design adopted at the time the plan was implemented, the copayment amounts — effective January 1, 2007 — for a 30-day supply are set at $8 for **generic** drugs (Tier I), $17 for **preferred brand name** drugs (Tier II), and $34 for **all other brand name** drugs (Tier III) when purchased at a participating retail pharmacy. You may purchase up to a 90-day supply of medication at a pharmacy when prescribed by your provider, by paying the applicable copayments (31- to 60-day supply — two copayments, 61- to 90-day supply — three copayments).

Mail order copayments for up to a 90-day supply are $8 for **generic** drugs, $25 for **preferred brand name** drugs, and $42 for **all other brand name** drugs.

Specialty pharmacy services also apply — for details see “Specialty Pharmacy Services“ on page 20.

Effective January 1, 2007, there is a $1,082 annual maximum in prescription drug copayments per person. Once a person has paid $1,082 in copayments, that person is no longer required to pay any prescription drug copayments for the remainder of the calendar year.

Note: The copayment and plan maximum amounts listed above may increase each year based upon a “set cost sharing formula” that is a part of the plan design.

A majority of pharmacies participate with Caremark, however, some do not have agreements with Caremark and are not a part of the Retiree Prescription Drug Plan. When using a non-participating pharmacy, you will be asked to pay the full cost of the prescription drug to the pharmacist and file a claim with Caremark for reimbursement. The reimbursement will be based on the participating pharmacy allowance rather than the actual charge(s) paid.

Some prescription drugs are covered by the Retiree Prescription Drug Plan only in certain quantities.

COORDINATION OF BENEFITS

Almost all group insurance plans, including NJ PLUS, provide for the coordination of benefits (COB).

Please note: The COB rules may change if Medicare is involved. Please refer to the Medicare section that begins on page 11 for more information.

For group plans that do have a COB provision, the following rules determine which is the primary plan.

- If you, the active employee, are the patient, NJ PLUS is primary for you. If your spouse, civil union partner, or eligible same-sex domestic partner is the patient, and covered under a health plan provided through his or her employer, that plan is the primary plan.
- When Medicare is involved, the benefits of the plan that covers an active employee and/or his or her dependents will be determined 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 COB 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, civil union partner, or eligible same-sex domestic 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 described above determine the order of benefits, the plan that has covered the patient for the longer period is the primary plan.

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

If you enroll in NJ PLUS and your spouse, civil union partner, or eligible domestic partner has primary coverage through another plan, your spouse/partner's visits to his or her primary care physician (PCP), under NJ PLUS, are covered in full after the appropriate copayment. Office visits to PCPs are covered under NJ PLUS as if NJ PLUS were the primary plan. All other services are subject to regular COB rules.

If your spouse, civil union partner, or eligible domestic partner is referred to a NJ PLUS specialist or goes to an in-network obstetrician/gynecologist, chiropractor, or optometrist or ophthalmologist for an annual vision examination, your spouse or partner need only give the provider the appropriate copayment plus any assistance required in completing claim forms to submit the charge to the spouse/partner's primary coverage. His or her plan will pay its benefit first, and NJ PLUS will cover the balance to the provider according to the in-network rules. If the visit is to an out-of-network provider, normal COB rules apply.

Please note: No individual can receive benefits under more than one NJ PLUS contract. There is no coordination of benefits for yourself or for any of your dependents if you and your spouse, civil union partner, or eligible domestic partner, through separate employment, have selected NJ PLUS as your plan.

PLAN BENEFITS

IN-NETWORK BENEFITS

You can benefit most from NJ PLUS when you use in-network benefits which means obtaining your care from network providers and having your care managed by your primary care physician (PCP). When you are treated in-network, you are covered for treatment of illness or injury as well as well-care and preventive services. The plan will pay, in most cases, the full cost after an appropriate copayment per visit (see page 53 for copayment information). Certain services, such as durable medical equipment, private duty nursing services, outpatient mental health care, prescription drugs, and ambulance services are paid at 90 percent. When your out-of-pocket amounts total $400 per individual/$1,000 per family, the plan will pay 100 percent of the reasonable and customary allowance for these services.

Your PCP manages the level of care you receive by referring you to the appropriate network specialists and hospitals. If your PCP determines that you require specialty care, he or she will refer you to a NJ PLUS specialist. If your PCP determines you require hospitalization, then s(he) will refer you to a NJ PLUS hospital and arrange for admission. If the specialty care or hospital service needed cannot be provided by a network specialist or hospital, then the patient will be referred to an appropriate non-network specialist or hospital. In the event this occurs, with the approval of NJ PLUS, the benefits can, in certain circumstances, be provided at the in-network level.

Selecting a Primary Care Physician (PCP)

When you enroll in NJ PLUS, you and each covered family member must select a PCP from the NJ PLUS Provider Network. Each family member may select his or her own PCP from NJ PLUS participating family practitioners, internists, general practitioners, and pediatricians. Patients may visit any participating obstetrician/gynecologist, chiropractor, or participating ophthalmologist/optometrist for related treatment without a referral from their PCP. (See the "Summary of Covered Services and Supplies" that begins on page 29 for limits on chiropractic care and vision care/annual eye examinations.)

How to Access Information That Will Help You Choose a PCP

The SHBP offers the Unified Provider Directory (UPD). Updated monthly, the UPD is available over the Internet and contains medical provider information for all of the SHBP's participating health plans. This information is in a uniform, easy to use format and displays timely and comprehensive information concerning health care providers and facilities that deliver their services through NJ PLUS. The site can be reached through the SHBP home page at: *www.state.nj.us/treasury/pensions/shbp.htm.* In addition, you may also access the *NJ PLUS Provider Directory* on the Horizon Blue Cross Blue Shield of New Jersey Web site at: *www.horizonblue.com.*

If you do not have Internet access, contact Horizon Blue Cross Blue Shield of New Jersey for provider information at 1-800-414-SHBP (7427).

OUT-OF-NETWORK BENEFITS

NJ PLUS includes an option for using out-of-network providers. When you use out-of-network providers, NJ PLUS covers hospital and other medical services similar to traditional or indemnity plans. When you exercise this out-of-network option, you incur an annual deductible and a coinsurance requirement of 30 percent of reasonable and customary allowances, and any amounts exceeding the reasonable and customary allowances. NJ PLUS out-of-network benefits do not cover well-care or preventive care. **If you use an out-of-network provider, all services, supplies, tests, etc. ordered by that provider will be paid at the out-of-network level. If your out-of-network provider contacts NJ PLUS for authorization prior to referring you to a network hospital for inpatient services, you may be eligible for in-network benefits for the facility fees.**

Deductibles

NJ PLUS has two separate deductibles. There is an annual deductible that each member must meet before an out-of-network charge is paid. There is also a deductible of $200 for each inpatient out-of-network hospital stay.

The annual individual deductible for out-of-network services is $100. The actual maximum deductible amount varies with the level of coverage that you elect:

- Single — $100;
- Member and Spouse, Civil Union Partner, or eligible Domestic Partner — $100 per person
- Parent and Child(ren) — $100 for you, $100 for one of your children, and up to $50 for any one of your other children (if more then one child) for a maximum family deductible of $250.
- Family — $100 for you, $100 for one other family member, and up to $50 for anyone of your other family members for a maximum family deductible of $250.

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 eligible charges that were applied toward the deductible may be counted toward meeting the deductible for the following year.

For example: you are charged $100 for an October 3, 2006 doctor's office visit. This is your first claim of the year and no other calendar year deductible has been met; therefore, the full $100 charge is applied to the deductible for 2007. Since this amount was applied in the last three months of 2006, the full $100 will be applied towards meeting the 2007 deductible.

If you are enrolling in the SHBP for the first time because your employer has decided to join, previously paid charges in the current calendar year can be used to meet the deductible requirements for NJ PLUS. You must submit documentation to NJ PLUS showing charges used to meet the deductible.

Coinsurance

NJ PLUS will pay 70 percent of the reasonable and customary allowance for eligible out-of-network charges. You are required to pay the other 30 percent of the cost of eligible out-of-net-

work charges up to the point at which your out-of-pocket amount for the year totals $2,000 per individual or $5,000 per family. Once the $2,000 out of pocket amount has been reached, the plan will pay 100 percent of the reasonable and customary allowance for that individual. Since the coinsurance applies to each person in your family, the actual amount you are required to pay each year will depend on the number of dependents on your coverage. 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 allowances do not count toward your out-of-pocket maximums. **Additionally, only preauthorized treatments count toward the NJ PLUS maximum out-of-pocket expense level.**

UTILIZATION MANAGEMENT

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 at the appropriate level of care (see page 17).

- When the treatment is proposed by an **in-network** provider, the provider is responsible for the UM contact.
- **Out-of-network** benefits that are actually payable will also depend on whether the patient or the provider of service 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.

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. Benefits would also be paid on this basis to an out-of-network provider in those instances where the patient is referred to an out-of-network provider by their PCP and it is authorized by NJ PLUS.

For out-of-network benefits when the patient or the provider of service has failed to contact the UM organization, treatment will be considered as unauthorized and expenses will not be applied to the annual out-of-pocket maximum (see also the UM appeal procedures on page 60). However, if the treatment is eligible, reimbursement will be made at 70 percent of reasonable and customary allowances if the deductible has been met.

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. Once the maximum lifetime benefit has been paid out, at the start of each calendar year, any previously unused portion of a covered person's maximum will be carried over and **$2,000** or the lesser amount needed to restore the full maximum will also be made available for benefits for that covered person.

