

Welcome to Horizon Blue Cross Blue Shield of New Jersey. Your Horizon Direct Access plan gives you referral-free access to many health care services and programs, and our large network of participating physicians and hospitals.

We want you to get the most from your Horizon Direct Access coverage. Please read this Member Handbook carefully. It will help you understand your coverage and how your Horizon Direct Access plan works.

If you have questions about your Horizon Direct Access benefits, we are here to help you. Just call Member Services at **1-800-355-BLUE (2583)** or visit <www.HorizonBlue.com>.

If you have feedback about this Horizon Direct Access Member Handbook or any other Horizon Direct Access materials you've received before enrolling in your plan, please send your comments or suggestions to:

e-mail: publications@HorizonBlue.com

Mail: **Enterprise Communications, PP-15Z**
Horizon BCBSNJ
PO Box 820
Newark, NJ 07101-0820

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

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Your Health Care Benefits

As a Horizon Direct Access member, you are eligible to receive health care benefits and services at the in-network level of benefits when provided by participating physicians, hospitals and other health care professionals. You may also use nonparticipating physicians or health care professionals, but your share of the costs will be greater.

Benefits may vary according to the plan design. Generally, they are based on medical necessity. Please check your Horizon Direct Access ID card or Benefit Booklet/Certificate for your specific cost-sharing amounts, benefit information and exclusions. Or, call Horizon BCBSNJ Member Services at **1-800-355-BLUE (2583)** with questions.

Accessing Horizon Direct Access Plan Information*

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

Interactive Voice Response (IVR) System

You may obtain 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 respond in a clear voice.

Member Services

You may also call our professional Member Services Representatives at **1-800-355-BLUE (2583)**, Monday, Tuesday, Wednesday and Friday, between 8 a.m. and 6 p.m., Eastern Time (ET), and Thursday, between 9 a.m. and 6 p.m., ET, to:

- Ask questions about benefits, coverage, participating physicians 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.

* The service area for your Horizon Direct Access plan is the state of New Jersey.

www.HorizonBlue.com

Horizon BCBSNJ offers a secure online service feature through our Web site. To become a registered user of Member Online Services, visit <www.HorizonBlue.com>.

When you register for Member Online Services, you'll be able to:

- View your enrollment history and benefits.
- Request a duplicate ID card.
- Print a Coverage Letter.
- Check the status of your claims.
- Enroll in the paperless Explanation of Benefits (EOB) option and view your EOBs online.
- Update your Coordination of Benefits (COB) information.
- Change your Primary Care Physician (PCP) or primary care dentist, if applicable.

When using or registering for Member Online Services, please keep the following in mind:

- You must have an e-mail address to register for Member Online Services.
- Member Online Services is available Monday through Friday, from 8 a.m. to 10 p.m., Eastern Time (ET) and Saturday, from 8 a.m. to 4 p.m., ET.
- The operating system that works with Member Online Services is Windows 98 or higher. The software does not currently operate on Macs.
- When accessing Member Online Services, you must use Internet Explorer 5.5 to 7.0. Other Internet browsers such as Firefox or Safari (Mac browser) are not currently supported.




If you need assistance, please call our e-Service Desk at **1-888-777-5075**, Monday through Friday, from 7 a.m. to 6 p.m., ET. (excluding holidays) or e-mail your questions to <Member_Portal@HorizonBlue.com>.

Your ID Card

Your ID card shows you are enrolled in Horizon Direct Access. 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 your copayment amounts.

If you lose your ID card, you may request a duplicate ID card through our IVR system by calling **1-800-355-BLUE (2583)** or through Member Online Services by visiting www.HorizonBlue.com.

If the information on your ID card is incorrect, please call Horizon BCBSNJ Member Services.

 	Horizon Direct Access
Horizon Blue Cross Blue Shield of New Jersey	
Member Name J DOE	OFFICE VISIT \$XX
Member ID Number YKP3HZN12345678	SPECIALIST \$XX
	EMERGENCY ROOM \$XXX
PRODUCT CODE XXXXX-XXXX	RXBIN 004336
EFFECTIVE DATE 05/01/2009	RXPCN HZRX ISSUER (80840)
BC/BS PLAN CODES 280/780	RXGRP XXXXXXXXXX
CONTRACT TYPE FAMILY	
	

Your Primary Care Physician

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

As a Horizon Direct Access member, you have the option of selecting a Primary Care Physician (PCP)* who provides and coordinates your medical care. When you choose a PCP and receive services from that PCP, you will pay a lower copayment and your medical services are considered in network** by your Horizon Direct Access plan.

In addition to your PCP, you can receive care from in-network physicians, without referrals, and pay lower cost-sharing amounts. If you do not use in-network physicians, hospitals or other health care professionals, in most cases, your care will be considered out of network and you will share in more of the costs for your care (see page 12 for more details).

If you select a PCP, he/she will:

- Perform most of your annual well care and preventive health exams.
- Handle most of your medical care in his/her own office.
- Provide medical care or refer you to a participating specialist*** or health care professional.
- Handle your emergency care needs, when possible.
- Coordinate health care services you obtain from physicians participating in the Horizon Managed Care Network, if your PCP has referred you to these physicians.
- Coordinate your network specialty care and obtain referrals and prior authorizations for medically necessary services.
- Be on call or appoint a covering physician to be available 24 hours a day, seven days a week.
- Meet our physician credentialing standards.

* Please visit our online Provider Directory at www.HorizonBlue.com or call Member Services at **1-800-355-BLUE (2583)** to verify that your PCP is participating in the Horizon Managed Care Network.

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

*** For in-network benefits, you do not need a referral form from your PCP to see a participating specialist.

Changing Your PCP

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

1. Visit our online *Provider Directory* at www.HorizonBlue.com to find a new participating PCP. By answering a few short questions, you can create a list of participating physicians near you, or check to see if a specific physician is participating in our network.

You may also refer to your *Horizon BCBSNJ Directory of Participating Physicians and Other Health Care Professionals* to find a new participating PCP.

2. There are three ways to notify Horizon Direct Access of your request to change your PCP:
 - If you're registered for Member Online Services, you may change your PCP online. Just visit www.HorizonBlue.com, log in to Member Online Services and click *Change Your Doctor*.
 - You may call Member Services at **1-800-355-BLUE (2583)** to change your PCP through our IVR system or speak with a Member Services Representative Monday, Tuesday, Wednesday and Friday, from 8 a.m. to 6 p.m., Eastern Time (ET), and Thursday, from 9 a.m. to 6 p.m., ET.

You will receive a letter confirming your new PCP selection. You may see your new PCP 14 days after notifying us.

3. Have your medical records transferred to your newly selected PCP. You can do this by sending the *Transfer of Medical Records Form*, located on page 79, to your former PCP. There may be a nominal cost from your former physician to transfer your records.

* We can only update your PCP for either the first or 15th of the month.

Making Appointments

Call your PCP or participating physician when you need an appointment for periodic physical exams. This helps ensure that you receive proper preventive care services. Please contact your PCP or participating physician 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 PCPs and Ob/Gyns. These physicians follow our Physician Access Standards when scheduling appointments with you.

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

Office Waiting Time

PCPs and participating physicians should keep office waiting room time to 30 minutes, or less, from the time of your scheduled appointment. You should be given the choice to reschedule or continue waiting if your wait is more than 30 minutes.

Physician Compensation

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

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

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

If you desire additional information about how a PCP or other physicians or health care professionals in our network are compensated, please call us at **1-800-355-BLUE (2583)**, or write to us at:

**Horizon Direct Access
PO Box 820
Newark, NJ 07101-0820**

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

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

Out-of-Network Care versus In-Network Care

With Horizon Direct Access, you may choose to receive care in network or out of network. The information below explains how your choices affect your out-of-pocket expenses. You can find tips to reduce your out-of-pocket expenses on page 16.

To get the most from your plan and save on out-of-pocket costs, you should use participating physicians, hospitals and health care professionals. You can do this by:

1. Selecting a PCP.*
2. Obtaining prior authorizations, when needed.
3. Receiving care from participating physicians, health care professionals and facilities. This is specific to participating physicians/health care professionals and facilities with Horizon BCBSNJ coverage and/or in the Horizon BCBSNJ service area.

If you do not use a participating physician or health care professional, in most cases, your care will be considered out of network,** and you will pay more for your care.

Receiving Out-of-Network Care

If you choose to receive out-of-network care, please know that:

- You must contact us for approval*** before you receive certain services. These services include hospital admissions and certain surgical and diagnostic procedures. If you do not receive our approval for these services when 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.

* You have the option of selecting a PCP. If you do, please make sure your PCP is participating in the Horizon Managed Care Network.

** "Out of network" is also referred to as "non-network" or "nonparticipating."

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

Cost Savings Examples*

Your choices affect what you will pay for your health care. The examples on these pages show the difference between using an out-of-network physician and paying \$210, or using an in-network physician and paying a \$30 copayment – a savings of \$180 for in-network care.

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

For this example, let's assume you have already met your deductible. Our allowance for this service is \$200 and your out-of-network benefit is 70/30 (Horizon BCBSNJ pays 70 percent; your coinsurance responsibility is 30 percent). Our payment for this service would be 70 percent of \$200, which equals \$140. Since your physician is out of network, he/she can balance bill you for \$210. Your total responsibility would be \$210 (\$150 for the not-covered amount, plus your \$60 coinsurance).

