



Horizon PPO Member Handbook

Horizon.



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.®



HorizonBlue.com

Health Care Reform

The Affordable Care Act (ACA), the federal health care reform law that was signed into law on March 23, 2010, mandates comprehensive health care reforms. Some reforms are already in effect and others will become effective in the next few years. Information about health care reform is available at HorizonBlue.com/reform.

This version of the Horizon PPO Member Handbook is up to date at the time of printing with the ACA's current requirements. As additional requirements of this law become effective, this member handbook will be updated.

We speak your language

If you do not speak English, you may access information about your health plan through the AT&T Language Line, a translation service. To be connected to the language line, please call Member Services at **1-800-355-BLUE (2583)**, Monday through Wednesday and Friday, between 8 a.m. and 6 p.m., Eastern Time (ET), or Thursday, between 9 a.m. and 6 p.m., ET.

Visita HorizonAzul.com, un sitio en internet en español de Horizon Blue Cross Blue Shield of New Jersey, que proporciona a los miembros acceso a información y planes de salud, tanto en español como en inglés.

If you have hearing or speech difficulties, please call the TTY/TDD line at **1-800-855-2881**.

Note: This is not a contract. In the event there appears to be a contradiction between the content contained in this member handbook and your group's health plan contract, your group's health plan contract will prevail.

Welcome to your Horizon Blue Cross Blue Shield of New Jersey PPO plan. This plan gives you referral-free access to many health care services and programs, as well as our large network of participating doctors, other health care professionals and hospitals.

We want you to get the most from your Horizon PPO plan. Please read this member handbook to help you understand your coverage and how your plan works.

You can manage your health care benefits and get answers to many of your benefit questions online. Sign in to Member Online Services at HorizonBlue.com to:

- Check the status of a claim.
- Print a copy of your ID card or proof of coverage letter for a dependent or request a new ID card.
- Check your eligibility and benefits.
- And more.

If you have questions about your benefits, we are here to help you. Please call Member Services at **1-800-355-BLUE (2583)***, Monday through Wednesday and Friday, between 8 a.m. and 6 p.m., Eastern Time (ET), or Thursday, between 9 a.m. and 6 p.m., ET.

Thank you for choosing Horizon BCBSNJ for your health care coverage. We look forward to *Making Healthcare Work* for you and your family.

* If you do not speak English, you may access information about your health plan through the AT&T Language Line. To be connected to the language line, please call Member Services at **1-800-355-BLUE (2583)**. If you have hearing or speech difficulties, please call the TTY/TDD line at **1-800-855-2881**.

Helpful Information

To manage your health care benefits online, register and sign in to Member Online Services at HorizonBlue.com to:

- Check the status of a claim.
- Print a copy of your ID card or proof of coverage letter for a dependent or request a new ID card.
- Check your eligibility and benefits.
- And more.

Horizon BCBSNJ Member Services:

1-800-355-BLUE (2585)

Representatives are available Monday through Wednesday and Friday, between 8 a.m. and 6 p.m., Eastern Time (ET), or Thursday, between 9 a.m. and 6 p.m., ET. If you have hearing or speech difficulties, please call the TTY/TDD line: **1-800-855-2881**.

24/7 Nurse Line:

1-888-624-3096 or check the back of your ID card.

Behavioral Health Services:

1-800-626-2212

Pharmacy Member Services:

1-800-370-5088

Special Investigations Unit's Anti-Fraud Hotline:

1-800-624-2048

PERSONAL INFORMATION

My Member ID Number:

My Doctor:

My Doctor's Phone Number:

Table of Contents

Access to safe and effective care

Benefit Information

| | |
|--|----|
| Benefit Highlights..... | 6 |
| Using a Participating Doctor | 8 |
| • Making Appointments | |
| • Physician Access Standards | |
| • Physician Compensation | |
| Out-of-Network Care | 12 |
| • How to File a Claim | |
| Out-of-Network Care versus In-Network Care | 14 |
| • Cost Savings Examples | |
| • Paying Out-of-Network Doctor Bills | |
| • Tips on Lowering your Health Care Costs | |
| Specialty Care and Prior Authorization | 18 |
| • Specialty Care Copayments | |
| • Prior Authorization | |
| Accessing Urgent and After-Hours Care | 21 |
| • Care on Nights and Weekends | |
| Emergency Care | 22 |
| • Emergency Room (ER) Copayments | |
| • Follow-Up Care After an ER Visit | |
| • Medical Emergency Screening Exam | |
| • Medical Emergency Procedures | |
| Dependent Coverage | 24 |
| Pharmacy Benefits | 26 |
| • Online Pharmacy Services | |
| • Specialty Pharmacy Services | |
| Maternity Care | 28 |
| • Partnering with your Ob/Gyn | |
| • Maternity Hospital Stays | |

Table of Contents

Behavioral Health and Substance Abuse Care 30

- Accessing Behavioral Health and Substance Abuse Care
- Available Services

Out-of-Area Coverage 31

- How BlueCard Works

Ease of navigating the health care system Information

Getting Information About your Horizon PPO Plan 32

- HorizonBlue.com
- Horizon Blue App
- Interactive Voice Response (IVR) System
- Member Services
- Your ID Card

Service excellence Service Guidelines

Laboratory Testing 36

- LabCorp and AtlantiCare Clinical Laboratories
- AtlantiCare Clinical Laboratories

Radiology/Diagnostic Imaging Services 37

- CareCore National, LLC
- Scheduling your Tests

Hospitalization 38

- Hospital Stays and Prior Authorization
- If You Go to a Nonparticipating Hospital

Healthier members ... healthier communities

Getting and Staying Healthy: Preventive Health Care Benefits 39

- Gynecological Coverage
- Mammography Coverage
- Preventive Health Care Guidelines

24/7 Nurse Line 42

- Chat with a Nurse

Chronic Care Program 43

Case Management 44

Table of Contents

| | |
|--|-------------------|
| Blue Distinction Centers for Transplants | 45 |
| Utilization Management Program | 46 |
| Blue365: Wellness Discounts | 47 |
| Appendix | |
| Frequently Asked Questions | 48 |
| Protection of your Private Information | 50 |
| Your Horizon BCBSNJ Member Rights | 51 |
| Your Horizon BCBSNJ Member Responsibilities | 54 |
| Medical Bills | 55 |
| Voicing a Concern | 56 |
| • Member Inquiry, Complaint and Appeal Rights | |
| • General Inquiries and Complaints | |
| • Horizon PPO Appeal Process | |
| • Time Frames for Initial ABDs | |
| • Appeal Process for ABD-Benefits | |
| • Appeal Process for ABD-Medical | |
| • Behavioral Health and Substance Abuse Care Appeals | |
| • Radiology/Diagnostic Imaging Services Medical Appeals | |
| • Prescription Drug Appeals | |
| Important Notices | 69 |
| • Medical Technology | |
| • Continuation of Care Benefits | |
| • How to Get Results of Independent Satisfaction Surveys | |
| Your Feedback | 71 |
| Glossary | 72 |
| Notes | 76 |
| Transfer of Medical Records Form | 77 |
| At Your Service | Inside Back Cover |

Benefit Highlights

As a Horizon PPO member, you are eligible to receive the following care and services when arranged or provided by participating doctors or other health care professionals. **Please remember to confirm with your doctor if he/she participates in our network before you receive care.** You may also use nonparticipating doctors or health care professionals, but you will pay more out of your pocket.

For a complete list of available benefits, please refer to your Benefit Booklet/Certificate.

Health Care Services

- Participating doctor office visits.
- Preventive care, including pediatric care and annual gynecological exam.
- Pediatric office visits.
- Maternity care – prenatal and postpartum.
- Gynecological specialty services.
- Specialist office visits and consultation.
- Diagnostic X-rays, laboratory tests and procedures.

Hospital Services

- Unlimited number of medically necessary inpatient days.
- Maternity (delivery) and nursery care.
- Anesthesia.

Additional Services

- Medical emergency care at any health care facility. (If possible, please call your Primary Care Physician [PCP], if one was selected, after your Emergency Room [ER] visit so that your PCP is kept aware of your condition.)
- Medical emergency screening examination.
- Out-of-state urgent care.
- Short-term therapies (benefit limitations apply).
- Skilled nursing facility care (benefit limitations apply).
- Chiropractic care (benefit limitations may apply).
- Same-day surgery.
- Home health care (benefit limitations may apply).
- Ambulance (when medically necessary).

Limitations and Exclusions:

Some in-network specialty care (excluding routine Ob/Gyn services) and all nonemergency hospitalizations must be authorized by Horizon BCBSNJ before receiving services. Horizon BCBSNJ will not pay for services or supplies that are not covered under your group's health plan contract.

Most services performed by a nonparticipating doctor are reimbursed at the out-of-network level of care, which is based on our allowance and subject to deductible and coinsurance.

Please check your Horizon BCBSNJ member ID card or Benefit Booklet/Certificate for your specific copayment, coinsurance and deductible amounts, benefit information and exclusions. Or call Member Services at **1-800-355-BLUE (2583)** with questions.

For your convenience, we have a Year-to-Date Account Balance tool that displays year-to-date deductible amounts and out-of-pocket maximums. To view your account balances, please sign in to Member Online Services at HorizonBlue.com and click the *View Year-to-Date Account Balances* link located on the home page or select *Year-to-Date Account Balances* within the *My Plan* tab.



| In Network, You Pay | Out of Network, You Pay |
|------------------------------------|---|
| Copayment. ¹ | Deductible and coinsurance. |
| No charge. ² | Coinsurance. |
| Copayment. ¹ | Deductible and coinsurance. |
| Copayment (one time). ³ | Deductible and coinsurance. |
| Copayment. ¹ | Deductible and coinsurance. |
| Copayment. ¹ | Deductible and coinsurance. |
| No charge. ¹ | Deductible and coinsurance. |
| In Network, You Pay | Out of Network, You Pay |
| No charge. ¹ | Deductible and coinsurance. |
| No charge. ¹ | Deductible and coinsurance. |
| No charge. ¹ | Deductible and coinsurance. |
| In Network, You Pay | Out of Network, You Pay |
| ER copayment or \$0 if admitted. | ER copayment. Deductible and coinsurance may apply. |
| ER copayment or \$0 if admitted. | ER copayment. |
| Copayment. ¹ | Deductible and coinsurance. |
| Copayment. ¹ | Deductible and coinsurance. |
| No charge. ¹ | Deductible and coinsurance. |
| Copayment. ¹ | Deductible and coinsurance. |
| No charge. ¹ | Deductible and coinsurance. |
| No charge. ¹ | Deductible and coinsurance. |
| No charge. ¹ | Deductible and coinsurance. |

¹ A deductible, coinsurance or copayment may apply to some policies.

² Under some group plans, preventive care services are subject to cost sharing for members. Check with your employer to see if this applies to your plan.

³ Effective **January 1, 2014**, maternity copayment may no longer apply under some group plans. Check with your employer to see if this applies to your plan.

If there is a discrepancy between the information contained in your group's health plan contract and this member handbook, your group's health plan contract will prevail.

Using a Participating Doctor

Chances are you have been affected by rising health care costs in one way or another. The good news is that you can lower your out-of-pocket costs. When it comes to the cost of health care, your choices make a big difference.