If your coverage under NJ PLUS ends and begins again at a later date, your individual lifetime maximum benefit resumes at the same level it was when your coverage ended.

Mental Health Maximums

The maximum benefits for non-biologically-based mental or nervous conditions are listed on page 57. NJ PLUS also contains a unique automatic restoration provision, which can restore benefits issued for non-biologically-based mental illnesses. This special restoration of benefits is in addition to the restoration provision for the overall plan lifetime benefit maximum. This provision is applicable in the calendar year immediately following the initial calendar year in which benefits are paid for mental illness. The patient must be a covered person at the beginning of the year the restoration begins. The maximum that may be restored in a calendar year is **$2,000.** The amount restored will be the lesser of **$2,000** or the amount that will bring the total lifetime benefits to **$50,000.** A maximum restoration of **$50,000** is available for the lifetime of the patient. Services for mental and nervous disorders, that are non-biologically-based, have a **$15,000** annual maximum/**$50,000** lifetime maximum with a **$2,000** automatic restoration provision for all in-network or out-of-network services.

SUMMARY OF COVERED SERVICES AND SUPPLIES

SPECIFIC COVERAGE AREAS

This section lists the various treatments, services, and supplies that NJ PLUS 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 Covered Services and Supplies; and benefit limitations and exclusions.

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 (see page 19).

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

Alcoholism and Substance Abuse

NJ PLUS 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. If you need care, you must contact NJ PLUS directly. You do not need a referral from your PCP for this care. For scheduled or emergency treatment relating to substance abuse, or alcoholism, you or your provider should call 1-800-991-5579. You must obtain a pre-treatment authorization for all in-network admissions. If you choose to receive your care out-of-network, you should also call NJ PLUS for pre-treatment authorization so that your coinsurance amounts, for these services, are applied to your out-of-pocket maximum.

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 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 eligible 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 precertified by calling NJ PLUS at 1-800-414-SHBP (7427).

NJ PLUS 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 needed and at the appropriate level of care. Pre-approval is required for these services to be considered at the in-network level of benefits. See exclusions on page 46 for hearing aids and hearing examinations.

Automobile-Related Injuries

NJ PLUS will provide secondary coverage to your mandatory New Jersey Personal Injury Protection (PIP) unless NJ PLUS has been elected as the primary coverage by or for the employee covered under this contract. 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 PLUS may be primary for one member, but not for another if the persons have separate auto policies and have made different selections regarding primacy of health coverage.

NJ PLUS is secondary to automobile insurance coverage. However, if the automobile insurance contains provisions which made the automobile insurance coverage secondary or excess to NJ PLUS, NJ PLUS will be primary.

If NJ PLUS 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 (see “Coordination of Benefits” on page 23) and only for those services normally covered under NJ PLUS.

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

If NJ PLUS 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.

Please note: There is no coordination of benefits for prescription drug expenses.

If NJ PLUS 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 PLUS been primary.

Biofeedback

Biofeedback to treat a medical or **biologically-based mental illness** diagnosis is covered the same as any other general condition. Mental health diagnoses that are considered non-biologically-based in nature will be subject to the mental health plan maximums under NJ PLUS.

Birthing Centers

As an alternative to conventional hospital delivery room care for low-risk maternity patients, NJ PLUS pays for care in birthing centers under contract with Horizon BCBSNJ. 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 NJ PLUS at 1-800-414-SHBP (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 PLUS 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 PLUS 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 benefit maximum for chiropractic services per person per calendar year**.** The chiropractor must be licensed, the services must be appropriate for the diagnosed condition(s), and must fall within the scope of practice of a chiropractor in the state in which he or she is practicing.

No referral is needed for the in-network level of coverage.

Congenital Defects

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

Dental Care

NJ PLUS 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.

Dental care that is required due to a medical condition, drug therapy, or medical care that has been rendered to treat a medical condition, is considered dental and not eligible for benefits under NJ PLUS.

NJ PLUS may provide coverage for the treatment of accidental dental injuries. You must have been covered by NJ PLUS 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. Examples of ineligible dental services include, but are not limited to, breaking a tooth on a popcorn seed, olive pit, or on a bone in a piece of meat.

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 under NJ PLUS.

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 who can submit convincing documentation for the medical need for the hospitalization/anesthesic services. Charges for the actual dental procedures would not be eligible for benefit under NJ PLUS.

Orthodontia is not covered.

Diabetic Self-Management Education

Benefits, limited to four visits per year, are included for expenses incurred for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of the member's condition.

- Benefits for self-management education and education relating to diet shall be limited to medically necessary visits upon:
  - The diagnosis of diabetes;
  - The diagnosis by a physician or nurse provider/clinical nurse specialist of a significant change in your symptoms or conditions which necessitate changes in your self-management; and
  - Determination of 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 free-standing 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.

Durable Medical Equipment and Supplies

Charges for the rental of durable medical equipment needed for therapeutic use are covered. NJ PLUS may cover the purchase of such items when it is less costly and more practical than renting such items. NJ PLUS does not cover the rental or purchase of any items which 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 NJ PLUS prior to purchase.

NJ PLUS 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.

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, NJ PLUS 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, regardless of whether the hospital was affiliated with NJ PLUS. All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered by NJ PLUS.

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. You must notify your PCP and/or NJ PLUS of the medical emergency within those 48 hours. Your PCP must then authorize the continuation of any necessary medical services in order for any such treatment received after those first 48 hours to continue being eligible for in-network benefits. This means if you are admitted to the hospital through the emergency room, you must notify your PCP and/or NJ PLUS of the emergency and get authorization for treatment and hospital days beyond the first 48 hours. If you do not notify your PCP and/or NJ PLUS within 48 hours, you will not receive in-network benefits.

- ***Urgent and After Hours Care***

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

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

  If you go directly to an emergency facility for urgent or after hours care and your situation is not a medical emergency, your care will not be covered at the in-network level of benefits.

- ***Away From Home Care***

  Under NJ PLUS you are covered for urgent care when traveling or away from home. Urgent care is medically needed and at the appropriate level of care for an unexpected illness or injury, not a life threatening condition, but one that should be treated before you return home. If you are traveling out of the service area and need urgent care, call NJ PLUS at 1-800-414-SHBP (7427) before receiving care from a local doctor. If you are unable to contact NJ PLUS before receiving care, call within 48 business hours of receiving care.

  When you call NJ PLUS before receiving care or within 48 business hours, eligible, medically needed and appropriate level of care services will be paid at the in-network

level of benefits. Any necessary follow-up care must be performed or referred by your PCP to receive the in-network level of benefits. Follow-up care that is not performed or referred by your PCP will be paid at the out-of-network level of benefits.

For all medical emergencies, present your NJ PLUS identification card to the hospital representative at the time of treatment. The identification card contains all necessary emergency instructions.

Emergency Room

Each time the member uses the hospital emergency room, the member must pay a copayment as designated in the "Summary Schedule of Services and Supplies" (see page 53). If the member is admitted within 24 hours, the copayment amount is waived.

Federal Government Hospitals

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

NJ PLUS 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.

Home Health Care

Home health care services and supplies are covered only if furnished by providers on a part-time or intermittent basis. Pre-approval of a skilled need 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 60 days.

Eligible home health services 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 (see page 42).
- 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 PLUS 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 primarily custodial in nature.

Home Hemophilia Treatment

Home hemophilia treatment will be considered when there is documented medical evidence that these services cannot be performed in an outpatient facility. Home hemophilia treatment needs to be authorized by NJ PLUS Utilization Management (see page 27).

Hospice Care Benefits

Benefits for hospice must be provided according to a physician prescribed course of treatment approved by NJ PLUS 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 (with prior authorization) and 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 NJ PLUS at 1-800-414-SHBP (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 should obtain authorization from NJ PLUS. For out-of-network services, call NJ PLUS at 1-800-414-SHBP (7427) to verify eligibility prior to enrolling in a hospital-based weight loss program.

- ***Inpatient Hospital-Based Weight Loss Programs*** — Inpatient hospital-based weight loss services must be authorized and reviewed for medical eligibility for both in-network and out-of-network benefits. Your physician should call NJ PLUS Utilization Management prior to admission (see page 27).

Immunizations

Immunizations are covered under NJ PLUS at the in-network level of benefits , however, travel immunizations and work-related immunizations are not eligible.

Well-child immunizations for children less than 12 months of age are the only immunizations allowed at the out-of-network level.

Infertility Treatment

The State Health Benefits Program has established Assisted Reproductive Technology (ART) benefits that were effective as of July 1, 2000, for members of the Traditional Plan, NJ PLUS, and Aetna. See “Appendix IV” on page 64 for plan details.

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 NJ PLUS at 1-800-414-SHBP (7427).

Lyme Disease Intravenous Antibiotic Therapy

All intravenous antibiotic therapy for the treatment of Lyme Disease must be pre-certified by NJ PLUS. When intravenous therapy is determined to be medically appropriate, the supplies, cost of the drug, and skilled nursing visits will be covered services.

To pre-certify intravenous therapy for treatment of Lyme Disease, your provider should call NJ PLUS at 1-800-414-SHBP (7427). The State Health Benefits Program’s policy on Lyme Disease treatment is found in *Appendix IV* and begins on page 67.

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 PLUS 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 PLUS 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;
- The mother is under the age of 23 and unmarried; **or**
- The mother is an over age dependent under the provisions of Chapter 375 (see page 8).

