Your Oxford Coverage

for all seasons

PLAN 2 - LIBERTY PLAN DIRECT

UnitedHealthcare®
Oxford

LIBERTY PLAN℠ DIRECT

10093 (11/08)

Dear Oxford Member,

Welcome, and thank you for selecting Oxford Health Plans.

At Oxford, your satisfaction is important to us, and we strive to help make your healthcare experience a positive one. As an Oxford Member, you have access to a series of programs and resources to help you along your road to health:

- A robust network of hospitals and providers from a local health plan with over 20 years of experience. If your employer's plan offers out-of-area coverage, you also have in-network national access outside of Oxford's tri-state service area through the UnitedHealthcare Choice Plus network.
- Our *Healthy Bonus*®[1] program, which consists of special offers and discounts that help you stay healthy and manage special conditions. Members can save on services such as weight loss programs, fitness equipment and publications.
- Our web site, *www.oxfordhealth.com*, which allows you to conduct business (e.g., request an ID card, update or correct any personal information, etc.) and access health information at your convenience.
- Healthcare guidance 24 hours a day, seven days a week, from Oxford's registered nurses through *Oxford On-Call*®
- *Healthy Mind Healthy Body*® magazine, your source for health information on prevention, nutrition, and exercise, as well as important benefit and coverage information.

The following information is enclosed: your new Summary of Benefits, Certificate of Coverage and other important plan information. If you have questions about your coverage, or want to learn more about Oxford's programs and resources, please log on to *www.oxfordhealth.com* or call Customer Service at the number on your Oxford ID card.

Wishing you the best of health,

Oxford Health Plans

[1] *Healthy Bonus* offers are not insured benefits and are in addition to, and separate from, your benefit coverage through Oxford Health Plans. These arrangements have been made for the benefit of Members, and do not represent an endorsement or guarantee on the part of Oxford. Offers may change from time to time and without notice and are applicable to the items referenced only. Offers are subject to the terms and conditions imposed by the vendor. Oxford Health Plans cannot assume any responsibility for the products or services provided by vendors or the failure of vendors referenced to make available discounts negotiated with Oxford; however, any failure to receive offers should be reported to Oxford Customer Service by calling the number on your Member ID card.

Oxford Health Insurance, Inc.
Direct Plan Summary of Benefits
Liberty Network
Abel HR, Inc.

Primary Care and Preventive Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Preventive Care		
Well-Baby and Well-Child Care	No Charge	40% Coinsurance
Adult Periodic Physical Examinations	No Charge	Deductible and 40% Coinsurance
Well-Woman Examinations, Family Planning and Breast Pumps	No Charge	Deductible and 40% Coinsurance
Screening for Prostate Cancer	No Charge	Deductible and 40% Coinsurance
Physician (Primary Care) Office and Home Visits - Treatment of Illness or Injury	$25 per visit	Deductible and 40% Coinsurance
Physician (Primary Care) Hospital Visits	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Diabetes Services (Primary Care)		
Supplies, Education and Self-Management	Supplies - $25 per 31-day supply of each item Education and Self-Management - $25 per visit	Deductible and 40% Coinsurance
Diabetes Medications	Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.	Deductible and 40% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance, Inc.
Direct Plan Summary of Benefits

Primary Care and Preventive Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Elective Termination of Pregnancy- This benefit is limited to a maximum of one procedure per Calendar Year.	Office Visits - $40 per visit Inpatient Facility - Deductible and 20% Coinsurance Outpatient Facility - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Physician (Specialist) Office and Home Visits	$40 per visit	Deductible and 40% Coinsurance
Physician (Specialist) Hospital Visits	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Diabetes Services (Specialty Care)		
Supplies, Education and Self-Management	Supplies - $40 per 31-day supply of each item Education and Self-Management - $40 per visit	Deductible and 40% Coinsurance
Diabetes Medications	Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.	Deductible and 40% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Maternity and Newborn Care	Maternity Care - 25 per initial visit only Inpatient hospital services are Covered subject to: the inpatient facility Out-of-Pocket Expense. *Routine prenatal office visits, as well as certain lab tests and counseling services as described in the United States Preventive Services Task Force A and B recommendations and the Health Resources and Services Administration women's health coverage requirements are considered preventive care and are covered at* ***No Charge*** *.*	Deductible and 40% Coinsurance
Allergy Testing and Treatment	$40 per visit	Deductible and 40% Coinsurance
Rehabilitation Services (Physical, Speech and Occupational Therapies) Inpatient services are limited to 60 days per Calendar Year. Outpatient services are limited to 60 visits per Calendar Year.	Outpatient- $40 per visit Inpatient - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
For Autism Spectrum Disorder and other Developmental Disabilities – Inpatient services are limited to 60 days per Calendar Year. Outpatient services are limited to 60 visits per Calendar Year. Please note that limits do not apply to the treatment of Autism Spectrum Disorder.	Outpatient- $40 per visit Inpatient - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Reconstructive and Corrective Surgery	Office Visits - $40 per visit Inpatient Facility - Deductible and 20% Coinsurance Outpatient Hospital Services- Deductible and 20% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 20% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Gender Dysphoria Services	Office Visits - $40 per visit	Deductible and 40% Coinsurance
	Inpatient Facility - Deductible and 20% Coinsurance	
	Outpatient Hospital Services- Deductible and 20% Coinsurance	
	Outpatient Ambulatory Surgical Center - Deductible and 20% Coinsurance	
	Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance	
Oral Surgery	Office Visits - $40 per visit	Deductible and 40% Coinsurance
	Inpatient Facility - Deductible and 20% Coinsurance	
	Outpatient Hospital Services- Deductible and 20% Coinsurance	
	Outpatient Ambulatory Surgical Center - Deductible and 20% Coinsurance	
	Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance	

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Outpatient Cardiac Rehabilitation– This benefit is unlimited.	No Charge	Deductible and 40% Coinsurance
Outpatient Pulmonary Rehabilitation	No Charge	Deductible and 40% Coinsurance
Orthoptic Exercises and Corneal Topographic Procedures	No Charge	Deductible and 40% Coinsurance
Outpatient Diagnostic Services		
Laboratory Procedures	No Charge Please remember, unless you are receiving preadmission testing, Network Hospitals are not Network Providers for outpatient laboratory procedures and tests.	Deductible and 40% Coinsurance
Radiology Services	***Major Diagnostic Procedures:*** Office Based Services - $40 per visit Free-Standing Radiology Center - Deductible and 20% Coinsurance Hospital Facility Based Services - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Outpatient Diagnostic Services		
Radiology Services	***All other Radiology:*** Office Based Services - $40 per visit Free-Standing Radiology Center - Deductible and 20% Coinsurance Hospital Facility Based Services - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Internal and External Prosthetic Devices **Please Note:** Reimbursement for these items will be at the same rate as under the Federal Medicare reimbursement schedule.	Internal - No Charge Surgery is subject to either the inpatient or outpatient facility Out-of-Pocket Expense. External - No Charge	Deductible and 40% Coinsurance
Durable Medical Equipment, Orthotics and Braces	No Charge	Deductible and 40% Coinsurance
Medical Supplies (Non-Diabetic)	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Treatment of Infertility – Limited to four completed egg retrievals (and the procedures and treatments associated with such retrievals) while covered under this plan or any plan with the same employer.	Office Visits - $40 per visit Inpatient Facility - Deductible and 20% Coinsurance Outpatient Hospital Services- Deductible and 20% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 20% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance Prescription Medications – Covered subject to the applicable Prescription Drug Out-of-Pocket Expense.	Deductible and 40% Coinsurance
Transplants	Transplants performed at Our approved facilities are Covered: Subject to the Inpatient facility Out-of-Pocket Expense When performed at other Network facilities – the services are Covered as an out-of-network benefit.	Deductible and 40% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Clinical Trials	Office Visits - $40 per visit Inpatient Facility - Deductible and 20% Coinsurance Outpatient Hospital Services- Deductible and 20% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 20% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Home Health Care – This benefit is limited to 60 visits per Calendar Year.	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Chemotherapy	Deductible and 20% Coinsurance Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.	Deductible and 40% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Hemodialysis	Office Visits - $40 per visit Inpatient Facility - Deductible and 20% Coinsurance Outpatient Facility - Deductible and 20% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Second and Third Opinions	At Your Request - $40 per visit At Our Request – No Charge	Deductible and 40% Coinsurance
Chiropractic Services- Out-of-Network coverage is limited to $500 per Member, per Calendar Year.	$30 per visit	Deductible and 50% Coinsurance
Hearing Aids – For Members through age 15, coverage for hearing aids is limited to one hearing aid for each hearing-impaired ear every 24 months. For Members age 16 and older, coverage for hearing aids is limited to $5,000 per hearing aid for each hearing-impaired ear every 24 months.	No Charge	Deductible and 40% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Specialty Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
New Jersey Early Intervention Family Cost Share Expense for Autism and other Developmental Disabilities	$25 per monthly expense	
Nutritional Counseling	$40 per visit	Deductible and 40% Coinsurance
Obesity Surgery Limited to one procedure during the entire period of time a Covered Person is enrolled under the Policy. Obesity surgery must be received at a Designated Facility to receive in-network benefits.	Office Visits - $40 per visit Inpatient Facility - Deductible and 20% Coinsurance Outpatient Hospital Services- Deductible and 20% Coinsurance Outpatient Ambulatory Surgical Center - Deductible and 20% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

Hospital & Facility Based Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Hospital Services	Inpatient - Deductible and 20% Coinsurance Outpatient - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Outpatient Ambulatory Surgical Center	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Hospital & Facility Based Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Skilled Nursing Facility Services- This benefit is limited to 30 days per Calendar Year.	Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Physician Fees for Surgical and Medical Services	Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance
Hospice Services- This benefit is limited to 180 days (inpatient and outpatient combined) per Lifetime. 5 sessions for bereavement counseling are available to the Member's family either before or after the Member's death.	Inpatient - Deductible and 20% Coinsurance Outpatient - Deductible and 20% Coinsurance Home Health Care - Deductible and 20% Coinsurance Skilled Nursing Facility Services - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

Mental Health Services and Substance Use Disorder Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Mental Health Services – This benefit is provided to the same extent as other surgical or medical benefits Covered under the Certificate.	Office Visits/Outpatient - $40 per visit Inpatient Facility - Deductible and 20% Coinsurance Partial Hospitalization/Intensive Outpatient Treatment - Deductible and 20% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Mental Health Services and Substance Use Disorder Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Substance Use Disorder Services – This benefit is provided to the same extent as other surgical or medical benefits Covered under the Certificate	Office Visits/Outpatient - $40 per visit Inpatient Facility - Deductible and 20% Coinsurance Partial Hospitalization/Intensive Outpatient Treatment - Deductible and 20% Coinsurance Physician Fees for Surgical and Medical Services - Deductible and 20% Coinsurance	Deductible and 40% Coinsurance

Medical Emergency Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Hospital Emergency Room Visits	$100 per visit (waived if Member is admitted to the Hospital)	Medical Emergencies (as defined in the Certificate) are Covered as an In-Network benefit.
Ambulance Services	Deductible and 20% Coinsurance	All Covered ambulance services for Medical Emergencies will be Covered as an In-Network benefit when Medically Necessary. For Non-emergency ambulances services - Deductible and 40% Coinsurance

Urgent Care Covered Services	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Urgent Care	$40 per visit	Deductible and 40% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Additional Coverage	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Outpatient Prescription Drugs **Retail Benefit -** The Out-of-Pocket Expenses are applied to each 31-day supply of a Prescription Drug to a maximum of a 90-day supply.	**Triple Tier -** Tier 1 Drugs- $25 Copayment Tier 2 Drugs- $50 Copayment Tier 3 Drugs- $75 Copayment Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.	Not Covered

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Additional Coverage	In-Network Out-of-Pocket Expenses	Out-of-Network Out-of-Pocket Expenses
Mail Order Benefit - up to a 90-day supply of Prescription Drugs will be provided.	You will be responsible for 2 retail Copayments for Prescription Drugs. Oral chemotherapy Prescription Drug Products will be provided at a cost level no more than if provided in an outpatient setting.	Not Covered
Exercise Facility Reimbursement	We will reimburse a Subscriber $200 per six-months. We will reimburse a Subscriber's spouse, civil union partner or domestic partner (if the Group has purchased this coverage) $100 per six-months.The Member must complete 50 visits within the six-month period.	