Charge/ Billed Amount	Allowed Amount	Coinsurance	Deductible	Not- Covered Amount	Horizon BCBSNJ Payment	Subscriber Responsibility (You Pay)
\$350	\$200	\$60 (assuming 30%)	Met	\$150	\$140 (assuming a 70% out-of-network benefit)	\$210 (\$60 coinsurance plus \$150 not covered amount)

* These amounts are for sample purposes only and do not reflect your actual plan benefits.

Example 2:* You choose to go **in network** for an office visit. The plan you have selected has no deductible for in-network services and \$30 office visit copayment. The charge is \$350. Our payment allowance for this service is \$150, less any copayment. We will pay \$120 and you would only pay your \$30 copayment.

As a participant in the Horizon BCBSNJ network, your physician has agreed to accept our allowance for the visit (less the applicable copayment) as full payment.

Charged/ Billed Amount	Allowed Amount	Copayment	Deductible	Horizon BCBSNJ Payment	Subscriber Liability (You Pay)
\$350	\$150	\$30	N/A	\$120	\$30

* These amounts are for sample purposes only and do not reflect your actual plan benefits.

Paying Out-of-Network Physician Bills

If you use a physician who does not participate in the Horizon Managed Care 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
<p>A physician or health care professional who is not participating in any of our networks.</p>	<p>Payment in full may be due at the time of service.</p> <p>You must send the bill to us to be reimbursed for our allowance for covered services.*</p>	<p>You must pay any required deductible, coinsurance and any charges over our allowance for covered services.**</p> <p>If the health care professional does not require payment at the time of service, you will have to turn over our claim payment to you for the service to the provider.</p>
<p>A physician or health care professional who participates with one of our other networks.</p>	<p>Payment is not due at the time of service to any physician in another Horizon BCBSNJ network. We will send you an Explanation of Benefits (EOB), which lists your responsibility.***</p>	<p>You must pay any required deductible and/or coinsurance according to your out-of-network benefits. Your physician cannot bill you for more than our allowance.</p>

* Please refer to the Medical Bills section on page 50 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.

Managing 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 are tips to help you manage your health care costs:

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

Use in-network physicians and facilities and obtain 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.

2 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.

Preventive Health Care Benefits

Horizon Direct Access covers you for well care and preventive health care benefits. When you select a Primary Care Physician (PCP), your PCP will coordinate and manage most of your well and preventive care services.

We encourage you to visit your PCP or participating physician for regular checkups. Early detection of any illness offers your best chance for recovery. Your PCP 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).
- Prostate cancer screenings.
- Tests (laboratory work, X-rays).

Preventive Health Care Guidelines

You may use the preventive health recommendations listed on the following pages as a guide for disease prevention. Horizon BCBSNJ encourages you to discuss these guidelines with your PCP or participating physician, and use them in planning to obtain preventive care services appropriate for you and your family. Call your PCP or participating physician to take advantage of the preventive care services offered through your health care plan. For more information, call Member Services at **1-800-355-BLUE (2583)** or visit www.HorizonBlue.com.

These preventive health guidelines are based on recommendations from the Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices, U.S. Preventive Services Task Force, American College of Obstetricians and Gynecologists, American Academy of Pediatrics and other nationally-recognized authorities, available at the time of publication. These preventive health guidelines are a general guide intended to be used for educational purposes only.

Recommendations are continually reviewed and updated and are subject to change. Always discuss your particular preventive care needs with your physician. Services and supplies described in these guidelines may not be covered benefits under your health benefit plan. Please refer to your Benefit Booklet/Certificate or other coverage documents to determine if services and supplies are covered benefits.

For adults:

Physical exams are an important part of preventive care. Be sure to schedule regular exams with your PCP or participating physician and consult with him or her about additional screenings, examinations and immunizations that may be appropriate for you.

For children:

Your child may need additional preventive care services, such as laboratory screenings. Consult your child's PCP or participating physician about specific recommendations for your child. Please refer to your Benefit Booklet/Certificate for specific coverage information.

There are recommended immunization catch-up schedules for children and adolescents who start late or fall behind on their immunizations. There is usually no need to restart a vaccine series, regardless of the time that has elapsed between doses. Your child's PCP or participating physician can provide guidance in this area.

For details on additional indications for immunizations for children/adolescents in high-risk groups, as well as the catch-up schedule, please visit the Centers for Disease Control and Prevention (CDC) Web site, <www.cdc.gov>. For immunization charts in English and Spanish, visit the CDC's National Immunization Program at <www.cdc.gov/vaccines>.

Birth to 2 years

Newborn assessment: At birth. Performed in the hospital.

Well-baby exam: At ages 1, 2, 4, 6, 9, 12, 15, 18 and 24 months. During these visits, your child's physician will review your child's medical history, growth and development milestones; perform a complete physical exam to include height, weight, body mass index (starting at age 2 years) and head circumference measurement; assess nutritional needs and elimination patterns; and provide counseling and anticipatory guidance. In addition to general advice on your baby's health and development, the physician may administer the following immunizations and screenings, depending on clinical presentation and physician assessment.

Immunizations:

Hepatitis B (HepB): First dose soon after birth before discharge from hospital; second dose between ages 1 and 2 months; third and final dose after age 24 weeks.

Diphtheria, Tetanus and acellular Pertussis (DTaP): First dose at age 2 months; second dose at age 4 months; third dose at age 6 months; fourth dose between ages 15 and 18 months.

Haemophilus influenzae type b (Hib): First dose at age 2 months; second dose at age 4 months; third dose at age 6 months; fourth dose between ages 12 and 15 months.

Inactivated Poliovirus (IPV): First dose at age 2 months; second dose at age 4 months; third dose between ages 6 and 18 months.

Measles, Mumps, Rubella (MMR): First dose between ages 12 and 15 months.

Varicella (chicken pox): First dose between ages 12 and 15 months.

Pneumococcal Conjugate vaccine (PCV): First dose at age 2 months; second dose at age 4 months; third dose at age 6 months; fourth dose between ages 12 and 15 months.

Pneumococcal Polysaccharide vaccine (PPSV): Administer PPSV to children ages 2 years or older with certain underlying medical conditions including cochlear implant.

Birth to 2 years

Immunizations (continued)

Meningococcal vaccine: Recommended for certain high-risk groups; minimum age 2 years.

Influenza (flu shot): Minimum age is 6 months for trivalent inactivated influenza vaccine (TIV) and 2 years for live, attenuated influenza vaccine (LAIV). Administer annually to children ages 6 months through 18 years.

Rotavirus: First dose at age 2 months; second dose at age 4 months; third dose at age 6 months. Children should receive the first dose of the vaccine between ages 6 and 14 weeks. Children should receive all three doses of the vaccine by age 32 weeks.

Hepatitis A (HepA): Recommended for children at age 1 year. Two doses should be administered at least six months apart. Also recommended for children and adolescents in selected states and regions and for certain high-risk groups who have not been immunized against hepatitis A. Can begin the hepatitis A immunization series during any visit.

Screenings:

Hearing: As a newborn in hospital and periodically monitoring to age 36 months for delayed onset hearing loss.

Vision status: Periodic screening and assessment subjectively by history at all well visits.

Gross and fine motor skills: Minimum of two recordings of gross and/or fine motor skills assessment by age 12 months.

Lead: Receive first test between ages 9 and 12 months; repeat between ages 18 and 26 months, and any child older than 26 months but less than 6 years who has never previously been screened. Children determined to be high risk should be tested starting at age 6 months.

Hemoglobin or hematocrit (Hgb/Hct): Test once between ages 9 and 12 months.

Birth to 2 years

Screenings (continued)

Hereditary and metabolic screening blood tests: Performed in the hospital before discharge. May need to be repeated within the first month of life.

Weight, length and head circumference: Perform and document on growth chart at each well visit.

Oral health/fluoride assessment: By age 6 months, consult with physician on fluoride availability in local water supply. Physician will prescribe supplementation, if necessary.

Tuberculosis: Can be done at ages 9, 12, 15, 18 or 24 months for infants at high risk.

Phenylketonuria (PKU), sickle cell anemia, hemoglobinopathies, hypothyroidism assessment: At birth to age 2 months.

High-risk screenings and reports for infectious diseases, sensory deficits and child abuse: Can be done at ages 9, 12, 15, 18 or 24 months for infants at high risk.

Documentation of developmental stage or history: As appropriate for age and/or symptoms.

Anticipatory guidance/counseling: For parent(s) and/or caregiver(s) on topics, as age appropriate, including, at minimum: postpartum depression; nutrition; oral health; sleep position; development; poison-proofing home; how to avoid falls, drowning, burns, choking, suffocation, other injuries; physical activity; bicycle safety, helmets and other accident prevention/safety precautions; use of car and booster seats and seat belts; violent behaviors; firearms; sexually transmitted diseases and human immunodeficiency virus; family planning; tobacco, alcohol and drug use.

Ages 3 to 12

Well child exam: Annually for ages 3 to 12 years. During these visits, your child's physician will review your child's medical, growth and developmental history; perform a complete physical exam to include height, weight, body mass index and blood pressure; assess diet, exercise and physical activity, sleep and nutritional needs; assess school and social history; and provide counseling and anticipatory guidance. In addition to general advice on your child's health and development, he/she may receive the following immunizations and screenings, depending on clinical presentation and physician assessment.