Coverage for the grandchild ends when the mother is discharged from the hospital. The grandparent may apply for coverage of the grandchild under the SHBP only if (s)he obtains legal custody of the child.

Mental or Nervous Conditions and Substance Abuse

NJ PLUS covers treatment for mental or nervous conditions and for substance abuse, including group therapy. If you need care you must contact NJ PLUS directly. You do not need a referral from your PCP for this care. For a scheduled or emergency mental health, substance abuse, or alcoholism hospitalization, you or your provider must call 1-800-991-5579. You must obtain pre-treatment authorization for all in-network admissions. If you choose to receive your care out-of-network, you must also call NJ PLUS for certification in order for your coinsurance for these services to be applied to your out of pocket maximum. Care must be medically necessary and may be reviewed.

When the Care Manager authorizes a member's treatment for mental or nervous conditions, or substance abuse, coverage will be provided at the in-network level of benefits. Payment will be made at a reduced level, or may not be approved if the Care Manager does not manage, assess, coordinate, direct, and authorize a member's treatment for mental or nervous conditions and substance abuse before expenses are incurred. The Care Manager will review and determine if services rendered were medically needed and at the appropriate level of care.

A member may receive covered treatment as an inpatient in an eligible hospital or a substance abuse facility. The member may also receive covered treatment at an eligible hospital or outpatient substance abuse center, or from any eligible provider, psychologist or licensed clinical social worker.

Services rendered for the treatment of a **biologically-based mental illness** 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 and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Nutritional Counseling

NJ PLUS allows three visits per year for nutritional counseling that is medically needed and at the appropriate level of care. The nutritional counseling must be prescribed by a NJ PLUS network provider.

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 not required out-of-network)
- Kidney (pre-approval not required out-of-network)

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

Pain Management

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

Horizon BCBSNJ contracts with CareCore National LLC for the review and authorization of pain management services. Participating physicians will obtain prior authorization on your behalf. If you are using a non-participating provider, it is your responsibility to ensure that authorization is obtained before services are rendered. Your physician can contact CareCore at 1-866-241-6603 to request authorization. If you or your physician do not obtain prior authorization for pain management services, those services will not be eligible for reimbursement. If

services are rendered without the proper authorization, benefits will be denied. A retroactive benefit review will not be conducted.

Pap Smears

Annual Pap smears provided by your PCP or a participating OB/GYN are covered at the in-network level of benefits. 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

Physical therapy that is medically needed and at the appropriate level of care is covered based on one session per day. A session of physical therapy is defined as up to one hour of physical therapy (treatment and/or evaluation) or up to three physical therapy modalities provided on any given day. Your provider needs to contact Utilization Management to request authorization for both in- and out-of-network benefits (see page 27).

Pre-Admission Hospital Review

To obtain in-network benefits all non-emergency hospital and other facility admissions must be reviewed by NJ PLUS before they occur. You or the network hospital or your provider must notify NJ PLUS and request a Pre-Admission Review by phone or facsimile. NJ PLUS 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 NJ PLUS 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 PLUS 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 PLUS 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.

Preventive Care

Preventive care services, except mammograms, an annual Pap smear, and certain immunizations, are not covered out-of-network. In-network benefits for certain covered services and supplies relating to preventive care including related diagnostic X-rays and laboratory tests are provided. The covered preventive care benefits are as follows:

- ***Gynecological Care and Examinations (In-Network Only)***

  Gynecological care and examinations are eligible, without a referral from the member's PCP. NJ PLUS provides coverage for one routine gynecological examination per year which may include one routine Pap smear, when provided by an in-network gynecologist.

- ***Mammography***

  NJ PLUS, both in- and out-of-network, 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.
  - A woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammography at such age and interval as deemed medically needed and at the appropriate level of care by the woman's health care by the woman's health care provider.

- ***Pap Smears***

  Charges involving a routine screening Pap smear are covered. 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.

- ***Routine Physicals and Immunizations (In-Network Only)***

  Routine physical examination(s) and adult immunizations for you, your spouse, civil union partner, or eligible domestic partner, and your dependent children are covered.

- ***Well-Child Care Benefits (In-Network Only)***

  Well-child care for your enrolled dependent children is covered.

- ***Well-Child Immunizations (other than those for children less than 12 months of age) and Lead Poisoning Screening and Treatment (In-Network Only)***

  Well-child immunizations and lead poisoning screening and treatment are covered.

- ***Well-Child Immunizations (Out-of-Network)***

  Well-child immunizations are covered out-of-network for your dependent children up to the age of 12 months. Beyond the age of 12 months, they are not eligible for benefit.

- ***Prostate Cancer Screening (In-Network Only)***

  One routine office visit per benefit period 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. Benefits provided for these services at the out-of-network level are subject to medical need and the appropriate level of care for the condition being treated.

Private Duty Nursing

Inpatient Private Duty Nursing is not covered when rendered in any type of facility.

Private duty nursing must be ordered by a doctor; and provided by one of the following:

- A registered nurse (R.N.), other than yourself, your spouse/partner, or a child, brother, sister, or parent of you or your spouse/partner; or
- A licensed practical nurse (L.P.N.), other than yourself, your spouse/partner, or a child, brother, sister, or parent of you or your spouse/partner.

Private duty nursing will not be covered if the care is:

- The type of care normally provided by or that should be provided by hospital nursing staff;
- Rendered by or could be provided by home health care aides;
- Primarily custodial care or assistance in the activities of daily living in a home, or facility of any kind.

Scalp Hair Prostheses

A benefit maximum of **$500** in a **24** month period, per person, is eligible — in accordance with the Durable Medical Equipment Benefit at 90 percent at the in-network level and 70 percent at the out-of-network level — when prescribed or authorized by a doctor, and only if 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 PLUS provides coverage for a second physician's personal examination of a patient following a recommendation for any eligible surgical procedure. The plan will pay for one consultation by a qualified specialist physician.

If the second opinion specialist does not confirm the need for surgery, NJ PLUS will provide coverage for one additional consultation if requested by the patient. The plan 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 PLUS provides benefits for electroshock treatments, insulin shock treatments, and other similar treatments. All treatment provided for a **non-biologically-based mental illness** will be counted towards the annual and lifetime mental health 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, board, including diets, drugs, medicines and dressings and general nursing service in a skilled nursing facility are covered.

Speech Therapy Benefit

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

- Speech therapy services to restore speech after a loss of a demonstrated previous ability to speak or impairment of a demonstrated previous ability to speak.

- Speech therapy 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 under NJ PLUS except when deemed medically necessary for a member with autism or PDD.

In addition, 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

- ***Multiple Procedures***

  If multiple procedures are performed during the same operative session, the procedure with the highest Relative Value Unit will be considered the primary procedure and the full reasonable and customary allowance will be allowed for that primary procedure minus any applicable deductible and coinsurance liability. The Relative Value Unit associated with the procedure codes represents the time and skill involved in the performance of the procedure. All additional procedures performed in the same operative session be secondary procedures 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 for one procedure. Services qualify as bilateral when anatomically there are two specific body parts 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.

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 (In-Network Only)

NJ PLUS covers an annual eye examination by a participating ophthalmologist or optometrist. You do not need a referral from your PCP for this annual routine examination. Any visits to an ophthalmologist or optometrist other than for the annual examination will be covered at the in-network level only when you have a referral from your PCP. There are no benefits available for frames, lenses, or contact lenses for any diagnosis. Contact lens fitting examinations are also not covered. There is no out-of-network preventive vision care benefit.

CHARGES NOT COVERED BY THE PLAN

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 by NJ PLUS:

- Automobile accident-related injuries or conditions. NJ PLUS 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.
- 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/civil union partner/domestic partner, your child, brother, sister, or parent of you or your spouse/partner).
- Charges for the completion of a claim form, photocopies of pertinent medical information, or medical records.
- 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. 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.

  Note: *This provision does not apply if the condition is due to an accidental injury that occurred while the injured person is enrolled in the plan.*
- Costs involving surrogate motherhood or a gestational carrier.
- Court ordered services or treatments.
- Custom-molded shoes, regardless of diagnosis.

- Deluxe models of wheelchairs, prosthetics, and other durable medical equipment.
- 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.

  In the case of a hospital stay, the length of the stay and hospital 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.
- 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 18).
- 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.
  - Eyeglasses or lenses of any type except initial replacement for loss of the natural lens after cataract surgery.
  - 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.
- 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.
- Herbal or alternative medicine treatments.
- Hot tubs, saunas, or pools of any type.
- Hypnosis.
- Immunizations and preventive vaccines when out-of-network (see exceptions under “Preventive Care” on page 40).
- Legal fees.
- Maintenance care — care that has reached a level where additional services will not appreciably improve the condition.
- Marriage counseling.
- Medicare providers — services rendered by providers who are not registered with, or who opt out of, Medicare.
- Modifications to an auto to make it accessible and/or driveable.
- Modifications to a home to make it accessible for a disabled person.
- Mouth conditions — charges for doctor's services or X-ray examinations for a mouth condition. This exclusion applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of Temporomandibular Joint disorders (TMJ) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring, or repositioning of teeth. See page 77 of the “Glossary” for the definition of a mouth condition.
- Nursing home care.
- Orthodontia.
- 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 SHBP participating employer does not provide prescription drug coverage.

- 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 PLUS out-of-network does not provide coverage 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 <u>not</u> 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; and
  - 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. Therefore, you may wish to request a pre-determination of benefits prior to having services rendered.
- Rent, transportation, and living expenses associated with an out-of-state or out-of-country procedure are not covered.
- 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, the plan 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.

- Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed (see page 42).
- 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 PLUS.
- 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 a current 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.

  Please note: If you collect benefits for the same injury or disease from both Workers' Compensation and the State Health Benefits Program, 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 private duty nursing is not covered under the plan while confined in a hospital, because these nursing services are provided by the hospital, the 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 the plan determines that the use is so new it is experimental, the plan will not pay for the drug.

Example 4: A hospital routinely requires an assistant to be present at certain operations. Other hospitals do not have that requirement. The plan will not pay for the assistant unless it can be demonstrated that the service was medically necessary.

THIRD PARTY LIABILITY

Repayment Agreement

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

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 NJ PLUS in recovering any amounts payable. NJ PLUS 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 PLUS' 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 NJ PLUS may find necessary to recover money from all sources when a third party may be responsible for damages or injuries.

WHEN YOU HAVE A CLAIM

SUBMITTING A CLAIM

IN-NETWORK

Generally you will not have to submit any claim forms to NJ PLUS for reimbursement for treatment from your Primary Care Physician (PCP) or any other network provider. You will simply pay the provider the required copayment amount and the provider will submit directly to NJ PLUS for the appropriate reimbursement.

OUT-OF-NETWORK

If you receive treatment out-of-network, claims must be submitted to the appropriate NJ PLUS address. Participating out-of-network Horizon BCBSNJ providers will file medical claims directly. If you do not use a participating provider you must submit the claim for reimbursement.

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

NJ PLUS
199 Pomeroy Road
Parsippany, New Jersey 07054
Phone: 1-800-991-5579

All other claims should go to one of the following addresses.

The three letters that appear on your NJ PLUS ID card before your identification number — the alpha prefix — is the indicator that determines where you should send your claims.

If your alpha prefix is **NJP**, send your claims to:

NJ PLUS
Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 820
Newark, New Jersey 07101-0820
Phone: 1-800-414-SHBP (7427)

If your alpha prefix is **HHP**, send your claims to:

Empire Health Choice
P.O. Box 5049
Middletown, New York 10940-5049
Phone: 1-800-228-4708

If your alpha prefix is **FLP** (see note below), send your claims to:

Blue Cross Blue Shield of Florida
National Account Service Company
P.O. Box 2988
Jacksonville, FL 32232
Phone: 1-800-414-SHBP (7427)

Note: If your alpha prefix is FLP and Medicare is your primary coverage, send your claims to the NJ PLUS New Jersey address on page 50.

Filing Deadline - Proof of Loss

NJ PLUS must be given written proof of a loss for which a claim is made under the plan. 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 2004, you would have until March 31, 2006, to file the claim.

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

Itemized Bills are Necessary

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

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

Foreign Claims

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

Filling Out the Claim Form

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

MEDICARE CLAIM SUBMISSION

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

If a member resides in another state and has Medicare primary coverage, the member will have to submit a copy of the *Medicare Explanation of Benefits,* an itemized bill, and a completed NJ PLUS claim form to Horizon BCBSNJ (see page 13).

AUTHORIZATION TO PAY PROVIDER

The medical expense coverage provided by NJ PLUS is not assignable. However, the member (or a qualified dependent in case of the member's death) can, with the agreement of NJ PLUS, request that payment of any benefit for eligible charges payable to the member, instead be paid directly to the provider of service or supplies. Once payment is made to the provider at the member's request, NJ PLUS will not have to pay the benefit again. This direct payment is done as a courtesy to our member and is not an assignment of benefits. In order for benefits to be payable directly to a non-participating provider, the member must authorize this direction of payment by completing the appropriate section of the claim form.

The providers that participate with any Blue Cross Blue Shield plan will be paid directly for eligible services.

QUESTIONS ABOUT CLAIMS

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

If for any reason the claim is not eligible, you will be notified of its ineligibility within 90 days of receipt of your claim. To request a review of the claim, you should follow the instructions described in the “Claim Appeal Procedures” section (page 62).

APPENDIX I

SUMMARY SCHEDULE OF SERVICES AND SUPPLIES

New Jersey statutes, administrative code, and agreements between the SHBP and Horizon BCBSNJ govern this plan. The following schedule of benefits is a summary description of plan benefits. It is not complete and does not describe all the limitations or conditions associated with the coverage as described in prior sections. All pertinent parts of this handbook should be consulted regarding a specific benefit. Health decisions should not be made on the basis of the information provided in this schedule.

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

Services and supplies provided by a Primary Care Physician (PCP), which the member selected to coordinate overall health care, or through a referral by a member's PCP are covered at the in-network level.

Services and supplies provided by an out-of-network provider or a provider not referred to or coordinated by a PCP or Care Manager are covered at the out-of-network level. Most services are subject to a reasonable and customary fee allowance.

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

All treatment for mental or nervous conditions, substance abuse or alcoholism, for both the in-network and out-of-network levels of coverage, must be preapproved and coordinated by the care manager.

YOUR SHARE OF COSTS

Copayments

Copayments apply to in-network services unless otherwise indicated.

All employees, retirees, and **covered dependents** enrolled in NJ PLUS pay a **$10.00** copayment for visits to a PCP and visits to a specialist with PCP referral.

Coinsurance

In-Network	Unless otherwise indicated, eligible charges are covered in full, after any applicable copayment.
Out-of-Network.....	**30 percent** of covered charges.

Maximum Out-of-Pocket

In-Network ..... **$400** per year per individual — coinsurance only.
$1000 per year per family — coinsurance only.

Out-of-Network..... **$2,000** per year per individual.
$5,000 per year per family.

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

- Non-Covered Charges.
- Deductibles.
- Copayments.
- Amounts above the reasonable and customary allowance.

Deductible/Out-of-Network (see "Deductibles" on page 26)

$100 per Member.

$250 per Family or Parent/Child ($100 for you, $100 for a spouse, civil union partner, eligible same-sex domestic partner, or one child, and $50 for a third person)

Hospital Admission Deductible

Out-of-Network..... **$200** per admission.

MAXIMUM PLAN BENEFITS

In-Network ..... **Unlimited.** Applies to all covered services and supplies.

Out-of-Network..... **$1,000,000.** Applies to all covered services and supplies.

MENTAL HEALTH MAXIMUMS

For Non-Biologically-Based Mental Illnesses

In-Network and
Out-of-Network..... **$15,000** per calendar year/ **$50,000** lifetime.
(Combined Maximum)

ELIGIBLE SERVICES AND SUPPLIES

Covered Services

Acupuncture for Pain Management Only

In-Network . . . . . **100 percent** coverage.

Out-of-Network . . . . . **70 percent** coverage.

Inpatient Alcohol or Substance Abuse

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage, subject to **$200** hospital deductible.

Outpatient Alcohol or Substance Abuse

In-Network ..... **100 percent** coverage (no copayment).

Out-of-Network..... **70 percent** coverage.

Allergy Testing and Treatment

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Ambulance Services

In-Network..... **90 percent** coverage.

Out-of-Network ..... **70 percent** coverage.

Ambulatory Surgery

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Anesthesia

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Biofeedback for General Conditions

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Biofeedback for Non-Biologically-Based Mental Illnesses

In-Network ..... **90 percent** coverage up to Mental Health Maximums.

Out-of-Network..... **70 percent** coverage up to Mental Health Maximums.

Chiropractic Services (No Referral Required)

In-Network ..... **100 percent** coverage for maximum of 30 visits per calendar year.

Out-of-Network..... **70 percent** coverage for maximum of 30 visits per calendar year.

Diagnostic Laboratory

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Diagnostic X-ray

In-Network..... **100 percent** coverage (copayment at a facility other than a hospital).

Out-of-Network ..... **70 percent** coverage.

Dialysis Center Charges

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Durable Medical Equipment

In-Network ..... **90 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Emergency Room

In-Network ..... **100 percent** coverage, after a **$25.00** copayment* (if reported within 48 hours).
70 percent coverage (if not reported within 48 hours).

Out-of-Network..... **100 percent** coverage, after a **$25.00** copayment* (if reported within 48 hours).
70 percent coverage (if not reported within 48 hours).

*For both in- and out-of-network services the $25 copayment amount is waived if admitted.

Hospital Charges

In-Network ..... **100 percent** coverage, subject to pre-approval.

Out-of-Network..... **70 percent** coverage, subject to hospital deductible.

Home Health Care Agency

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Hospice Care

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Inherited Metabolic Disease Medical Foods

In-Network..... **90 percent** coverage.

Out-of-Network ..... **70 percent** coverage.

Inpatient Physician Services

In-Network..... **100 percent** coverage.

Out-of-Network ..... **70 percent** coverage.

Maternity/Obstetrical Care

In-Network ..... **100 percent** coverage, after a **$10.00** copayment for initial visit.

Out-of-Network..... **70 percent** coverage.

Non-Biologically-Based Mental or Nervous Conditions

- ***Inpatient***

  In-Network ..... **100 percent** coverage for up to **25** days per benefit period. Additional services will be covered at **90 percent**, subject to the annual/lifetime maximum.

  Out-of-Network..... **50** days per calendar year at **50 percent,** subject to a **$200** deductible per confinement and the annual/lifetime maximums.

- ***Outpatient***

  In-Network..... **90 percent** coverage, subject to the annual/lifetime maximum.

  Out-of-Network ..... **70 percent** coverage, subject to the annual/lifetime maximum.