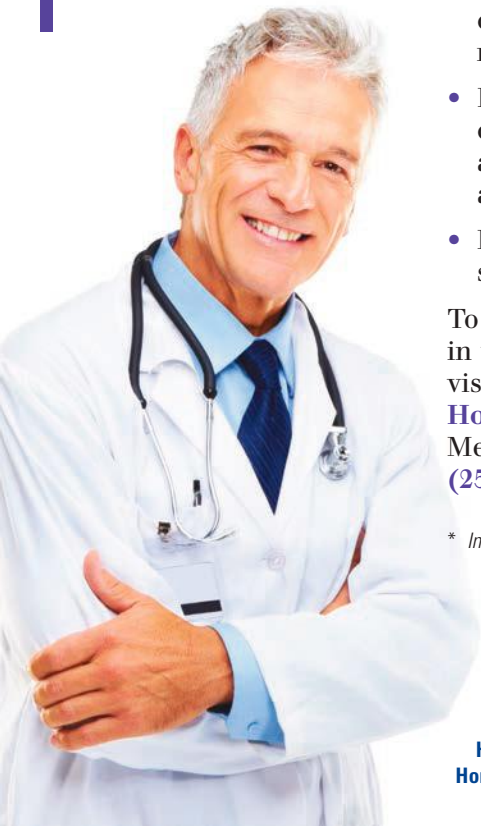
As a Horizon PPO plan member, when you use a participating doctor, health care professional or facility, you pay less for your care and services. Medical care and services are considered in network* when received from a participating doctor.

When you use a participating doctor, he/she will:

- Handle most of your medical care in his/her office.
- Perform most of your annual well care and preventive health exams.
- Provide medical care or refer you to a participating specialist or health care professional.
- Handle your emergency care needs, when possible.
- Coordinate your network specialty care and prior authorizations for medically necessary services.
- Be on call or have an appointed, covering health care professional available 24 hours a day, seven days a week.
- Meet our physician credentialing standards.

To verify that your doctor participates in the Horizon PPO Network, please visit our online *Provider Directory* at HorizonBlue.com/directory or call Member Services at **1-800-355-BLUE (2585)**.

* *In network* is also referred to as *network* and *participating*.



Using a Participating Doctor

Making Appointments

Call your doctor when you need an appointment for routine physical exams. This helps ensure that you receive proper preventive care services. Please contact your doctor whenever you have medical concerns or questions.

Physician Access Standards

It is important for you to receive a timely appointment. To help make sure you have access to the medical care you need, when you need it, we developed Physician Access Standards for our doctors and participating Ob/Gyns.* These doctors follow our Physician Access Standards, located on page 10, when scheduling appointments with you.

* Applies to doctors who are directly under contract with Horizon BCBSNJ.



Horizon BCBSNJ is committed to providing you with access to safe and effective care. Our participating doctors and other health care professionals must meet certain guidelines when scheduling your appointment.

Using a Participating Doctor

Physician Access Standards

| If you need an appointment for: | You must be offered: |
|---|--|
| Routine Care – includes any condition or illness that does not require urgent attention or is not life-threatening, as well as routine gynecological care. | An appointment as soon as possible, but not to exceed two weeks from the date of your call. |
| Routine Physical Exam – includes an annual health assessment, as well as routine gynecological exams for new and established patients. | An appointment as soon as possible, but not to exceed four months from the date of your call. |
| Urgent Care – includes medically necessary care for an unexpected illness or injury. | An appointment within 24 hours from the time of your call. |
| Emergent Care – includes a medical condition of such severity that a prudent layperson, with an average knowledge of health and medicine, would call for immediate medical attention and care. | To be seen immediately , or directed to an emergency care facility. |
| After-Hours Care – care received after your doctor's normal business hours. | A response to your call for urgent or emergent care within 30 minutes . |
| Office Waiting Time – the time you spend in your doctor's office waiting to be seen. | A wait of no more than 30 minutes for a scheduled appointment. If the waiting time is expected to exceed the 30-minute standard, the office staff must offer you the option of waiting or rescheduling the appointment. |

Physician Compensation

You have a right to know how we pay the doctors and facilities in the Horizon PPO Network, so you will know if there are any financial incentives or disincentives tied to medical decisions. You also have the right to ask doctors and other health care professionals how they are compensated for their services.

Participating doctors and other health care professionals in our Horizon PPO Network have agreed to be paid each time he/she treats you (fee-for-service).

Using a Participating Doctor

Physician Compensation (continued)

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

If you want more information about how doctors or health care professionals in our network are compensated, please call us at **1-800-355-BLUE (2585)**, or write to us at:

**Horizon PPO
PO Box 1609
Newark, NJ 07101-1609**

The laws of the state of New Jersey at N.J.S.A. 45:9-22.4 et seq., require that a doctor, chiropractor or podiatrist, who is permitted to make referrals to other health care professionals or facilities in which he/she has a significant financial interest, inform his/her patients of that financial interest when making such a referral.

For more information, contact your doctor, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, call the New Jersey Division of Consumer Affairs at **1-800-242-5846** or **1-973-504-6200**.

* Horizon BCBSNJ does not have withholds as a method of payment.



Physician compensation is how Horizon BCBSNJ pays participating doctors and other health care professionals for the care and services they give to you. It depends on their agreement with us.

How we pay your doctor does not affect the care he/she gives to you.

Out-of-Network Care

Horizon PPO members can choose to use a nonparticipating doctor, hospital or other health care professional for care and/or medical services.

If you receive care from an out-of-network doctor, facility or other health care professional, remember:

- You will generally have to meet an annual deductible.
- You are responsible to get prior authorization.
- Usually the doctor, facility or other health care professional that you use will ask that you pay the entire medical bill up front at the time of your visit. It will then be your responsibility to file claims for partial reimbursement.
- Nonparticipating doctors, facilities and other health care professionals may balance bill you. This means that after we pay our portion of your filed claim up to our allowance, the doctor, facility or other health care professional may bill you for the balance of the medical bill. If you used an out-of-network doctor, facility or health care professional, it is your responsibility to pay these charges.
- You must still contact us for approval¹ before you receive certain services. This includes hospital admissions and certain surgical and diagnostic procedures. If you do not receive our approval for these services when it is required, you may not be eligible for full benefits and our payments may be reduced.
- Most out-of-network services have a deductible and coinsurance. This means you will have to pay more out of your pocket for your care.

¹ Please call Member Services or refer to your Benefit Booklet/Certificate for services that require prior authorization.

Out-of-Network Care

How to File a Claim

Please send your out-of-network claims to the address on your member ID card. If you need a copy of the *Claim Form – Medical – PPO–Traditional* form, please visit [HorizonBlue.com/Members](https://www.HorizonBlue.com/Members) and mouse over *Forms* and click *Search by Form Type*.

Send the form, bill with your member ID number and the date you received the services to:

Horizon PPO Claims
PO Box 1609
Newark, NJ 07101-1609


Out-of-Network Care versus In-Network Care

Cost Savings Examples

Your choices affect how much you will pay for your health care. The examples on these pages show the difference between using an out-of-network doctor and paying \$190, or using an in-network doctor and paying a \$10 copayment – a savings of \$180 when using in-network care.


Example 1: You choose to go **out of network** for an office visit. The charge is \$350. Since your doctor is not participating in any Horizon BCBSNJ network, you will pay your deductible, coinsurance and up to the full charge of the service.

Let's assume you have already met your deductible. Our allowed amount for this service is \$200 and your out-of-network benefit is 80/20 (Horizon BCBSNJ pays 80 percent; your coinsurance responsibility is 20 percent). Our payment for this service would be 80 percent of \$200, which equals \$160. You are responsible for your coinsurance. Plus, since your doctor is out of network, he/she can balance bill you for \$150. Your total responsibility would be \$190 (\$150 for the balance-billed amount, plus your \$40 coinsurance).



Bill

| | |
|-------------------------------|--------------|
| Charge | \$350 |
| Horizon BCBSNJ Allowed Amount | \$200 |
| Deductible | Met |




Payment

| | |
|---|--------------|
| Horizon BCBSNJ Payment | \$160 |
| <small>(Based on 80% out-of-network benefit)</small> | |
| Coinsurance | \$40 |
| <small>(Based on 20%)</small> | |
| Member Responsibility (You Pay) | \$190 |
| <small>(\$40 coinsurance + \$150 balance-billed amount)</small> | |


Out-of-Network Care versus In-Network Care

Example 2: You choose to go **in network** for an office visit. The charge is \$350. Your Horizon PPO plan has a \$10 office visit copayment. Since you received the service in network, your deductible does not apply. Our allowed amount for this service is \$150, less any copayment. We would pay \$140 and you would only pay \$10.

If your doctor participates in the Horizon PPO Network, you **cannot be billed** for the balance of any charges over the amount we would pay for these in-network services.



| Bill | |
|-------------------------------|--------------|
| Charge | \$350 |
| <hr/> | |
| Horizon BCBSNJ Allowed Amount | \$150 |
| <hr/> | |
| Deductible | N/A |



| Payment | |
|---|-------------|
| Horizon BCBSNJ Payment | \$140 |
| <hr/> | |
| Copayment | \$10 |
| <hr/> | |
| Member Responsibility (You Pay) | \$10 |

Out-of-Network Care versus In-Network Care

Paying Out-of-Network Doctor Bills

If you use a doctor who does not participate in the Horizon PPO Network, your bills will be paid according to who provided the care or service. Please review the examples below:

| If care is provided by | Your payment | Your responsibility |
|--|--|---|
| A doctor or health care professional who is not participating in any of our networks. | Payment in full may be due at the time of service. You must send the bill and a completed claim form to us to be reimbursed for our allowance for covered services.* | You must pay any required deductible, coinsurance and any charges over our allowance for covered services.** |
| A doctor or health care professional who participates in the Horizon Managed Care Network ¹ and not in the PPO network. | Payment is not due at the time of service to any doctor in another Horizon BCBSNJ network. We will send you an Explanation of Benefits (EOB) which lists your responsibility.*** | You must pay any required copayment, deductible and/or coinsurance indicated on the EOB. Your doctor cannot bill you for more than our allowance. |

* Please refer to the Medical Bills section on page 55 for more information.

** See your Benefit Booklet/Certificate for specific deductible and coinsurance amounts.

*** Your EOB lists:

- Services received.
- Amount billed.
- Payment made by us.
- Amount you owe for the services.

You can also view your EOB by signing in to Member Online Services at HorizonBlue.com/Members.

¹ To find out if your doctor or other health care professional is in our Horizon PPO Network, please visit our online *Provider Directory* at HorizonBlue.com/directory.

Out-of-Network Care versus In-Network Care

Tips on Lowering your Health Care Costs

To get the most from your plan and save on out-of-pocket costs, we encourage you to receive in-network care. Here is some useful information to help you see how your choices impact your health care costs and responsibilities.



Receive in-network care to lower your out-of-pocket expenses

Use in-network doctors and facilities and get prior authorizations, when needed. When you do, you:

- Pay only your copayment, deductible and/or coinsurance, as applicable.
- Don't have to file claims.
- Maximize your benefits by receiving care at the highest level of coverage.
- Will not be responsible for balance billing by a participating doctor, hospital or other health care professional.