Precertification List

Breast Pumps, Insulin Pumps, Inpatient admissions for obstetrical services, Allergy Testing and Treatment performed outside a physician's office, Inpatient Rehabilitation Services, Inpatient Admission for Reconstructive and Corrective Surgery, Outpatient Cardiac Rehabilitation, Outpatient Pulmonary Rehabilitation, Orthoptic Exercises and Corneal Topographic Procedures, Inpatient Admission for Oral Surgery, Laboratory Procedures (Precertification is not required for routine blood work and screening tests), Major Diagnostic Procedures, Infertility Services, Chemotherapy, Internal Prosthetic Devices, Durable Medical Equipment (Precertification required before purchase of $500 or more), Transplants, Clinical Trials, Home Health Care, Services Delivered in the Home, Medical Supplies, Hemodialysis, Home Treatment of Hemophilia, Chiropractic Services, Inpatient Hospital Services, Outpatient Hospital Services, Ambulatory Surgical Center Services, Inpatient or In-Home Hospice Services, Skilled Nursing Facility Services, Inpatient and Intermediate Care Substance Use Disorder Services, Inpatient and Intermediate Care Mental Health Services, Nutritional Counseling, Non-Urgent Ambulance Services, and Gender Dysphoria Services.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Additional Plan Information	
Plan Deductible for In-Network Covered Services	Individual: $2,000 per Calendar Year Family: $4,000 per Calendar Year
Plan Deductible for Out-of-Network Covered Services	Individual: $2,000 per Calendar Year Family: $4,000 per Calendar Year
Deductible for Prescription Drugs	$100 per Member per Calendar Year. The Deductible is waived for Tier 1 Drugs. Please note that benefits for oral chemotherapeutic agents are not subject to the Deductible for Prescription Drugs.
Out-of-Pocket Maximum for In-Network Covered Services	Individual: $4,000 per Calendar Year Family: $8,000 per Calendar Year Remember, only In-Network Coinsurance and/or Copayments and the amounts paid to meet your In-Network Deductible (and Pharmacy Deductible, if applicable) count toward the In-Network Out-of-Pocket Maximum. Coinsurance paid for Out-of-Network benefits, amounts paid to meet the Out-of-Network Deductible, amounts paid for Non-Covered Services, and any amounts paid as a penalty do not count toward the In-Network, Out-of-Pocket Maximum.
Out-of-Pocket Maximum for Out-of-Network Covered Services	Individual: $8,000 per Calendar Year Family: $16,000 per Calendar Year Remember, only Out-of-Network Coinsurance and the amounts paid to meet your Out-of-Network Deductible count toward the Out-of-Network Out-of-Pocket Maximum. Coinsurance and/or Copayments for In-Network benefits, amounts paid to meet the In-Network Deductible, amounts in excess of Our Fee Schedule, amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the Out-of-Network Out-of-Pocket Maximum.
Precertification Penalty	If you fail to request a required Precertification for an Out-of-Network Benefit identified in the Precertification List, you will be subject to a 50% reduction in benefits for charges that would have otherwise been covered.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Additional Plan Information

Out-of-Network Reimbursement

Out of Network Reimbursement Amount: The Out of Network Reimbursement Amount is based upon 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception of the following:

- 50% of CMS for the same or similar laboratory services.
- 45% of CMS for the same or similar durable medical equipment or CMS competitive bid rates.

Please refer to your Certificate of Coverage for more information on the Out-of-Network Reimbursement Amount.

You are responsible for obtaining any required Precertification for services received from a Non-Network Provider.

Additionally, if you want in-network coverage, **it is your responsibility to verify that a provider is a Network Provider.** Therefore when your PCP or other Network Provider arranges services for you, you should make sure that the provider is in Our Network by using Our online directory www.oxfordhealth.com, or by calling Us at the 1-800 number provided on your ID card.

More information regarding Our fee schedule policy and administration is available. You may request a copy of Our fee schedule policy in the same manner as any Medical Policy. Please see your Certificate of Coverage for information on how to obtain copies of Our Policies.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Eligibility & Effective Dates of Coverage

Eligibility Limits	The limiting age for Dependents (as defined in the Certificate) is 26. Coverage ends at the end of the Calendar Year in which the child reaches the limiting age. Please note, extended coverage is available up to the age of 31 for Dependents who meet the definition of an Over-Age Dependent, as defined in the Certificate.
Effective Dates of Coverage	
Initial Enrollment (During initial Group Open Enrollment Period)	Coverage is effective on the effective date of the Agreement.
Newly Eligible Employee (Application within 31 days of becoming eligible)	Coverage is effective as of the date the employee became eligible.
Newly Eligible Dependent(s) (Application within 31 days of becoming eligible)	Coverage is effective as of the date the dependent became eligible. Coverage is effective at birth for newborns and newly born adopted children subject to the enrollment requirements as described in the Certificate.
Group Open Enrollment Period	Coverage is effective on the renewal date of the Agreement.

IMPORTANT: This document is not a contract. It is only a summary of your coverage. Please read your Certificate of Coverage and Member Handbook for a full description of your Covered Services, exclusions and other terms and conditions of coverage.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance, Inc.

Oxford Health Insurance, Inc.. does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card TTY 711, Monday through Friday, 8 a.m. to 8 p.m..

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文

(Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

Oxford Health Insurance, Inc.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yániłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

here specifically changed by this Rider.

Women's Health and Cancer Rights Act

As required by the *Women's Health and Cancer Rights Act of 1998*, benefits are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of complications resulting from a mastectomy (including lymphedema).

If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following covered health services, as you determine appropriate with your attending physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such covered health services (including copayments, coinsurance and any annual deductible) and the benefit coverage limitations are the same as are required for any other covered health service as described in your Certificate of Coverage or Summary Plan Description.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of- pocket costs, you may be required to obtain precertification. For information on precertification, call the toll-free Customer Service telephone number on your Oxford member ID card.

Notification of Language Assistance Program

We understand that we serve an increasingly diverse membership. More than ever, we believe that it is important to accommodate language preferences, especially when it comes to our members accessing care and services to ensure that language is not an obstacle to receiving proper care.

We offer language assistance services to limited English proficiency (LEP) members. Language assistance services are provided free of charge to members. If you need assistance or have any questions about these services, please call the toll-free Customer Service telephone number on the back of your Oxford member ID card.

OXFORD HEALTH INSURANCE, INC.

Liberty Network
Direct Plan

Certificate of Coverage

This Certificate is governed by the laws of the State of New Jersey

Welcome and Thank you for Choosing Oxford.

This Certificate of Coverage ("Certificate") contains detailed information to help you understand your coverage, your rights and responsibilities as a Member and a detailed description of your Plan. You should be familiar with all of its terms and conditions. The terms and conditions determine what coverage you have and what amounts We will pay when you choose to receive Covered Services.

Please feel free to contact Us at the number on the back of your ID Card with any questions, issues or concerns you may have. In addition, We welcome your input and suggestions on how We can improve Our administrative polices. If you have a question and prefer to speak in a language other than English, please call Us to make arrangements to speak with one of Our translators. When the Representative answers your call please say " Spanish (or the language you require)." The Representative will place your call on hold while they make arrangements with the appropriate translator. Do not hang-up! With the help of the translator, the Representative will be able to answer your questions.

MANAGED HEALTH CARE CONSUMER ASSISTANCE PROGRAM

This program was created as a means to assist consumers in better understanding the current status of the health insurance market and particularly managed care. The toll-free number for the Managed Health Care Consumer Assistance Program is (888) 393-1062.

Please note: You can request additional information about Oxford and your coverage under this Certificate. Upon your written request, We will provide information pertaining to: Our provider reimbursement methodologies; Our Quality Assurance program; Our Utilization Review Department; and Our individual products.

CERTIFICATE OF COVERAGE ("Certificate")
for
OXFORD HEALTH INSURANCE, INC. ("Oxford")

Please read this entire Certificate carefully, including your Summary of Benefits, which contains information specific to your Group. These documents, and any attached riders, describe your rights and obligations as well as those of Oxford.

Under this Certificate, you engage Oxford to make arrangements through which medical and Hospital services will be delivered in accordance with the terms and conditions of this Certificate and in reliance upon the statements you made on your Enrollment Form for coverage. Oxford agrees with the Group to provide the Covered Services set forth in this Certificate, as may be amended from time to time by Oxford or the Group's Board of Directors.

Please note:

- This Certificate and any riders, schedules or attachments have been delivered in consideration of the Group's timely payment of Premiums.
- No services are Covered under this Certificate in the absence of current payment of Premiums, subject to a 31-day Grace Period and the terms and conditions of the Certificate.
- No services are Covered under this Certificate unless coverage was in force at the time the service was obtained.
- In some instances, a medical procedure may not be Covered or may require Precertification. It is your responsibility to understand the terms and conditions in this Certificate.
- Covered under this Certificate is subject to Our appeals and Complaints processes outlined in Section III. Initial Coverage Determination Timeframes and Appeals and Complaints Processes.
- This Certificate replaces any older Certificate issued to you which provided coverage under the Plan.
- This Certificate is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.

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Section VIII. What Happens If I Lose Coverage?

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Section XI. General Administrative Policies and Procedures

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Section I. How the Plan Works

1. ACCESSING PROVIDERS.

A. Network Providers

This product does not have a gatekeeper, usually known as a Primary Care Physician or PCP. You may see any Network Provider for Primary Care and Preventive Care or Specialty Care. You will never need a Referral from a Network Provider or from Us in order to access Covered Services from another Network Provider. If you are uncertain what type of Specialist should be seen, you may call us at the number on the back of your ID Card for assistance.

To find out if a provider is a Network Provider, you can:

- check Our directory of Network Providers;
- call Customer Care; or
- visit Our Website.

B. Non-Network Providers

The Plan also provides coverage when you elect not to use a Network Provider. You will however, pay a higher portion of your medical expenses. Covered Services will be subject to the cost share outlined in your Summary of Benefits and the Out-of-Network Reimbursement Amount.

Any Covered Service you obtain from a Non-Network Provider will be Covered on an out-of-network basis.

The only exceptions to this provision are for Medical Emergencies, Urgent Care when travelling outside of the Service Area or when Our Medical Director determines that We do not have an appropriate Network Provider who can deliver the care you need or as discussed in the Transitional Care section of this Certificate.

In an instance where it is determined We do not have an appropriate Network Provider who can deliver the care you need, Our Medical Director will approve a referral to a Non-Network Provider. All such referrals will be made only when Our Medical Director, after consulting with the Non-Network Provider and you, approves the treatment plan for the delivery of these services. Covered Services rendered by this Non-Network Provider will be paid as if they were received from a Network Provider. You will be responsible only for any applicable in-network cost share. You may call Our Medical Management department ("Medical Management") and initiate the request for this special referral.

C. Hospitalizations and Inpatient Facility Services

If a Network Physician recommends Hospital or surgical services he or she will need to obtain authorization from Us before such services can be performed. This process is referred to as Precertification. Before entering the Hospital, you may want to check with Us to verify that the Hospital is a Network Provider and that Precertification has been obtained.

You are responsible for obtaining any required Precertification when using a Non-Network Provider. You must call (or you may have your Physician call) Medical Management to obtain the Precertification. Please make the call at least 14 days in advance of the procedure or admission. Failure to Precertify will result in a 50% reduction in benefits.

D. Medical Emergencies

If you have a Medical Emergency, you should obtain medical assistance immediately or call 911. Hospital emergency room care is not subject to Our prior approval. However, only Medical Emergencies, as defined in this Certificate, are Covered in an emergency room. Therefore, before you seek treatment, you may want to be certain that this is the most appropriate place to receive care. If you would like assistance assessing the situation, you can call Medical Management. They are available 24 hours a day, 7 days a week.

