# Your Benefit Booklet

# The Horizon Vision Care Program

Subject to the terms and conditions of the Policy and this Booklet, Horizon Insurance Company (Horizon) agrees to provide the Vision Care Benefits described herein for Covered Persons, in consideration of the Policyholder's payment of the premiums required for the coverage. Please read this Booklet carefully. It describes the services that are covered and what you must pay out of pocket for them. It also describes those services that will not be covered. This Program is administered on behalf of Horizon by our Vision Care Manager, Davis Vision.

In order for most services to be covered, they must be provided by Horizon's Vision Care Manager. There is only limited coverage for services provided by Out-of-Network Providers, and they may balance bill for charges that exceed the payment owed or due them under this Program. You may also have to file claims for such services. You will not have to file claims for the In-Network Provider services.

Your Booklet's Schedule of Benefits shows the Policyholder and the Group Policy Number(s).

Benefits and Amounts: The available benefits and the amounts of insurance are described in the Booklet.

This Booklet is an important document and should be kept in a safe place.

The Booklet is made part of the Group Policy, which is delivered in and governed by the laws of the State of New Jersey. Future changes in coverage will be described in either a Booklet Notice of Change or in a new Booklet. All benefits are subject in every way to the entire Group Policy, which includes this Booklet.

**Horizon Insurance Company**
**3 Penn Plaza East**
**Newark, New Jersey 07105-2200**

# DEFINITIONS

This section defines certain important terms used in this Booklet. The meaning of each defined word, whenever it appears in this Booklet, is governed by its definition below.

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

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

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

**Calendar Year:** A year starting January 1.

**Child Dependent**: A person who: has not attained the age of 19; is unmarried; and is:

- The natural born child or stepchild of you or your Spouse regardless of where or with whom the child lives;
- A child who is : (a) legally adopted by you or your Spouse, regardless of where or with whom the child lives; or (b) placed with you for adoption. But, proof of such adoption or placement satisfactory to Horizon must be furnished to us when we ask;
- You or your Spouse's legal ward who: (a) resides with you in a regular parent-child relationship; and (b) is chiefly dependent on you for support and maintenance. But, proof of guardianship satisfactory to Horizon must be furnished to us when we ask. But, proof of guardianship satisfactory to Horizon must be furnished to us when we ask.
- This term includes a Child Dependent who:
    - Is living with you or your Spouse, or Civil Union Partner, in a parent child relationship; or
    - Is placed for adoption with, or is party in a suit for adoption by, you or your Spouse, or Civil Union Partner; or
    - Is required to be provided coverage by you or your Civil Union Partner or Spouse under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).

**Civil Union Partner:** A person who has established and is in a Civil Union.

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

**Covered Expense(s):** The benefits listed in the Schedule of Benefits. The term "Covered Expense" or "Covered Expenses" does not include:

1. Any services or materials that are not listed in the Schedule of Benefits; or

2. Any services or materials shown as "No Benefit" in the Schedule of Benefits; or

3. An additional exam, frame, pair of spectacle lenses or contact lenses for which you have already received either an In-Network Provider benefit or an Out-of-Network Provider benefit during any one Frequency Period; or

4. More than one type of contact lens at a time during any one Frequency Period; or

5. The fitting and follow-up care or adjustments to eyeglasses (frames and spectacle lenses (including additional In-Network Provider items), or contact lenses (including evaluation, fitting and follow-up care) if vision correction is not recommended by a Provider following an eye examination.

**Covered Person or Covered Persons**: An eligible Employee or an eligible Dependent for whom an enrollment form has been accepted by Horizon and for whom coverage under the Policy remains in force.

**Dependent or Dependents:** An Employee's:

1. Child Dependent.

2. Spouse; or

3. Civil Union Partner

**Employer:** Collectively, all employers included under the Group Policy.

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

**Family or Medical Leave of Absence:** A period of time of predetermined length, approved by the Policyholder, during which the Employee does not work, but after which the Employee is expected to return to Active service. Any Employee who has been granted an approved leave of absence in accordance with the Family and Medical Leave Act of 1993 shall be deemed to be Active for purposes of eligibility for coverage under this Program.