Receive out-of-network care and you'll have higher out-of-pocket expenses



When you receive care out of network, you are:

- Subject to a higher out-of-pocket expense.
- Responsible for paying your out-of-network deductible, as applicable.
- Responsible for your out-of-network coinsurance payments.
- Responsible for any balance-billed amount over our allowance.
- Responsible for submitting your own claims and obtaining authorizations, as applicable.

Specialty Care and Prior Authorization

At times, your participating doctor may feel it is appropriate for you to receive specialty care services. Your doctor will find the appropriate specialist to provide the specialty care you need.

Specialty Care Copayments

You are responsible for your copayment amount when you receive specialty care, including Ob/Gyn services. This copayment is due at the time you receive services. You can find your participating doctor and specialty care copayment amounts on your Horizon BCBSNJ ID card.



Specialty Care and Prior Authorization

Prior Authorization

Prior authorization is the approval we give you and your participating doctor before you receive certain medical care.

Some services require prior authorization under your Horizon PPO plan. Please check your Benefit Booklet to see how this may apply to you.

Your participating Horizon PPO doctor can handle most of your prior authorization requirements for you. With the proper prior authorization, you can be sure that the services are eligible for coverage.

If you use a nonparticipating or out-of-network doctor for your care, you will be responsible for contacting us for any necessary prior authorization. If your services are not authorized, your benefits may be reduced or you may not be covered at all.

When do I need Prior Authorization?

We require prior authorization for some hospital-related care, some outpatient services and some durable medical equipment (DME).

Please note prior authorization is handled by CareCore National, LLC for radiology and pain management services.

If you have questions about which services need prior authorization under your Horizon PPO plan, please speak with your doctor or other health care professional. If you still have questions regarding prior authorization, please call Member Services at **1-800-355-BLUE (2583)**.

How do I get a Prior Authorization?

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

Specialty Care and Prior Authorization

If you have pharmacy benefits through Horizon BCBSNJ, the following applies:

Prior Authorization for prescription drugs

Horizon BCBSNJ has a quality process that focuses on select prescription drugs or prescription drug categories known to have the potential for misuse, abuse and adverse effects. These prescription drugs are commonly used for purposes other than those approved by the U.S. Food and Drug Administration (FDA). In this program, Horizon BCBSNJ checks for medical necessity and appropriateness based on FDA-approved use, peer review, clinical literature and national standards.

How do I get a medication that requires Prior Authorization?

When your pharmacist enters your prescription into his/her computer system, a prior authorization message may appear. You, your pharmacist or doctor must call our pharmacy benefits manager at the Pharmacy Member Services number on the back of your ID card to request a prior authorization.

It is important that you or your doctor initiate a review as soon as possible to help eliminate any delay in receiving your medication from the pharmacy. If prior authorization has not been received, you may be limited to a 96-hour supply while waiting for the prior authorization process to be completed.

Need more information?

For more information about prior authorization for prescription drugs or a complete list of drugs that require prior authorization:

- Visit HorizonBlue.com/Members, mouse over *Education Center* and click *Pharmacy & Prescriptions*.
- Or, call Pharmacy Member Services at the number located on the back of your Horizon BCBSNJ member ID card.

Accessing 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 a medical emergency. It is medical care you can safely postpone until you can call your doctor. Examples of urgent care include:

- Earache.
- Sore throat.
- Moderate fever.
- Sprains.

If you reasonably believe you have a medical emergency, follow the medical emergency procedures on page 23.

If your doctor determines your situation is a medical emergency, he/she will suggest you go directly to an emergency facility. If it is not a medical emergency, your doctor may tell you how to treat the problem yourself or may make an appointment to see you.

The Emergency Room (ER) may not be your best option for an acute illness or injury. Unless your situation is a true emergency, you'll likely get quicker medical care in an Urgent Care Center for less cost.

We have participating urgent care facilities throughout New Jersey. Urgent Care Centers can treat patients who have an injury or illness that requires immediate care but is not serious enough for a visit to the ER.

Saving you time and money

Going to an Urgent Care Center may save you time because you often can get treated faster than you would at an ER. Most Urgent Care Centers have extended and weekend hours and can handle problems like stitches, sprains and other conditions that need immediate attention, but aren't life-threatening. All participating Urgent Care Centers can perform X-rays, draw and test blood and monitor heart rates.

You can also save money by using a participating Urgent Care Center because you only pay your specialist copayment and not the ER copayment.

Finding a participating Urgent Care Center

Visit [HorizonBlue.com/directory](https://www.horizonblue.com/directory) and select the *Other Healthcare Services* tab.

Care on Nights and Weekends

If you need care after hours or on weekends, your participating doctor or his/her covering health care professional is available 24 hours a day, seven days a week.

Emergency Care

You are covered for medical emergency care 24 hours a day, seven days a week. Emergency care is a medical condition of such severity that a prudent layperson with average knowledge of health and medicine would call for immediate medical attention.

Some examples of a medical emergency include:

- Obvious bone fractures.
- Heart attack.
- Loss of consciousness.
- Poisoning.
- Severe burns.
- Stroke.
- Wounds requiring stitches.

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

Emergency Room (ER) Copayments

Most Horizon PPO members have an ER copayment, even if your doctor refers you. Each time you receive treatment in an ER for a medical emergency or are given a medical emergency screening exam, you will pay that copayment. If you are admitted as an inpatient within 24 hours, we'll waive the ER copayment.*

Follow-up Care After an ER Visit

To be covered at the in-network level, all medical emergency follow-up care should be coordinated by your doctor.

* Applicable to Major Account Markets only. Please refer to your Benefit Booklet/Certificate for additional information.

Emergency Care

Medical Emergency Screening Exam

Sometimes you may not be sure if you need emergency care. In these cases, your plan covers a medical emergency screening exam. This is an evaluation performed in a hospital ER by a qualified health care professional, to determine if a medical emergency exists.

We will cover the cost of the medical emergency screening exam. If you are advised that your condition is not a medical emergency and you continue to receive services at the ER, you will have to pay for the non-emergency services.

Medical Emergency Procedures

In a medical emergency, please follow the steps below:

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

You do not need to call Member Services to notify us of a medical emergency.

Members who use the ER for routine or non-emergency care will be responsible for all charges.



You are covered for emergency care 24 hours a day, seven days a week. You don't have to worry about checking whether the hospital participates in our network if you have a medical emergency. Please remember to call your doctor, so that he/she can coordinate your follow-up care.

Dependent Coverage

Your eligible dependents may be covered under your Horizon PPO plan.

| Dependent | Eligibility* |
|---|--|
| Newborn ¹ | Your newborn is automatically covered for up to 31 days following his/her date of birth. Please send a completed enrollment form to your employer within 31 days from the date of your child's birth to ensure your newborn is covered past those first 31 days. |
| Child | An eligible child may include your own child, a legally adopted child, stepchild, civil union partner's child ¹ or a child for whom you have court-appointed guardianship. If your employer offers domestic partner coverage, an eligible child may include the child of your domestic partner. |
| Handicapped child | Your child may be eligible past the group's limiting age if he/she has a mental/physical incapacity or developmental disability. Proof of handicap is required. |
| Child dependents to age 26 ² | Most children under age 26 years are eligible under federal health care reform law to be covered under their parent's coverage. |
| Dependents under age 31 ¹ | Dependent children under age 31 years may continue coverage if they are older than the limiting age on their parent's plan and meet certain eligibility requirements. For more information, and to determine eligibility, please contact your employer or benefits administrator. |
| Spouse | We must receive your enrollment form within 31 days of your marriage date for your spouse to be added to your plan, effective on your marriage date. Proof of marriage is required when your last name and your spouse's last name are different. |
| Civil union partner ¹ | You may add a civil union partner to your coverage. If we receive your enrollment form within 31 days of your civil union partner's eligibility date (which is generally the date of establishment of the civil union), a civil union partner's coverage will become effective on his or her eligibility date. If we don't receive your form within 31 days of the applicable eligibility date, your civil union partner's coverage will become effective on the date we receive your enrollment form. ³ Proof of civil union is required when your last name and your partner's last name are different. |
| Domestic partner | Please contact your benefits administrator to determine if this coverage option was selected for your plan. |

Dependent Coverage

For information and instructions on how to apply for dependent coverage, please refer to your Benefit Booklet/Certificate or call Member Services at **1-800-355-BLUE (2583)**. You may also find necessary enrollment forms at **[HorizonBlue.com/Members](https://www.HorizonBlue.com/Members)** under *Forms*.

* Information current at the time of printing. Due to health care reform laws, content is subject to change.

- ¹ New Jersey requires automatic coverage for newborns and coverage for dependents under age 31 and civil union partners. These New Jersey provisions are optional for self-insured groups. Please check with your benefits administrator to find out if they are included in your plan.
- ² Certain group plans do not allow dependent children who have access to their own coverage to be covered under their parents' group plan. Check with your employer for details.
- ³ Some members must wait until the next open enrollment to enroll. Please check with your employer.



Pharmacy Benefits

Your Horizon PPO plan may include prescription drug coverage administered by Prime Therapeutics LLC (Prime). Look at your Horizon BCBSNJ ID card for the Prime logo or read your Benefit Booklet/Certificate to find out if this is part of your Horizon BCBSNJ benefits.

Horizon BCBSNJ has a list of Preferred and non-Preferred prescription drugs. This list is maintained by our Pharmacy and Therapeutics (P&T) Committee. This committee regularly reviews new and existing drugs based on criteria such as safety and how well the drugs work.

Online Pharmacy Services

Go to HorizonBlue.com/Members and click the *Prescription Resources* icon to:

- Look up prescription drug coverage and pricing.
- Learn about generic drugs.
- Set up mail-order service for your prescription medications.
- Find prescription drug information.
- Find a nearby pharmacy.

You may need to sign in to Member Online Services at HorizonBlue.com to access some of the features.



If you have mail service as part of your pharmacy coverage and take medicine on an ongoing or regular basis, you may benefit from PrimeMail®. This service can help you save time and money by having prescriptions delivered right to you. To learn more about the program and how you can get started, visit HorizonBlue.com/members/services/pharmacy-prescriptions/prescriptions-mail.

Pharmacy Benefits

Specialty Pharmacy Services

Drugs that require special monitoring, administration or handling are categorized as specialty drugs. Horizon BCBSNJ has contracted with pharmacies that specialize in these types of drugs. These pharmacies will:

- Give you condition-specific information to help you learn about your medicine.
- Help with your pharmacy claims.

If you take a specialty drug, your doctor will work with Horizon BCBSNJ on the medical necessity determination.

For more information about your prescription drug benefits or specialty pharmaceuticals:

- Go to HorizonBlue.com/Members, mouse over *Services* and click *Specialty Rx Program*.
- Or, call Pharmacy Member Services at **1-800-370-5088**.

Maternity Care

Most pregnant women have questions and concerns about their pregnancy and delivery. That's why we developed PRECIOUS ADDITIONS®, a program that gives helpful information during this exciting time. For more information about PRECIOUS ADDITIONS or to sign up, visit HorizonBlue.com/Members and:

- Mouse over *Health and Wellness* and click *Health Programs*.
- Or call Member Services at **1-800-355-BLUE (2583)**.