- ***Inpatient Medical Visits***

  In-Network..... **100 percent** coverage, subject to the annual/lifetime maximum.

  Out-of-Network ..... **70 percent** coverage, subject to the annual/lifetime maximum.

Nutritional Counseling

In-Network ..... **100 percent** coverage (3 visits per year).

Out-of-Network..... **No coverage**.

Physical Therapy

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Pre-Admission Testing

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Preventive Care

- ***Gynecological Care and Examinations (Routine)***

  In-Network ..... **100 percent** coverage, no referral is required.

  Out-of-Network ..... **No coverage** for routine care. Care for treatment of a diagnosed condition is covered at **70 percent** coverage.

- ***Mammography***

  In-Network ..... **100 percent** coverage.

  Out-of-Network..... **70 percent** coverage.

- ***PAP Smears***

  In-Network ..... **100 percent** coverage.

  Out-of-Network..... **70 percent** coverage (annual only).

- ***Routine Physicals and Immunizations***

  In-Network ..... **100 percent** coverage.

  Out-of-Network ..... **No coverage**.

- ***Well-Child Care***

  In-Network ..... **100 percent** coverage.

  Out-of-Network ..... **No coverage**.

- ***Well-Child Immunizations***

  In-Network ..... **100 percent** coverage.

  Out-of-Network..... **70 percent** coverage, if under 12 months of age.

- ***Prostate Cancer Screening***

  In-Network ..... **100 percent** coverage.

  Out-of-Network..... **No coverage**.

Private Duty Nursing

In-Network..... **90 percent** coverage.

Out-of-Network ..... **70 percent** coverage.

Second Surgical Opinion Charges (Voluntary)

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Skilled Nursing Facility Charges

In-Network ..... **100 percent** coverage for up to 120 days per calendar year.

Out-of-Network..... **70 percent** coverage for up to 60 days per calendar year.

Specialist Services

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Specialized Non-Standard Infant Formula

In-Network..... **90 percent** coverage.

Out-of-Network ..... **70 percent** coverage.

Speech Therapy

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

Surgical Services

In-Network..... **100 percent** coverage.

Out-of-Network ..... **70 percent** coverage.

Transplant Benefits

In-Network ..... **100 percent** coverage.

Out-of-Network..... **70 percent** coverage.

APPENDIX II

UTILIZATION REVIEW APPEAL PROCEDURE

If you are not satisfied with any utilization review decision, including but not limited to hospitalization admission denials or a reduction of benefits payable, you or your provider may appeal such decision by writing to NJ PLUS. A nurse reviewer will collect any additional medical information required and submit the case to a NJ PLUS appeal physician designated by NJ PLUS. This physician will review the case with the reviewer who made the initial decision. The appeal physician may discuss the case with your provider. You or your provider will be notified of the appeal recommendation.

You (or a provider acting on your behalf and with your consent) may appeal any administrative and utilization management determinations made by NJ PLUS with respect to its coverage. These determinations involve benefit issues — including denials, terminations, or other limitations of covered services and supplies.

First Level Appeal

You initiate the appeal process by calling 1-800-414-SHBP (7427) to receive instructions on how to submit a written appeal. All First Level Appeals must be made within 12 months from the date you were notified of the original determination.

A provider initiates an appeal by writing to the provider services representative or NJ PLUS Utilization Department. All pertinent information will be reviewed by a NJ PLUS Medical Director and a decision will be made on the appeal.

A First Level Appeal must be submitted in writing, dated and signed, with the following information:

- Name(s) and address(es) of the member(s) or providers involved;
- The member's NJ PLUS identification number;
- Date(s) of service;
- Details regarding the actions in question;
- The nature and reason behind the appeal;
- The remedy sought; and
- All documentation to support the appeal.

Second Level Appeal

If either you or your provider is not satisfied with the determination made on your First Level Appeal, you can file a Second Level Appeal before other health care professionals selected by NJ PLUS who were not involved in the initial determination. You or your provider will receive notification of the final determination of the Second Level Appeal, the reasons therefore and instructions for filing an external appeal.

External Appeal

If you are dissatisfied with the results of NJ PLUS internal appeal process, you or your legal representative can appeal in writing to the State Health Benefits Commission. The right to such an appeal is contingent upon full compliance with both stages of the NJ PLUS internal appeal process.

APPENDIX III

CLAIM APPEAL PROCEDURES

You or your authorized representative may appeal and request that your health plan reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be of an administrative or medical nature. Administrative appeals might question eligibility or plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of medical need, appropriateness of treatment, or experimental and/or investigational procedures.

The following information must be given at the time of each inquiry.

- Name(s) and address(es) of patient and employee;
- Employee's identification number;
- Date(s) of service(s);
- Provider's name and identification number;
- The specific remedy being sought; and
- The reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim that was not given when the claim was first submitted, be sure to include it.

If dissatisfied with a final health plan decision on a medical or administrative appeal, only the member or the member's legal representative (this does not include the provider of service) may appeal, in writing, to the State Health Benefits Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf. Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to the following address:

Appeals Coordinator
State Health Benefits Commission
PO Box 299
Trenton, NJ 08625-0299

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

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

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

APPENDIX IV

STATE HEALTH BENEFITS PROGRAM MEDICAL TREATMENT POLICIES

INFERTILITY TREATMENT

The following State Health Benefits Program (SHBP) Assisted Reproductive Technology (ART) benefits were effective as of July 1, 2000, for members of the Traditional Plan, NJ PLUS, and Aetna HMO.

[In Vitro Fertilization (IVF), Embryo Transfer (ET), Zygote Intrafallopian Transfer (ZIFT), Gamete Intrafallopian Transfer (GIFT)]

All services must be provided at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetrics and Gynecology.

Eligible Services

- Consultations with infertility specialists and/or at comprehensive infertility centers are covered. Under the Traditional Plan and NJ PLUS out-of-network, screening tests such as HIV, routine PAP, hepatitis panels, etc., which may be required prior to infertility treatments will not be covered expenses. Under HMO and NJ PLUS in-network, those expenses will be covered.
- Ovulation Induction and Monitoring are covered.
- Laparoscopy, laparotomy, and hysteroscopy for diagnosis or treatment of infertility are covered.
- Attempts to reverse prior sterilizations are covered.
- Infertility treatment is covered if the member had a prior sterilization procedure.
- Up to six attempts at artificial insemination are covered when in concert with ovarian hyperstimulation or when using donor sperm. Artificial insemination is less invasive than other infertility procedures and significantly less expensive and should be attempted when it is likely to succeed.
- The SHBP limits the reimbursement of ART procedures (i.e., IVF[1], ZIFT[2], GIFT[3]) and related services to three attempts per successful pregnancy resulting from

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[1]IVF is In Vitro Fertilization which is a four step procedure. 1) Eggs produced by administering fertility drugs (gonadotropins) are 2) retrieved from the woman's body and 3) fertilized by sperm in a laboratory dish. The resulting embryos are 4) transferred by catheter to the uterus.

[2]ZIFT is Zygote Intrafallopian Transfer in which eggs are fertilized by sperm in a laboratory dish and resulting embryos are transferred to the woman's fallopian tubes from which they travel naturally to the uterus.

[3]GIFT is Gamete Intrafallopian Transfer wherein, following hormonal stimulation of egg production, a mixture of sperm and eggs is transferred, using a minor surgical procedure, to the fallopian tubes, where fertilization may occur.

IVF. *An attempt is recorded for IVF or ZIFT when egg harvesting or retrieval and either culture and fertilization of oocyte(s) or intracytoplasmic sperm injection (ICSI) is performed; or, with GIFT, when the gametes are actually transferred to the recipient's fallopian tube.* A successful pregnancy is defined as producing a live newborn. Embryo transfers using frozen embryos do not count as a separate IVF or ZIFT attempt. If the first three attempts are not successful, there is no further IVF, ET, ZIFT or GIFT benefit. This is a lifetime benefit maximum regardless of what plan or how many plans provided the service under the SHBP self-funded plans.

Examples of some of the related services that would be covered within the three attempts include initial consultation, office visits, cost of the drug(s), laboratory and/or radiologic procedures, testicular sperm aspiration (TESA) and percutaneous epididymal sperm aspiration (PESA) and the process of cryopreservation of embryos[4] although not the storage costs. These procedures would all be subject to the member's **deductible** and **coinsurance** or copayment requirements and any lifetime major medical benefit maximum.

- In addition, any necessary ovum or sperm donor costs would be covered, including but not limited to office visits, costs of drugs, laboratory and/or radiologic procedures, retrieval, cryopreservation, etc. but not including costs for transportation, lodging, or any compensation.
- An attempt is recorded based on the criteria as defined regardless of whether fertilization or transfer is successful. This is also true whether or not the pregnancy goes to term, results in a live birth, or if it results in an ectopic pregnancy.
- The number of embryos to be transferred must follow standards set by the American Society of Reproductive Medicine.
- Fetal reductions are covered.
- Blastocyst transfer is covered.
- Assisted hatching techniques are covered, including, but not limited to partial zona dissection, laser zona dissection, zona pellucida, or subzonal drilling.
- Microscopic assessment of oocyte(s), thawing and preparation of cryopreserved embryos, sperm identification from aspiration and preparation for transfer of embryos are covered services.
- Pre-implantation Genetic Diagnosis (PGD) requires prior authorization to determine eligibility.
- The health plan may negotiate global fees for Assisted Reproductive Technology services and procedures with providers. Global fees would include office visits, would remain at the prevailing reimbursement rate (customary charge level), and would be based on an attempt basis. Where global fees cannot be negotiated, reasonable and customary allowances will be paid.
- The process of cryopreservation and sperm banking for a male undergoing cancer treatment who may become infertile as a result are covered. Expenses for storage are not covered.