Immunizations:

Diphtheria, Tetanus and acellular Pertussis (DTaP): Fifth dose (final dose in the series) between ages 4 and 6.

Tetanus and diphtheria toxoids and acellular pertussis (Tdap):

Recommended at ages 11 to 12 years for those who have completed the recommended DTP/DTaP vaccination series and not received a Td booster dose. Adolescents ages 13 to 18 years who missed the 11-to-12 year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended DTP/DTaP vaccination series. Subsequent routine Td boosters are recommended every 10 years.

Human Papillomavirus (HPV): Recommended for females ages 11 to 12 years and up to age 26; the vaccination series can be started in females as young as age 9 years. Recommended in a three-dose schedule with the second dose administered two months after the first and the third dose given six months after the first dose.

Measles, Mumps, Rubella (MMR): Second dose between ages 4 and 6 years. If not received between ages 4 and 6, must receive second dose to complete schedule by ages 11 to 12 years.

Hepatitis B (HepB): All children and adolescents who have not been immunized against hepatitis B should begin the hepatitis B immunization series at any visit.

Varicella (chicken pox): Second dose of varicella vaccine at ages 4 to 6 years.

Ages 3 to 12

Immunizations (continued)

Inactivated Poliovirus (IPV): Fourth dose between ages 4 and 6 years.

Influenza (flu shot): Minimum age is age 6 months for trivalent inactivated influenza vaccine (TIV) and age 2 years for live, attenuated influenza vaccine (LAIV). Administer annually to children ages 6 months through 18 years.

Hepatitis A (HepA): Recommended for children and adolescents in selected states and regions and for certain high-risk groups who have not been immunized against hepatitis A. Can begin the hepatitis A immunization series during any visit.

Pneumococcal Conjugate vaccine (PCV): One dose of PCV to all healthy children ages 24 to 59 months having any incomplete schedule.

Pneumococcal Polysaccharide vaccine (PPSV): Administer PPSV to children ages 2 years or older with certain underlying medical conditions including cochlear implant.

Meningococcal vaccine (MCV4): All children between ages 11 and 12 years and all children in high-risk groups.

Recommended supplements: Daily multivitamin. Address compliance annually. Consult with physician on fluoride availability in local water supply. Physician will prescribe supplement, if necessary.

Ages 3 to 12

Screenings:

Hearing: Periodic monitoring to age 4 years for delayed onset hearing loss.

Vision status: Between ages 3 and 4 years, or as the child's physician advises for suspected problems.

Lead: Children older than age 24 months but less than age 6 years should be screened if they have never been tested or are assessed as high risk.

Weight, height, body mass index and blood pressure: Annually at well visit.

Dental health: One to two times per year as recommended by dentist.

Urinalysis: Should be done at age 5 years.

High-risk screening for infectious diseases, high cholesterol or pertinent cardiac history, sensory deficits and signs of child abuse: As appropriate for age and/or symptoms.

Anticipatory guidance/counseling: Topics for this age group, as age appropriate, include at a minimum: nutrition; development; poison-proofing home; how to avoid falls, drowning, burns, choking, suffocation, other injuries; physical activity; bicycle safety, helmets and other accident prevention/safety precautions; use of car and booster seats and seat belts; violent behaviors; firearms; sexually transmitted diseases and human immunodeficiency virus; family planning; tobacco, alcohol and drug use.

Ages 13 to 18

Well adolescent visits: Well exam annually for ages 13 to 18. During these visits, your adolescent's physician will review your adolescent's medical, growth and developmental history; perform a complete physical exam to include height, weight, body mass index and blood pressure; assess diet, exercise and physical activity, sleep and nutritional needs; assess school and social history; and provide counseling and anticipatory guidance. In addition to the general advice on your adolescent's health and development, your adolescent may receive the following immunizations and screenings, depending on clinical presentation and physician assessment.

Immunizations:

Hepatitis B (HepB): All children and adolescents who have not been immunized against hepatitis B should begin the hepatitis B immunization series during any visit.

Human Papillomavirus (HPV): A catch-up vaccination is recommended for females ages 13 to 26 years who have not been vaccinated previously or who have not completed the full vaccine series. The human papillomavirus vaccine (HPV) is recommended in a three-dose schedule with the second dose administered two months after the first and the third dose given six months after the first dose.

Measles, Mumps, Rubella (MMR): If not previously vaccinated, administer two doses of MMR during any visit, with four or more weeks between the doses.

Varicella (chicken pox): Susceptible persons ages 13 to 18 years should receive two doses, given at least four weeks apart.

Influenza (flu shot): Minimum age is age 6 months for trivalent inactivated influenza vaccine (TIV) and age 2 years for live, attenuated influenza vaccine (LAIV). Administer annually to children ages 6 months through 18 years.

Ages 13 to 18

Immunizations (continued)

Meningococcal vaccine: At ages 13 to 18 years if not previously vaccinated. All college freshmen living in dormitories should also be vaccinated, preferably with MCV4, although meningococcal polysaccharide vaccine (MPSV4) is an acceptable alternative. Also recommended for certain high-risk groups, including, but not limited to U.S. military recruits, if not previously immunized. Other adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated.

Hepatitis A (HepA): Recommended for children and adolescents in selected states and regions and for certain high-risk groups who have not been immunized against hepatitis A. Can begin the hepatitis A immunization series during any visit. Two doses should be administered at least six months apart.

Tetanus and diphtheria toxoids and acellular pertussis (Tdap): Adolescents ages 13 to 18 years, who missed the 11-to-12 year Td/Tdap booster dose or received Td only, are encouraged to receive a single dose of Tdap five years after last Td/Tdap dose. Subsequent routine Td boosters are recommended every 10 years.

Pneumococcal polysaccharide (PPSV): Recommended for certain high-risk groups and those with certain underlying medical conditions.

Recommended supplements: Daily multivitamin. Address compliance annually for ages 13 to 18 years. Consult with physician on fluoride availability in local water supply. Physician will prescribe supplementation, if necessary.

Screenings:

Hearing: Subjective by history at ages 13, 14, 16 and 17 years. Objective standard testing method by ages 15 and 18 years.

Vision: Subjective by history at ages 13, 14, 16 and 17 years. Objective standard testing method by ages 15 and 18 years.

Height, weight, body mass index (BMI) and blood pressure: Annually at well visit.

Ages 13 to 18

Screenings (continued)

Dental health: One to two times per year as recommended by dentist; should floss and brush with fluoride toothpaste daily.

Selective cholesterol screening: For children and adolescents at risk (due to family history).

Documentation of school, social and menstrual histories: Appropriate for age to assess for problems.

Hemoglobin and hematocrit: Annually for menstruating female adolescents.

Pap test: Screening three years after becoming sexually active, but no later than age 21 years, regardless of sexual history. Should be repeated annually based on individual's history.

Chlamydia screening: Annually, if sexually active.

Testicular exam: Annually by health care professional. Monthly self-exam beginning at age 18 years.

Tuberculin screening: To be performed for adolescents at risk.

Urinalysis: Between ages 13 and 18 years.

Anticipatory guidance/counseling: As age appropriate, topics include at a minimum: nutrition; poison-proofing home; how to avoid falls, drowning, burns, choking, suffocation and other injuries; bicycle safety, helmets, other accident prevention and safety precautions; use of car and seat belts; violent behaviors; firearms; sexually transmitted diseases and human immunodeficiency virus; family planning; tobacco avoidance and cessation; recommendation or discussion of medication to assist with quitting alcohol, drug use; depression, suicide prevention; body piercing and tattooing.

Ages 19 and older

Well person visits: Annually for ages 19 and older. In addition to general advice on your health, you may receive the following immunizations and screenings, depending on clinical presentation and physician assessment.

Immunizations:

Influenza vaccine (flu shot): Ages 19 to 49 years annually for those at high risk; annually for those age 50 years and older. Also recommended for household members of those in high-risk groups, including children ages 0 to 59 months.

Pneumococcal Polysaccharide vaccine (PPSV): Recommended once, with booster every five years, if high risk, for all age groups ages 19 years and older.

Tetanus and diphtheria, pertussis (Td/Tdap) booster: Tdap should replace a single dose of Td for adults less than age 65 years who have not previously received a dose of Tdap. Td should be used for adults age 65 years and older. Booster every 10 years.

Hepatitis B (HepB): Certain high-risk groups.

Hepatitis A (HepA): Selected states and regions for certain high-risk groups.

Measles, Mumps, Rubella (MMR): Adults born after 1956 should receive one dose with some high-risk groups needing a second dose.

Meningococcal vaccine: Recommended for certain high-risk groups including but not limited to college freshmen living in dormitories and U.S. military recruits, if not previously immunized. Revaccination after five years might be indicated for previously vaccinated adults who remain at risk.

Varicella (chicken pox): Recommended for all adults without evidence of immunity to varicella. Special consideration should be given to those who have close contact with persons at high risk for severe disease or those at high risk for exposure or transmission.