Remember to send a completed enrollment form to your employer within 31 days from the date of your child's birth to ensure your newborn is covered past those first 31 days. Please make sure your employer sends your form to our enrollment team as soon as possible.

For specific information about dependent coverage, please read the chart on page 24 or refer to your Benefit Booklet/Certificate. Please call Member Services if you do not receive a form to add your newborn to your coverage.

Partnering with your Ob/Gyn

We support the recommendation of the American College of Obstetricians and Gynecologists for 12 Ob/Gyn visits during a normal pregnancy. Your obstetrician will determine the number of visits that are right for you.

If your obstetrician feels you need more specialized care, you may be referred to one of our case management nurses. This nurse works with you and your doctor throughout your pregnancy to help ensure that you and your unborn baby have access to the most appropriate care. For more information about our case management services, please call us at **1-888-621-5894**, option **2**.

Maternity Care

Maternity Hospital Stays

Pregnant women are certified to stay in the hospital for:

| | |
|--------------------------------|---------------------------------------|
| 48 hours | After a vaginal delivery. |
| 96 hours | After a cesarean section (c-section). |
| More time, if medically needed | Must be approved by Horizon BCBSNJ. |

If you are advised by your doctor to leave the hospital early, you may be eligible to receive home care services.* These services can support you during your transition from hospital to home.

* You are eligible to get a home care visit if you leave the hospital within one day after a vaginal birth or within two days after a c-section. Visits must be scheduled by your Ob/Gyn within seven days for a nurse/lactation consultant and 14 days for a home health aide.



Behavioral Health and Substance Abuse Care

Managed behavioral health and substance abuse care is a covered benefit under your Horizon PPO plan. An extensive network of participating doctors will provide biologically based and nonbiologically based behavioral health and substance abuse care services (including treatment of alcoholism). Prior authorization is required for all inpatient care. Outpatient hospital care and office visits do not require prior authorization.

Accessing Behavioral Health and Substance Abuse Care

For routine behavioral health or alcohol/substance abuse care, please call **1-800-626-2212**.^{*} Behavioral health and substance abuse care is available 24 hours a day, seven days a week. All calls are confidential.

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

Available Services

The behavioral health professionals in the network offer a full range of counseling services, including:

- Addiction recovery programs.
- Individual and group psychotherapy.

For more information, visit HorizonBlue.com and search for *Behavioral Health* or call the Behavioral Health Services number on the back of your Horizon BCBSNJ ID card.



You are covered for behavioral health and substance abuse care. Call the number on the back of your Horizon BCBSNJ ID card for help.

Out-of-Area Coverage

If you or a covered family member needs care when out of state, you're covered. No matter where you go, you can feel at ease because, as a Horizon BCBSNJ member, you can enjoy the convenience of the BlueCard® network.

How BlueCard Works

1. When you are outside the state of New Jersey and need medical care or services, call **1-800-810-2585** or download the Blue Finder app on your web-enabled mobile device to find the nearest participating Blue Cross and/or Blue Shield doctor or hospital.
2. You are responsible for getting any prior authorization from us.
3. Present your Horizon BCBSNJ ID card to the participating Blue Cross and/or Blue Shield doctor or hospital.
4. The doctor or hospital will recognize the BlueCard logo (the *suitcase logo* pictured at right) and will verify your eligibility for benefits.
5. After you receive medical care, your claim is routed to us. All doctors are paid directly and you are only responsible for your office visit copayment.



If you are outside of the U.S. and need care, please call the BlueCard Worldwide Service Center at **1-800-810-BLUE (2583)** or call collect at **1-804-673-1177**.

Getting Information About your Horizon PPO Plan

Having access to your benefit information helps you get the most from your plan. We offer four easy ways for you to get the information you need:

1. [HorizonBlue.com](https://www.horizonblue.com)

Horizon BCBSNJ offers secure, online tools through our website. Our Member Online Services makes it easier for you to manage your health care information and Horizon BCBSNJ benefits from a Mac® or PC. To register for Member Online Services, please follow these easy steps:

1. Visit [HorizonBlue.com/Members](https://www.horizonblue.com/Members).
2. Click *Register Today* and follow the instructions.

At Member Online Services, you can:

- View your enrollment history and claim details.
- Print a copy of your ID card or request a duplicate ID card.
- View referrals and authorizations.
- Check the status of your claims.
- Sign up to receive paperless Explanation of Benefits (EOB).
- Update your Coordination of Benefits (COB) information.
- Manage and track your health care information through *My Health Manager*, powered by *WebMD*®.
- Find a participating doctor, facility or other health care professional.

Getting Information About your Horizon PPO Plan

When you visit HorizonBlue.com to use Member Online Services, please keep the following in mind:

- You must have a valid e-mail address when registering for Member Online Services.
- The operating systems that work with Member Online Services are Microsoft® Windows and Mac OS.
- The browsers that are supported are Internet Explorer® 6 or higher, Firefox® 3 or higher, Chrome™ and Safari®.
- You will need Adobe® Acrobat Reader to view select content on Member Online Services.
- If you have problems accessing Member Online Services, please e-mail Member_Portal@HorizonBlue.com. Representatives are available Monday through Friday, between 7 a.m. and 6 p.m., Eastern Time, excluding holidays.

2. Horizon Blue App

With our Horizon Blue App, you can use your web-enabled hand-held device to find everything from health plan options and information, to our online *Provider Directory*, which includes information for our 72* network hospitals and more than 37,000* doctors and health care professionals located across New Jersey.

* Numbers current at time of printing.



Getting Information About your Horizon PPO Plan

3. Interactive Voice Response (IVR) System

You may get information about your plan during and after our regular business hours through our Interactive Voice Response (IVR) system. You can access the IVR 24 hours a day, seven days a week (generally including weekends and holidays) by calling **1-800-355-BLUE (2583)**. When using the IVR, please be sure to listen carefully to the prompts and speak your responses in a clear voice.

4. Member Services

Our professional Member Services Representatives are available to help you. Call **1-800-355-BLUE (2583)**, Monday through Wednesday and Friday, between 8 a.m. and 6 p.m., Eastern Time (ET), or Thursday, between 9 a.m. and 6 p.m., ET, to:

- Ask questions about benefits, coverage, participating doctors and other health care professionals.
- Inform us of any name, address, telephone or dependent coverage changes.
- Notify us of any other health insurance coverage for Coordination of Benefits (COB).
- Let us know if there is something we are doing well or that we can do better.

Your ID Card

Your ID card shows you are enrolled in a Horizon PPO plan. Keep your ID card with you at all times and present it each time you receive medical care. Your ID card lists important information, including copayments, deductibles and coinsurance amounts.

If you lose your ID card, please use Member Online Services to view and print a copy of your ID card or to request a duplicate ID card.

If the information on your ID card is incorrect, please call Member Services at **1-800-355-BLUE (2583)**.

Getting Information About your Horizon PPO Plan



1. Member name.
2. ID number.
3. Coverage verification information. This information will vary based on your plan.
4. The name of your plan.
5. Copayment information. This information will vary based on your plan.
6. The suitcase logo means you have coverage when traveling outside the state of New Jersey.



7. Claim filing information. This information will also vary based on your plan.
8. Prime Therapeutics logo indicating prescription drug coverage, if you have prescription drug coverage through Horizon BCBSNJ.
9. Website for Member Online Services.
10. Service phone numbers. This information will also vary based on your plan.

Laboratory Testing

To receive the in-network level of benefits and pay less out of your pocket for laboratory work, please use a participating laboratory such as Laboratory Corporation of America® (LabCorp) or AtlantiCare Clinical Laboratories. Your doctor or other health care professional may draw blood in his/her office or send you directly to LabCorp or AtlantiCare Clinical Laboratories for testing.

LabCorp and AtlantiCare Clinical Laboratories

Your doctor or other health care professional may refer you directly to a LabCorp Patient Service Center. If so, you will need a LabCorp Requisition Form or prescription to take with you. You may also use this form at AtlantiCare Clinical Laboratories. Please present the requisition form and your Horizon BCBSNJ ID card at the participating laboratory.

To find a LabCorp Patient Service Center near you, visit Labcorp.com/psc or call **1-888-LAB-CORP (522-2677)**. To schedule an appointment you may use this website or call LabCorp Customer Service at **1-800-745-0233**.

AtlantiCare Clinical Laboratories

AtlantiCare Clinical Laboratories has a special relationship with Horizon BCBSNJ and LabCorp. Horizon PPO members may use AtlantiCare Clinical Laboratories to draw laboratory specimens on behalf of LabCorp on an in-network basis. For more information and to locate the most convenient AtlantiCare testing center, visit our online *Provider Directory* at HorizonBlue.com/directory or visit AtlantiCare.org, click *Locations* and then click *Clinical Laboratories*.

Remember, if you do not use LabCorp or AtlantiCare Clinical Labs, you may pay more. If you receive a bill for lab work from LabCorp or AtlantiCare Clinical Labs, please call Member Services at **1-800-355-BLUE (2583)**.



You must have your lab work done by either LabCorp or AtlantiCare Clinical Laboratories to be covered at the in-network level and to avoid higher out-of-pocket expenses.

Radiology/Diagnostic Imaging Services

CareCore National, LLC

Horizon BCBSNJ contracts with CareCore National, LLC to manage Advanced Imaging Services for our members through Prior Authorizations*/Medical Necessity Determinations (PA/MND) with doctors. CareCore helps to ensure our members receive appropriate radiology/imaging services, provides clinical consultation to our participating health care professionals and helps with scheduling of radiology/imaging services. Your ordering doctor must call CareCore at **1-866-496-6200**, before you receive any of the Advanced Imaging Services listed below:

- CT/CTA scans.
- Diagnostic left heart catheterization.
- Echocardiogram.
- Echo stress.
- MRIs/MRAs.
- PET scans.
- Nuclear medicine studies (including Nuclear Cardiology).

Once the test is approved, CareCore will call you to schedule the procedure at a participating location. When possible, CareCore will conduct a three-way call with you and the location you choose to schedule the appointment. You may also call CareCore directly at **1-866-969-1254** to schedule the approved procedure. You will also receive a letter from CareCore confirming the scheduled appointment.

Scheduling your Tests

You may schedule all other radiology services through CareCore's easy-to-use Scheduling Line. The Scheduling Line replaces the referral process. The scheduling staff will coordinate with the participating radiology/diagnostic imaging center of your choice to schedule your exam and give you a confirmation number.

To make an appointment and get a confirmation number, please call the Scheduling Line toll-free at **1-866-969-1254**, Monday through Friday, between 7 a.m. and 7 p.m., Eastern Time (ET).

For more information, please call Member Services at **1-800-355-BLUE (2583)**.

* Effective **January 1, 2014**, under some group plans, the CareCore prior authorization requirement will no longer be offered. Please check with your employer to see if this applies to your plan.

Hospitalization

The Horizon Hospital Network includes many hospitals throughout New Jersey and nearby in Pennsylvania, Delaware and New York. To find a participating hospital or facility, please use our *Provider Directory* at HorizonBlue.com/directory or call Member Services at **1-800-355-BLUE (2583)**. You can also use a web-enabled mobile device to access the online *Provider Directory* by visiting Mobile.HorizonBlue.com or by downloading our Horizon Blue App.