E. Urgent Care

In Urgent Care situations, you are encouraged to call your Physician or you can call Medical Management and they will assist you in locating an Urgent Care provider. Please note that only when travelling outside of the Service Area, coverage for Urgent Care will be provided regardless of whether you receive Covered Services from a Network Provider or Non-Network Provider.

F. Outpatient Diagnostic Services

If a Network Physician recommends diagnostic testing, remind him or her to use a Network Provider. Unless you are hospitalized or are receiving preadmission testing, Hospitals are not Network Providers for these tests.

G. Oxford On-Call℠

You also have the option of calling *Oxford On-Call*℠ if you are not sure what care you may need. This service is available 24 hours a day, 7 days a week. The number is listed on your ID Card.

A trained Nurse Consultant will take your call. When you call, you and the Consultant will discuss your medical needs. The Consultant will then make an assessment and recommend an appropriate course of action. The Consultant will also obtain any required Precertification for the recommended treatment.

2. PRECERTIFICATION.

All admissions to health care facilities and certain other services and supplies must be authorized in advance by Us before you are admitted or receive treatment. This process is referred to as Precertification.

Precertification starts with a call to Medical Management. Medical Management professionals will examine the case, consult with the provider and discuss the clinical findings. If all agree the requested admission, test or procedure is appropriate, the Precertification is provided. This comprehensive evaluation assures that the treatment you receive is appropriate for your needs and is delivered in the most cost effective setting.

Covered inpatient services are Precertified for a specific number of days. If the Physician believes that a longer stay is Medically Necessary, the extension must be Precertified in order for it to be Covered.

Network Providers are responsible for obtaining any required Precertification and are aware of when Precertification is required. However, if you wish to double-check that the Network Provider has contacted Us about your case, please feel free to contact Us and inquire.

You are responsible for obtaining any required Precertification when using a Non-Network Provider. You must call (or you may have your Physician call) Medical Management to obtain the Precertification. Please make the call at least 14 days in advance of the procedure or admission. Failure to Precertify will result in a 50% reduction in benefits.

Remember, not all diagnostic and therapeutic procedures and surgeries are Covered under the Plan. If you are not sure if Precertification is required or if a service or supply is Covered, please do not hesitate to call Us at the number on the back of your ID Card.

Please note: Any Precertification you receive will not be valid if your coverage under the Plan terminates. This means that Covered Services received after your coverage has terminated will not be Covered even if they were Precertified (unless coverage is reinstated due to continued coverage under this Certificate).

3. SECOND AND THIRD OPINIONS.

We reserve the right to require a second opinion for any surgical procedure. At the time of Precertification, you may be advised that a second opinion will be required in order for the services to be Covered. If a second opinion is required, We will refer you to a Network Provider for a second opinion.

In the event that the first and second opinions differ, a third opinion will be required. We will designate a new Network Provider. The third opinion will determine whether or not the surgery is Precertified. There will be no cost to you for the second or third opinion.

You may also request a second opinion. Please see Second and Third Opinions under *Section V. Covered Services* for a complete explanation.

4. UTILIZATION REVIEW.

All services that you seek to have Covered under this Certificate are subject to Utilization Review. This means that Medical Management may review pertinent medical information to evaluate whether or not the proposed service, the service currently being provided, or the service that

was provided is Medically Necessary and a Covered Service under the Certificate. Utilization Review is also required when We need to make a determination that a service is or is not experimental or investigational.

Section II. Provider Information

1. PROVIDER PARTICIPATION

We cannot promise that a specific provider, even though listed in Our directory of Network Providers, will be available. A Network Provider may end his or her contract with Us, or decide not to accept additional patients. If you have any questions about whether or not a particular provider is currently participating or accepting new patients, please feel free to call Customer Care and inquire. If your Network Specialist leaves the network, you should choose another Network Specialist. However, if you are undergoing a course of treatment at the time a Network Provider leaves the Network, you may be eligible for Transitional Care as described below.

2. TRANSITIONAL CARE

Your provider Leaves the Network

If you are undergoing a course of treatment when your provider leaves the Network, you may be able to continue to receive Covered Services from your former Network Provider. Depending on your condition, you may receive Covered Services for the following timeframes:

- Post-Operative Follow-Up Care: you may receive Covered Services for up to 6 months from the date your provider disenrolls.
- Oncological or Psychological Treatment (excluding substance abuse): you may receive Covered Services for up to 1 year from the date your provider disenrolls.
- Pre-Natal Care: you may receive Covered Services for up to 6 weeks following a normal, vaginal delivery or 6 months following a C-Section.
- For any other Medically Necessary condition: you may receive Covered Services for up to 4 months from the date your provider disenrolls.

Except for pregnancy, Our Network Providers have agreed to provide this coverage only when it is Medically Necessary. If We and your former Network Provider agree that this coverage is Medically Necessary and the provider agrees to follow Oxford's reimbursement rates, policies and procedures, you will receive these Covered Services as if they are being provided by a Network Provider. You will only be responsible for any applicable Network cost share. Pregnancies that are affected by this provision are automatically Covered. You will only be responsible for any applicable Network cost share.

Please note: Transitional Care is not available if a provider is terminated based upon: (1) a determination that the provider is an imminent danger to a patient or the public health; (2) a determination of fraud; (3) a breach of contract; or (4) the provider is subject to disciplinary action by the State Board of Medical Examiners.

New Members Currently Undergoing a Course of Treatment

If you are undergoing a course of treatment with a Non-Network Provider at the time your coverage under this Certificate becomes effective, you may be able to receive Covered Services from the Non-Network Provider for up to 60 days from the effective date of your coverage under the Certificate. This coverage is available only if the course of treatment is for a Life-Threatening Disease or Condition or a degenerative and disabling disease/condition. Coverage is limited to the disease/condition. Regarding pregnancy, if your coverage becomes effective while you are in your second trimester, you may receive Covered Services from your Non-Network Provider through delivery and any post-partum care directly related to the delivery.

However, Transitional Care is available only if the provider agrees to accept as payment Our negotiated fees for such services. Further, the provider must agree to adhere to all of Our Quality Assurance procedures as well as all other policies and procedures required by Us regarding the delivery of Covered Services. If the provider agrees to these conditions, you will receive these Covered Services as if they are being provided by a Network Provider. You will only be responsible for any applicable in-network cost share.

New Members: In order to obtain Transitional Care, you or your provider should call Us at the number on your ID Card and request this coverage.

3. PATIENT/NETWORK PROVIDER RELATIONSHIP

Network Providers are solely responsible for all health services that you receive. They will use their best efforts to render all necessary and appropriate professional services in a manner compatible with your wishes. All services are, of course, subject to the Network Provider's

professional judgment. If you refuse to follow a recommended treatment, and the Network Provider believes that no professionally acceptable alternative exists, you will be so advised. In such a case, subject to the second opinion process, neither We nor the Network Provider will have any further responsibility to provide care for the condition under treatment.

4. PROVIDER REIMBURSEMENT AND QUALITY ASSURANCE

Reimbursement

Different Providers in Our Network have agreed to be paid in different ways by Us. Your Network Provider may be paid each time he or she treats you ("fee for service"), or 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 providers more ("bonuses") or less ("withholds") based on many factors: member satisfaction; quality of care; and control of costs; and use of services among them.

If you desire additional information about how Our Primary Care Physicians or any other Network Provider is compensated, please call Us at the number on your ID Card.

The Laws of the State of New Jersey at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make referrals to other health care providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest that he or she may have in a health care provider or facility when making a referral to that health care provider or facility. If you want 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, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504- 6200 OR (800) 242-5846.

Quality Assurance

We carefully select the providers who deliver services to Our Members as Network Providers. This helps Us to insure that you receive consistent, quality care.

For more information about Our Quality Assurance Program, please call Us at the number on your ID Card.

Section III. Initial Coverage Determination Timeframes and Appeals and Complaints Processes

1. INITIAL COVERAGE DETERMINATION TIMEFRAMES

This section is intended to educate you about the timeframes within which initial coverage determinations will be made. Please note, that there are two different types of coverage determinations discussed in this section: benefits and administrative issues; and Utilization Review determinations.

Benefits and Administrative Issues

What are benefit and administrative issues?

Benefit issues include, but are not limited to, denials based on benefit exclusions or limitations and claims payment disputes. Administrative issues concern other requirements of your health Plan such as access to providers. Benefit and administrative issues do not include determinations concerning the Medical Necessity of services.

Will I need to submit additional information?

We may request additional information to evaluate your issue. If We request additional information, you will have up to 45 days from the date you receive Our request to provide the additional information. For Urgent Care services, you will have 48 hours to provide the requested information.

Please Note: In all cases, if **no information** is received within the required timeframes, the claim or request for service will be denied.

Please Note: Regarding benefit issues, if you do not submit the requested additional information within the above timeframes, your claim or request for services will be denied. Regarding administrative issues, We will assume you are no longer concerned or interested in pursuing the issue.

When will initial determinations for benefit and administrative issues be made?

Initial determinations for benefit and administrative issues will be made in the following timeframes:

	If no additional information is requested…	If additional information is requested…
Requests for Service (Pre-Service):	Within 15 days of Our receipt of the request.	Within 15 days of Our receipt of the information, or upon the expiration of the period allowed to provide the information (i.e., 45 days).
Coverage for Services Rendered (Post-Service):	Within 30 days of Our receipt of the claim.	Within 15 days of Our receipt of the information, or upon the expiration of the period allowed to provide the information (i.e., 45 days).
Requests for Urgent Care (Pre-service) - (includes any claim for medical service that if subjected to standard timeframes, could seriously jeopardize your life or health):	Within 72 hours of Our receipt of the claim.	Within 48 hours of Our receipt of the information, or the expiration of the original request for additional information, whichever is sooner (i.e., 45 days).

How will I be notified of Oxford's determination?

We will inform you of Our decision in writing by mail or electronic means.

A notice of an Adverse Benefit Determination will be culturally and linguistically appropriate and will include the date of service, the name of Your provider, the claim amount (if applicable) as well as information on the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning. Please note that any request for such diagnosis and treatment information following an initial Adverse Benefit Determination will be responded to as soon as practicable, and the request itself will not be considered a request for appeal.

The notice will also include the reasons for Our decision, the clinical rationale if applicable, and specific plan provisions on which the determination was based. It will also include information on how to file a first-level appeal, and how, with respect to benefit denials, you can request (free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim. It will also include information on the availability of and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists Members with claims, internal appeals and External Appeals.

When We receive an initial Post-Service claim from a Network Provider, in some instances, We may deny the claim. In this situation, you may not receive a notice from Us. You cannot be held responsible for any amount above your Network cost share and you will not incur any additional financial liability. If a Network Provider attempts to balance bill you for an amount above your Network cost share, please contact Us.

Initial Utilization Review (Medical Necessity) Determinations

What are Utilization Review issues?

Utilization Review issues include items that concern Medical Necessity Determinations. Although many determinations are made prior to services being rendered, Medical Necessity Determinations may be made after services are rendered. All services are subject to a review by Us to determine the Medical Necessity of proposed services, services currently being provided, or services already provided. Denials will be made by the appropriate clinical personnel.

Who conducts Utilization Review?

Utilization Review will be conducted by the following:

- Administrative personnel trained in the principles and procedures of intake screening and data collection. Administrative personnel will only perform intake screening, data collection and non-clinical review functions and will be supervised by a licensed health care professional.
- A health care professional who is appropriately trained in Our principles, procedures and standards. A health care professional who is not a Clinical Peer Reviewer cannot render an Adverse Benefit Determination.
- A Clinical Peer Reviewer where the review involves an Adverse Benefit Determination.

Please Note: In all cases, if no information is received within the required timeframes, the claim or request for service will be denied.

Will I need to submit additional information?

We may request additional information from your provider to evaluate your issue. If We request additional information, your provider will have up to 45 days from the date of Our request to provide the additional information. For Urgent Care services, your provider will have 48 hours to provide the requested information.