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[4]Cryopreservation is freezing of embryos after a previous ART cycle for later thawing and transferal to the uterus without the need for repeat stimulation and retrieval during subsequent cycles.

Ineligible Services

- Services or procedures that are not eligible for separate or additional reimbursement since they are considered part of another more global service or procedure include, but are not limited to:
  - Medical management fees, cycle management fees, administrative fees, and/or professional management fees billed in addition to office visits.
  - Donor compensation fees.
  - Documentation of fertilization.
  - Mock transfers.
  - Uterine sounding.
- The following services are considered investigational and therefore ineligible for benefit:[5]
  - Acrosome reaction assay - a diagnostic tool that may be used in the evaluation of male infertility or sub-fertility. The acrosome (part of the sperm) is observed under a microscope for "reaction" after being subjected to a stimulus. Based on the reaction, it is proposed that poorly fertilizing sperms can be differentiated from those with good fertilizing capacity.
  - Subzonal insemination (SUZI).
  - Intratubal insemination.
- The following are ineligible for benefit:
  - Ovulation kits or sperm testing kits and supplies.
  - Donor search fees.
  - Cycle management fees or medical management fees.
  - Storage of frozen embryos or sperm.
  - Costs involving surrogate motherhood are not covered.
  - Under the Traditional Plan and out-of-network in NJ PLUS, screening tests are not covered, including the PAP, HIV, hepatitis panels, etc. which are routinely required prior to IVF. These tests are covered under the HMO plans and in-network NJ PLUS.
  - Psychological evaluation or testing of donor(s).
  - Cryopreservation of oocytes.
  - Gestational carriers.

[5]This list is not all inclusive and does not include all investigational services and procedures. Denials are not limited to those on this list.

LYME DISEASE INTRAVENOUS ANTIBIOTIC THERAPY

All intravenous antibiotic therapy for the treatment of Lyme Disease must be pre-certified by Horizon BCBSNJ or the claims will be denied, whether or not the care was medically needed and appropriate to the level of care. When intravenous therapy is pre-certified to be medically needed and appropriate, the supplies, cost of the drug, and skilled nursing visits will be covered services.

To pre-certify intravenous therapy for treatment of Lyme Disease, please call Horizon BCBSNJ at 1-800-664-BLUE (2583).

Diagnosis

All testing should be initiated by antibody capture immunoassay, enzyme-linked immunosorbent assay (ELISA), or immunoflourescence assay (IFA) as "screening" tests. Because these tests are generally sensitive, specimens negative by ELISA or IFA need not be further tested since the diagnosis of Lyme disease can virtually be excluded. However, specimens that are positive, minimally reactive, or equivocal by ELISA or IFA should be confirmed by Western blots because of their relatively low specificity.[6] If early Lyme Disease is suspected clinically despite a negative antibody titer, serological investigations (starting with ELISA or IFA) should be repeated approximately 2 to 4 weeks later since 60 percent of infected individuals may test negative at the early stage. Antibiotic therapy may prevent an increase in specific antibodies and seroconversion may even occur after antibiotic therapy.

IgM Western blot is considered positive if two of the following three bands are present: 24 Da (OspC), 39 kDa (BmpA), and 41 kDa (Fla). IgG Western blot is considered positive if five of the following 10 bands are present: 18 kDa, 21 kDa (OspC), 28 kDa, 30 kDa, 39 kDa, 41 kDa (Fla), 45 kDa, 58 kDa (not GroEl), 66 kDa, and 93 kDa.

Serological findings are dependent on disease duration and clinical manifestation.

Early Localized Lyme Disease (Erythema migrans rash)

- With *early localized Lyme Disease*, less than half of patients have detectable specific antibodies, predominantly IgM. Serologic testing is unnecessary.

  Covered Treatment: Early localized Lyme Disease should be treated with oral antibiotic therapy, preferably a 21-day course of doxycycline or amoxicillin, not intravenous therapy. [Patients intolerant to those oral medications may be treated with cefuroxime axetil (oral), clarithromycin (oral), or azithromycin (oral).][7] Intravenous therapy is not appropriate unless oral medications are not tolerated. If intravenous antibiotic therapy must be used, 14 days of antibiotic therapy is equivalent to 21 days of oral doxycycline.[8]

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[6]In the early stage of the disease (localized or even disseminated), there may be isolated IgM reactivity to ELISA or IFA, or in a minority of patients, there may only be an IgG response. Therefore, both IgM and IgG Western blots are recommended in the early stage.

[7]Note: cefuroxime axetil, clarithromycin, and azithromycin have been studied only in early, localized Lyme Disease, and azithromycin has been shown to be inferior to amoxicillin.

[8]"Ceftriaxone compared with doxycycline for the treatment of acute disseminated Lyme Disease." New England Journal of Medicine 1997. 337:289-94.

Early Disseminated Lyme Disease (Erythema migrans rash with multiple lesions, migratory joint pains and brief arthritis attacks, meningitis, cranial neuritis (usually facial palsy), carditis (usually AV nodal block))

- With early disseminated Lyme Disease, the proportion of detectable specific antibodies rises to 70-90 percent with a switch from IgM to IgG. In order to be considered medically appropriate, the following criteria must be met where applicable:

  1) Medical certification of early disseminated disease (disseminated infection with cardiac and neurological problems);

  2) Symptomatic pregnant women with failed course of oral antibiotics.

Covered Treatment: Early disseminated disease is treated with oral antibiotics (doxycycline 100 mg. twice a day or amoxicillin 500 mg. three times a day for 21 days).

- Facial palsy with meningitis: doxycycline 200 mg. twice a day or ceftriaxone 2 grams daily for 21 days or, if that is not tolerated, may treat with intravenous antibiotic therapy.
- Intravenous therapy is appropriate for Lyme Carditis or AV block with PR interval greater than 0.3 seconds, for children under the age of nine, or if patient is unable to tolerate oral antibiotics (nausea, vomiting, or malabsorption syndrome).
- Oral antibiotic therapy may be medically appropriate instead of intravenous therapy for palpitations in the absence of EKG changes; "funny feeling on one side of the face" in the absence of facial droop; facial palsy with normal cerebrospinal fluid results.

All intravenous therapy for treatment of Lyme Disease must be pre-certified by Horizon BCBSNJ. When intravenous therapy is determined to be medically appropriate, the supplies, cost of the drug, and skilled nursing visits will be covered services.

Pulse therapy, pulse treatment with Imipenem, therapy with Vancomycin, and diagnostic tests involving urine antigen and urine and serum polymerase chain reaction (PCR) are to be considered investigational.

Late/Chronic Disease Lyme Arthritis
and Late/Chronic Disease Neuroborreliosis (Persistent infection with prolonged arthritis attacks, chronic encephalomyelitis, chronic axonal polyradiculopathy, acrodermatitis chronica atrophicans)

In order to be considered medically appropriate, the following criteria must be met where applicable:

- Diagnosis based on objective findings including, but not limited to, serologic tests, spinal fluid analysis, neuropsychologic studies, and/or MRI.
- Neuroborreliosis, there is no role for IgM ELISA or Western Blot in late stage disease because the IgM tests have been shown to have a high number of false

positives (low specificity) in patients whose symptoms have been present for more than one month. IgG Western Blot is usually sensitive and specific in this stage. IgG titers are usually high and may remain so for several years, even when treatment is successful. Elevated serum IgG alone indicates previous exposure to B. burgdorferi but not necessarily recent or active infection. In no case should serologic reactivity be considered synonymous with active infection.

- Spinal fluid analysis is mandatory in testing for neuroborreliosis unless a patient has a reactive serum test with a confirmatory IgG Western blot and signs of neurologic disease. If a patient has a clinical picture consistent with neuroborreliosis, spinal fluid analysis may be appropriate even in the absence of a positive serologic test. Intravenous antibiotic therapy will not be covered for possible neuroborreliosis in the absence of a reactive serologic test without performing further studies to confirm the diagnosis, i.e., CSF analysis and neuropsychological testing or SPECT scanning.[9]
- Expressing cerebrospinal fluid (CSF) and serum ELISA results as a ratio may help correct for passive diffusion of anti-Borrelia antibodies across the blood brain barrier and can also be used to support (but not confirm) a clinical diagnosis of neuroborreliosis. If the patient has cognitive dysfunction, neuropsychologic studies should be done. If there is peripheral nerve damage, EMG and nerve conduction velocity (NCV) studies are indicated: if there are sensory changes only, somatosensory evoked potentials (SSEP) are in order.

Covered Treatment: may be treated with up to 30 days of intravenous antibiotic therapy.

A second or extended course of intravenous therapy must be pre-certified by Horizon BCBSNJ at its sole discretion prior to extending the course of therapy. There must be sufficient objective evidence, including objective clinical and laboratory findings, of new or extended manifestations of the disease. The plan administrator may require a consultation with an appropriate specialist.