For eligible hospital charges to be considered in network:

- You must receive care in, or be admitted to, a network hospital.
- Your doctor or participating health care professional must follow our prior authorization (PA) procedures.

If you do not get PA before you receive care at a nonparticipating hospital for a condition that is not an emergency, only part of the available benefits will be paid or, in some cases, the claims for the admission will be denied entirely.

Hospital Stays and Prior Authorization

If you need to be hospitalized, your doctor or other participating health care professional must contact us for PA. Once your hospital stay has been authorized, we will give your doctor a PA number.

If you are being admitted to a nonparticipating hospital it is your responsibility to contact us for PA.

If you need emergency care, go directly to the nearest hospital or emergency facility without worrying about finding a participating facility. If you are admitted into the hospital, you or the hospital's admitting staff need to call Horizon BCBSNJ to let us know.

If You Go to a Nonparticipating Hospital

If you do not use a hospital in the Horizon Hospital Network, your care will be considered out of network. This means you will have to pay more out of pocket for your care and may have to file claim forms for reimbursement. Even if a participating doctor admits you to a nonparticipating hospital, you will most likely still pay more out of pocket because this hospital is not in our network.

Please note: We are not responsible for payment of services not included in your contract or those specifically excluded.

Getting and Staying Healthy: Preventive Health Care Benefits

Healthier members ...
healthier communities

You are covered for well care and preventive health care under your Horizon PPO plan. Your doctor manages most of your well and preventive care services.

We encourage you to visit your participating doctor for regular checkups. Early detection of any illness is your best defense for recovery. Your participating doctor may order tests and X-rays, refer you to a participating specialist or arrange for other services, if needed.

The following services are included as part of your well and preventive care coverage:

- Regular office visits.
- Well-child care (including immunizations and lead screenings).*
- Annual dilated retinal exam, if you are diagnosed with diabetes.*
- Prostate cancer screenings.
- Tests (laboratory work, X-rays).

* Some group contracts may not cover this annual exam. Please refer to your Benefit Booklet/Certificate for specific benefit information.



Getting and Staying Healthy: Preventive Health Care Benefits

Gynecological Coverage

You are covered for routine gynecological exams and services when performed by an Ob/Gyn, doctor or other health care professional.

To find a participating Ob/Gyn, use the online *Provider Directory* at HorizonBlue.com/directory.

Mammography Coverage

Your Horizon PPO plan covers mammography screenings. The mammogram may be part of the annual Ob/Gyn exam, or your participating Ob/Gyn may send you for a diagnostic or screening mammogram when necessary.

Female members have the following mammography benefits:

- One baseline mammogram for women between ages 35 and 39 years.
- Annual mammogram for women ages 40 years and older and considered average risk.
- Mammograms, as prescribed, for high-risk patients.

A woman who is younger than age 40 and has a family history of breast cancer or other breast cancer risk factors may have a mammogram examination as deemed medically necessary by the woman's participating doctor.*

* These services must be authorized by Horizon BCBSNJ prior to being rendered for women under age 40.

You do not need a referral to receive a routine mammogram; however, you need a prescription from your doctor or participating Ob/Gyn to have a mammogram at a participating hospital or participating imaging center.

Getting and Staying Healthy: Preventive Health Care Benefits

Preventive Health Care Guidelines

Horizon BCBSNJ is committed to helping our members get and stay healthy by supporting the recommendations from the Centers for Disease Control and Prevention (CDC) and other nationally recognized authorities for routine preventive screenings and immunizations. We encourage you to speak with your participating doctor about which screenings and immunizations are right for you. For a complete list of the preventive health care guidelines:

- Visit [HorizonBlue.com/Members](https://www.horizonblue.com/members).
- Mouse over *Health & Wellness* and click *Health Programs*.

Read your Benefit Booklet/Certificate or call Member Services to find out which services and supplies are covered under your Horizon BCBSNJ benefits.



24/7 Nurse Line*

The 24/7 Nurse Line is a nonurgent health care information service of Horizon BCBSNJ.* Registered nurses are available 24 hours a day, seven days a week to help you:

- Find out if the Emergency Room (ER), an office visit or self-care is right for your needs.
- Learn about symptoms and reactions to medications and other health-related topics.
- Learn how nutrition and exercise can help you maintain a healthy lifestyle.
- Get health information based on your immediate needs.

Chat with a Nurse

Our 24/7 Nurse Line offers you access to an online chat feature where you can interact online in real time with a nurse about various health and wellness issues. To chat with a nurse, sign in to Member Online Services at HorizonBlue.com and:

- Mouse over *Tools & Resources* and click *Self Service*.
- Click *Nurse Chat*.

* This service is not available to all members and some group clients may not offer this service. Please check with your benefits administrator. Nurses cannot diagnose problems or recommend specific treatment. They are not a substitute for your doctor's care. The 24/7 Nurse Line services are not an insurance program and may be discontinued at any time. In the event of an emergency or if you believe you have a life-threatening medical situation, please go to the nearest hospital or call **911** or your local emergency number.



You can get general health and wellness information 24 hours a day, seven days a week. Registered nurses can help you better understand your health. Just call the 24/7 phone number on the back of your ID card.

Chronic Care Program

Our Chronic Care Program helps members who have chronic conditions take better care of their health, understand their care choices and help improve their well-being. This program is available at no added cost to eligible members who have:

- Asthma.
- Chronic Kidney Disease (CKD), including members receiving dialysis/End-Stage Renal Disease (ESRD).
- Chronic Obstructive Pulmonary Disease (COPD).
- Coronary Artery Disease (CAD).
- Diabetes.
- Heart Failure.

For more information or to enroll:

- Visit HorizonBlue.com/Members and:
 - Mouse over *Health & Wellness* and click *Health Programs*.
- Or, call **1-888-334-9006**, Monday through Friday, between 8 a.m. and 7 p.m., Eastern Time. If you have hearing or speech difficulties, please call the TTY/TDD line at **1-800-855-2881** during the same hours.



A chronic health condition is a health problem that lasts a long time. Horizon BCBSNJ can help you if you have been diagnosed with a chronic illness.

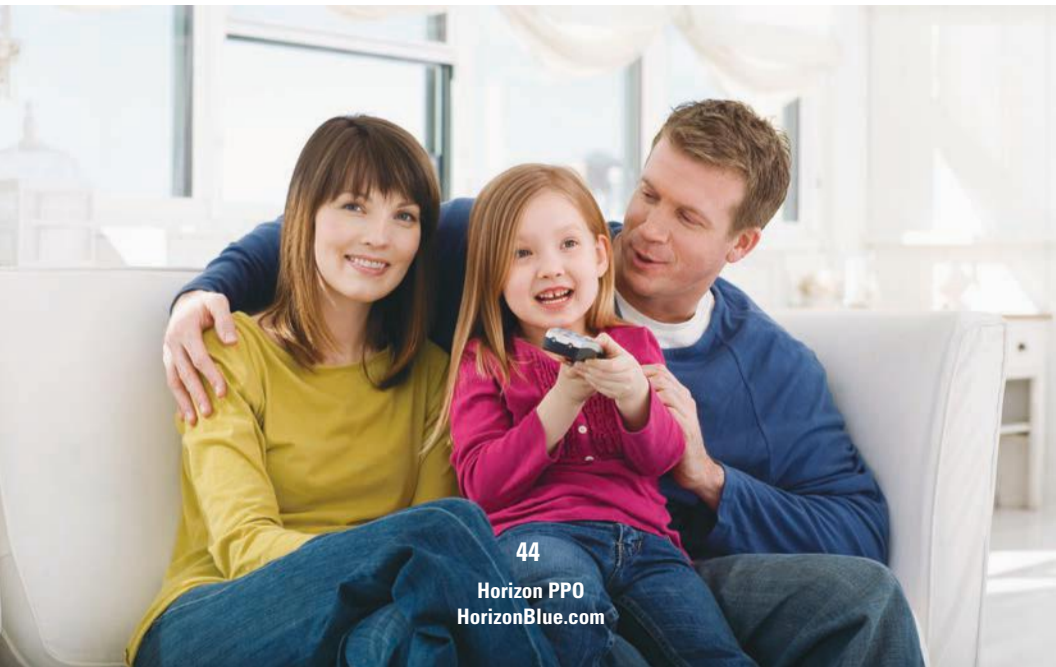
Case Management

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

Your case manager can work with you and your doctor(s) to make sure you get the most appropriate and effective treatment. He/she will also:

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

For more information or to sign up, call **1-888-621-5894**, option **2**, Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time. This program is available at no added cost to eligible members.



Blue Distinction Centers for Transplants

In addition to our local quality centers for transplants, Horizon BCBSNJ members have access to the Blue Distinction Centers for Transplants®, a national comprehensive network of transplant centers for both solid organ and bone marrow transplants.

The Blue Distinction Centers for Transplants are designated facilities within various participating Blue Cross and/or Blue Shield plan service areas that meet stringent quality criteria established by national organizations and expert clinician panels. By meeting these requirements, the centers demonstrate better outcomes and consistency of care and provide greater value for our members.

There are Blue Distinction Centers for Transplants for the following transplant types:

- Bone marrow/stem cell (autologous and allogeneic).
- Heart.
- Combination heart/bilateral lung.
- Liver (deceased and living donor).
- Combination liver/kidney.
- Lung (deceased and living donor).
- Pancreas After Kidney (PAK) and Pancreas Transplant Alone (PTA).
- Simultaneous pancreas/kidney (SPK).

If you need a transplant, our dedicated Case Management team is available to help you and your doctor. For more information about our participating local and national transplant facilities, please call **1-888-621-5894** and select option **2** for Case Management. You can also get information at bcbs.com/bluedistinction.

Utilization Management Program

Horizon BCBSNJ's Utilization Management (UM) Program makes sure that our members get the right care at the right time and place of service. UM activities look for care and treatment choices that give high-quality care and outcomes and, when possible, help doctors give care that is medically appropriate and cost effective.

We:

- Make UM decisions based on needed and proper care and services in view of your benefits.
- Do not give those in charge of making UM decisions incentives or bonuses to deny medically needed and appropriate covered services.
- Give you access to medically needed and cost-effective health care services and encourage the reporting, investigation and elimination of underutilization and overutilization.

Understanding health care terms

Overutilization is the unneeded treatment, tests and studies that a member may go through.

Underutilization is too little care or services that do not properly meet the needs of a member.

Both overutilization and underutilization can result in costly and inappropriate use of services.

Our UM staff is available at the toll-free UM number on the back of your ID card, Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time, to respond to authorization requests and inquiries about UM. Our on-call staff is also available for emergency requests after normal business hours, including weekends and most holidays. If you have hearing or speech difficulties, please call the TTY/TDD line at **1-800-855-2881**.

Blue365: Wellness Discounts*

Horizon BCBSNJ understands that helping members live a healthy life requires more than regular doctor visits – it's helping them find time for the things that matter most.

That is why Horizon BCBSNJ is proud to offer Blue365®, a national program that offers exclusive access to information, discounts and savings, making it easier and more affordable to make healthy choices.

Exclusive discounts on health and wellness

Blue365 includes select savings on products and services that can be used to improve and maintain your health every day. Leading national companies from a wide range of categories have created special offerings and discounts just for Blue Cross and/or Blue Shield members.