Please Note: If your provider does not submit the requested additional information within the above timeframes, your claim or request for services will be denied.

When will I be notified that a service is not Medically Necessary or is experimental or investigational?

Notification of Our decision that a service is not Medically Necessary or is experimental or investigational will be provided as follows:

	If no additional information is requested…	If additional information is requested…
Requests for service (Pre-Service):	Within 2 business days of Our receipt of the necessary information, not to exceed 15 calendar days from receipt of the request	Within 2 business days of Our receipt of the information, or 2 business days from the expiration of the period allowed to provide the information (i.e., 45 days).
Current services for a Member in an ongoing course of treatment:	Within 1 business day of Our receipt of the necessary information.	Within 1 business day of Our receipt of the information, or the expiration of the original request for information (i.e., 45 days).
Home Health Care Services Following a Hospital Admission	Within 1 business day of Our receipt of the necessary information. If the day subsequent to the request falls on a weekend or holiday, within 72 hours of Our receipt of the necessary information.	Within 1 business day of Our receipt of the necessary information, or the expiration of the original request for information (i.e., 45 days). If the day subsequent falls on a weekend or holiday, within 72 hours of Our receipt of the necessary information.
Urgent Care for a Member in an ongoing course of treatment:	As soon as possible but not to exceed 24 hours of Our receipt of the request if the request is made at least 24 hours before expiration of the prescribed period or number of treatments.	Within 48 hours of Our receipt of the information, or the expiration of the original request for information (i.e., 45 days).
Coverage for services rendered (Post-Service):	Within 30 days of Our receipt of the claim.	Within 15 days of Our receipt of the information, or expiration of the period allowed to provide the information (i.e., 45 days).

How will I be notified of Oxford's determination?

We will inform you and your provider of Our decision in writing by mail or electronic means.

A notice of an Adverse Benefit Determination will be culturally and linguistically appropriate and will include information sufficient to identify the claim involved such as the date of service, the name of Your provider, the claim amount (if applicable) as well as information on the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning. Please note that any request for such diagnosis and treatment information following an initial Adverse Benefit Determination will be responded to as soon as practicable, and the request itself will not be considered a request for appeal.

The notice will also include the reasons for Our decision, the clinical rationale, if applicable, and specific plan provisions on which the determination was based. It will include information on how to file a first-level appeal, and any new or additional evidence or rationale, which We relied upon, considered or used in making Our decision. It will also include information on the availability of and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists Members with claims, internal appeals and External Appeals.

In the event that We render an Adverse Benefit Determination without attempting to discuss the matter with the provider who specifically recommended the Health Care Service, procedure or treatment under review, the provider will have the opportunity to request a reconsideration of the Adverse Benefit Determination. Except in cases of Retrospective Reviews, the reconsideration will occur within one business day of receipt of the request and will be conducted by your provider and the Clinical Peer Reviewer making the initial determination or a designated Clinical Peer Reviewer if the original Clinical Peer Reviewer is not available. In the event that the Adverse Benefit Determination is upheld after reconsideration, We will provide notice as outlined in this section. Nothing in this section will preclude you from initiating an appeal of an Adverse Benefit Determination.

2. APPEALS AND COMPLAINTS

Our appeal and Complaint processes provide Members with a meaningful, dignified and confidential process to hear and resolve issues between Members, Us and providers in a timely manner. This Section describes (1) The Utilization Review (UR) appeals process, (2) the appeal process for benefit, network and administrative Issues, and (3) the Complaint process. The process you will need to use depends upon the type of issue you are trying to resolve. Please read the information in this Section carefully, as it describes what the different review processes are and when and how to use them. If you are still not sure of the process to follow, contact Us at the phone number on your ID Card.

All information pertaining to appeals will be fully documented and retained for at least three years.

Copies of these processes are available in many languages and can be forwarded to you subject to availability. We can also arrange to have an independent interpreter available, however Our ability to provide this service depends on the availability of the interpreter. We may need to arrange to call you at a time when an interpreter is available. Additionally, you always have the right to designate a representative during this process.

Additionally, Members may write to the New Jersey Department of Banking and Insurance at any time during the appeal and Complaint process at the following address or phone number:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
20 West State Street
P.O. Box 329
Trenton, NJ 08625-0329

Phone: (888) 393-1062

Designees

You have the right to use these processes. It is your responsibility to initiate an appeal or Complaint within the timeframes set forth in this Certificate.

You may designate a person to act on your behalf, including your healthcare provider ("Designee"). For appeals of benefit determinations concerning Urgent Care, We are required to allow your healthcare provider, with knowledge of your condition, to act as your authorized representative without your written consent. A benefit determination concerning Urgent Care is defined as a determination which, if subject to the standard appeal time frames, could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a Physician with knowledge of your condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the determination.

For all other circumstances, to authorize a Designee to act on your behalf, you must provide Us with written consent at the time your appeal or Complaint is submitted. Because your medical records are privileged and confidential, and We want to ensure that you wish to appeal, each Member must submit an original signed written consent. Members who are 18 years of age or older, including a Member's Spouse or children, will need to provide their own signed written consent. If the Member is a minor a written consent must be signed by the Member's parent or guardian.

Your Designee will only be authorized to act on your behalf and is required to comply with all of the conditions of your Certificate that would apply to you when you initiate any appeal or Complaint. Your Designee is not entitled to obtain any benefits or rights under your Certificate.

Copies of Our consent forms to designate a representative are available on Our web site or by calling Us at the number in the front of your Handbook.

Part 1 – Utilization Review (UR) Appeals

UR will occur whenever judgments pertaining to Medical Necessity and the provision of services or treatments are rendered. The Utilization Review appeals process should be used after you have received an initial Adverse Benefit Determination related to Medical Necessity as described in the Initial Coverage Determination Timeframes section on page 12, if you do not agree with Our decision. Adverse Benefit Determinations concerning cosmetic, custodial and convenience items are included in the determinations eligible for review through this process. All appeals are subject to a review by Us to evaluate the Medical Necessity of the services.

You or your Designee may also appeal an Out-of-Network denial by submitting a written statement from your attending Physician, who must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area of practice appropriate to treat you for the health service sought, that the requested Out-of-Network health service is materially different from the Covered Service that was approved to treat your health care needs and two documents from the available medical and scientific evidence that the Out-of-Network health service is likely to be more clinically beneficial to you than the alternate recommended in-network Covered Service and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network Covered Service.

Our UR appeal process provides for two levels of internal review and one level of External Review by an outside clinical reviewer. You may use this process to appeal Adverse Benefit Determinations relating to all UR determinations, regardless of whether the services requested by you or on your behalf have not yet been rendered (Precertification), are currently being rendered (concurrent care) or have been rendered (Retrospective Adverse Benefit Determinations).

Please Note: This UR appeals process should not be used for appeals relating to benefit and administrative issues. Please refer to Part 2 of this section for information on the appeal process for benefit, network and administrative issues.

Our Internal UR appeal process provides for both a first-level UR appeal and a second-level UR appeal. Additionally, the first-level UR appeal may be expedited as described in this section. All UR appeals will be conducted by Clinical Peer Reviewers other than the Clinical Peer Reviewer who rendered the initial Adverse Benefit Determination.

First-Level UR Appeals

A first-level UR appeal may be made within the standard timeframes or may be expedited as described in this section. All non-expedited first-level UR appeals must be initiated by you or your Designee 180 days from receipt of an Adverse Benefit Determination (i.e., receipt of the determination notice). All requests for expedited first-level UR appeals must be initiated within 45 days from receipt of an Adverse Benefit Determination, or from the date when the condition necessitating the need for an expedited appeal arose. You may still pursue a standard UR appeal within 180 days from receipt of an Adverse Benefit Determination if you choose not to pursue an expedited appeal or circumstances have changed and do not justify an expedited review (i.e., you have already received the services).

While a first-level UR appeal may be filed by telephone or in writing, We strongly recommend that you file your appeal in writing. The written request will give Us a clearer understanding of the issues being appealed. To initiate the first-level UR appeal process, you may call Us at the number on your ID Card, fax Us at 1-203-459-5423 (for expedited first-level UR appeals) or write to Us at:

Oxford Health Plans, Attn: Clinical Appeals, P.O. Box 29139 Hot Springs, AR 71903

Please Note: Our toll-free telephone line is available for forty hours per week during normal business hours. After normal business hours We have an answering machine available to record your call. We will respond to recorded messages within one business day after the date on which the call was received. Additionally, if you have any questions regarding where to seek care, you may receive health care guidance from a registered nurse 24 hours a day, seven days a week, at the number in the front of your Handbook.

In addition to your request for an appeal, you or your Designee must send any documentation/information already requested by Us (if not previously submitted) and any additional written comments and documentation/information you would like to submit in support of the appeal. At the time of Our review, We will review all available comments, documentation and information.

Unless We have already issued a written determination, We will use Our best efforts to provide written acknowledgment of the receipt of your appeal within 5 business days. Our decision to either uphold or reverse the Adverse Benefit Determination will be made as follows:

- Requests for service (Precertification): Within 10 days of Our receipt of the appeal.
- Current services for a Member in an ongoing course of treatment (Concurrent): Within 2 business days of Our receipt of all necessary information.
- Not later than 72 hours of receipt of a request for Precertification of Urgent Care, Emergency Care or an admission, availability of care, continued stay, Health Care Services for which the claimant received emergency services but has not been discharged from a facility.
- Coverage for services rendered (Retrospective): Within 10 days of Our receipt of the appeal.

Our determination will be communicated to you, your Designee and/or provider (if applicable) within 10 business days of Our rendering of the determination within the above timeframes.

If the Adverse Benefit Determination is upheld, the notice of Our determination will be culturally and linguistically appropriate and will include information sufficient to identify the claim involved such as the date of service, the name of Your provider, the claim amount (if applicable) as well as information on the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning. Please note that any request for such diagnosis and treatment information following an Adverse Benefit Determination will be responded to as soon as practicable, and the request itself will not be considered a request for second-level appeal.

The notice will also include the reasons for Our decision, the clinical rationale, if applicable, and specific plan provisions on which the determination was based. It will include information on how to file a second-level appeal, and any new or additional evidence or rationale, which We relied upon, considered or used in making Our decision. It will also include information on the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists Members with claims, internal appeals and External Appeals.

Please Note: Appeals of an Adverse Benefit Determination of home Health Care Services following an inpatient Hospital admission will be handled on an expedited basis as described below.

Expedited First-Level UR Appeal

You can expedite your first-level UR appeal when:

- you receive an Adverse Benefit Determination involving continued or extended Health Care Services, procedures or treatments or additional services while you are undergoing a course of continued treatment (Concurrent) prescribed by a health care provider or for home Health Care Services following discharge from an inpatient Hospital admission;
- the timeframes of the non-expedited UR appeal process would seriously jeopardize your life, health or ability to regain maximum function;
- in the opinion of a Physician with knowledge of the health condition, the timeframes of the non-expedited UR appeal process would cause you severe pain that cannot be managed without the care of treatment that was requested; or
- your Physician believes an immediate appeal is necessary because the timeframes of the non-expedited UR appeals process would significantly increase the risk to your health.

The expedited process cannot be used to seek review of Adverse Benefit Determinations for services which have already been provided (Retrospective).

The expedited first-level UR appeal process includes procedures to facilitate a timely resolution of the appeal including, but not limited to, the sharing of information between your provider and Us by telephone or facsimile. We will provide reasonable access to Our Clinical Peer Reviewer within 1 business day of receiving notice of an expedited first-level UR appeal.

Expedited first-level Utilization Review appeals will be determined within 2 business days of receipt of necessary information or 72 hours from Our receipt of the appeal, whichever is shorter. If you are not satisfied with the outcome of the expedited first-level UR appeal, you may further appeal through the second-level UR appeal process.

If the Adverse Benefit Determination is upheld, the notice of Our determination will be culturally and linguistically appropriate and will include information sufficient to identify the claim involved such as the date of service, the name of Your provider, the claim amount (if applicable) as well

as information on the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning. Please note that any request for such diagnosis and treatment information following an Adverse Benefit Determination will be responded to as soon as practicable, and the request itself will not be considered a request for second-level appeal.