Ages 19 and older

Immunizations (continued)

Human Papillomavirus (HPV): Routine vaccination with HPV is recommended for females ages 11 to 12 years; vaccination series can be started in females as young as age 9 years. Catch-up vaccination is recommended for females ages 13 to 26 years who have not been vaccinated previously or who have not completed the full vaccine series. Recommended in a three-dose schedule with the second dose administered two months after the first and the third dose given six months after the first dose.

Herpes Zoster (Shingles) vaccine: All adults ages 60 years and older should receive a single dose of the Herpes Zoster (Shingles) vaccine.

Recommended supplements: Multivitamin and calcium recommended daily for all groups ages 19 years and older. Folic acid recommended daily for women of childbearing age (18 to 50 years).

Screenings:

Height, weight, body mass index and blood pressure: Annually for all age groups.

Vision exam with eye care professional: Once initially for ages 20 to 39 years, every two to four years for ages 40 to 64 years and every one to two years for ages 65 years and older.

Glaucoma test: Every five years beginning at age 35 years.

Ear health: Every two to four years for ages 40 to 64 years and every one to two years for ages 65 years and older.

Hearing screening: Every 10 years, then as needed for ages 40 and older.

Dental health visits: One to two times per year for all age groups as recommended by dentist.

Blood tests (cholesterol level, hemoglobin, glucose level): Annually beginning at age 20.

Blood tests (thyroid test): Every five years, starting at age 35 years.

Ages 19 and older

Screenings (continued)

Diabetes screening: Should be considered for all high-risk, asymptomatic adults who are overweight (BMI \geq 25kg/m²) or obese. Otherwise, every three years, starting at age 45 years.

Colorectal cancer screening: Beginning at age 50 years, men and women who are at average risk for developing colorectal cancer and age 45 years or older if African American should have one of the five screening options below:

- A fecal occult blood test (FOBT) or fecal immunochemical test (FIT) every year*;
- A flexible sigmoidoscopy every five years*;
- Annual FOBT (or FIT) and flexible sigmoidoscopy every five years*;
- A double-contrast barium enema every five years**;
- A colonoscopy every 10 years**.

Direct visualization through colonoscopy is regarded as the most accurate method of diagnosis.

* For FOBT or FIT, the take-home multiple sample method should be used. Combined testing is preferable over either annual FOBT or FIT, or flexible sigmoidoscopy every five years, alone. People who are at moderate or high risk for colorectal cancer should be tested earlier based on risk factors and family history.

** Colonoscopy should be done if the FOBT or FIT shows blood in the stool, if sigmoidoscopy results show an adenomatous polyp or cancer, or if double-contrast barium enema studies show anything abnormal. If possible, polyps should be removed during the colonoscopy.

Skin health/mole exam: Monthly self-mole exam for all ages; every three years by a health care professional for ages 20 to 39 years, then annually for ages 40 years and older.

Self-breast exam for females: Every month, with technique reviewed during physical exam by health care professional.

Professional breast exam for females: For females beginning in their 20s, every one to three years, if performed within the scope of the professional's practice. Annually, if performed within the scope of the professional's practice, for ages 40 years and older.

Ages 19 and older

Screenings (continued)

Mammography: Annually for women ages 40 years and older. Annual mammogram for women under age 40 years with a family history of breast cancer or other breast risk factors, beginning at an age deemed medically necessary by the physician.

Pap test: Screening three years after becoming sexually active, but no later than age 21 years, regardless of sexual history. Repeat annually. Beginning at age 30, women who have had three normal Pap test results in a row may get tested every two to three years. Women with certain risk factors should be tested annually.

Chlamydia screening: Annually if sexually active, age 25 years and younger. Women ages 26 to 39 years, if at high risk for chlamydia or other STDs, may need to be screened.

DEXA screening (bone density): Recommended for all women age 65 years and older and men age 70 years and older regardless of clinical risk factors. Also recommended for younger postmenopausal women, and men ages 50 to 70 years based on their clinical risk factor profile.

Testicular exam: Monthly self exam beginning at age 18 years; annually by health care professional for all age groups.

Prostate health, digital rectal exam (DRE): Annually for men ages 50 years and older, if asymptomatic; annually for men ages 40 years and older with a family history of prostate cancer or other prostate cancer risk factors.

Prostate health, prostate-specific antigen (PSA): Recommended for all males annually beginning at age 50 years. Starting at age 45 years for males at high risk, including African Americans and those with a strong family history. Those at even higher risk, due to multiple first degree relatives affected at an early age, may begin testing at age 40 years.

Thyroid test: Every five years starting at age 35 years.

Lipid screening: Fasting fractionated lipid screening every five years for men over age 34 years and women over age 44 years.

Ages 19 and older

Screenings (continued)

Anticipatory guidance/counseling: Topics, as age appropriate, include at a minimum: smoking cessation; alcohol and drug use; sexually transmitted diseases and human immunodeficiency virus prevention; perimenopause and menopause; depression and suicide prevention; domestic violence; nutrition, body mass index calculation, weight management and limiting fat and cholesterol; sun exposure; oral health; maintaining regular physical activity; lower back protection; seat belt use; discussion of use of aspirin to prevent coronary heart disease for those at high risk.

Urgent and After-Hours Care

Urgent care* is medically necessary care for an unexpected illness or injury that is not life-threatening. Although, this care is not considered a medical emergency, it should be treated within 24 hours. It is medical care you can safely postpone until you can call your physician.

If you need urgent care, speak to your physician or his/her covering physician first. He/She can tell you what to do.

If you go directly to an emergency facility for urgent care and your situation is not considered a medical emergency, the care you receive after the medical emergency screening exam may not be covered at the in-network level of benefits. This means you may share in more of the costs.

If you believe your condition requires emergency care, follow the medical emergency procedures on page 37.

Some examples of urgent care include:

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

Care on nights and weekends

If you need care after hours or on weekends for a condition requiring urgent care, your PCP or participating physician should be available 24 hours a day, seven days a week. If your PCP or participating physician is not available, his/her covering physician will help you.

* For a complete definition, please refer to the Glossary beginning on page 75.

24/7 Nurse Line

The 24/7 Nurse Line is a non-urgent health care information service brought to you by Horizon BCBSNJ. The nurse line services are available to Horizon Direct Access members 24 hours a day, seven days a week.

24/7 Nurse Line

The 24/7 Nurse Line is staffed by registered nurses who can give you the support you and your family need to make wise health care decisions and get the best health care possible. The 24/7 Nurse Line program is completely voluntary and all calls are strictly confidential. The nurses who staff the 24/7 Nurse Line can tell you about various treatments to help you understand a medical problem, or assist you with planning questions for your physician. The toll-free number is **1-888-624-3096**.

24/7 Nurse Line online

The 24/7 Nurse Line is also available on the Web. The 24/7 Nurse Line Web site is a comprehensive source of information designed to inform, educate and assist you in deciding what level of health care you might need. The 24/7 Nurse Line service has taken their extensive health education experience and combined it with leading sources of health and medical information, to provide reliable information on a broad range of topics.

For more information on health symptoms, wellness, drug information, up-to-date health news and much more, visit the *Health and Wellness* section on <www.HorizonBlue.com>.

Emergency Care

Horizon Direct Access covers you for medical emergency* care, 24 hours a day, seven days a week. A medical emergency 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:

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

Less severe medical problems and chronic conditions may be better handled by your PCP or participating physician in his/her office.

Medical Emergency Screening Exam

Sometimes, you may not be sure if you need emergency care. Your plan covers a medical emergency screening exam. This is an evaluation, performed in a hospital Emergency Room (ER) by qualified health care personnel, to determine if a medical emergency exists.

We will cover the cost of the emergency screening exam. However, if it is determined that a medical emergency does not exist, please follow up with your PCP or participating physician for instructions.

If you continue to receive services in the ER after you have been advised that your condition is not a medical emergency, you will have to pay more for the nonemergency services.

* For a complete definition, please refer to the Glossary beginning on page 75.

Medical Emergency Procedures

In a medical emergency, please follow the steps below.

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

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

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

ER Copayments

All Horizon Direct Access members have an ER copayment, even if a PCP or participating physician refers you. Each time you receive treatment in an ER for a medical emergency or are given a medical emergency screening exam, you will have to pay a copayment and deductible. 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 PCP or participating physician.

Coordination of Care and Specialty Care

Coordination of care is the approval we give you and your physician before you receive certain specialty services. Without the proper coordination of care, you may receive services that are not covered by insurance.

Behavioral health and substance abuse care

To obtain coordination of care, please call Magellan Behavioral Health™ at **1-800-626-2212**. Behavioral health and substance abuse care is available 24 hours a day, seven days a week. All calls are confidential. Please refer to page 43 for more information.

Hospitalization

The Horizon Hospital Network is one of the largest hospital networks in the region. When you use these hospitals, you may be admitted by either a participating or nonparticipating physician. In either case, when the hospital is participating, your hospitalization will be covered at the in-network level of benefits.

To lower your out-of-pocket hospital or facility expenses:

- Receive care from a participating hospital or other participating health care facility.

For the most up-to-date listing of the Horizon Hospital Network, visit www.HorizonBlue.com, and use the *Provider Directory* search tool. You may also refer to your *Horizon BCBSNJ Directory of Participating Physicians and Other Health Care Professionals* or call Member Services at **1-800-355-BLUE (2583)**.

If you do not obtain prior authorization before you receive care at a nonparticipating hospital for a condition that is not an emergency, you may be subject to higher cost sharing. Nonparticipating physician services will also be subject to higher cost sharing.