Easy access on the web

You can begin taking advantage of everything Blue365 has to offer at HorizonBlue.com/Blue365.

* Blue365 offers access to savings on items and services that members may purchase directly from independent vendors. To find out what is available to you through Blue365, visit the website mentioned above. Please note that the Blue Cross and Blue Shield Association (BCBSA) may receive payments from Blue365 vendors. Also, neither Horizon BCBSNJ nor the BCBSA recommend, warrant or guarantee any specific Blue365 vendor or discounted item or service.



Blue365 offers exclusive health and wellness deals, helping to keep you healthy and happy every day of the year.

Frequently Asked Questions

Horizon BCBSNJ is committed to helping you navigate the health care system so you can get access to safe and effective care. Understanding your benefits is an important part of your health care because when you understand your benefits, you can focus on getting and staying healthy. Below are answers to some frequently asked questions.

Q1. I lost my Horizon BCBSNJ ID card. How do I get a new ID card?

A1. You can get a new ID card by:

- Signing in to Member Online Services at HorizonBlue.com and clicking *Request a New ID Card* or *Print a Temporary ID Card*.
- Calling our Interactive Voice Response System at **1-800-355-BLUE (2583)** and follow the prompts.
- Speaking with a Member Services Representative at **1-800-355-BLUE (2583)**, Monday through Wednesday and Friday, between 8 a.m. and 6 p.m. Eastern Time (ET), or Thursday, between 9 a.m. and 6 p.m., ET, to request a new ID card.

Q2. I recently moved. How can I update my mailing information?

A2. To update your information, please sign in to Member Online Services at HorizonBlue.com and click *Profile*, or speak with a Member Services Representative at **1-800-355-BLUE (2583)**.

Some members must update their address with their employer. Please check with your employer for more information.

Frequently Asked Questions

Q3. *How much is my copayment?*

A3. For copayment information, you can:

- Check the front of your Horizon BCBSNJ ID card.
- Sign in to Member Online Services at HorizonBlue.com and click *Additional Benefits*.
- Speak with a Member Services Representative at **1-800-355-BLUE (2585)**.

Q4. *How can I find a doctor outside New Jersey?*

A4. To find a participating doctor in another state:

- Visit HorizonBlue.com/directory and click *Providers Outside of NJ* at the top of the page.
- Download our free Horizon Blue App or the Blue National Doctor and Hospital Finder app and let your mobile device be your guide for Blue Cross and/or Blue Shield participating health care provider information.
- Call **1-800-810-2585** to find information about the nearest participating Blue Cross and/or Blue Shield doctor or hospital.

Q5. *I need to have blood work done. Is LabCorp the only in-network lab I can go to?*

A5. No. LabCorp is one of the in-network labs that you may use. Refer to the online *Provider Directory* for other in-network labs.

Protection of your Private Information

Horizon BCBSNJ is committed to keeping your medical and claims information confidential. State and federal laws set forth requirements relating to how Horizon BCBSNJ may use and disclose your private information.

Our *Notice of Information Privacy Practices* describes how we collect, maintain, use and disclose your private information. To read our *Notice of Information Privacy Practices*, visit HorizonBlue.com/privacy-policy.



Your Horizon BCBSNJ Member Rights

As a Horizon BCBSNJ member, you have the right to:

- Receive information about your rights and responsibilities, and about Horizon BCBSNJ's services, policies and procedures, products, networks, appeal procedures, coverage limitations and other information you need to understand your benefits and get care.
- Ask for, and get, a current directory of network doctors and other health care professionals. The directory includes addresses and phone numbers, and lists professionals who speak languages other than English.
- Be notified, not more than 30 days following the effective date, if any of your benefits end or change.
- Get information about whether a health care professional who is treating you has a financial interest in a facility, group, etc. to which he/she is referring you.
- Know how Horizon BCBSNJ reimburses network professionals and to be made aware of any financial incentives or disincentives tied to medical decisions.
- Receive from your doctor or other health care professional, in terms you understand, an explanation of your complete medical condition, such as information regarding your health status, medical care or treatment options, including alternative treatments that may be self-administered, recommended treatment, risk(s) of the treatment, expected results of the treatment and reasonable medical alternatives, whether or not these are covered benefits. You also have the right to be provided the opportunity to decide among all relevant treatment options. If you are not capable of understanding the information, the explanation shall be provided to your next of kin or guardian and documented in your medical record.
- Have full, candid discussions about the risks, benefits and consequences regarding appropriate or medically necessary diagnostic services and treatment or non-treatment options with your participating doctors, regardless of cost or benefit options.

Your Horizon BCBSNJ Member Rights

- Refuse treatment and to express preferences about future treatment options.
- Receive from your doctor or health care professional, in terms you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of the treatment, expected results of the treatment and reasonable medical alternatives, whether or not these are covered benefits. If you are not capable of understanding the information, the explanation shall be provided to your next of kin or guardian and documented in your medical record.
- Select a Primary Care Physician* (PCP), if your plan requires or allows you to. Once selected, you can change your PCP, subject to the availability of a replacement PCP. If your chosen PCP subsequently leaves, or is terminated from the network, you have the right to be notified of that fact within 30 days. (This does not apply in certain cases, such as when the PCP is terminated immediately due to fraud or as a danger to the public.)

* In general, a PCP is a qualified professional whom you select to provide your basic health care services and to supervise and coordinate your overall health care. Not all health insurance plans require or allow you to select a PCP.

- Have access to medical care and services 24 hours a day, seven days a week, 365 days a year for urgent or emergency conditions. Call the **911** emergency response system or an appropriate local emergency number in a potentially life-threatening situation, or go to an Emergency Room. You do not need prior approval in a potentially life-threatening situation.
- Choose from appropriate network specialists, subject to the specialist's availability to accept new patients and any plan requirements regarding a referral or prior authorization.
- Get help in finding network doctors and other health care professionals with experience in treating patients who have chronic conditions.

Your Horizon BCBSNJ Member Rights

- Receive a written explanation for the denial or limitation of a requested service. Our doctor who made the decision must also directly communicate with your doctor or other health care professional or supply your professional with his/her phone number.
- Be free from balance billing by network professionals for covered services or supplies, excluding any copayments, coinsurance and/or deductible amounts that you must pay according to the terms of your plan.
- Voice complaints or file internal and external appeals about your claim or the care provided with Horizon BCBSNJ or the New Jersey Department of Banking and Insurance. You also have the right to receive a response to your complaint or appeal within a reasonable period of time. Neither you nor your doctor or other health care professional can be penalized for complaining or appealing.
- Participate with your doctors and other health care professionals in decision making about your health care.
- Be treated with courtesy and consideration, and with respect for your privacy and dignity.
- Request and receive a copy of your Private Information maintained in Horizon BCBSNJ's records. Exercise your privacy right by requesting an amendment of your Private Information that is believed to be inaccurate.
- Develop an advance directive and have it implemented.
- Access any and all rights afforded to you by law or regulation as a patient in a licensed health care facility. This includes your right to refuse medication and treatment after possible consequences of this decision have been explained in language you can understand and be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Make recommendations for the Horizon BCBSNJ Member Rights and Responsibilities Policy.

Your Horizon BCBSNJ Member Responsibilities

As a Horizon BCBSNJ member, you have the responsibility to:

- Read and understand your member rights and responsibilities, your member handbook and all other member materials that explain your coverage.
- Understand that, if your plan provides benefits for services of non-network doctors, you will not receive the same level of benefits as you would if you used in-network doctors. Also, if you use non-network doctors, you need to understand that you must pay for the charges for their services that exceed Horizon BCBSNJ's allowance.
- Make and keep appointments for nonemergency medical care. If you need to cancel an appointment, you must give adequate notice.
- Provide, to the extent possible, information about your health that Horizon BCBSNJ, its network doctors and other health care professionals need to properly care for you.
- Understand your health problems and to participate, to the extent possible, with your health care professionals in developing mutually agreed-upon treatment goals and in making medical decisions regarding your health.
- Follow the plans and instructions for care that you agreed to with your doctor or other health care professional. If you choose not to comply, you must advise your doctor or other health care professional.
- Be considerate and courteous to doctors and other health care professionals and their office staff and employees.
- Pay any required copayments, deductibles or coinsurance.
- Pay for charges that are not covered under your plan.

Medical Bills

You may receive a medical bill. Please do not assume we have also received a copy of your bill. Sometimes doctors may bill you directly.

If you receive a medical bill, please send it to us. Include your Horizon BCBSNJ ID number, the patient's name, the patient's date of birth and your relationship to the patient. Send this information to:

Horizon PPO Claims
PO Box 1609
Newark, NJ 07101-1609

If Magellan Behavioral Health®* is your behavioral health administrator, please send behavioral health and substance abuse care claims to:

Magellan Behavioral Health
PO Box 5172
Columbia, MD 21045-5172

Remember to always keep copies of your medical bills for your records.

Note: Claims that are sent to us 12 months or more after the date of service may be automatically denied for untimely submission. For more information, please call Member Services at **1-800-355-BLUE (2583)**.

* In 2014, we will transition our behavioral health management contract to ValueOptions® Inc. from Magellan Behavioral Health.

Voicing a Concern

We are dedicated to providing you with access to quality care and service. We would like to hear from you if you have any concerns regarding the care or service you are receiving. The following pages explain the procedures you should follow to voice a concern through inquiries, complaints and/or appeals.

If you are ever dissatisfied with any aspect of Horizon PPO, including the quality of care or service you have received, you, a doctor, other health care professional or authorized representative acting on your behalf (and with your consent) may file an inquiry, complaint or appeal with Horizon BCBSNJ. No member or doctor who makes an inquiry, files a complaint or pursues an appeal will be subject to disenrollment, discrimination or penalty by Horizon BCBSNJ.

Our Member Services phone number* and address are on your ID card. This information is also listed on the following page.

Member Inquiry, Complaint and Appeal Rights

Horizon BCBSNJ offers inquiry, complaint and appeal processes designed to provide a prompt response and resolution to all requests. These processes relate to:

- Medical issues.
- Our utilization management decision making.
- Other nonutilization management issues.

* If you do not speak English, you can voice a concern using the AT&T Language Line. Please call Member Services to be connected to the translation service. If you have hearing or speech difficulties, please call the TTY/TDD line at **1-800-855-2881**.

Voicing a Concern

General Inquiries and Complaints

Member Services Representatives are ready to answer your inquiries or respond to your complaints, or those made by a doctor or other approved representative acting on your behalf and with your consent. We can often resolve such inquiries and complaints during the call. You can speak with a Member Services Representative, Monday through Wednesday and Friday, between 8 a.m. and 6 p.m., Eastern Time (ET), or Thursday, between 9 a.m. and 6 p.m., ET.

If you have a complaint or inquiry, you may call Member Services at **1-800-355-BLUE (2585)**. Both verbal and written inquiries and complaints are accepted.

General inquiries and complaints may be submitted, in writing, to Member Services at the addresses below:

For general inquiries:

**Horizon PPO
Member Services
PO Box 420
Newark, NJ 07101-0420**

For complaints or appeals:

**Horizon PPO
Appeals Coordinator
PO Box 317
Newark, NJ 07101-0317**

Our goal is to resolve your initial inquiry or complaint within 30 days in most instances.