The notice will also include the reasons for Our decision, the clinical rationale, if applicable, and specific plan provisions on which the determination was based. It will include information on how to file a second-level appeal, and any new or additional evidence or rationale, which We relied upon, considered or used in making Our decision. It will also include information on the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists Members with claims, internal appeals and External Appeals.

If an appeal results in a reversal of some but not all parts of an Adverse Benefit Determination, you or your Designee may submit a written second-level UR appeal for the services that remain denied.

Second-Level UR Appeals

If You remain dissatisfied with the results of the first-level UR appeal, you or your Designee may submit a second-level UR appeal to Us. The request for a second-level UR appeal and any additional information must be submitted to:

Oxford Health Plans, Appeal Review Department, 4 Research Dr. Shelton, CT 06484

You or your Designee will need to include all information previously requested by Us (if not previously submitted), and include any additional facts or information that you believe to be relevant to the issue. You or your Designee may send Us written comments, documents, records or other information regarding the claim. We will consider all available information relevant to your appeal when making Our review.

A second-level UR appeal must be filed within 180 days of the date on which you received notice of the first-level UR appeal determination. Unless We have already issued a written determination, We will use Our best efforts to provide written acknowledgment of the receipt of your second-level UR appeal within 5 business days, but in no event later than 10 business days from the date of receipt.

We will provide you, your Designee, or your provider (if applicable) with Our written decision (by mail or electronic means) which will include the detailed reasons for Our decision.

Our decisions will be communicated as follows:

- Requests for service (Precertification): Within 15 days of Our receipt of the appeal.
- Current services for a Member in an ongoing course of treatment (Concurrent): Within 15 days of Our receipt of the appeal.
- Not later than 72 hours of receipt of a request for Urgent Precertification or Concurrent services.
- Coverage for services rendered (Retrospective): Within 20 days of Our receipt of the appeal.
- 72 hours of receipt of a request for Precertification of Urgent Care, Emergency Care or an admission, availability of care, continued stay, Health Care Services for which the claimant received emergency services but has not been discharged from a facility.

Please note: only the first-level UR appeal may be expedited.

If the Adverse Benefit Determination is upheld, the notice of Our determination will be culturally and linguistically appropriate and will include information sufficient to identify the claim involved such as the date of service, the name of Your provider, the claim amount (if applicable) as well as information on the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning. Please note that any request for such diagnosis and treatment information following an Adverse Benefit Determination will be responded to as soon as practicable, and the request itself will not be considered a request for External Appeal.

The notice will include the reasons for Our decision, the clinical rationale, if applicable, and specific plan provisions on which the determination was based. It will include any new or additional evidence or rationale, which We relied upon, considered or used in making Our decision. We will also include a notice of your right to initiate an External Appeal along with a description of the process and the associated timeframes as well as information on the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists Members with claims, internal appeals and External Appeals.

This is considered Our Final Internal Adverse Benefit Determination. All information pertaining to each appeal will be fully documented, and retained for at least three years.

Please note: You are relieved of Your obligation to complete the internal review process and may proceed directly to the External Review Process under the following circumstances:

- We fail to comply with any of the deadlines for completion of the internal appeals process without demonstrating good cause or because of matters beyond Our control while in the context of an ongoing, good faith exchange of information between parties and it is not a pattern or practice of noncompliance;
- We for any reason expressly waive Our rights to an internal review of any appeal; or
- You and/or Your provider have applied for expedited external review at the same time as applying for an expedited internal review.

Please note that in such a case where We assert good cause for not meeting the deadlines of the appeals process, you or your Designee and/or your provider may request a written explanation of the violation. We will provide the explanation within 10 days of the request and will include a specific description of the bases for which We determine the violation should not cause the internal appeals process to be exhausted. If an external reviewer or court agrees with Us and rejects the request for immediate review, You will have the opportunity to resubmit Your appeal.

External UR Appeals

If You or your Designee is not satisfied with the results of the appeal process, You or your Designee may pursue an External Appeal through an Independent Utilization Review Organization ("IURO") for Final Internal Adverse Benefit Determinations, except where the Final Internal Adverse Benefit Determination was based on eligibility, including rescission, or the application of a contract exclusion or limitation not related to medical necessity. You must complete both a first-level and second-level appeal before you can request a review by an IURO, except when:

- We fail to comply with any of the deadlines for completion of the internal appeals process without demonstrating good cause or because of matters beyond Our control while in the context of an ongoing, good faith exchange of information between parties and it is not a pattern or practice of noncompliance;
- We for any reason expressly waives Our rights to an internal review of any appeal; or
- You and/or Your provider have applied for expedited external review at the same time as applying for an expedited internal review.

Please note that in such a case where We assert good cause for not meeting the deadlines of the appeals process, you or your Designee and/or your provider may request a written explanation of the violation. We will provide the explanation within 10 days of the request and will include a specific description of the bases for which We determine the violation should not cause the internal appeals process to be exhausted. If an external reviewer or court agrees with Us and rejects the request for immediate review, You will have the opportunity to resubmit Your appeal.

To initiate the External Appeal, you or your Designee must:

1. File a written request with the New Jersey Department of Banking and Insurance within 4 months of receiving a Final Internal Adverse Benefit Determination on your appeal. The written request must be made on the form supplied to you by Us (enclosed with the appeal decision);

2.You must sign a release that that will allow the IURO to review all of the necessary medical records that are related to the appeal; and

3.You must also include a check or money order in the amount of $25.00 made payable to: New Jersey Department of Banking and Insurance. Upon a determination of financial hardship, the fee may be waived. In such instances, you must show the Department that you are eligible for either: Pharmaceutical Assistance to the Aged and Disabled, Medicaid, General Assistance, SSI, or New Jersey Unemployment Assistance. Please note that annual filing fees for any one Member shall not exceed $75.00.

The form, release and check must be sent to:

Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
PO Box 329
Trenton, NJ 08625-0329

Phone: (888)393-1062

When the Department has all three items, they will assign your appeal to an IURO.

When the IURO receives the appeal, it will conduct a preliminary review. It will accept your appeal for processing only if:

1. You are or were a Member of Plan at the time of the event that is the subject of the Adverse Benefit Determination;

2. The service in question reasonably appears to be a Covered Service under the Certificate;

3. Unless We have failed to comply with the deadlines for completion of the internal appeals process without good cause or We have expressly waived Our rights to an internal review or You or Your Designee has applied for expedited external review at the same time as applying for an expedited internal review, you must have completed both an first-level and a second level appeal; and

4. You have provided all information required by the IURO and the Department to make the preliminary determination, including the appeal form and a copy of any information provided by Us regarding Our decision to deny, reduce or terminate the Covered service, and a fully executed release to obtain any necessary medical records from Us and any other relevant health care provider.

Once the preliminary review is completed, the IURO will inform You or your Designee, in writing, as to whether or not the appeal is accepted for processing, and if not, the reasons therefore. The IURO shall additionally notify You and/or Your provider of Your right to submit in writing, within five business days of receipt of the notice of acceptance of Your appeal, any additional information to be considered in the IURO's review. The IURO shall provide Us with any such additional information within one business day of receipt of the information.

If the appeal is accepted, the IURO will conduct a full review to determine whether, as a result of the Our Final Internal Adverse Benefit Determination, You were deprived of coverage of Medically Necessary Covered services. In reaching this determination the IURO shall take into consideration all pertinent medical records, consulting Physician reports and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by Us.

The review will be conducted by an expert Physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final decisions of the IURO will be approved by the medical director of the IURO, who will be a New Jersey licensed Physician.

The review will be completed within 45 days of the IURO's receipt of the appeal application. If the appeal involves care for urgent or emergency care, an admission, availability of care, continued stay, Health Care Services for which the claimant received emergency services but has not been discharged from a facility or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the Member or jeopardize the Member's ability to regain maximum function, the IURO shall complete its review within no more than 48 hours following its receipt of the appeal. If the IURO's determination of the appeal provided within no more than 48 hours was not in writing, the IURO shall provide written confirmation of its determination within 48 hours of providing the verbal determination.

If the IURO determines that the denial, reduction or termination of benefits deprived you of Medically Necessary Covered services, it shall advise to You, Your provider, the Department of Banking and Insurance and Us its decision regarding the appropriate, Medically Necessary Health Care Services that you should receive. The IURO's determination will be binding on both parties, except to the extent that other remedies are available to either party under State or Federal law. If all or part of the IURO's decision is in favor of you, We shall promptly provide coverage, including payment on the claim) for the Health Care Services found by the IURO to be Medically Necessary Covered services. If you are not in agreement with the IURO's decision, you may seek the services outside of the health plan, at your own expense.

Within 10 business days of Our receipt of the determination of the IURO, We will submit a written report to the IURO, You and/or Your provider, and the Department of Banking and Insurance, indicating how We will implement the IURO's determination.

It is your RESPONSIBILITY to initiate the External Appeal process. Any Member or any provider acting on behalf of a Member with the Members written consent may initiate the External Appeal process by filing a completed application with the New Jersey State Department of Banking and Insurance.

Please note that We will provide continued coverage of an ongoing course of treatment pending the outcome of an *active* first-level, second-level or External Appeal.

Part 2 - Appeal Process - Benefit, Network and Administrative Issues

The appeal process is used after you receive an initial Adverse Benefit Determination concerning a claim for benefits or an administrative issue. Benefit issues include, but are not limited to: denials based on benefit exclusions or limitations and claims payment disputes. Administrative issues concern other requirements of your health plan. Administrative issues would include issues such as access to providers, eligibility, enrollment issues or rescission of coverage.

Do not use this process to appeal Medical Necessity determinations or Experimental and Investigational determinations.

Please Note: Benefit and administrative issues do not include determinations concerning the Medical Necessity of Covered Services. If We have denied your claims or request for services because We believe the services are not Medically Necessary, do not use this appeal process. Please refer to Part 1 of this Section for information on how to file a UR appeal.

Our appeal process provides for two levels of internal review by Us. The process may follow standard timeframes or may be done on an expedited basis.

An expedited appeal process is available and should be used when the standard timeframes for response would:

- significantly increase the risk to your life, health or ability to regain maximum function; or
- in the opinion of a doctor with knowledge of your health condition, cause you severe pain that cannot be managed without the care or treatment that was requested.

The Expedited Appeal process cannot be used to seek review of Adverse Benefit Determinations when the services have already been provided (Retrospective).

First-Level Appeals

While an appeal may be filed by telephone or in writing, We strongly recommend that you or your Designee file your appeal in writing. The written request will give Us a clearer understanding of the issues being appealed. To initiate the appeal regarding benefits and administrative issues (except for those related to quality of care) you or your Designee may call Us at the number on Your ID Card or write to Us at:

Oxford Health Plans, P.O. Box 29134 Hot Springs, AR 71903

Quality of Care: To initiate an appeal concerning the quality of care you received from a Network Provider, you or your Designee must submit a written appeal to Us at the following addresses:

Appeals Regarding Individual Providers and Facilities: Oxford Health Plans, Quality Management Department, P.O. Box 29139 Hot Springs, AR 71903

Appeals Regarding Dental Providers: Oxford Health Plans, Dental Department, P.O. Box 29139 Hot Springs, AR 71903

You or your Designee must submit any documentation/information already requested by Us (if not previously submitted) and any additional written comments and documentation/information you would like to submit in support of the appeal. At the time of Our review, We will review all available comments, documentation and information.

Unless We have already issued a written determination, We will provide written acknowledgment of the receipt of your appeal within 15 business days. The acknowledgment will include the name, address and telephone number of the department designated to review the appeal.

Standard: All standard appeals must be initiated by you or your Designee 180 days from receipt of an Adverse Benefit Determination (i.e., an Explanation of Benefits, Denial Notice), or, for other issues, 180 days from the date when you became aware of the issue that initiated the appeal.