Note: *Requests for more than 30 days require clinical/laboratory documentation of the need.*

A second course of intravenous therapy is warranted for any one of the following indications:

- Clinical evidence of recurrent or new synovitis if other causes have been ruled out;

[9]Single photon emission computed tomography (SPECT) scanning in and of itself is not suitable to establish the diagnosis of Lyme Disease. It is, however, useful to evaluate regional cerebral blood flow and is to be covered by the plan administrator for patients suspected of Late/Chronic Neuroborreliosis. SPECT scanning has been reported to show at six months that perfusion abnormalities improve in patients with Lyme encephalopathy after a one-month course of intravenous ceftriaxone. Therefore, it may be helpful to demonstrate whether a patient with suspected Lyme Disease actually has encephalopathy and may be helpful to follow response to therapy. SPECT scanning is not required in all patients and should only be used as an adjunct to other diagnostic tests when there is uncertainty as to the patient's diagnosis or response to therapy.

- Clinical evidence of recurrent or new objective neurologic physical findings in the absence of other explanations;
- Laboratory evidence of persistent (non-improving) CSF pleocytosis if other causes have been ruled out (if the spinal fluid showed a marked improvement but not complete resolution of the pleocytosis soon after completing therapy, another course of therapy may not be warranted);
- Laboratory evidence of persistently positive CSF and/or synovial fluid culture, i.e., positive after initial intravenous treatment;
- Laboratory evidence of positive Polymerase Chain Reaction[10] (PCR) in CSF[11] and/or synovial fluid - PCR urine or blood tests are not to be considered.

Extended intravenous therapy beyond 30 days as a second course may be approved only if there is:

- Recurrent Lyme arthritis with active synovitis after a 30-day course of appropriate antibiotics (ceftriaxone, cefotaxime, penicillin G); or
- Recurrent neuroborreliosis, documented by CSF pleocytosis, CSF culture, or PCR of CSF[12], or neuropsychological studies.

  Examples of cases where an extension or repeat course of intravenous therapy may be medically appropriate include: a patient who had left knee arthritis and received treatment only to develop neurologic disease or arthritis of another joint after termination of treatment; a patient who had treatment of established Lyme Disease in the past and now develops new findings with increasing reactivity with Borrelia Burgdorferi as indicated by expansion of the immunologic reactivity with new bands on Western blot.

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[10]PCR testing of CSF and synovial fluid are to be covered by the plan administrator for patients suspected of Late/Chronic Lyme Disease. Coverage for PCR testing for other uses or fluids will be determined by the plan administrator.

[11]A persistently positive PCR in spinal fluid should be interpreted with caution. It's not really known what it means. In conjunction with other clinical/laboratory data, it may help support the need for a second course of antibiotics. In and of itself, it would not mandate therapy.

[12]It would be reasonable to extend or repeat treatment if a patient had a persistently positive CSF PCR and ongoing symptoms.

APPENDIX V

GLOSSARY

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

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

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

Allowable Expense — The allowance for charges for services rendered or supplies furnished by a health care provider that would qualify as a covered expense.

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

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

Benefit Period — The twelve-month period starting on January 1st and ending on December 31st. The first and/or last Benefit Period may be less than a calendar year. The first Benefit Period begins on your coverage date. The last Benefit Period ends when you are no longer covered.

Biologically-Based Mental Illness — Diagnosed conditions including schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Blue Card Program — A national Blue Cross Blue Shield (BCBS) electronic claims billing program through which participating hospitals and doctors can transmit bills for BCBS plan members to any BCBS-administered health insurance program.

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

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

Civil Union Partner — A member 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.

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

Coinsurance — The portion of an eligible charge which is the member's financial responsibility for out-of-network services.

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

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

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

Covered Person — An employee, retiree, or COBRA participant or a dependent of an employee, retiree, or COBRA participant who is enrolled in NJ PLUS.

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

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

Deductible — The portion of the first eligible charges submitted for payment in each calendar year that the out-of-network portion of NJ PLUS requires the member or covered dependent to pay.

Dependent Coverage — Coverage of an eligible family member of an enrolled member.

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

Domestic Partner — For eligibility in the SHBP, a domestic partner is defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, as a person of the same sex with whom the employee or retiree has entered into a domestic partnership by registering with the local registrar and receiving a New Jersey *Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners. Domestic partner SHBP coverage is only available to State employees/retirees and to Local/Educational

employees/retirees whose employer has adopted a resolution to participate in health benefits coverage under the Domestic Partnership Act.

Durable Medical Equipment — Equipment, which is designed and able to withstand repeated use and is customarily used to serve a member with a medical condition.

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

- Medically needed at the appropriate level of care for the medical condition.
- Listed in covered services and supplies.
- Ordered by a doctor (as defined by the plan) for treatment of illness or injury.
- Not specifically excluded (listed in the "Charges Not Covered by the Plan" section beginning on page 44).
- Provided while you or your eligible family members were covered by the plan.

Eligible Dependent — A member's spouse, civil union partner, or same-sex domestic partner (as defined by Chapter 246, P.L. 2003) and unmarried child(ren) under the age of 23 who lives with and is substantially dependent upon the member for support. Children include natural, adopted, foster, and stepchildren. If a covered child is not capable of self-support when he or she reaches age 23 due to mental illness, mental retardation, or a physical disability, coverage under the SHBP may be continued (see page 8).

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

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

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

Employer — The State or a local employer which participates in the State Health Benefits Program.

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

Family or Medical Leave of Absence — A period of time of pre-determined length, approved by the employer, during which the employee does not work, but after which the employee is expected to return to active service. Any employee who has been granted an approved leave of absence in accordance with the Family and Medical Leave Act of 1993 shall be considered to be active for purposes of eligibility for covered services and supplies under your group's program.

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

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

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

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

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

(1) It is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals and Medicare approved.

(2) It (a) is legally operated, (b) is supervised by a staff of doctors, (c) has 24-hour-a-day nursing service by registered graduate nurses, and (d) mainly provides general inpatient medical care and treatment of sick and injured persons by the use of the medical, diagnostic, and major surgical facilities in it.

(3) It is licensed as an ambulatory or separate surgical center. The center must mainly provide outpatient surgical care and treatment.

(4) It is an institution for the treatment of alcoholism not meeting all the tests of (1) or (2) but which is:

- A licensed hospital; or
- A licensed detoxification facility; or
- A residential treatment facility which is approved by a state under a program that meets standards of care equivalent to those of the Joint Commission on Accreditation of Hospitals.

(5) It is a birth center that is licensed, certified, or approved by a department of health or other regulatory authority in the state where it operates or meets **all** of the following tests:

- It is equipped and operated mainly to provide an alternative method of childbirth.
- It is under the direction of a doctor.
- It allows only doctors to perform surgery.
- It requires an exam by an obstetrician at least once before delivery.
- It offers prenatal and postpartum care.
- It has at least two birthing rooms.
- It has the necessary equipment and trained people to handle foreseeable emergencies. The equipment must include a fetal monitor, incubator, and resuscitator.
- It has the services of registered graduate nurses.
- It does not allow patients to stay more than 24 hours.
- It has written agreements with one or more hospitals in the area that meet the tests in sections (1) or (2), listed above, and will immediately accept patients who develop complications or require post-delivery confinement.
- It provides for periodic review by an outside agency.
- It maintains proper medical records for each patient.

"Hospital" does not include a nursing home. Neither does it include an institution, or part of one, that:

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

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 should obtain authorization from NJ PLUS. For out-of-network services, call NJ PLUS at 1-800-414-SHBP (7427) to verify eligibility prior to enrolling in a hospital-based weight loss program.

Illness — Any disorder of the body or mind of a covered person.

Injury — Damage to the body of a covered person.

Local Employee — For purposes of SHBP coverage, a local employee is a full-time employee receiving a salary and working for a Participating Local Employer. Full-time shall mean employment of an eligible employee who appears on a regular payroll and who receives salary or wages for an average number of hours specified by the

employer, but not to be less than 20 hours per week. It also means employment in all 12 months of the year except in the case of those employees engaged in activities where the normal work schedule is 10 months. In addition, for local coverage, employee shall also mean an appointed or elected officer of the local employer, including an employee who is compensated on a fee basis as a convenient method of payment of wages or salary but who is not a self-employed independent contractor compensated in a like manner. To qualify for coverage as an appointed officer, a person must be appointed to an office specifically established by law, ordinance, resolution, or such other official action required by law for establishment of a public office by an appointing authority. A person appointed under a general authorization, such as to appoint officers or to appoint such other officers or similar language is not eligible to participate in the program as an appointed officer. An officer appointed under a general authorization must qualify for participation as a full-time employee.

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

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

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

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

Medicare — The federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. Medical coverage consists of two parts: Part A is Hospital Insurance Benefits and Part B is Medical Insurance Benefits. A Retired Group member and/or spouse, civil union partner, or eligible same-sex domestic partner who are eligible for Medicare cover-

age by reason of age or disability must be enrolled in Parts A and B to enroll or remain in SHBP Retired Group coverage.

Member — An employee, retiree, or dependent who is enrolled under NJ PLUS.

Mental or Nervous Condition — A condition which manifests symptoms which are primarily mental or nervous, whether organic or non-organic, biological or non-biological, chemical or non-chemical in origin and regardless of cause, basis or inducement, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication. Mental or nervous conditions include, but are not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. Mental or nervous condition does not include substance abuse or alcoholism.

Morbid Obesity — A body mass index (BMI) greater than 40kg/m^2, **or** a BMI greater than 35kg/m^2 with associated life-threatening or disabling co-morbidities including, but not limited to, coronary heart disease, diabetes, hypertension, or obstructive sleep apnea.

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

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

Out-of-Network Benefits — Benefits provided by NJ PLUS when members do not use network providers for their medical treatment or do not follow the managed care guidelines, i.e., go directly to a network specialist without obtaining a referral from the Primary Care Physician.