If we require additional information, we must allow you or your doctor 45 days to send the requested information to us.

You'll be notified in writing of our determination. Our final response to your inquiry or complaint will describe what further rights you may have concerning the matter in question.

Horizon PPO Appeal Process

If you have a claim for benefits that is denied, and you are dissatisfied, you* have the right to appeal the decision.

* As used here and throughout this section, "you" means the member/covered person, or a doctor or authorized representative acting on behalf of the member/covered person with his/her consent.

Voicing a Concern

To fully understand the appeal process, you need to know the following terms and their meanings.

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

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

Adverse Benefit Determination involving medical judgment (ABD-Medical): An ABD decision involving the use of medical judgment, e.g., that an item or service is deemed by the plan to be: not medically necessary or appropriate; in the trial stage or investigational; a cosmetic service; a dental item or service; or given for a pre-existing condition and therefore excluded.

Claim: A request by you or your health care professional for payment of health care services or supplies.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by Horizon BCBSNJ at the end of the internal review process.

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

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

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

Voicing a Concern

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

- (a) Could, in the judgment of a prudent layperson possessing an average knowledge of health and medicine, seriously jeopardize your life or health, or your ability to regain maximum function; or
- (b) Would, in the opinion of a doctor with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Time Frames for Initial ABDs

You will be told of Horizon BCBSNJ's initial Adverse Benefit Determination as quickly as possible based on the medical circumstances, but in no event later than:

- (a) 72 hours from receipt of an Urgent Care claim;
- (b) 15 days from receipt of a Pre-service claim; or
- (c) 30 days from receipt of a Post-service claim.

After a decision has been made, Horizon BCBSNJ will give written notice within two business days and will include an explanation of the applicable appeals process.

You may appeal Horizon BCBSNJ's ABD. No covered person or health care professional who files an appeal will be subject to disenrollment, discrimination or penalty by Horizon BCBSNJ.

Voicing a Concern

Appeal Process for ABD-Benefits

You may appeal ABD-Benefits within 180 days from the date of the determination.

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

You can appeal ABD-Benefits by calling or writing Horizon BCBSNJ at the phone number or address on your ID card. We will inform you as to the information that you need to provide.

If the initial ABD-Benefits is upheld, after Horizon BCBSNJ's informal review of the appeal, and you are still dissatisfied, you can file an appeal for a formal second-level review that will be decided by Horizon BCBSNJ professionals who were not involved in the prior decisions. All ABD-Benefits denials include a written explanation of the appeal process with instructions on how to go on to the next level of the appeal process.

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

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

Voicing a Concern

For each level of appeal, Horizon BCBSNJ will provide you with notice of the outcome and, if the ABD-Benefits is upheld, instructions for filing the next level of review. If the initial ABD-Benefits is upheld through both levels of the internal review process, no further remedies are available from Horizon BCBSNJ. In this event, Horizon BCBSNJ will provide you with information regarding the availability of contact information for the consumer assistance program of the New Jersey Department of Banking and Insurance.

Appeal Process for ABD-Medical

The appeal process for Adverse Benefit Determinations involving medical judgment (ABD-Medical) includes: (a) an informal, Stage 1 internal review by Horizon BCBSNJ; (b) a formal, Stage 2 internal review by Horizon BCBSNJ; and (c) a formal external review by an Independent Utilization Review Organization (IURO). The initial appeal must be filed within 180 days after Horizon BCBSNJ's initial ABD-Medical.

Except as otherwise provided below, the steps for filing the three levels of appeal must be followed. If they are not, your appeal review may be delayed or forfeited.

a. First Level Appeal – Stage 1

You can file a First Level Stage 1 Appeal by calling or writing Horizon BCBSNJ at the phone number or address on the initial Adverse Benefit Determination letter. We will inform you as to the information that you need to provide.

At the First Level Appeal, you may discuss the ABD-Medical directly with the Horizon BCBSNJ doctor who made the decision or with the medical director chosen by Horizon BCBSNJ.

Voicing a Concern

Horizon BCBSNJ will decide First Level Appeals within 24 hours in the case of an ABD-Medical involving:

- (a) An Urgent Care claim or a medical emergency;
- (b) An inpatient admission;
- (c) The availability of medical care;
- (d) The continuation of an inpatient facility stay; or
- (e) A claim for medical services for a covered person who has received emergency care, but who has not been discharged from a facility.

Horizon BCBSNJ will decide all other First Level Stage 1 ABD-Medical Appeals within 10 calendar days of receipt of the required documentation. Horizon BCBSNJ will give you: (a) written notice of the result; (b) the reasons for the decision; and (c) if the initial ABD-Medical is upheld, instructions for filing a Second Level Stage 2 Appeal.

b. Second Level Appeal – Stage 2

You can file a Second Level Stage 2 Appeal of the ABD-Medical if you are not satisfied with Horizon BCBSNJ's First Level Appeal decision. This appeal, if filed, will be decided by a panel of doctors and/or other health care professionals chosen by Horizon BCBSNJ who were not involved in the original and First Level Appeal decisions. The panel will have access to health care professional consultants who are trained or who practice in the same specialty that would usually manage the case being appealed. Upon your request, such consultant practitioners will take part in the appeal.

Voicing a Concern

Horizon BCBSNJ will acknowledge the filing of Second Level Appeals in writing within five business days of receipt and include instructions about the scheduling and how to take part in the hearing. After the hearing, Horizon BCBSNJ will then give written notice of the final decision on the appeal or verbal notice within 48 hours followed by a written notice in the case of an ABD-Medical involving:

- (a) An Urgent Care claim or a medical emergency;
- (b) An inpatient admission;
- (c) The availability of medical care;
- (d) The continuation of an inpatient facility stay; or
- (e) A claim for medical services for a covered person who has received emergency care, but who has not been discharged from a facility.

If the Second Level Appeal is denied, Horizon BCBSNJ will give you and/or your health care professional written notice of the reasons for the denial, together with a written notice of your right to go on to an external appeal. Horizon BCBSNJ will include: (a) specific instructions as to how you may arrange for such an external appeal; and (b) any forms needed to start the appeal.

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

In certain cases, you may not have to complete Horizon BCBSNJ's internal appeal process with respect to an ABD-Medical, and may go directly to the external appeal process, if:

- (a) Horizon BCBSNJ does not meet a time frame described above for the First and Second Level Appeals;
- (b) Horizon BCBSNJ waives its right to an internal review; or
- (c) You have applied for an expedited external review at the same time you applied for an expedited internal review.

Voicing a Concern

Regarding (a), listed previously, moving directly to the external appeal without finishing the internal appeal process will not apply if Horizon BCBSNJ can show that: (a) the violation did not cause, and is not likely to cause, prejudice or harm to you; (b) the violation was for a good reason or due to matters beyond Horizon BCBSNJ's control; (c) the violation occurred in the context of an ongoing, good-faith exchange of information between Horizon BCBSNJ and you; and (d) the violation does not reflect a pattern or practice of non-compliance by Horizon BCBSNJ.

If Horizon BCBSNJ claims this exception, you may ask for a written explanation of the violation from us. It must include a description of the basis for the assertion that the violation should not cause the internal process to be waived. If there are disputes about this exception, they will be decided by an external reviewer.

If it is decided that Horizon BCBSNJ meets the standard for this exception, you may then resubmit and follow the internal appeal process. The time frame for refiling the claim will start upon your receipt of the notice.

d. External Appeal

If you are still dissatisfied with the results of Horizon BCBSNJ's internal appeal process with respect to an ABD-Medical, you can pursue an external appeal with an IURO chosen by the New Jersey Department of Banking and Insurance (DOBI). Except as otherwise described above under part (c), your right to such an appeal depends on your full compliance with both stages of Horizon BCBSNJ's internal appeal process.

Voicing a Concern

To start an external appeal, you must send a written request within four months from receipt of Horizon BCBSNJ's Final Internal Adverse Benefit Determination (or within four months from the date of an occurrence described in [a], [b] or [c] under *Right to Waive Horizon BCBSNJ's Internal Appeal Process*, page 63).

You must use the required forms and include both:

- A **\$25** check made payable to **New Jersey Department of Banking and Insurance**; and
- An executed release to allow the IURO to get all medical records pertinent to the appeal.

Send your information to:

**New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
PO Box 529
Trenton, New Jersey 08625-0329
1-888-393-1062**

www.state.nj.us/dobi/enfcon.htm

The \$25 fee will be refunded to you if the IURO reverses Horizon BCBSNJ's ABD-Medical decision.

If you cannot afford to pay the fee, it will be waived if you can show proof of financial hardship. Proof of financial hardship must prove that one or more members of your household are getting aid or benefits under:

- Pharmaceutical Assistance to the Aged and Disabled;
- Medicaid;
- General Assistance;
- Social Security Insurance;
- NJ FamilyCare; or
- The New Jersey Unemployment Assistance Contract.

Annual filing fees for any one covered person will not be more than \$75.

Voicing a Concern

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

1. Patient is or was a covered member of Horizon BCBSNJ;
2. Service or supply which is the subject of the appeal reasonably appears to be a covered service or supply under the patient's contract; and
3. Patient has furnished all information needed by the IURO and the DOBI to make the preliminary determination. This includes: the appeal form; a copy of any information furnished by Horizon BCBSNJ about its final Adverse Benefit Determination; and the fully executed release.

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

If the appeal is accepted, the IURO will let you know of the right to send in writing, within five business days, any further information to be considered in the review. The IURO will give Horizon BCBSNJ this information within one business day after its receipt.

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

- An Urgent Care claim or a medical emergency.
- An inpatient admission.
- The availability of medical care.
- The continuation of an inpatient facility stay.

Voicing a Concern

- A claim for medical services for a patient who has received emergency care, but who has not been discharged from a facility.
- A medical condition for which the standard time frame would seriously jeopardize the life or health of the patient or his/her ability to regain normal function.

When the IURO completes its review, it will state its findings in writing and make a determination of whether Horizon BCBSNJ's denial, reduction or termination of benefits deprived you of medically necessary and appropriate treatment. If a decision made within 48 hours was not in writing, the IURO will give a written confirmation within 48 hours after the verbal decision.

If the IURO decides that the denial, reduction or termination of benefits deprived you of medically necessary and appropriate treatment, this will be conveyed to you and/or your health care professional and Horizon BCBSNJ. The IURO will also describe the medically necessary and appropriate services that should be received. This determination is binding upon Horizon BCBSNJ and you, except to the extent that other remedies are available to either party under state or federal law.

If all or part of the IURO's decision is in your favor, Horizon BCBSNJ will provide coverage for those covered services and supplies that are decided to be medically necessary and appropriate. Unless there is a judicial decision stating otherwise, this will be done without delay, even if Horizon BCBSNJ plans to seek a judicial review or other remedies.

And, within 10 business days of its receipt of a decision in your favor (or sooner, if the medical facts of the case indicate a more rapid response), Horizon BCBSNJ will send a written report to the IURO, you and the DOBI that describes how Horizon BCBSNJ will carry out the IURO's determination.