**Frequency Period :** The time period shown in the Schedule of Benefits during which a Covered Person is eligible for the Covered Expenses shown therein. The time period is measured from the date of the last eye examination or the date the covered person received the eyeglasses, frame, spectacle lenses or contact lenses.

**Horizon :** Horizon Insurance Company.

**In-Network:** A Provider who has entered into a contract with our Vision Care Manager to provide eye examinations and/or materials on a Scheduled Fee basis. These Providers are part of the Network.

**Medicaid:** The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

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

**Network**: A group of Providers who have entered into a contract with our Vision Care Manager to provide eye examinations and/or materials on a Scheduled Fee basis.

**Out-of-Network Provider:** Providers of optometric services, including ophthalmologists and opticians, who have not entered into a contract with our Vision Care Manager to provide vision care services.

**Policyholder:** The entity shown in this Booklet's Schedule of Benefits.

**Prior Authorization:** Authorization by Horizon or the Vision Care Manager for a Provider to provide specified vision care to you or your covered Dependent.

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

**Provider:** A practitioner who is a legally qualified professional providing eye examinations, refractive and/or post-refractive services and surgery within the scope of his/her license. This term includes an ophthalmologist, an optometrist, an optician or a surgeon recognized as such in accordance with the laws of the State in which the services are provided. The Policy recognizes two categories of Providers; In-Network Providers and Out-of-Network Providers. Refer to these definitions for further information.

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

**Usual and Customary Charge**: That portion of a charge, as determined by us, made by a Provider for a Covered Expense shown in the Schedule of Benefits which does not exceed the lesser of:

1. The customary charge made by other Providers rendering or furnishing such care, treatment or supplies within the same geographic area; or

2. The usual charge the Provider most frequently makes to patients for the same service.

We will base our determination of the customary charges within a geographical area on a study or survey done to determine such charges. Consideration will be given to the nature and severity of the condition being treated including any complications which require additional time, skill, treatment or expertise.

**Waiting Period:** The period of time between enrollment in the Program and the date when a person becomes eligible for benefits.

**War:** Includes, but is not limited to, declared war, and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization.

**We, Us and Our:** Horizon .

**You, Your:** An Employee or Dependent, as the context indicates.

# Schedule of Benefits

Policyholder: **Hackensack Meridian Health**

**GROUP POLICY NO.: 0076234-0120 through 0157**

**Note:** If a Member needs vision care from an Out-of-Network Provider in an emergency situation, reimbursement for such care will be provided in accordance with this Schedule of Benefits as if the care were provided by an In-Network Provider.

**Eye Examination:** Inclusive of dilation

Frequency Period: Once a Calendar Year.

**In-Network Provider**

Copayment : **$10.00**

**Out-of-Network Provider**

Maximum Reimbursement: Up to **$50.00**

**Spectacle Lenses:**

Frequency Period: Twice per Calendar Year.

**In-Network Provider**

Copayment : **$20.00**

**Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any Rx):**

**In-Network Provider**

Copayment: **$20.00**

**Out-of-Network Provider**

Single Vision: Maximum reimbursement: **$50.00.**
Bifocal/Progressive: Maximum reimbursement: **$75.00.**
Trifocal: Maximum reimbursement: **$100.00.**
Lenticular: Maximum reimbursement: **$100.00.**

**Oversize Lenses:**

**In-Network Provider**

Copayment **$0.00**

**Out-of-Network Provider**

No Benefit

**Tinting of Plastic Lenses:**

**In-Network Provider**

Copayment: **$0.00**

**Out-of-Network Provider**

No Benefit

**Scratch Resistant Coating:**

**In-Network Provider**
Copayment **$0.00**

**Out-of-Network Provider**
No Benefit

**Polycarbonate Lenses- ((Child Dependents, monocular) patients and patients with prescriptions +/- 6.00 diopters or greater):**