Hospital stay and prior authorization

If you require inpatient or outpatient* hospitalization and want your care to be covered at the in-network level of benefits, your PCP or participating physician must contact us for prior authorization and you must receive care from an in-network facility. If your care is provided by a nonparticipating physician, **you** must call Member Services to obtain prior authorization for the services.

Emergency hospital admissions

If you go to the ER and are admitted, you or your authorized representative should call your PCP or participating physician as soon as possible. This will help your PCP or participating physician coordinate your care.

* Not all outpatient hospital services require prior authorization. For more information, please refer to your Benefit Booklet/Certificate or call Horizon BCBSNJ Member Services at the number on the back of your ID card.

Maternity Care

Most expectant mothers have questions and concerns about their pregnancy and delivery. That's why we developed the PRECIOUS ADDITIONS® program. This program is designed to provide helpful information during this exciting time. To enroll in PRECIOUS ADDITIONS, please call Members Services at **1-800-355-BLUE (2583)**.

PRECIOUS ADDITIONS participants will receive the following information:

- A pregnancy journal.
- Information about a \$50 reimbursement for a childbirth education class.
- Information about childhood immunizations.
- Information about enrolling your newborn in your health plan.

Newborns must be added to your coverage within 31 days from the date of birth to be covered continuously beyond the initial 31 days of life. Please send your application to our enrollment team as soon as possible.

Please call Member Services at **1-800-355-BLUE (2583)** to enroll your newborn under your coverage. You may also obtain an application online at <www.HorizonBlue.com>.

Partnering with your Ob/Gyn

We support the recommendation of the American College of Obstetricians and Gynecologists for 12 obstetrical 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 physician 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 hospital stays

Expectant mothers are certified for a hospital stay of 48 hours following a vaginal delivery or 96 hours following a caesarean section. Your hospital stay may be extended if your physician feels additional time is medically necessary. For your extended stay to be covered, your physician will need to have the additional days approved by us.

If you are advised by your physician 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.

For specific information about dependent coverage, please refer to to your **Benefit Booklet/Certificate**.

* You are eligible to receive a home care visit if you leave the hospital within one day after a vaginal delivery or within two days after a caesarean section. Visits must be scheduled by the Ob/Gyn within seven (nurse/lactation consultant) to 14 (home health aide) days.



Laboratory Testing

Laboratory work for Horizon Direct Access members is provided by Laboratory Corporation of America (LabCorp) or AtlantiCare Clinical Laboratories. Your PCP may draw blood for the test in his/her office or send you to a participating laboratory for testing.

LabCorp and AtlantiCare Clinical Laboratories

Your PCP or participating physician may refer you directly to a LabCorp Patient Service Center. If so, he/she will give you a LabCorp Requisition form to take with you. This form may also be used for AtlantiCare Clinical Laboratories. Please present the requisition form and your Horizon Direct Access ID card at the participating laboratory facility.

Find the LabCorp Patient Service Center nearest you by visiting www.labcorp.com/psc.

AtlantiCare Clinical Laboratories are located in:

- Atlantic City at The HealthPlex, 1401 Atlantic Avenue.
- Egg Harbor Township at 2500 English Creek Road, Building 900, Suite 910 and at 3205 Fire Road (between Mill Road and Tilton Road).
- Hammonton at 120 South White Horse Pike.
- Marmora at 210 South Shore Road, Suite 200.
- Northfield at 1750 Zion Road, Suite 209.
- Ocean City at 208 Asbury Avenue.
- Pomona at Stockton Medical Center, 72 West Jimmie Leeds Road, Suite 2300.
- Ventnor at 6725 Ventnor Avenue.

If you do not use LabCorp or AtlantiCare Clinical Laboratories, you will not be covered in full and will have to pay more for your laboratory work.

If you receive a bill for laboratory work from LabCorp or AtlantiCare Clinical Laboratories, call Member Services at **1-800-355-BLUE (2583)**.

Behavioral Health and Substance Abuse Care

You are covered for managed behavioral health and substance abuse care. Our network of participating physicians and facilities is extensive.

Prior authorization from Magellan Behavioral Health™ is required for all inpatient care. Outpatient hospital care and office visits do not require prior authorization but require coordination of care.

The BlueCard network of behavioral health or substance abuse care professionals and facilities are available for your use should you require behavioral health services when you travel outside of our local area. By utilizing these professionals and facilities who participate with the servicing plan, you can minimize your out-of-pocket expenses.

Getting behavioral health and substance abuse care

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

Available services

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

- Individual and group psychotherapy.
- Family counseling and crisis intervention.
- Addiction recovery programs.

* 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 obtain a member's behavioral health/substance abuse treatment information.

Out-of-Area Coverage

Peace of mind means knowing you're covered for urgent and emergent care no matter where you are. Whether your traveling across the country or around the world, **BlueCard®** gives you the freedom to choose participating physicians and hospitals in more than 200 countries.

How BlueCard Works

1. You are outside the Horizon BCBSNJ service area (the state of New Jersey) and need health care services.
2. Call **1-800-810-BLUE (2583)** for information about the nearest Blue Cross and/or Blue Shield physician or hospital. If you are outside of the U.S., you may call collect at **1-804-673-1177**.
3. You are responsible for obtaining any prior authorization from us. For more details on prior authorization, see page 39.
4. Visit the Blue Cross and/or Blue Shield participating physician or hospital and present your Horizon Direct Access ID card.
5. The physician or hospital will recognize the BlueCard logo (the *suitcase logo* pictured at right) and will verify your eligibility for benefits using the BlueCard Eligibility Line.
6. After you receive medical care, your claim is routed to us. You are responsible for any applicable deductible, coinsurance and copayment.



For BlueCard, all claims are adjudicated at the out-of-network level.

Care Provided by a BlueCard Participating Physician

If you are out of our service area (the state of New Jersey) and have a medical, behavioral health or substance abuse urgent/emergency, call BlueCard Access at **1-800-810-BLUE (2583)**. A BlueCard representative will help you locate the nearest Blue Cross and/or Blue Shield participating physician. When you visit a physician who participates with a local Blue Cross and/or Blue Shield Plan, you'll pay only your copayment at the time of service. The physician will verify your membership and coverage with Horizon Direct Access and will submit all the paperwork for you.

Urgent and emergent care is considered in network and all other services (other than those authorized by Horizon BCBSNJ) are considered out of network.

Care Provided by a Nonparticipating Physician

If you do not use a Blue Cross and/or Blue Shield participating physician, you:

- May have to pay the difference between the amount we allow for coverage of the service(s) provided and what the physician charges.
- May be asked to pay the entire bill up front (including your copayment) at the time of service.
- Will have to submit the claims paperwork yourself. Send the bill, your Horizon Direct Access ID number and the date(s) of service to:

Horizon Direct Access Claims
PO Box 820
Newark, NJ 07101-0820

Foreign claims should be translated into English and converted into U.S. currency before submission.

Follow-up Care

If possible, all routine follow-up care should be done by your PCP or participating physician to be covered at the in-network level of benefits.

Horizon Health and Wellness Education Program

As a Horizon Direct Access member, you have access to a variety of health education programs to help you manage your health care and remain informed about your chronic conditions. Our health and wellness programs include the:

- Asthma Health Education Program.
- Chronic Kidney Disease (CKD) Health Education Program.
- Chronic Obstructive Pulmonary Disease (COPD) Health Education Program.
- Coronary Artery Disease (CAD) Health Education Program.
- Diabetes Health Education Program.
- End Stage Renal Disease (ESRD).
- Heart Failure Health Education Program.
- Hepatitis C Health Education Program.
- Hypertension Health Education Program.
- Multiple Sclerosis Health Education Program.
- Weight Management Health Education Program.

All these programs, excluding the Hypertension Health Education Program, are URAC accredited. URAC accreditation is widely recognized by physicians and other health care professionals and accepted as a measure of quality and accountability.

For more information on the Horizon Health and Wellness Education Program, please call **1-888-334-9006**. Members who are hearing-impaired may call **1-800-855-2881**.

Case Management Program

If you are diagnosed with a serious medical condition or are advised that you need major surgery, you may be eligible for Horizon BCBSNJ's Case Management program. Through this program, a case manager, who is a registered nurse, will help you examine your options regarding available specialists, hospitals and your medical care, while maximizing your benefits.

Your case manager can:

- Provide advocacy and clinical information during a complex situation in conjunction with the attending physician.
- Coordinate medically necessary services, equipment and supplies as requested by the attending physician and other health care professional.
- Provide educational materials, training resources and information about community-based services.
- Monitor the patient's progress in following the treatment plan established by the physician(s) and other health care professionals.
- Collaborate with the patient, caregivers and physician(s) on an ongoing basis to help ensure the patient is receiving the most effective and appropriate care.
- Evaluate and ensure that all follow-up actions are pursued in the patient's best interest.

While you are in the hospital, your Horizon BCBSNJ case manager can help ensure that the care you receive is timely and appropriate. When you leave the hospital, your Horizon BCBSNJ Case Manager will help ensure your needs are met.

When you face a challenging medical condition, Horizon BCBSNJ's case managers are available to help – at no additional cost to you. Call us at **1-888-621-5894**, option **2**. Case managers are available to speak with you, Monday through Friday, between 8 a.m. and 6 p.m., Eastern Time (ET).