Participating Hospital — A health care facility licensed by the State it is in to provide hospital care and services or any U.S. Government-operated hospital which has an agreement with Blue Cross Blue Shield to provide hospital care both to a) the Blue Cross plan's subscribers and b) other Blue Cross plans' subscribers through the Blue Card Program.

Participating Provider — A doctor or hospital which has a written agreement with their local Blue Cross Blue Shield plan to provide care to both that plan's members and other Blue Cross Blue Shield plan members.

Point of Service — A plan that provides managed care to its members through its own network of providers. The plan also provides reimbursement to members for services rendered by non-network providers at a lower reimbursement rate and subject to a calendar year deductible. In a point of service plan, you must choose a Primary Care Physician to manage your healthcare.

Primary Care Physician — A participating provider who provides basic healthcare services to, and arranges specialized services for, those members who select that provider as their Primary Care Physician (PCP).

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

Provider — Under the SHBP, the term is used to define an eligible provider and includes medical doctors, dentists, podiatrists, acupuncturists, psychologists, psychiatrists, nurse midwives, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, board certified behavior analysts, chiropractors, certified nurse practitioners, clinical nurse specialists, physical therapists, occupational therapists, optometrists, and audiometrists who are properly licensed and are working within the scope of their practice.

Public Employer — A federal, state, county, or municipal government, authority, or agency; a local board of education; or a state or county university or college.

Reasonable and Customary — The plan makes payments based on the reasonable and customary allowance for supplies and services in a specific geographic area. The reasonable and customary allowance is the general level of charges made by others in the area for like services or supplies as determined by the Prevailing Healthcare Charges System (PHCS). This schedule is updated on a semi-annual basis. Reasonable and customary allowances are based on actual charges by physicians in a specific geographical area for specific services.

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

Retired Group Member — An eligible retiree of a state-administered or local public pension fund who has met the requirements for participation and has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP for him/herself and, if applicable, any eligible dependents. Also includes a surviving spouse, civil union partner, or eligible same-sex domestic partner of a deceased Retired Group member who has met the requirements for and has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP for him/herself and, if applicable, any eligible dependents. Also includes a surviving dependent child of a deceased Retired Group member who had parent-child(ren) coverage, providing he or she has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP.

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

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

Spouse — This is a member of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* is required for enrollment.

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

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

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

State Monthly Employee — For purposes of SHBP coverage, state monthly employee shall mean a full-time employee of the State, or an appointed or elected officer, whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). Full-time shall mean the usual full-time weekly schedule for the particular title, which normally requires 35 hours per week.

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

- Rutgers, the State University of New Jersey
- Palisades Interstate Park Commission
- New Jersey Institute of Technology
- University of Medicine & Dentistry of NJ
- Thomas A. Edison State College
- William Paterson University
- Ramapo State College
- Rowan University
- College of New Jersey
- Montclair State University
- New Jersey City University
- Kean University
- Stockton State College
- New Jersey State Library
- New Jersey State legislature and legislative offices

- New Jersey Building Authority
- New Jersey Commerce and Economic Growth Commission
- Waterfront Commission of New York Harbor
- Agencies or special projects that are supported from, or whose employees are paid from, sources of revenue other than general funds, which other funds shall bear the cost of benefits under this program.

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

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

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

Surgical Procedure — This includes cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, application of plaster casts, electrocauterization, tapping (paracentesis), administration of pneumothorax, endoscopy, or injection of sclerosing solution.

Waiting Period — The period of time between enrollment in the State Health Benefits Program and the date when you become eligible for benefits.

APPENDIX VI

NOTICE OF PRIVACY PRACTICES TO ENROLLEES IN THE NEW JERSEY STATE HEALTH BENEFITS PROGRAM

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

EFFECTIVE DATE: APRIL 14, 2003.

Protected Health Information

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

The SHBP is required by law to abide by the terms of this Notice. The SHBP reserves the right to change the terms of this Notice. If the SHBP makes material change to this Notice, a revised Notice will be sent.

SHBP Uses and Disclosures of PHI

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

- The SHBP may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The SHBP may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The SHBP receives PHI from employers, including the member's name, address, Social Security number, and birth date. This enrollment information is provided to our Business Associates so that they may provide coverage for health care benefits to eligible members.

- The SHBP and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.
- The SHBP may provide PHI to a provider, a health care facility, or a health plan that is not our Business Associate that contacts us with questions regarding the member's health care coverage.
- The SHBP may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The SHBP may use and disclose PHI for fraud and abuse detection.
- The SHBP may allow use of PHI by our Business Associates to identify and contact our members for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services or about treatment alternatives that may be of interest to them.
- In the event that a member is involved in a lawsuit or other judicial proceeding, the SHBP may use and disclose PHI in response to a court or administrative order as provided by law.
- The SHBP may use or disclose PHI to help evaluate the performance of our health plans. Any such disclosure would include restrictions for any other use of the information other than for the intended purpose.
- The SHBP may use PHI in order to conduct an analysis of our claims data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

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

When using or disclosing PHI, the SHBP will make every reasonable effort to limit the use or disclosure of that information to the minimum extent necessary to accomplish the intended purpose. The SHBP maintains physical, technical and procedural safeguards that comply with federal law regarding PHI.

Member Rights

Members of the SHBP have the following rights regarding their PHI:

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

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

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

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

Right to an Accounting of Disclosures*:* Members have the right to receive an accounting of the instances in which the SHBP or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years or back to April 14, 2003, whichever period is shorter. We will provide the member with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those made for treatment, payment or health benefits operation purposes or made in accordance with an authorization) and will not appear on the accounting.

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

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

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

Questions and Complaints

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

If members think the SHBP may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the use or disclosure of their information, or to have the SHBP communicate with them in confidence by alternative means or at an alternative location, they must submit their complaint in

writing. To obtain a form for submitting a complaint, use the contact information found at the end of this Notice.

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

The SHBP supports member rights to protect the privacy of PHI. It is your right to file a complaint with the SHBP or with the U.S. Department of Health and Human Services.

Contact Office:	The State Health Benefits Program—HIPAA Privacy Officer
Address:	State of New Jersey Department of the Treasury Division of Pensions and Benefits Bureau of Policy and Planning PO Box 295 Trenton, NJ 08625-0295
Fax:	(609) 341-3410
E-mail:	*hipaaform@treas.state.nj.us*

STATE HEALTH BENEFITS PROGRAM CONTACT INFORMATION

ADDRESSES

Our Mailing Address is . . . . . The State Health Benefits Program
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299

Our Internet Address is . . . . . *www.state.nj.us/treasury/pensions/shbp.htm*

Our E-mail Address is . . . . . .*pensions.nj@treas.state.nj.us*

TELEPHONE NUMBERS

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

Division of Pensions and Benefits:

Office of Client Services . . . . . (609) 292-7524

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

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

Rutgers University Personnel Counseling Service (EAP) . . . . . (732) 932-7539

New Jersey State Police
Employee Advisory Program (EAP) . . . . . (856) 234-5652
. . . . . (908) 231-1077
. . . . . (609) 633-3718
. . . . . 1-800-FOR-NJSP

University of Medicine and Dentistry of New Jersey (EAP) . . . . (973) 972-5429

New Jersey Department of Banking and Insurance

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

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

New Jersey Department of Human Services

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

New Jersey Department of Health and Senior Services

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

Insurance Counseling 1-800-792-8820

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

Centers for Medicare and Medicaid Services 1-800-Medicare

New Jersey Medicare - Part A 1-866-641-2007

New Jersey Medicare - Part B 1-800-462-9306

STATE HEALTH BENEFITS PROGRAM PUBLICATIONS

The publications and fact sheets available from the Division of Pensions and Benefits provide information on a variety of subjects. The publications listed below are available for viewing or printing over the Internet at: *www.state.nj.us/treasury/pensions*

Employees and retirees can also obtain copies of these publications by contacting their employers or by calling the Division's Office of Client Services.

General Publications

State Health Benefits Program Summary Program Description booklet

State Health Benefits Program Comparison Summary - Plan comparison chart

SHBP Fact Sheets

Fact Sheet #11, *Enrolling in the State Health Benefits Program When you Retire*

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

Fact Sheet #25, *Employer Responsibilities under COBRA*

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

Fact Sheet #30, *The Continuation of New Jersey State Health Benefits Program Coverage Under COBRA*

Fact Sheet #37, *SHBP Employee Dental Plans*

Fact Sheet #47, *SHBP Retired Coverage Under Chapter 330 - PFRS & LEO*

Fact Sheet #51, *Continuing SHBP Coverage for Overage Children with Disabilities*

Fact Sheet #60, *Voluntary Furlough Program*

Fact Sheet #66, *SHBP Coverage for State Part-Time Employees*

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

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

Fact Sheet #73, *Retiree Dental Expense Plan*

Fact Sheet #74, *SHBP Coverage of Children to Age 30 Under Chapter 375*

Fact Sheet #75, *Civil Unions*

SHBP Member Handbooks

SHBP Traditional Plan Member Handbook

SHBP NJ PLUS Member Handbook

SHBP HMO Member Handbooks — available over the Internet. (Aetna HMO, AmeriHealth HMO, CIGNA HealthCare, Health Net HMO, and Oxford Health Plans.)

SHBP Employee Prescription Drug Plan Member Handbook

SHBP Employee Dental Plans Member Handbook

SHBP Retiree Dental Expense Plan Member Handbook

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