**In-Network Provider**
Copayment **$0.00**

**Out-of-Network Provider**
No Benefit

**Polycarbonate Lenses:**

**In-Network Provider**
Copayment: **$30.00**

**Out-of-Network Provider**
No Benefit

**Ultraviolet Coating:**

**In-Network Provider**
Copayment: **$12.00**

**Out-of-Network Provider**
No Benefit

**Standard Anti-Reflective (AR) Coating:**

**In-Network Provider**
Copayment: **$35.00**

**Out-of-Network Provider**
No Benefit

**Premium AR Coating:**

**In-Network Provider**
Copayment: **$48.00**

**Out-of-Network Provider**
No Benefit

**Ultra AR Coating**:

**In-Network Provider**
Copayment: **$60.00**

**Out-of-Network Provider**
No Benefit

**Standard Progressive Lenses**:

**In-Network Provider**
Copayment: **$50.00**

**Out-of-Network Provider**
No Benefit

**Premium Progressives:**

**In-Network Provider**
Copayment: **$90.00**

**Out-of-Network Provider**
No Benefit

**Ultra Progressives:**

**In-Network Provider**
Copayment: **$140.00**

**Out-of-Network Provider**
No Benefit

**Intermediate-Vision Lenses**:

**In-Network Provider**
Copayment: **$0.00**

**Out-of-Network Provider**
No Benefit

**High-Index Lenses:**

**In-Network Provider**
Copayment: **$55.00**

**Out-of-Network Provider**
No Benefit

**Polarized Lenses**:

**In-Network Provider**
Copayment: **$75.00**

**Out-of-Network Provider**
No Benefit

**Plastic Photosensitive Lenses**:

**In-Network Provider**
Copayment: **$65.00**

**Out-of-Network Provider**
No Benefit

**Scratch Protection Plan -** Single Vision:

**In-Network Provider**
Copayment: **$20.00**

**Out-of-Network Provider**
No Benefit

**Scratch Protection Plan -** Multifocal Lenses**:**

**In-Network Provider**
Copayment: **$40.00**

**Out-of-Network Provider**
No Benefit

**Frames:**
Frequency Period: Twice a Calendar Year.

**Non-Collection Frames:**

**In-Network Provider**
Maximum reimbursement: **$150**

**An additional $50 reimbursement applies if Non-Collection Frames are purchased at retail stores designated by the Vision Care Manager.**

**Out-of-Network Provider**
Maximum reimbursement: **$70**

**Collection Frames - Fashion Level Frames;**

**In-Network Provider**
Copayment: $0.00

**Collection Frames - Designer Level Frames:**

**In-Network Provider**

Copayment: **$0.00**

**Collection Frames - Premier Level Frames;**

**In-Network Provider**
Copayment: **$0.00**

**Contact Lens- In Lieu of Eyeglasses:** Frequency Period: Twice a Calendar Year.

**Non-Collection Contact Lenses - Other:** (Evaluation, fitting & follow-up care)**:**

**Non-Collection Contacts:**

**In-Network Provider**
Maximum reimbursement: **$150.00**

**Out-of-Network Provider**

Maximum reimbursement: **$105.00**

**Collection Contact Lens - Other:** (Evaluation, fitting & follow-up care)**:**

**In-Network Provider**
Copayment: **$0.00**

**Out-of-Network Provider**
No Benefit

**Collection Contact Lenses:** (in lieu of Allowance)

**In-Network Provider**

- Disposable - 4 boxes/multipacks
- Planned Replacement – 2 boxes/multipacks

**Out-of-Network Provider**
No Benefit

**Laser Corrective Surgery**

**In-Network or Out-of-Network Provider**
Per lifetime maximum: **$250**

**Retinal Imaging**

**In-Network Provider**

Copayment: **$39**

**Out-of-Network Provider**
No Benefit

# GENERAL INFORMATION

**How To Enroll**

If you meet your Employer's and Horizon's eligibility rules, including any Waiting Period established by the Employer, you may enroll by completing an enrollment card. If you enroll your eligible Dependents at the same time, their coverage will become effective on the same date as your own.