Pharmacy Benefits

Your Horizon Direct Access plan includes prescription drug coverage administered by CVS Caremark. Please read this section for more information about your prescription drug benefits.

For additional information, you may call CVS Caremark at **1-866-881-5603**, or visit our Web site at <www.HorizonBlue.com>.

Preferred Brand and non-Preferred Generic Prescription Drugs

Horizon BCBSNJ has a list of Preferred brand and generic prescription drugs. The list, also called a formulary, is maintained by our Pharmacy and Therapeutic (P&T) Committee, an independent group of physicians and pharmacists. The P&T Committee regularly reviews new and existing prescription drugs based on clinical efficacy and patient safety.

To learn more about the prescription drugs covered under our formulary, visit www.HorizonBlue.com and select *Pharmacy Services*.

Online Pharmacy Services

With a few clicks of your mouse, you can save money, manage your prescription drug benefits, research medicines and access a wealth of health care information. Simply log on to www.HorizonBlue.com and select *Pharmacy Services* to:

- View your prescription drug benefit plan.
- Look up prescription drug coverage and pricing.
- Search the prescription drug information center.
- Use reference tools.
- Set up prescription drug mail service.
- Locate a nearby pharmacy.



Prior Authorizations

Some prescriptions require prior authorizations.

For the most up-to-date listing of the prescription drugs requiring prior authorization, please visit *Pharmacy Services* at www.HorizonBlue.com. We encourage your physician to call CVS Caremark at **1-800-294-5979** to receive prior authorization, if necessary.

Specialty Pharmacy Services

Specialty pharmaceuticals are a class of prescription drugs typically produced through biotechnology (sometimes known as biologicals) and require special patient monitoring and handling. Specialty pharmaceuticals require unique education prior to use and may have distribution procedures restricted by the manufacturer.

To help members taking specialty pharmaceuticals, Horizon BCBSNJ has contracted with pharmacies that specialize in these therapies. These pharmacies provide our members with a high level of service and prescription drug- and condition-specific education and support, along with:

- Personal attention from a pharmacist-led team that provides condition-specific education, medication administration instruction and expert advice to help manage therapy.
- Claims assistance to help determine individual coverage and file necessary paperwork.
- Easy access to pharmacists and other health experts 24 hours a day, seven days a week.
- A single, reliable source for specialty medication needs.
- Easy ordering with a dedicated toll-free number.
- Confidential and convenient delivery to the location of choice (e.g., home, physician's office, vacation spot, etc.)

All specialty pharmaceuticals are subject to a medical necessity and appropriateness review.

For more information on specialty pharmaceuticals, visit www.HorizonBlue.com and select *Pharmacy Services*.

Medical Bills

Sometimes, you may receive a bill for the services you received. If you do, please note the following:

If care is provided by a participating physician:	Your physician should bill us.
If care is provided by a nonparticipating physician:	You must pay the physician and then send us the bill. We will reimburse* you for covered services. When you submit the bill to us, please complete a claim form, including: <ul style="list-style-type: none">• Your ID number.• The name of the patient.• The patient's date of birth.• Your relationship to the patient.

To download a claim form, visit www.HorizonBlue.com, *Downloadable Forms*. Or, call Member Services at **1-800-355-BLUE (2583)**.

Mail claims to:

Horizon Direct Access Claims
PO Box 820
Newark, NJ 07101-0820

Behavioral health and substance abuse care claims should be sent to:

Magellan Behavioral Health
PO Box 5172
Columbia, MD 21045-5171

Always keep a copy of your medical bills for your records.

Claims must be sent to us within **12 months** after the date of service. After **12 months**, claims will automatically be denied for untimely submission. Call Member Services for more information.

* Reimbursement is based on our allowance and your plan's out-of-pocket cost requirements.

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 concerns regarding the care or service you are receiving.

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

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

If you are ever dissatisfied with any aspect of Horizon Direct Access, including the quality of care or service you have received, you, a physician or 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 physician who makes an inquiry, files a complaint or pursues an appeal will be subject to disenrollment, discrimination or penalty by Horizon BCBSNJ.

If your inquiry is related to a utilization management decision, it may be forwarded to our Utilization Management (UM) team for resolution through the UM Appeals process described on page 56.

The following pages explain the procedures you should follow to voice a concern through inquiries, complaints and/or appeals.

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

* If you are a member who does not speak English, you may voice a concern using the AT&T Language Line. Please call Member Services to be connected to the AT&T Language Line.

A Quick Guide to Voicing a Concern

Do you have a benefit or claim question that you need answered, or want to file a complaint or appeal? Please follow these steps:

1 ***For general inquiries:*** Call Member Services. A representative will answer your questions and advise you of your benefit information.

Call **1-800-355-BLUE (2583)**, Monday, Tuesday, Wednesday and Friday, Eastern Time (ET), between 8 a.m. and 6 p.m., and Thursday, between 9 a.m. and 6 p.m., ET.

–or–

Write to:

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

2 ***To file a complaint or an appeal:*** If you are not satisfied with the information provided to you, you may file a complaint or appeal by writing to:

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

3 ***To file an appeal:*** If you are not satisfied with our decision regarding your care, you may initiate an appeal by writing to the Appeals Coordinator address noted above.

Non-utilization Management Inquiries, Complaints and Appeals

All nonmedical/non-utilization management inquiries or complaints are handled by Member Services Representatives. Member Services Representatives are available to respond to your inquiries or complaints, or those made by a physician or other authorized representative acting on your behalf and with your consent. We are often able to immediately resolve questions at the point of contact. Member Services Representatives are available during regular business hours, Monday, Tuesday, Wednesday and Friday, between 8 a.m. and 6 p.m., Eastern Time (ET), and Thursday, between 9 a.m. and 6 p.m., ET.

Both verbal and written inquiries, complaints and appeals are accepted. If you have a nonmedical complaint or inquiry or a non-utilization management appeal, you may call Member Services at **1-800-355-BLUE (2583)**.

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

For general inquiries:

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

For complaints:

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

Our goal is to resolve your initial inquiry or complaint within:

- 15 days from receipt if your issue involves a claim for benefits where Horizon BCBSNJ's prior approval is required for benefits to be payable on the claim.
- 30 days in most other instances.

If we require additional information from your physician, we must allow your physician 45 days to send us the requested information.

You'll be notified by telephone and/or 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.

Requesting a non-utilization management appeal

After you receive our determination of your initial complaint, you, your physician or other authorized representative, acting on your behalf and with your consent, may request a second level appeal. You may do so in person, by telephone or in writing, as instructed by Horizon BCBSNJ in its complaint determination. Please send your appeal request, whether by phone or in writing, to the appeals unit at the address and telephone number supplied in our determination letter.

An Appeals Coordinator will investigate your case and collect the information necessary to forward the case to the Appeals Committee. An Appeals Coordinator will mail a letter to you acknowledging your request for appeal, describing the Appeals Committee process and the actual hearing date.

Resolving your non-utilization management appeal

Cases are scheduled and heard promptly after receiving your request. Your appeal is generally heard and decided within:

- 15 days from receipt if your issue involves a claim for benefits where Horizon BCBSNJ's prior approval is required for benefits to be payable on the claim.
- 30 days in most other instances.

If we require additional information from your physician, we must allow your physician 45 days to get the requested information to us.

You have the option of attending the hearing in person or via telephone conference. The Appeals Coordinator will make the appropriate arrangements. You may also elect to have the Appeals Committee decide your appeal without your appearance.

Cases are scheduled and heard promptly after receiving your request. An Appeals Coordinator will contact you and advise you of the various appeal options available to you, as well as our timeframes for notifying you of our decision.

Your appeal options and our notification timeframes are as follows:

If you:	We will notify you of our decision:
Attend the hearing in person ...	By telephone on the day of the hearing, whenever possible.
Conference in, via telephone ...	By telephone on the day of the hearing, whenever possible.
Elect to have the Appeals Committee represent you without your appearance ...	In writing within two business days of our decision.
Have an urgent or emergent appeal ...	As soon as possible. Your appeal may be expedited.

Utilization Management or Medical Appeals

Members, their authorized representatives and physicians, acting on behalf of the member and with the member's written consent, generally have the right to pursue an appeal of any adverse utilization management decision made by Horizon BCBSNJ. An adverse utilization management decision is a decision to deny or limit an admission, service, procedure or extension of stay, based on Horizon BCBSNJ's clinical and medical necessity criteria. We will provide a copy of the criteria used for an individual determination upon request.

There are three levels to the medical appeals process: a first level medical appeal, a second level medical appeal and an external, third level medical appeal. External appeals are available only for cases involving a denial for medical necessity and/or appropriateness.

If we fail to comply with the medical appeals process or waive our rights to an internal review of your appeal, you, your authorized representative, physician or other health care professional, acting on your behalf and with your consent, may proceed directly to the external appeal stage.

A complete copy of the medical record may be useful in your appeal.

The addresses and telephone numbers used for Horizon BCBSNJ's medical appeals processes are:

For northern New Jersey:

Horizon Direct Access Appeals Department, PP-14E
PO Box 420
Newark, NJ 07101-0420
1-888-221-6392

For southern New Jersey:

Horizon Direct Access Appeals Department, MT-03W
PO Box 110
Newark, NJ 07101-0110
1-888-645-5533

Please refer to your determination letter for the appropriate address and telephone number to pursue an appeal.