Expedited: All requests for expedited appeals must be initiated within 45 days from when the condition necessitating the need for an expedited appeal arose. However, if We do not agree to an Expedited review, you may still submit a standard appeal as described in this section.

We will provide you, or your Designee and/or provider with Our written decision (by mail or electronic means) and the detailed reasons for Our decision.

Our decisions will be communicated as follows:

- Requests for service (Precertification): Within 15 days of Our receipt of the appeal.
- Coverage for services rendered (Retrospective): Within 30 days of Our receipt of the appeal.
- Expedited appeal (Urgent Care, Emergency care or an admission, availability of care, continued stay, Health Care Services for which the claimant received emergency services but has not been discharged from a facility): Within 48 hours of receipt of all necessary information or 72 hours from receipt of the appeal, whichever is shorter.
- Administrative matters concerning Our Network Providers: Within 45 days of Our receipt of all necessary information.

If the Adverse Benefit Determination is upheld, the notice of Our determination will be culturally and linguistically appropriate and will include information sufficient to identify the claim involved such as the date of service, the name of Your provider, the claim amount (if applicable) as well as information on the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning. Please note that any request for such diagnosis and treatment information following an Adverse Benefit Determination will be responded to as soon as practicable, and the request itself will not be considered a request for second-level appeal.

The notice will also include the reasons for Our decision, the clinical rationale, if applicable, and specific plan provisions on which the determination was based. It will include information on how to file a second-level appeal, and any new or additional evidence or rationale, which We relied upon, considered or used in making Our decision. It will also include information on the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists Members with claims, internal appeals and External Appeals.

Second-Level Appeals

If you are dissatisfied with the first-level appeal decision, you or your Designee may submit a second level appeal. If an appeal is clinical in nature, the review will include a licensed, certified or registered individual who did not review your first-level appeal. If the appeal is administrative in nature, individuals of a "higher level" than those who reviewed the first-level appeal will review the second level appeal.

You or your Designee have 180 business days from the date you received notice of Our first-level appeal decision to file a second-level appeal.

To initiate a second level appeal, You or your Designee must write to Us at:

Oxford Health Plans, Appeal Review Department, 4 Research Dr. Shelton, CT 06484

You or your Designee have 180 days from the date you received notice of Our first-level appeal decision to file an appeal. Unless We have already issued a written determination, We will provide written acknowledgment of the receipt of your appeal within 10 business days of receipt. The acknowledgment will include the name, address and phone number of the individual designated to review your appeal and what additional information, if any, must be provided for Us to render a decision.

Additionally, you or your Designee must submit any documentation/information already requested by Us (if not previously submitted) and any additional information you would like to submit in support of the appeal. You may send written comments, documents, records or other information regarding the claim. At the time of Our review, We will review all available comments, documentation and information.

After consideration of all available information, You will be provided with a written or electronic determination notice containing the detailed reasons for Our decision.

Our decisions will be communicated as follows:

- Requests for service (Precertification): Within 15 days of Our receipt of the appeal.
- Coverage for services rendered (Retrospective): Within 20 days of Our receipt of the appeal.
- Administrative matters concerning Our Network Providers: Within 20 days of Our receipt of all necessary information.
- A request for Urgent Care, Emergency care or an admission, availability of care, continued stay, Health Care Services for which the claimant received emergency services but has not been discharged from a facility (Expedited): Within 72 hours of Our receipt of all necessary information.

If the Adverse Benefit Determination is upheld, the notice of Our determination will be culturally and linguistically appropriate and will include information sufficient to identify the claim involved such as the date of service, the name of Your provider, the claim amount (if applicable) as well as information on the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning. Please note that any request for such diagnosis and treatment information following an Adverse Benefit Determination will be responded to as soon as practicable.

The notice will also include the reasons for Our decision, the clinical rationale, if applicable, and specific plan provisions on which the determination was based. It will include any new or additional evidence or rationale, which We relied upon, considered or used in making Our decision. We will also include information on the availability of and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists Members with claims, internal appeals and External Appeals. We will also include information on how you can request, free of charge, reasonable access to, and copies of documents, records, and other information relevant to your claim.

This will be considered Our Final Internal Adverse Benefit Determination. All information pertaining to each appeal will be fully documented, and retained for at least three years.

Please note that We will provide continued coverage of an ongoing course of treatment pending the outcome of an *active* first-level or second-level appeal.

Part 3 – Complaint Process

The Complaint process is a mechanism used to provide you or your Designee with a method for submitting Complaints to Us. Types of Complaints concerning Our operations include Complaints about customer service, personnel, balance billing and complaints about privacy and HIPAA protected health information. Complaints about Network Providers may include quality issues, access to care and communication.

Please Note: Dissatisfaction with benefit and Medical Necessity determinations are not considered Complaints. Please refer to Part 1 of this section for information on the UR appeal process and Part 2 of this section for information on the appeal processes for benefit, Network and administrative Issues.

Our Complaint process provides for either one level of internal review by Us or, if an appeal is available, two levels of internal review by Us.

All Complaints must be filed with Us either verbally or in writing not later than 180 days from the date you became aware of the issue that initiated the Complaint. All requests to expedite the Complaint process must be made within 45 days from when the condition necessitating the need for an expedited Complaint arose, after which you may still submit a non-expedited Complaint within the timeframes described in this paragraph.

Verbal Complaints:

Verbal Complaints must be made by calling the telephone number listed on the back of your Oxford ID Card. At the time of the call, you or your Designee must identify who is calling and indicate that you wish to file a Complaint. You must provide the specific nature of your Complaint and may be asked to provide other relevant information. We will attempt to resolve your Complaint at the time of the call. If a Complaint can be resolved on the phone, no further follow-up will be provided. An electronic record will be made of any verbal communication. To receive a written response to a Complaint, you or your Designee must submit the Complaint in writing to Oxford's Correspondence Department.

Written Complaints:

You or your Designee may also write to Us at the following addresses:

Complaints Regarding Individual Providers and Facilities: Oxford Health Plans, Quality Management Department, P.O. Box 29139 Hot Springs, AR 71903

Complaints Regarding Dental Providers: Oxford Health Plans, Dental Department, P.O. Box 29139 Hot Springs, AR 71903

Complaints Regarding Our operations: Oxford Health Plans, Correspondence Department, P.O. Box 29135 Hot Springs, AR 71903

Complaints about PHI: Oxford Health Plans, Correspondence Department, P.O. Box 29135 Hot Springs, AR 71903

You or your Designee must submit the specific nature of your Complaint and any other relevant comments and documentation/information you would like to submit in support of your Complaint. We will review all comments, documentation and information available at the time of Our review.

We will log and investigate the Complaint and provide a response verbally or in writing within 30 days of receipt of the information necessary to resolve the Complaint. Complaints involving clinically urgent matters will be resolved in a shorter timeframe.

There are some Complaints that may not be resolved immediately or for which We may not be able to notify you or your Designee of the resolution. For these types of cases, at a minimum, We will notify you or your Designee that the Complaint was received and investigated.

If We have already responded to a Complaint in writing, We will not respond to follow-up communications regarding the Complaint.

If you remain dissatisfied with the outcome of your Complaint, you may have the right to file an appeal. An appeal is a request to change a previous decision made by Us. Appeal rights are available for those Complaints where an Adverse Benefit Determination is made. The formal appeal process provides a method for addressing any Adverse Benefit Determination made by Us, including the outcome of a Complaint, if appropriate. For those Complaints where appeal rights are available, We will inform you or your Designee of your right to appeal with the initial notification of the decision.

For instructions on how to initiate an appeal of a Complaint for which an Adverse Benefit Determination has been rendered, please refer to the second level appeal process in Part 2 of this section. Please note that you cannot waive the second level appeal and request an External Review.

Section IV. Who Can Join?

1. ELIGIBILITY

A. The Subscriber

To be eligible to enroll as a Subscriber, you must be:

A full-time (or part-time if applicable) employee of the Group who is eligible for coverage on the date Our coverage commences and is entitled on their own behalf (in accordance with standard Group policy, including satisfaction of any standard probationary or waiting period established by Group and agreed to by Us) to participate in the medical and Hospital benefits arranged by the Group.

B. Dependents

To be eligible to enroll as a Covered Dependent, a person must be listed on the Enrollment Form completed by the Subscriber and meet all Dependent eligibility criteria established by the Group. Eligible Dependents include:

1. The Subscriber's lawful Spouse; or

2. Any child who is either a step-child, legally adopted child or proposed adoptive child (who is physically placed in Subscriber's home), or a natural child of either the Subscriber or the Subscriber's Spouse. In addition, a child for whom the Subscriber or the Subscriber's Spouse is a court appointed legal guardian is eligible for coverage as a Covered Dependent provided proof of such guardianship is submitted with the Dependent's Enrollment Form.

   Any such Dependent child must be:

   i. under age 26; or

   ii. a child, irrespective of age, who is or becomes and continues to be both: (1) incapable of self-sustaining employment by reason of intellectual disability, Mental Illness, Developmental Disability or physical handicap, which condition arose prior to attaining the age of 19; and (2) chiefly dependent upon the Subscriber for economic support and maintenance.

   If the child becomes incapacitated while Covered under the Plan, the Subscriber must provide Us with proof of such incapacity and dependency within thirty-one (31) days of the date Dependent coverage would otherwise terminate.

   For any such child, We will subsequently require proof of continued incapacity. Such proof will be required annually after the initial two-year period following the child's becoming eligible by reason of this provision. Our determination of eligibility shall be conclusive; or

   iii. a newborn child of a Subscriber or Subscriber's Spouse, including a newly born adopted child.

   New Jersey Continuation Rights for Over-Age Dependents

   A. Definitions:

   New Jersey Continuation Rights for Over-Age Dependents (NJCROD): A Dependent who has elected to continue his or her coverage under the Group plan under which his or her parent is currently covered pursuant to NJCROD shall not be entitled to further continue coverage under COBRA when continuation pursuant to NJCROD ends.

   As used in this provision, "Over-Age Dependent" means an Employee's child by blood or law who:
   a) has reached the limiting age of 26 (or as otherwise specified in the Summary of Benefits), as applicable, but is 30 years of age or younger;
   b) is not married or in a Civil Union or Domestic Partnership;

c) has no Dependents of his or her own;
d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School;
e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the Over-Age-Dependent continuation coverage begins; and
f) there is evidence of prior Creditable Coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare.

B. Eligibility for Continuation Through NJCROD

If a Dependent child's group health benefits end or have ended due to his or her attainment of the age 26 limiting age, he or she may elect to continue such benefits until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends sections below.

1. Conditions for Election

An Over-Age Dependent is only entitled to make an election for continued coverage if all of the following conditions are met.

a) The Over-Age-Dependent must provide evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare. Such prior coverage must have been in effect on the date the Over-Age-Dependent reached the limiting age, or at any time after such date but prior to making an election for this Over-Age-Dependent coverage.

b) A parent of an Over-Age Dependent must be enrolled as having elected Dependent coverage at the time the Over-Age Dependent elects continued coverage. Except, if the Employee has no other Dependents, or has a Spouse who is covered elsewhere, the Over-Age-Dependent may nevertheless select continued coverage.

2. Election of Continuation

To continue Group health benefits, the Over-Age Dependent must make written election to Us. The effective date of the continued coverage will be the later of:

a) the date the Over-Age Dependent gives written notice to Us; or
b) the date the Over-Age Dependent pays the first Premium; or
c) the date the Dependent would otherwise lose coverage due to attainment of the limiting age.

For a Dependent whose coverage has not yet terminated due to the attainment of age 26, the written election must be made within 30 days prior to termination of coverage due to the attainment of age 26.

For a person who did not qualify as an Over-Age Dependent because he or she fails to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election must be made within 30 days after the person first subsequently meets all of the requirements for an Over-Age Dependent.