**Your Identification (ID) Card**

You will receive an ID card to show to the Provider when you or a Dependent receive services or supplies. Your ID card shows: (a) the group through which you are enrolled; (b) your type of coverage; and (c) your ID number and (d) the Coverage Date. All of your covered Dependents share your identification number as well. Always carry this card and use your ID number when you or a Dependent receive Covered Services or Supplies. If you lose your card, you can still use your coverage if you know your ID number. The inside back cover of this Booklet has space to record your ID number, along with other information you will need when asking about your benefits. You should, however, contact your benefits. You should, however, contact your benefits representative quickly to replace the lost card.

You cannot let anyone other than you or a Dependent use your card or your coverage.

**Types Of Coverage Available**

You may enroll under one of the following types of coverage:

- **Single** - provides coverage for you only.
- **Family** - provides coverage for you, your Spouse and your Child Dependents.
- **Husband and Wife/Two Adults** - provides coverage for you and your Spouse only.
- **Parent and Child(ren)** - provides coverage for you and your Child Dependents, but not your Spouse.

**Change In Type Of Coverage**

If you marry, you should arrange for enrollment changes within 31 days before or after your marriage.

If: (a) you gain or lose a Covered Person of your family; or (b) someone covered under this Program changes family status, you should check this Booklet to see if coverage should be changed. This can happen in many ways, e.g., due to the birth or adoption of a child, divorce, or death of a Spouse.

**For example:**

- If you are already enrolled, your newborn infant or adopted child is automatically included. However, if you are enrolled for Family or Parent and Child(ren) coverage, you must still submit an enrollment form to notify us of the addition. If you are enrolled for Single coverage, you must enroll your child and pay any required additional premium within 31 days in order to continue the child's coverage beyond that period.
- If you have Single coverage and marry, your new Spouse will be covered from the date you marry if you apply for Husband and Wife or Family coverage within 31 days.

**Enrollment of Dependents**

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

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

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

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

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

- Permit you to enroll your Child Dependent, without any enrollment restrictions;
- Permit: (a) the Child Dependent's other parent; (b) the Division of Medical Assistance and Health Services; or (c) the Division of Family Development as the State IV D agency, in the Department of Human Services, to enroll the Child Dependent in this Program, if the parent who is the Covered Person fails to enroll the Child Dependent; and
- Not terminate coverage of the Child Dependent unless the parent who is the Covered Person provides Horizon with satisfactory written proof that:
    - the court or administrative order is no longer in effect: or
    - the Child Dependent is or will be enrolled in a comparable health benefits plan which will be effective on the date coverage under this Program ends.

**Multiple Employment**

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

**Eligible Dependents**

Your eligible Dependents are your Spouse and your Child Dependents

Coverage for your Spouse or Civil Union Partner will end: (a) at the end of the month in which you divorce or the Civil Union dissolves; or (b) at the end of the month in which you tell us to delete your Spouse or Civil Union Partner from coverage following marital separation.Or the dissolution of the Civil Union.

Coverage for a Child Dependent ends at the first to occur of the following: (a) the last day of the Benefit Month in which the Child Dependent marries; (b) the last day of the month in which the Child Dependent

reaches age **19**; or (c) the date on which the Child Dependent becomes employed and eligible for vision coverage due to that employment.

You may have an unmarried child with a Developmental Disability, who is incapable of earning a living. Subject to all of the terms of this section and the Policy, such a child may stay eligible for Dependent vision benefits past this Policy's age **19** limit for eligible Dependents.

The child will stay eligible as long as the child is and remains unmarried and incapable of earning a living, if: a) the child's condition started before he or she reached this Policy's age limit; b) the child became covered under this Policy or any other policy or contract before the child reached the age limit and stayed continuously covered or covered after reaching such limit; and c) the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send Us written proof that the child is Developmentally Disabled and depends on You for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for proof more than once a year.