First Level Medical Appeals

You will be advised how to initiate a first level medical appeal at the time our adverse utilization management decision is made. If you disagree with our decision, you have one year following the date of receipt of our original decision to request an appeal. First level medical appeals are reviewed by our medical administration. Nonemergent appeals are reviewed within five business days. Urgent and emergent first level medical appeals are reviewed within 72 hours.

If the denial is upheld, members, their authorized representatives and physicians, acting on behalf of the member and with the member's written consent, may submit a second level medical appeal.

Second Level Medical Appeals

If you disagree with our decision on your first level medical appeal, you have one year following the date of receipt of our original decision to request a second level medical appeal. The letter you receive explaining our first level medical appeal determination will advise you of the address to use if you want to submit a second level medical appeal. If a second level medical appeal is received, it is submitted to our Appeals Committee, which is made up of a Horizon BCBSNJ Medical Director and staff, physicians from the community and consumer advocates. A smaller subcommittee reviews expedited second level medical appeals.

Our Appeals Coordinator will advise you of the date of your hearing. You have the option of attending the hearing in person, or via telephone conference, if you wish. Our Appeals Coordinator makes these arrangements with you. You may also elect to have the Appeals Committee review and decide your second level medical appeal without your appearance. In addition, you have the option to request a consultant practitioner's participation in the panel of physicians in reviewing the second level medical appeal.

Second level medical appeals will be reviewed and decided in the following timeframes:

- Standard second level medical appeals involving requests for services, supplies or benefits, which require our prior authorization or approval in advance to receive coverage under your plan, are reviewed and decided within 15 calendar days of our receipt.
- Expedited second level medical appeals are decided as soon as possible in accordance with the medical urgency of the case, but will not exceed 72 hours from our receipt of your second level medical appeal request.
- All other second level medical appeals are decided within 20 business days of our receipt.

If you participate in the hearing, you will be notified of the Appeals Committee's decision by telephone on the day of the hearing, whenever possible. Written confirmation of the decision is sent to you, your physician or other authorized representative who pursued the second level medical appeal on your behalf. If you choose not to appear at the hearing, you will be notified of the Appeals Committee's decision in writing within five business days of its decision. Our letter will include the specific reasons for the determination. If our decision is not in your favor, you have the right to pursue an external third level medical appeal through an Independent Utilization Review Organization (IURO) as described on the next page.

External, Third Level Medical Appeals

If the Appeals Committee upholds the second level medical appeal, you, your authorized representative or your physician, acting on your behalf and with your written consent, may request an external, third level medical appeal with the IURO assigned by the New Jersey Department of Banking and Insurance (DOBI). The IURO will only consider appeals on denials based on medical necessity. Denials based on contract issues are not reviewed by the IURO.

To file an external third level medical appeal, you must submit a written request within 60 days from receipt of our second level medical appeal determination letter. All requests are required to be filed on the forms enclosed with our second level medical appeal determination letter.

After you have completed the forms, including a release to obtain your medical records, please mail the forms, the signed release and your \$25 check* made payable to the *New Jersey Department of Banking and Insurance*, to:

**Consumer Protection Services
Department of Banking and Insurance
20 West State Street, 9th Floor
PO Box 329
Trenton, NJ 08625-0329
1-609-292-5316**

You may also submit complaints online by selecting DOBI's online complaint form at <www.state.nj.us/DOBI>.

* Horizon BCBSNJ is responsible for the costs of the IURO appeal; however, you still must pay the \$25 application fee.

If you cannot afford to pay the \$25 application fee, mail the completed forms with a \$2 fee and show proof of financial hardship. Financial hardship can be demonstrated through evidence of your eligibility for any of the programs listed below:

- Pharmaceutical Assistance to the Aged and Disabled (PAAD).
- Medicaid.
- NJ FamilyCare.
- General Assistance.
- Social Security Insurance.
- New Jersey Unemployment Assistance.

After the DOBI receives your appeal and appropriate fee, your appeal will be immediately assigned to an IURO for a preliminary review. Your appeal will be accepted for processing if:

- You are a member.
- The services reasonably appear to be covered services or if we have waived the internal review or failed to meet a deadline for completion of the review.
- You have fully complied with our internal appeals system.
- You have provided all information required by the IURO, including an executed release and copy of any information provided by us regarding our decision to deny, reduce or terminate the covered service.

Once your third level medical appeal is submitted to the DOBI, you, your duly authorized representative, physician or other health care professional, acting on your behalf and with your consent, will be notified in writing whether your appeal has been accepted for processing and, if not accepted, the reason(s). You will be notified of the IURO's recommended decision within 30 business days from receipt of all documentation necessary to complete the review. In some cases, the period of review may need to be extended. If this is necessary, you will be notified, in writing, of the status of the appeal and reasons for delay. In no event will the IURO render its determination later than 90 days after it receives a completed application. If the appeal involves urgent or emergent care, the IURO will complete its review within 48 hours from receipt of the documentation.

If the IURO determines that the denial, reduction or termination of benefits deprived you of medically necessary and appropriate covered services, this shall be conveyed to you and Horizon BCBSNJ along with a recommendation as to the appropriate medically necessary and appropriate covered services that should be received. This determination shall be binding upon us. If all or part of the IURO's decision is in favor of you, we shall provide coverage for those services determined to be medically necessary and appropriate covered services.

If you are not in agreement with the IURO's decision, you may seek the desired health care services outside of the health benefits plan at your own expense.

If you have questions about filing a complaint or an appeal, please call Member Services at **1-800-355-BLUE (2583)**.

Behavioral Health and Substance Abuse Care Appeals

If Magellan Health Services is your behavioral health administrator, you may appeal a behavioral or substance abuse (including alcoholism) care decision directly with Magellan Health Services. Please send your appeal to:

Magellan Health Services
199 Pomeroy Road
Parsippany, NJ 07054

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

Prescription drug appeals may be sent to:

CVS Caremark
Prescription Drug Appeals, MC-109
PO Box 52084
Phoenix, AZ 85072-2084

Or, you may fax your appeal to **1-866-443-1172**. For more information, call the CVS Caremark Appeals Department at **1-866-443-1183**.

Utilization Management Program

It's important that you get the right care, at the right time, and use your covered services correctly. To help ensure that the care you receive is medically necessary, Horizon BCBSNJ has a Utilization Management Program in place, which helps to monitor underutilization or overutilization of services.

Horizon BCBSNJ endeavors to monitor for underutilization and overutilization to facilitate the delivery of appropriate care.

- **Underutilization** – Not getting your annual checkup(s) or preventive vaccinations, as recommended.
- **Overutilization** – Getting medical care, medications, laboratory testing or surgical procedures when they are not medically necessary.

Horizon BCBSNJ's Utilization Management (UM) Program provides a monitoring system to assess the medical necessity and appropriateness of the health care services members receive or are proposed to be provided. Utilization management activities are intended to identify optimal modes of practice that produce high-quality care and outcomes, and, when possible, to help ensure physicians manage care in a medically-appropriate and cost-effective manner. The program promotes the continuing education of, and understanding amongst, participating physicians and other health care professionals, Horizon BCBSNJ's employees, our members and employers with whom Horizon BCBSNJ does business.

Horizon BCBSNJ adheres to the following UM principles. Horizon BCBSNJ:

- 1.** Makes UM decisions based solely on the necessity and appropriateness of care and services within the parameters of the member's benefit package.
- 2.** Does not compensate those responsible for making UM decisions in a manner that incents them to deny coverage for medically necessary and appropriate covered services.
- 3.** Does not offer incentives to those responsible for UM determinations to encourage denials of coverage or services and does not provide financial incentives to physicians to withhold covered health care services that are medically necessary and appropriate.
- 4.** Emphasizes the provisions of medically necessary, appropriate and cost-effective delivery of health care services to members and encourages the reporting, investigation and elimination of underutilization.

Horizon Wellness Discounts*

As a Horizon Direct Access member, you can save money on products and services beyond your health care coverage. We have relationships with a variety of businesses to provide discounts and savings on popular products and services for you and your family.

You can receive discounts on:

- Fitness club memberships and weight loss programs.
- Child safety and baby-proofing products.
- Alternative health services.
- Hearing screening tests, counseling and supplies.
- LASIK vision correction.
- Vitamins and supplements.
- And more.

For an up-to-date listing of offered programs and information on ways you can save money, visit <www.HorizonBlue.com/Discounts>.

To receive your discount, simply:

- Present your Horizon Direct Access ID card at participating businesses;
- Mention that you are a Horizon BCBSNJ member when calling each business directly at the toll-free number listed; or,
- Use the discount codes provided when ordering online.

* Products and services offered as Horizon Wellness Discounts are not covered health benefits. Programs may be terminated, and pricing, discount rates and other program features may be modified at any time. Suppliers that participate in these programs are solely responsible for the quality of the goods and services they provide. Discounts cannot be combined with Horizon Direct Access benefits, unless otherwise noted.