This election opportunity is explained in greater detail as follows:

- If a person did not qualify because he or she was married, the notice must be given within 30 days of the date he or she is no longer married.
- If a person did not qualify because he or she had a Dependent of his or her own, the election must be made within 30 days of the date he or she no longer has a Dependent.
- If a person did not qualify because he or she either was not a resident of New Jersey or was not a full-time student at an Accredited school, the election must be made within 30 days of the date he or she becomes a resident of New Jersey, or becomes a full-time student at an accredited school.
- If a person did not qualify because he or she was covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or was entitled to Medicare, the election must be made within 30 days of the date he or she is no longer covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or is no longer entitled to Medicare.

Each year, there will be an Open Enrollment Period during which an Over-Age Dependent who previously did not elect to continue coverage, may make an election to continue coverage. A Group Open Enrollment Period will be held at least annually.

C. Application of a Pre-Existing Condition Exclusion

An Over-Age Dependent who was covered under prior Creditable Coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he or she was covered under the Creditable Coverage toward the application of the Pre-Existing Condition exclusion under the Certificate.

D. Premium Payments:

- The first month's Premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

- The Over-Age Dependent must pay subsequent Premiums monthly, in advance, at the times and in the manner specified by Us. The monthly Premium will be set by Us, and will be no more than 102% of the applicable portion of the charge for dependent coverage, consistent with the requirements of P.L. 2005, c. 375.

- An Over-Age Dependent's Premium payment is timely if, with respect to the first payment after the Over-Age Dependent elects to continue, such payment is made no later than 30 days after such election. In all other cases, such Premium payment is timely if it is made within 30 days of the date it is due.

E. Continued Benefits

The continued coverage shall be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an Employee under the plan. If coverage is modified for Dependents who are under the limiting age of 26, the coverage for Over-Age Dependents shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

F. When Continuation Ends

An Over-Age Dependent's continued Group health benefits end on the first of the following:

a. the end of the month in which the Over-Age Dependent turns 31;

b. the date the Over-Age Dependent:

1) marries or enters into a Civil Union Partnership;
2) acquires a Dependent;
3) is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
4) becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare.

c. the end of the period for which Premium has been paid for the Over-Age Dependent, subject to the Grace Period for such payment;

d. the date the Group ceases to provide coverage to the Over-Age Dependent's parent who is the Employee under the Group Enrollment Agreement ("Agreement").

e. The date the Agreement under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.

f. The date the Over-Age Dependent's parent who is covered as an Employee under the Agreement waives Dependent coverage. Except, if the Employee has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Employee waiving Dependent coverage.

Please Note: This Plan will not Cover an individual as both a Subscriber and a Dependent.

2. APPLYING FOR COVERAGE

Applying for coverage is easy. Fill out an Enrollment Form, and submit it to your employer's Employee Benefits Department. The form should list each eligible Dependent that you would like to have Covered. Include all requested information. Please remember to sign the form before submitting it. You and your eligible Dependents may enroll only at the times and under the conditions described below.

Important: If you are continuing coverage under COBRA, you may need to submit the Enrollment Form and the Premium directly to Us. Please check with your employer or Our Customer Care Department for further information.

Electronic Enrollment

If you are enrolling by telephone or electronically, your employer will tell you how to transmit your Enrollment Form to Us. By enrolling in this manner, you agree that all of the terms and conditions that apply to paper enrollment also apply to your telephonic or electronic enrollment. For example, you agree to the release of medical information pertaining to you and your Dependents.

A. Group Open Enrollment Period. A Group Open Enrollment Period will be held at least annually. At this time, eligible employees and eligible Dependents may enroll as Members under this Certificate. No evidence of good health will be required.

Please note: Coverage selections (either benefits or choice of carrier) made during the Group Open Enrollment Period will determine your coverage until the next Group Open Enrollment Period. Even if a provider you are seeing or wish to see has left Our Network, you cannot disenroll and select another of your employer's plans. However, if you move during the year and no longer have reasonable access to the Service Area, you may disenroll from this Plan and apply for coverage under any other plan being provided by your employer at that time.

B. Newly Eligible Employee. A new employee, hired by the Group after the Group Open Enrollment Period, may apply for coverage for himself or herself and eligible Dependents, within 31 days of becoming eligible, subject to the Group's eligibility requirements. No evidence of good health will be required.

C. Newly Eligible Dependents. Any person who becomes a Dependent may be enrolled by submitting an Enrollment Form within 31 days of becoming a Dependent. Dependents that are being enrolled pursuant to a court order must enroll within 60 days of the date of the court order. No evidence of good health will be required. This provision also applies to adopted and prospective adopted children (except for newborns as discussed below). In order for such child to be enrolled, the Subscriber must be legally obligated for the child's financial support and the child must be physically placed (in residence) in the Subscriber's home.

D. Newborns and Newly Born Adopted Children. A newborn child of the Subscriber or Subscriber's Spouse will be automatically Covered for the first 31 days after the birth of the child. No Premium will be required for the first 31 days. If coverage is to continue beyond the first 31 days, the Subscriber must complete and submit an Addition/Termination/Change Form specifically adding the newborn child as well as submit any applicable Premium to Us within 31 days following the birth.

IMPORTANT: Even if the Subscriber is already paying the maximum Premium (Family Rate) and no additional Premium is required, an Addition/Termination Change Form is still necessary. We must have knowledge of the child's presence on the Plan in order to produce an accurate HIPAA Certificate of Prior Coverage. You will need (and are entitled to) such certificate if your coverage ends under this plan.

A HIPAA (Health Insurance Portability and Accountability Act) Certificate is generated for all Members when coverage under the Plan ends. It documents how long each Member was Covered under the Plan. If you seek to obtain coverage under another group's plan, the group or the group's carrier may request this form.

E. Change in Family Circumstances. If Group has established a plan in accordance with Section 125 of the U.S. Internal Revenue Code, eligible persons will be permitted to enroll without submitting an evidence of good health if the enrollment is the result of a "change in family circumstance," as defined by the Group's plan and Section 125.

F. Special Enrollment Periods

Individuals who do not meet any of the below special enrollment period requirements may only be enrolled at the next Group Open Enrollment Period.

In addition, no person is eligible to re-enroll if he or she has had coverage from Us terminated for cause as described in the termination provisions of this Certificate.

1) Change in Family Circumstances. Subscribers who previously declined coverage under any of the Group's plans may join "off-cycle" when they gain a dependent either through marriage, birth or adoption. The Subscriber and the new dependent(s) must enroll within 30 days of the event (the marriage, birth or adoption). Existing eligible dependents that had previously declined coverage may also enroll at this time.

2) Loss of Other Coverage. If all of the following conditions are met, an individual may be enrolled before the next open enrollment:

   - the employee or dependent was covered under another group health plan or other health insurance at the time that coverage under this Certificate was initially available; and
   - the employee stated in writing that being covered under other coverage was the reason for rejecting coverage under this Certificate; and
   - the previous coverage has ended because of any of the following:
     - it was COBRA coverage that has been exhausted;

- the individual lost coverage due to a loss of eligibility (legal separation, divorce, death, termination of employment or reduction in work hours);
- the individual lost coverage due to a loss of eligibility under Medicaid or Children's Health Insurance Program (CHIP);
- the employer contribution toward such coverage was terminated.

If all of these conditions are met and he or she otherwise meet the eligibility requirements of this Certificate, the employee or dependent may request enrollment. The individual must enroll within 30 days of the termination of the previous coverage or employer contribution. When loss of coverage is due to a loss of eligibility under Medicaid or CHIP, coverage will begin only if We receive the completed Enrollment Form and any required Premium within 60 days of the date coverage ended.

3) Medicaid or CHIP Subsidy Eligibility. Subscribers who previously declined coverage under any of the Group's plans may join "off-cycle" when the Subscriber and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP. Coverage will begin only if We receive the completed Enrollment Form and any required Premium within 60 days of the date of determination of subsidy eligibility.

3. EFFECTIVE DATE OF COVERAGE

Subject to all of the applicable terms and conditions of the Agreement (including the payment of Premiums by Group and Our receipt of completed Enrollment Forms), coverage will become effective as follows:

A. Initial Enrollment (During The initial Group Open Enrollment Period). Coverage is effective on either the first day of the next calendar month following the date of the Group Open Enrollment Period or the effective date of the Agreement. Please read your Summary of Benefits to determine which is applicable.

B. Newly Eligible Employee (Enrollment within 31 days of becoming eligible). Coverage is effective on either the first day of the next calendar month following the date on which We receive the Enrollment Form or as of the date the employee became eligible. Please read your Summary of Benefits to determine which is applicable.

C. Newly Eligible Dependents (Enrollment within 31 days of becoming eligible). Coverage is effective on either the first day of the next calendar month following the date on which We receive the Enrollment Form or as of the date the Dependent became eligible. Please read your Summary of Benefits to determine which is applicable. Coverage is effective at birth for newborns and newly born adopted children subject to the enrollment requirements as described above.

D. Group Open Enrollment Period. Coverage will be effective on either the first day of the next calendar month following the date of the Group Open Enrollment Period or the renewal date of the Agreement. Please read your Summary of Benefits to determine which is applicable.

E. Special Enrollment Periods. Coverage will be effective the first day of the first calendar month beginning after the date the completed request for enrollment is received.

4. INCREASE OR REDUCTION IN BENEFITS

If for any reason your benefits must increase or decrease (because of a change in classification, earnings, etc.), your benefits will be adjusted accordingly. Any such change will be effective as of the date of the event that necessitated the change.

5. NOTICE OF CHANGE IN STATUS

It is your responsibility to notify Us and your employer of any changes which will affect your eligibility or that of your Dependents for Covered Services under this Certificate. This becomes very important should you or any of your Covered Dependents require a HIPAA Certificate of Prior Coverage.

Section V. Covered Services

You will receive Covered Services in accordance with the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- On an in-network basis: Provided by a Network Provider, except as described in Sections I. and III. of this Certificate;
  On an out-of-network basis: Provided by an appropriately licensed provider;
- Properly Precertified, when required;
- Received while your coverage is in force;
- Not excluded under this Certificate; and
- Not in excess of the benefit limitations described in this Certificate or your Summary of Benefits.

Important: We reserve the right to provide benefits in the manner We determine to be the most cost effective. Based on Our Medical Policies, We reserve the right to provide benefits in the manner, and to the extent, We believe is Medically Necessary.

IMPORTANT: Except as discussed in Sections I. and II. of this Certificate , any Covered Service you obtain without the use of a Network Provider will not be Covered on an in-network basis.

All Covered Services are subject to the member cost shares (Copayments, Coinsurance and/or Deductibles) and plan limitations specified in the Summary of Benefits as explained in Section XI. of this Certificate. Reimbursement for services rendered by Non-Network Providers is also subject to Our Out-of-Network Reimbursement Amount. Charges for Covered Services that exceed Our Out-of-Network Reimbursement Amount are not Covered and will not be counted toward your Deductible or Out-of-Pocket Maximum.

1. PRIMARY CARE AND PREVENTIVE CARE

While you may obtain primary care and preventive care from any Physician, We encourage you to use those Physicians who specialize in this type or care and are the best prepared to provide these services. We recommend that you obtain primary care and preventive care from the following types of Physicians:

- Family Practitioners
- General Practitioners
- Internists
- Pediatricians
- OB/GYNs (as well as nurse practitioners and nurse midwives)

A. Primary Care

Covered Benefits

We Cover primary care services, which consist of office visits, house calls and Hospital visits provided by a Physician for consultations, diagnosis and treatment of medical conditions, injury and disease that do not require the services of a Specialist Physician.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

B. Preventive Care

We Cover preventive care services, which consist of the following services, performed by a provider for the purpose of promoting good health and early detection of disease.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

1) Well-Baby and Well-Child Care

Covered Benefits

We Cover Well-baby and well-child care which consist of routine physical examinations, including vision screenings (no refractions), hearing screenings (including electrophysiologic screening measures and periodic monitoring of infants for delayed onset of hearing loss), developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. Immunizations and boosters as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the New Jersey Department of Health and Senior Services are also Covered. This benefit is provided to Members from Birth through age 19.

We also Cover screening by blood lead measurement for lead poisoning, including confirmatory blood lead testing, medical evaluation and any Medically Necessary follow-up and treatment.