The child's coverage ends when Your coverage ends.

**Student Dependent Coverage**

Your unmarried Child Dependents between the ages of 19 and 23 who are full-time students at an accredited institution of higher learning, are eligible for coverage until the end of the month in which their 23rd birthday occurs.

When the child no longer qualifies as a student or marries, coverage will end on the last day of the Benefit Month.

**When Coverage Ends**

Your coverage under this Program ends when the first of these occurs:

- The end of the month in which you cease to be eligible due to termination of your employment or any other reason.
- The date on which the Group Policy ends for the class of which you are a member.
- You fail to make, when due, any required contribution for the coverage.

**Coverage for a Dependent ends:**

- When your coverage ends.
- When coverage for Dependents under this Program ends.
- When you fail to make, when due, any required contribution for the Dependent coverage.

As otherwise described under "Eligible Dependents", above.

In addition to the above reasons for the termination of coverage under the Program, an act or omission by a Covered Person which, as determined by Horizon shows intent to defraud Horizon (such as: (a) the intentional and/or repeated misuse of Horizon's services; or (b) the omission or misrepresentation of a material fact on a Covered Person's application for enrollment, health statement or similar document) will, upon 30 days prior written notice, result in the cessation of the Covered Person's coverage under this Program. Such an act includes, but is not limited to:

- The submission of any claim and/or statement with materially false information.
- Any information which conceals for the purpose of misleading.
- Any act which could constitute a fraudulent insurance act.

Any termination for fraud will be retroactive to the Coverage Date. Horizon retains the right to recoup from any involved person all payments made and/or benefits paid on his/her behalf.

Also, coverage under this Program will end for any Covered Person who misuses an ID card issued by Horizon.

**If You Leave Your Group Due To Total Disability**

If you become ineligible for coverage under this Program due to Total Disability, you can arrange to continue the Program's coverage for you and your covered Dependents, IF any, if:

- You were continuously enrolled under the Program for the three months immediately prior to the date your employment or eligibility ended;
- You notify your Employer in writing that you want to continue your coverage (within 31 days of the date your coverage would otherwise end);
- You make any required contribution toward the group rate for the continued coverage.

The continued coverage under this Program for you and your covered Dependents, IF any, will end at the first of these to occur:

- Failure by you to make timely payment of any contribution required by your Employer. If this happens, coverage stops at the end of the period for which contributions were made.
- The date you become employed and eligible for benefits under another group health plan ;or, in the case of a Dependent, the date the Dependent becomes employed and eligible for such benefits.
- The date this Program ends for the class of which you were a member.

- In the case of a Dependent, the date that he/she ceases to be an eligible Dependent.

Coverage under this Program is also available to you (and any eligible Dependents), subject to the above requirements, if you are a Totally Disabled former Employee whose group health coverage for you and those Dependents under your Employer's plan provided by another carrier was continued without interruption pursuant to state law.

For the purpose of this provision and the following provision "Extension of Coverage Due to Termination of the Group Policy", **Total Disability or Totally Disabled** means a condition wherein an Employee, due to illness or injury: (a) cannot perform any duty of any occupation for which he or she is, or may be, suited by education, training and experience; and (b) is not, in fact, engaged in any occupation for wage or profit. A Dependent is Totally Disabled if he or she cannot engage in the normal activities of a person in good health and/or of like age and sex. The Member who is Totally Disabled must be under the regular care of a physician.

**NOTE**: If: (a) you lose your coverage under this Program due to Total Disability; (b) you elect the continuation coverage available under COBRA (see "Continuation of Coverage under COBRA", below) instead of the continuation coverage described in this section; and (c) your COBRA coverage terminates, the continuation coverage described in this section will still be available to you and your eligible Dependents if you: (i) request the coverage in writing within 31 days after the COBRA coverage ends; and (ii) agree to make the required contributions for the coverage.