Voicing a Concern

Behavioral Health and Substance Abuse Care Appeals

Check your Horizon BCBSNJ ID card to see if Magellan Behavioral Health is your behavioral health administrator. If yes, then you may appeal a behavioral or substance abuse (including alcoholism) care decision directly with Magellan Behavioral Health. Please send your appeal to:

Magellan Behavioral Health
Attn.: Appeals Department
199 Pomeroy Road
Parsippany, NJ 07054

Please note: In 2014, we will transition our behavioral health management contract to ValueOptions® Inc. from Magellan Behavioral Health.

Radiology/Diagnostic Imaging Services Medical Appeals

Medical appeals for radiology/diagnostic imaging services may be sent to:

CareCore National, LLC
Attn.: Clinical Appeals, Mail Stop 600
400 Buckwalter Place Boulevard
Bluffton, SC 29910-5150

Or, you may fax your appeal to **1-866-699-8128**.

Prescription Drug Appeals

If your Horizon PPO plan offers prescription drug coverage, prescription drug appeals may be sent to:

Prime Therapeutics LLC
Attn: Clinical Review Dept.
1505 Corporate Center Drive, Bldg. N10
Eagan, MN 55121

Or, you may fax your appeal to **1-877-897-8808**. For more information, call the Prime Therapeutics Appeals department at **1-888-214-1784**.

Important Notices

Medical Technology

We review new medical technology for the purpose of determining its eligibility for coverage. This process incorporates input from the professional and medical community, including input from medical health care professionals in New Jersey, as well as the results of literature research.* In addition, we review current policies about existing technology and amend them as appropriate.

Continuation of Care Benefits

If you are receiving covered services other than obstetrical care, post-operative care, oncological treatment or psychiatric treatment from a terminated health care professional who was under contract with us at the time treatment was initiated, you may continue care for services for up to **four months**, when medically necessary.

If you are receiving obstetrical care, post-operative care, oncological treatment or psychiatric treatment by a terminated health care professional who was under contract with us at the time the treatment was initiated, you may continue to be treated by that health care professional for the duration of the treatment or care as follows. In the case of:

- Pregnancy, medical necessity shall be deemed demonstrated and coverage of services shall continue to the postpartum evaluation, up to **six weeks** after delivery.
- Post-operative follow-up care, coverage of services may continue for a period of up to **six months** from the date of the doctor's termination.
- Oncological treatment, coverage of services may continue for a period of up to **one year** from the date of the doctor's termination.
- Psychiatric treatment, coverage of services may continue for a period of up to **one year** from the date of the doctor's or health care professional's termination.

* *Literature research* is a review of current evidence-based data published in scientific journals.

Important Notices

These continuation of care guidelines do not apply if the health care professional is terminated immediately based upon:

- The opinion of Horizon BCBSNJ's Medical Director that the health care professional is an imminent danger to a patient or public health, safety and welfare.
- A determination of fraud or a breach of contract by the health care professional.
- Being the subject of disciplinary action by the State Board of Medical Examiners.

Please call Member Services at **1-800-355-BLUE (2585)** if you have questions about your continuation of doctor care benefits. All benefits are subject to contract limits and Horizon BCBSNJ policies and procedures, including, but not limited to, prior authorization and utilization management requirements.

How to Get Results of Independent Satisfaction Surveys

The general public may get results of independent consumer satisfaction surveys and results of analysis of quality outcomes for health care services provided under managed care plans in New Jersey by contacting:

**Actuarial Bureau
Department of Banking and Insurance
20 West State Street, 11th Floor
PO Box 325
Trenton, NJ 08625-0325
1-609-292-5427**

Your Feedback

We welcome your feedback about this Horizon PPO Member Handbook and any other Horizon PPO materials you've received at any time. Please forward comments, concerns or suggestions to:

E-mail: publications@HorizonBlue.com

Mail: **Horizon BCBSNJ, PP-08Z
Enterprise Communications
PO Box 820
Newark, NJ 07101-0820**

Talk to Us

Join the *Talk to Horizon* member panel. Share your opinions with us and help shape your health care experience. Visit TalkToHorizon.com/join2 to sign up today. Members who complete an online survey are entered in a quarterly drawing to win one of three \$250 prizes.



Glossary

Benefit Booklet/Certificate – A booklet that outlines your Horizon PPO benefits and exclusions. Please use or refer to it along with your member handbook.

Case Management – The coordination of services to help meet a member's health care needs, usually when a member has a condition that requires multiple services from multiple health care professionals. This term is also used to refer to the coordination of a member's care during and after a hospital stay.

Coinsurance – The dollar amount or percentage of the cost of medical care that a member pays. Horizon BCBSNJ covers the remaining percent. For example, under an 80/20 plan, Horizon BCBSNJ would pay 80 percent of the allowable charge and a member would pay 20 percent. The 20 percent paid by the member is the coinsurance.

Copayment – The specified dollar amount a member must pay for each medical visit or service.

Deductible – The amount of out-of-pocket medical expenses a member must pay before Horizon BCBSNJ begins paying for covered medical expenses, usually based on a calendar year. For example, if a member has a health plan with a \$200 deductible, the member must meet that deductible before his/her health plan begins to provide benefits for the covered services and supplies.

PPO Plan – Access to physicians, specialists, hospitals and other health care professionals in the Horizon PPO Network without referrals.

Explanation of Benefits (EOB) – A statement Horizon BCBSNJ provides to a member describing how a claim was processed. It includes services provided, amount billed, payment made and any charges that are the member's responsibility. You can sign in to Member Online Services at HorizonBlue.com to review your EOBs.

Facility – A hospital or ancillary medical facility that provides medical care.

Glossary

Independent Utilization Review Organization (IURO) –

An independent organization commissioned by the New Jersey Department of Banking and Insurance to review utilization management appeals that have already gone through our internal appeal process. It is often referred to as an IURO.

In network – The doctors, other health care professionals and facilities that Horizon BCBSNJ has selected and contracted with as part of the Horizon PPO Network to care for its members.

Inpatient care – When you are admitted as a patient at a hospital, your care is considered inpatient care.

Medical emergency – A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

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

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

Glossary

Medical necessity – A number of factors are used to determine medical necessity, including the prudent clinical judgment as exercised by a health care professional for the purpose of evaluating, diagnosing or treating an illness, injury or disease; and that the service is “in accordance with generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person’s illness, injury or disease; not primarily for the convenience of the covered person or the health care professional; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person’s illness, injury or disease.”

Nonparticipating – Doctors, health care professionals or facilities that do not contract with us to provide care to Horizon PPO members. Nonparticipating may also be referred to as out of network or non-network.

Out-of-area urgent care – Medical care which is provided outside the Horizon BCBSNJ service area. It may be needed for an unexpected illness or injury that is not life-threatening, but should be treated before you return to the service area.

Out of network – Doctors, health care professionals and facilities that are not in the Horizon PPO Network. Out of network is also called non-network or nonparticipating.

Out-of-pocket costs – Costs for medical services and/or supplies not covered under your Horizon BCBSNJ plan. You are responsible for paying these costs.

Out-of-pocket maximum – The maximum amount of out-of-pocket coinsurance, copayments and/or deductibles that a member or family would have to pay during a specified period of time, usually a calendar year or benefit period. After the maximum is reached, most, if not all, covered services are paid at 100 percent for the rest of the specified period.

Glossary

Participating – A Primary Care Physician (PCP), specialty care doctor or other medical services professional or organization (hospitals, laboratory facilities, etc.) that contracts with us, including a behavioral health and substance abuse care participating facility or participating practitioner. Participating may also be referred to as in network.

Preventive care – Medical and dental services aimed at early detection and intervention. Preventive care includes, but is not limited to, routine physical exams, screening tests and immunizations.

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

Prior authorization/preapproval – Written approval by us, prior to the date of service, for a doctor or other health care professional or facility to provide specific services or supplies.

Referral – The written recommendation by your PCP for you to receive care from a participating doctor or facility.

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

We, us and our – Horizon Blue Cross Blue Shield of New Jersey and Horizon Healthcare of New Jersey, Inc.

Notes

Transfer of Medical Records Form

If you wish to have medical records transferred to your newly selected Primary Care Physician, please fill out the information below and mail it to your former doctor. Please print clearly.

To: _____
Name of previous or present doctor.

Address: _____

I hereby request my medical records be released to:

Doctor Name: _____

Address: _____

The following medical records for the period on or about: _____

- Complete Medical Record
- Other (please specify) _____

Patient Name: _____

Address: _____

Date of Birth: ____/____/____ **Member ID #:** _____

Signature: _____ **Date:** _____
Patient or Parent/Guardian Signature



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

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At Your Service

The chart below includes some of the most frequently needed contact information.

| If you need help with | Contact | Via |
|--|---|---|
| Locating an approved quality transplant center | Blue Distinction Centers for Transplants® | bcbs.com/distinction 1-888-621-5894 ext. 46404 |
| Managing a complex illness | Case Management | 1-888-621-5894 Press 2 |
| Managing a chronic illness | Chronic Care Program | 1-888-334-9006 |
| Pharmacy benefits | Prime Therapeutics LLC* | 1-800-370-5088 |
| Savings on health-related products and services | Blue365 | Blue365deals.com |
| Laboratory testing and services | LabCorp | LabCorp.com |
| Behavioral health/substance abuse care | Magellan Behavioral Health** | 1-800-626-2212 |
| Horizon BCBSNJ's online self-service tools | Member Online Services | HorizonBlue.com or horizon_helpdesk@HorizonBlue.com |
| Benefits, claims, etc. | Member Services | 1-800-355-BLUE (2583) |
| Getting care outside the Horizon BCBSNJ service area | Out-of-Area Coverage | 1-800-810-2583 |
| Getting prior approval | Prior Authorization | 1-800-355-BLUE (2583) |
| Scheduling imaging services | Radiology Scheduling Line | 1-866-969-1234 |

* For members who have prescription drug benefits through Horizon BCBSNJ.

** For members who have behavioral health/substance abuse care benefits through Magellan: In 2014, we will transition our behavioral health management contract from Magellan Behavioral Health to ValueOptions® Inc. .

Interacting with you is just another way we're *Making Healthcare Work.*



Horizon Blue Cross Blue Shield of New Jersey has joined active users on Facebook® with our own corporate page, [facebook.com/HorizonBCBSNJ](https://www.facebook.com/HorizonBCBSNJ).



You can stay up to date with the latest company news and health and wellness information. Follow us on Twitter™, twitter.com/HorizonBCBSNJ.



See an introductory video explaining how we're transforming the health care delivery system in New Jersey, [youtube.com/BCBSNJ](https://www.youtube.com/BCBSNJ).



Learn how to stay connected with Horizon Blue Mobile anytime, anywhere, mobile.HorizonBlue.com.



The new Horizon Blue App gives you access to your health insurance information anytime, anywhere.



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Magellan Behavioral Health® is a registered mark of Magellan Health Services, Inc.

Microsoft® is a registered mark of Microsoft, Inc.

Prime Therapeutics LLC is an independent company administering pharmacy benefits.

PrimeMail® is a registered mark of Prime Therapeutics LLC.

Safari® is a registered mark of Apple, Inc.

Twitter™ is a trademark of Twitter, Inc.

ValueOptions® is a registered mark of ValueOptions Inc.

WebMD® is a registered mark of WebMD, LLC.

YouTube™ is a trademark of Google, Inc.

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