Your Member Rights

As a Horizon Direct Access member, you have the right to:

Access information

- Receive information about Horizon BCBSNJ and its services, policies and procedures, products, physicians, appeals procedures, coverage limitations and other information about the organization and the care provided.
- Be provided with the information needed to understand your benefits and obtain care through the Horizon Managed Care Network.
- Obtain a current directory of participating physicians in our network, upon request. The directory includes addresses, telephone numbers and a listing of physicians who speak languages other than English.
- Receive prompt notification (not more than 30 days following the effective date) of the termination or change in benefits and services; and to receive notice of termination of your Primary Care Physician (PCP), if selected, from the physician network (when applicable, 30 days prior notice).
- Obtain information about whether a referring physician has a financial interest in the facility or services to which a referral is being made.
- Know Horizon BCBSNJ's payment method for physicians, to know if there are financial incentives or disincentives tied to medical decisions.
- Receive from your physician 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.

- Have full, candid discussions regarding appropriate or medically necessary diagnostic and treatment options with your participating physicians, regardless of cost or benefit coverage.
- Know your rights and responsibilities as a Horizon BCBSNJ member.

Your Primary Care Physician (PCP)

- Choose and change your PCP, if selected, within the limits of your benefits and the physician's availability.
- Have access to your PCP, if selected, and available services when medically necessary. This includes the availability of care 24 hours a day, seven days a week, 365 days a year for urgent or emergent conditions.

Medical emergency and urgent care

- Call the 911 emergency response system or an appropriate local emergency number in a potentially life-threatening situation, without prior approval.
- Have Horizon BCBSNJ provide coverage for a medical screening exam in an emergency facility to determine whether a medical emergency condition exists.
- Go to an Emergency Room without prior approval when it appears to you that serious harm could result from not obtaining immediate treatment.

Specialty and hospital care

- Choose from appropriate, participating specialists following an authorized referral (as needed), subject to the specialist's availability to accept new patients.
- Receive assistance in locating and obtaining referrals (if applicable) to participating physicians with experience in treatment of patients who have chronic disabilities.

Approval of your care

- Receive a written explanation why approval of a covered service requested by you or your physician was denied or limited under your Horizon Direct Access plan.
- Have a Horizon BCBSNJ physician determine to deny or limit your admission, service, procedure or extension of stay. Our physician who made the decision must directly communicate with your physician or supply your physician with his/her telephone number. You also have the right to know that the person denying or limiting a covered service is a physician.
- Be free from balance billing by participating physicians for medically necessary services that were authorized (as applicable) or covered by Horizon BCBSNJ. Balance billing does not include copayments, coinsurance and deductibles that you must pay under your plan.

Voice a concern

- Voice complaints or file internal and external appeals about your plan or the care provided. Please see the *Voicing a Concern* section of this Member Handbook, beginning on page 52.
- File a complaint or appeal with Horizon BCBSNJ or the New Jersey Department of Banking and Insurance. You have the right to receive an answer to your complaint or appeal within a reasonable period of time.
- Know that neither you nor your physician can be penalized for voicing a complaint or appeal about your Horizon Direct Access plan or the care provided.

Your personal rights

- Participate with your physicians or other health care professionals in decision-making regarding your health care.
- Be treated with courtesy and consideration, and with respect for your privacy and dignity.

Formulate and have advance directives implemented.

- Have access to all the rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in a language you understand.
- Make recommendations for changes to the Horizon BCBSNJ Member Rights and Responsibilities Policy.

Your Member Responsibilities

As a Horizon Direct Access member, you have the responsibility to:

- Read and understand your Horizon Direct Access Member Handbook, Benefit Booklet/Certificate and all other member materials.
- Coordinate most nonemergency care through your PCP, if selected.
- Make appointments for nonemergency medical care and keep your appointments. If necessary, you will give adequate notice when canceling an appointment.
- Provide, to the extent possible, information regarding your health that Horizon BCBSNJ and its physicians and health care professionals need in order to care for you.
- Know how to change your PCP, if you selected one.
- Understand your health problems and participate in developing mutually agreed upon treatment goals and medical decisions regarding your health (to the degree possible).
- Follow the plans and instructions for care that you agreed upon with your physician. If you choose not to comply, you will advise your physician.
- Be considerate and courteous to physicians and staff.
- Make payment for copayments, deductibles and coinsurance as listed in your Benefit Booklet/Certificate.
- Pay for charges that exceed Horizon BCBSNJ's allowance for services that are covered under the policy in those instances in which service is provided by an out-of-network physician.
- Pay for charges incurred that are not covered under the policy or contract.

Protection of Your Private Information

It is the policy of Horizon BCBSNJ* to:

- Meet the requirements of state and federal law in maintaining the privacy and security of your protected health information (PHI) and other personal, customer information (collectively referred to as private information or PI) in accordance with its Notice of Information Privacy Practices and privacy policies and procedures.
- Only request, access, use, disclose and retain your private information in accordance with the requirements of this policy and more fully with our Notice and privacy policies and procedures.
- Permit access of private information by our personnel only when performing their assigned responsibilities, and only to the minimum extent necessary to accomplish these purposes. Horizon BCBSNJ personnel are prohibited from disclosing information to unauthorized persons except as permitted by law, in accordance with our privacy policies and procedures.

All Horizon BCBSNJ activities shall be conducted in a manner to ensure the privacy and security of member private information. For example, a member's:

- Name, diagnosis, treatment dates and services rendered can be shared with Horizon BCBSNJ employees and other appropriate persons on a *need-to-know* basis. This information is generally necessary to conduct verification of eligibility, to process claims, and for many other everyday payment and health care operations activities.
- Past treatment history, clinical status, treatment plan and discharge plan are typically shared with licensed clinicians and others who need to access such information in order to perform their roles/functions for Horizon BCBSNJ. Private information may also be disclosed to reviewing bodies (e.g., National Committee for Quality Assurance [NCQA]) and others, in accordance with state and federal law and Horizon BCBSNJ privacy policies and procedures.

* For purposes of the privacy policies and procedures applicable to this coverage, the reference to "Horizon BCBSNJ" includes its affiliated covered entities.

Filing a privacy complaint

You may file a complaint with Horizon BCBSNJ if you feel your privacy rights have been violated by us or our business associates.

All complaints must be submitted in writing (an oral complaint will be processed, but you must then document it in writing). To file a privacy complaint with Horizon BCBSNJ, you may write to either of the following addresses:

**Horizon BCBSNJ
Centralized Correspondence Unit
PO Box 820
Newark, NJ 07101-0820**

– or –

**Horizon BCBSNJ
Privacy Office, PP-16F
Three Penn Plaza East
Newark, NJ 07105-2200**

For detailed information on how we protect, safeguard, use and disclose, your private information, please refer to your Notice of Information Privacy Practices pamphlet enclosed in your Member Welcome Kit, or visit www.HorizonBlue.com and click *Privacy Policy*.

Important Notices

Medical Technology

We review new medical technology for the purpose of determining its eligibility for coverage. The breadth of this process incorporates input from the professional and medical community (including input from medical practitioners in New Jersey), as well as the results of literature research. In addition, we review current policies regarding 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**, where 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 physician's termination.
- Oncological treatment, coverage of services may continue for a period of up to **one year** from the date of the physician's termination.
- Psychiatric treatment, coverage of services may continue for a period of up to **one year** from the date of the physician's or health care professional's termination.

These 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 the public health, safety and welfare.
- A determination of fraud or a breach of contract by the health care professional.
- If the health care professional is the subject of disciplinary action by the State Board of Medical Examiners.

Please call Member Services at **1-800-355-BLUE (2583)** if you have questions about your continuation of physician care benefits. All benefits shall be subject to contract limits and Horizon BCBSNJ policies and procedures, including, but not limited to, prior authorization and utilization management requirements.

The general public may obtain 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**

Glossary

Benefit Booklet/Certificate – A booklet that outlines your Horizon Direct Access benefits and exclusions. Please use or refer to it along with your Member Handbook.

copayment – The specified dollar amount a member must pay for each medical visit or service. Your copayment amounts are listed on your Horizon Direct Access ID card.

coinsurance – The percentage of a covered charge that you must pay. It does not include deductibles, copayments or charges that are not covered.

deductible – The amount of money you must pay before benefits are paid by us. This does not include any copayments or coinsurance.

facility – A hospital or ancillary that provides medical care.

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

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

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

medical emergency screening exam – 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.

medical necessity – Definition describes a number of factors used to determine medical necessity, including the prudent clinical judgment as exercised by a health care provider 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 provider; 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 – Physicians, health care professionals and facilities that do not contract with us to provide care to Horizon BCBSNJ 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 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 – Physicians, health care professionals and facilities that are not in the Horizon Managed Care 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 Direct Access plan. You are responsible to pay these costs.

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

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. A PCP is responsible for coordinating all aspects of medical care for those members who have selected him or her. These responsibilities include personally providing medical care or referring members to the appropriate source for medical care, whether that source is a specialist physician, ancillary physician or inpatient facility. In addition, other specialists or health care professionals with appropriate qualifications may serve as a member's Primary Care Physician where Horizon BCBSNJ so agrees.

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

referral – The recommendation by your PCP for you to receive care from a participating physician 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 physician within 24 hours.

we, us and our – Horizon Blue Cross Blue Shield of New Jersey.

Transfer of Medical Records Form

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

To: _____
Name of previous or present physician.

Address: _____

I hereby request my medical records be released to:

Physician 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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