**Continued Coverage Under The Federal Family And Medical Leave Act**

If you take a leave that qualifies under the Federal Family and Medical Leave Act (FMLA) (e. g., to care for a sick family member, or after the birth or adoption of a Child Dependent), you may continue coverage under this Program. You may also continue coverage for your Dependents. You will be subject to the same Program rules as an Active Employee. But, your legal right to have your Employer pay its share of the required premium, as it does for Active Employees, is subject to your eventual return to Active work.

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

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

Consult your benefits representative for application forms and further details.

**Continued Coverage For Surviving Dependents**

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

- The date which is 180 days after the Employee's death.
- The date the Dependent fails to make any required contribution for the continued coverage.
- The date on which the Dependent is no longer an eligible Dependent.
- The date the Program's coverage for the deceased Employee's class ends.

Consult your benefits representative for further details.

**Continuation of Coverage under COBRA**

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

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

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

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

* (See "If You Leave Your Group Due To Total Disability" above for your continuation rights if your employment ends due to total disability.)

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

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

If you and/or your Dependents elect to continue coverage, it will be identical to the health care coverage for other members of your class. It will continue as follows:

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

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

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

- This Program ends for the class you belong to.
- The person fails to make required payments for the coverage.
- The person becomes covered under any other group health plan. But, coverage will not end due to this rule until the end of any period for which pre-existing conditions are excluded, or benefits for them are limited, under the other plan.
- The person becomes entitled to Medicare benefits.

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

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

**Extension Of Coverage Due To Termination of the Group Policy**

This applies if a Covered Person is Totally Disabled on the date coverage under this Program ends due to termination of the Group Policy. In this event, benefits will continue to be available for that person for Covered Expenses needed due to the illness or injury that caused the disability. Benefits will continue to be paid during the uninterrupted period of the disability, but not for more than 90 days from the date the coverage ends.

# EXCLUSIONS

Benefits will not be paid for and the term "Covered Expenses" will not include charges:

1 For any Covered Expense not shown in the Schedule of Benefits.

2 For eye examinations required by an employer as a condition of employment except, as otherwise provided under the Occupational and Safety Program.

3 For services or materials provided in connection with special procedures such as orthoptics and visual training; or in connection with medical or surgical treatment (including laser vision correction), except as otherwise provided herein.

4 For lenses which do not provide vision correction.

5 For charges for the replacement of lost or stolen lenses or frames.

6 For sickness or injury covered by a workers' compensation act or other similar legislation, if application for such benefits has been made.

7 Incurred as a direct or indirect result or war (declared or undeclared).

8 Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.

9 For services or supplies furnished to a Covered Person before the effective date of his/her coverage under the Policy or after the date a Covered Person's coverage ends.

10 For any vision care rendered outside the United States or Canada.

11 For services rendered by practitioners who do not meet the definition of Provider.

12 For charges above the Usual and Customary Charge.

# CLAIMS PROVISION

**In-Network**

A Covered Person must contact an In-Network Provider before receiving services for a Covered Expense. The In-Network Provider will verify the Covered Person's eligibility for Covered Expenses with Horizon or our Vision Care Manager before the examination takes place. The Provider will submit the Covered Person's claim directly to us or to our Vision Care Manager.

**Out-of-Network**

When a Covered Person uses an Out-of-Network Provider, he/she must pay the billed charge at the point of sale. The Provider must then submit a claim for any reimbursement, unless the Covered Person elects to do so instead of the Provider.

1. Notice of Claim - Written or authorized electronic/telephonic notice of claim must be given to us within 31 days after a Covered Expense is incurred or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to us or to our Vision Care Manager. Notice should include the Policyholder's name and the Covered Person's name, address, and Group Number.

2. Claim Forms - We will send claim forms for filing proof of loss when we receive notice of a claim. If such forms are not provided within 15 days after we receive notice, the proof requirements will be met by submitting, within the time for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

3. Proof of Loss - Written or authorized electronic proof of loss satisfactory to us must be given to us or to our Vision Care Manager within 90 days of the loss for which claim is made.

If: (a) benefits are payable as periodic payments; and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which we are liable.

If written or authorized electronic notice is not given within the applicable 90-day period, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible.

We will remit payment for claims submitted in accordance with the above requirements no later than the 30th calendar day following receipt of the claim by the payer; or no later than the time limit established for the payment of claims in the Medicare program, whichever is earlier, if the claim is submitted by electronic means; and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means.

4. Payment of Claims - We will pay benefits due under the Policy for any loss immediately upon receipt of due written or authorized electronic proof of such loss.

All benefits payable under the Policy, unless otherwise stated, will be payable to the Covered Person or to his/her estate.

If we are to pay benefits to the Covered Person's estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage that we believe is equitably entitled. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment and release us from all liability.

**Review**

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;

2. Reference to specific Program provisions, rules or guidelines on which the denial was based;

3. A description of the additional information needed to support your claim;

4. Information concerning your right to request that we review our decision; and

5. A description of our review procedures, time limits and notice of your right to bring civil action.

This request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. As part of this review, you may:

1. Send us written comments;

2. Review any non-privileged information relating to your claim; or

3. Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 60 days after we receive your request, or within 120 days if there are special circumstances that require more time. Our decision will be in writing and will include reference to specific Policy provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

**Legal Actions**

No action at law or in equity may be brought to recover under the Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by the Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

**Recovery of Overpayment**

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods within 18 months after the date the first payment on the claim was made:

1. A request for lump sum payment of the overpaid amount.

2. A reduction of any amounts payable under the Policy.

If there is an overpayment due when the Covered Person dies, we may recover the overpayment from the Covered Person's estate.

We will not attempt to collect from a Provider for overpayment on or before the 45th calendar day following the submission of the reimbursement request to the Provider.

# BENEFITS PAYABLE FOR AUTOMOBILE RELATED INJURIES

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

**Definitions**

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

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

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

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

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

**Application of this Provision**

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

**Determination of Primary or Secondary Coverage**

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

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

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

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

If this Program is primary to PIP or OSAIC, it will pay benefits for Covered Expenses in accordance with its terms.

**Benefits This Program Will Pay if it is Secondary to PIP**

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

a. the Covered Expenses left uncovered after PIP has provided coverage (minus this Program's deductibles, Copayments, and/or coinsurance, if any); o

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

**Medicare**

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

# GENERAL PROVISIONS

**Incontestability**

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of a claimant's death or incapacity, his/her applicable representative will be given a copy.

After two years from a Covered Person's effective date of coverage, or from the effective date of increased benefits, no such statement will cause coverage or the increased benefits to be contested except for fraud.

**Clerical Error**

A Covered Person's coverage will not be affected by error or delay in keeping records of coverage under the Policy. If such error or delay is found, we will adjust the premium fairly.

**Conformity with Statutes**

Any provisions in conflict with the requirements of any state or federal law that applies to the Policy are automatically changed to satisfy the minimum requirements of such laws.

# HORIZON HEALTHCARE SERVICES, INC

## CERTIFICATE OF COVERAGE

Horizon Healthcare Services, Inc. (Horizon BCBSNJ) certifies that insurance is provided according to the applicable Group Policy for each insured Covered Person. Your Booklet's Schedule of Benefits shows the Group Policyholder and the Group Policy Number.

Insured Covered Person: You are insured under the Group Policy. This Certificate of Coverage together with your Booklet forms your Group Insurance Certificate.

Your Booklet and this Certificate of Coverage replace any older booklets and certificates issued to you for the coverage described in your Booklet. The Booklet and Certificate of Coverage are made part of the Group Policy, which is delivered in and governed by the laws of the State of New Jersey. Future changes in coverage will be described in either a Booklet Notice of Change or new Booklet. All benefits are subject in every way to the entire Group Policy, which includes this Group Insurance Certificate.

**Horizon Healthcare Services, Inc.**
**3 Penn Plaza East**
**Newark, New Jersey 07105-2200**