Exclusions and Limitations

- Third party requests for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining insurance coverage; foreign travel; school admissions or attendance including examinations required for participation in athletic activities.

- Learning and behavioral disorders are not Covered. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; intellectual disability; developmental and learning disorders or behavioral problems are not Covered. We also do not Cover behavioral training, visual perceptual or visual motor training related to learning disabilities, or cognitive rehabilitation. Behavioral and learning disorders related to congenital abnormalities such as Down's Syndrome are not Covered.

- Refractions are not Covered unless the Group has purchased "Vision Care" coverage.

- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

2) Adult Periodic Physical Examinations

Adult periodic physical examinations according to the schedule established by Our Medical Advisory Board including but not limited to:

1. For all Members 20 years of age or older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotien (HDL) level;

2. Vision screenings (which do not include refractions). For all Members 35 years of age or older, a glaucoma eye test every three years;

3. For all Members 40 years of age or older, an annual stool examination for presence of blood;

4. For all Members 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years;

5. For all adult Members, recommended immunizations; and

6. For all women 20 years of age or older, a pap smear in accordance with applicable law. Please see the Well Woman Benefit for information.

7. For all women 40 years of age or older, a mammogram examination in accordance with applicable law. Please see the Well Woman Benefit for information.

8. For all Members 20 years of age or older, an annual consultation with a Physician to discuss lifestyle behaviors that promote health and well-being including, but not limited to: smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles.

   Please note: Memberships in diet or exercise clubs; special diet foods or aides; and exercise equipment; are not Covered. Hypnotherapy or any other type of therapy or self-help course for the purpose of losing weight or smoking cessation is not Covered. Nicorette, transdermal patches or other smoking cessation aides are not Covered. Allergy testing and treatment is Covered only as described in this Certificate. This benefit does not provide additional allergy coverage.

9. Colorectal screening tests will be Covered for persons age 50 and over and for persons of any age who are considered to be at high risk for colorectal cancer.

   For purposes of this benefit High risk for colorectal cancer means a person has:

   a. a family history of: familial adenomatous polyposis; hereditary non- polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;

   b. chronic inflammatory bowel disease; or

   c. a background, ethnicity or lifestyle that the Physician believes puts the person at elevated risk for colorectal cancer.

   The method and frequency of screening to be utilized shall be in accordance with the most recent published guidelines of the American Cancer Society and as determined to be Medically Necessary by the Member's Physician, in consultation with the Member.

Exclusions and Limitations

- Refractions are not Covered unless the Group has purchased "Vision Care" coverage (please check the Additional Coverage of your Summary of Benefits to see if this coverage has been included in your Plan).

- We do not Cover third party requests for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; obtaining insurance coverage; foreign travel; school admissions or attendance including examinations required for participation in athletic activities.

- Court ordered psychological or behavioral evaluations or counseling related to marital disputes, divorce proceedings, or child custody proceedings are not Covered.

- "Executive" physical examinations. For the purposes of this benefit Executive Physical Examinations are defined as unnecessary and excessive tests for individuals who are asymptomatic, and have no identified condition or disorder: Examples of Executive Physical Examinations include, but are not limited to: Pulmonary function tests, stress tests, total body CAT scans.

- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

3) Well -Woman Examinations, Family Planning and Breast Pumps

Covered Benefits

Well-woman examinations: We Cover well-woman examinations that consist of a routine gynecological examination, Pap smear and breast examination.

For purposes of this benefit " Pap smear" means an initial Pap smear and any confirmatory test when Medically Necessary and as ordered by the Member's Physician and includes all laboratory costs associated with the initial Pap smear and any such confirmatory test.

Preventive care mammograms are also Covered as follows:
- one baseline screening mammogram for women age 35 through 39; and
- one baseline screening mammogram annually for women age 40 and over (one every 10-12 months).

If a woman of any age has a history of breast cancer or her mother or sister has a history of breast cancer or other breast cancer risk factors, We will Cover mammograms as recommended by her Physician.

Only one preventive care screening per Calendar Year is Covered, except for women under the age of 40 with a family history of breast cancer or other breast cancer risk.

Diagnostic mammograms are unlimited and are Covered whenever they are Medically Necessary.

Family Planning Services: Covered family planning services consists of counseling on use of contraceptives and related topics. The costs related to the measuring and fitting of a contraceptive device are Covered if the service is performed during one of the well-woman examinations. FDA approved contraceptive devices and appliances, such as IUD's, implants, cervical caps and diaphragms are also Covered when insertion is

performed in the Physician's office. Injectable contraceptive drugs are also Covered when injection is performed in the Physician's office. We also Cover vasectomies and tubal ligations.

Breast Pumps: Covered Services defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Precertification is required before obtaining a breast pump.

Exclusions and Limitations

- We do not Cover: birth control pills, self-injectable contraceptive drugs, condoms, foams, contraceptive jellies and ointments even if they are being prescribed or recommended for a medical condition other than birth control. Some of these items may be Covered under your pharmacy benefit if your Group has purchased coverage for Outpatient Prescription Drugs. Please check the "Additional Coverage" section of your Summary of Benefits to verify if this coverage has been purchased.
- Services to reverse voluntary sterilizations are not Covered.
- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

4) Screening for Prostate Cancer

Covered Benefits

- An annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.

- Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate specific antigen test at any age for men having a prior history of prostate cancer.

- Additionally, if a Physician feels that a different schedule of tests and services is medically appropriate for a certain individual, such services and tests will be provided in accordance with the terms and conditions of the Certificate.

Exclusions and Limitations

All applicable exclusions and limitations listed in Section VI. "Exclusions and Limitations" apply.

C. Diabetes Services

1. Supplies, Education and Self-Management

Covered Benefits

Diabetic Supplies, Education and Self-Management are Covered as follows:

Supplies. The following equipment and related supplies will be Covered for insulin dependent and non-insulin dependent Members when Medically Necessary as determined by the Member's Physician:

Acetone Reagent Strips
Acetone Reagent Tablets
Alcohol Wipes
All insulin preparations
Automatic Blood Lance Kit
Blood Glucose Kit
Blood Glucose Strips (Test or Reagent)

Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor (models with special features for the visually impaired must be Precertified by Our Medical Director).
Cartridges for the visually impaired
Diabetes data management systems
Disposable insulin and pen cartridges
Drawing-up devices for the visually impaired
Equipment for use of the Pump
Glucose Acetone Reagent Strips
Glucose Reagent Strips
Glucose Reagent Tape
Injection Aides
Injector (Busher) Automatic
Insulin Cartridge Delivery
Insulin Infusion Devices
Insulin Pump (Precertification is required for this item)
Lancets
Syringe with needle; sterile 1 cc box
Urine testing products for glucose and ketones

Additional items may also be Covered if the Member's Physician determines they are Medically Necessary and prescribes them for the Member.

Self Management and Education: Education on self-management and treatment of diabetes is Covered: 1) upon the initial diagnosis; 2) if there is a significant change in the Member's condition; or 3) the Physician decides that a refresher course is necessary. It must be provided:

- In a Physician's office either by the Physician or his/her qualified nurse during an office visit or in a group setting.
- By an appropriate licensed non-Physician, medical educators (qualified health providers): certified diabetes nurse educators; certified nutritionists; certified dietitians; registered dietitians; and a registered pharmacist in the State qualified with regard to management education for diabetes by any institution recognized by the board of pharmacy of the State of New Jersey.
- Whenever possible, in a group setting, regardless of whether the Network Provider is a Physician or a qualified health provider. Education will also be provided in the Member's home if the Member is Homebound (as defined in the "Definitions" Section).

2. Diabetes Medications

Diabetic medications (including insulin, oral agents such as glucose tablets and gels, Glucagon for use with injections to increase blood glucose concentration and oral anti-diabetic agents used to reduce blood sugar levels) are subject to the cost share listed on your Summary of Benefits. If the Group has purchased the Outpatient Prescription Drug benefit, the cost share for Outpatient Prescription Drugs will apply for diabetic drugs and medications. If the Group has not purchased the Outpatient Prescription Drug benefit, your office visit cost share will apply. The cost share is applicable to each 30-day supply of each medication. We will not Cover the cost of replacing lost or stolen medications.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations:

- The items must be Medically Necessary, as determined the Member's Physician and will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for the Member.
- All requests for insulin pumps must first be reviewed by one of Our Medical Case Managers and approved by Our Medical Director.
- Only basic models of blood glucose monitors will be Covered, unless the Member has special needs relating to poor vision or blindness
- Portable insulin pumps and special home blood glucose monitors must be purchased through a vendor approved by Us.
- The following are not Covered as diabetic services or supplies: services or supplies that are not both Medically Necessary and prescribed by the Member's Physician or qualified health professional; membership in health clubs, diet clubs or plans for the purpose of losing weight even if recommended by the Member's Physician or qualified health professional; any counseling or courses in diabetes management other than as described as Covered under this Certificate; stays at special facilities or spas for the purpose of diabetes education or management; and special foods, diets aids and supplements related to dieting.

- All applicable exclusions and limitations as listed in Section VI. “Exclusions and Limitations” apply.

D. Interruptions of Pregnancy

Elective and therapeutic abortions are Covered. RU486 is Covered as a method of abortion.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

All other applicable exclusions and limitations as listed in Section VII. "Exclusions and Limitations” apply.

2. SPECIALTY CARE

Specialty care consists of medical care and services, including office visits, house calls, Hospital visits and consultations for the diagnosis and treatment of disease or injury as described below.

Please note: Most specialty care services require Precertification. We have noted the Precertification requirements with an asterisk.

A. Maternity and Newborn Care.

* *Precertification is required for certain services.*

Covered Benefits

Maternity Care: Services and supplies for maternity care provided by a Physician, Certified Nurse Midwife, Hospital or Birthing Center will be Covered for prenatal care (including one visit for genetic testing), postnatal care, delivery and complications of pregnancy. We provide a minimum inpatient stay of 48 hours following a vaginal delivery and 96 hours following a cesarean delivery for both the mother and the newly born child or children. While in the Hospital, maternity care also includes, at a minimum, parent education, assistance and training in breast or bottle-feeding and the performance of any necessary maternal and newborn clinical assessments. Unless the admission to the Hospital or Birthing Center is made on a Medical Emergency basis, the admission must be Precertified.

The mother has the option to leave the Hospital sooner than described above. If she decides to be discharged early, she will be provided with one home visit. The home visit must be requested by the mother within 48 hours of a vaginal birth or within 96 hours of a cesarean birth. The visit will occur within 24 hours of the later of: the mother’s request; or her discharge from the Hospital. The visit will not be deducted from the Home Health Care visits Covered under the Certificate.

The home visit consists of a visit by a professional RN to provide the following post delivery care: an assessment of the mother and child, instruction on breastfeeding, cleaning and care for the child; and any required blood tests ordered by either the mother’s or the child’s Physician.

In Network coverage for a routine delivery or maternity care outside of the Service Area is limited. We define a “routine delivery” as a full-term delivery that has occurred without any complications. If you arrange to give birth at a facility outside of the service area, and the delivery is routine, the Service will be Covered as an Out-of-Network benefit and will be subject to Deductible and Coinsurance. We will assume that you have arranged to give birth at a facility outside of the Service area if you travel to the area of the facility near the time of your delivery. In those instances where the Non-Network facility is near the service Area, routine deliveries will be Covered as an Out-of-Network benefit if you could safely have delivered in a Network Facility. Exceptions will be made on a “case” by “case” basis if We determine that circumstances beyond your control (such as a death in your family) required you to be outside of the Service Area at the time of your delivery.

Newborn Care

**Precertification is required for certain services.*

Care for newborns include preventive health care services (including electrophysiologic screening measures and periodic monitoring of infants for delayed onset of hearing loss), routine nursery care, and treatment of disease and injury. Treatment of disease and injury includes treatment of prematurity and medically diagnosed congenital defects and birth abnormalities which cause anatomical functional impairment. We also Cover, within the limits of this Certificate, necessary transportation costs from the place of birth to the nearest specialized treatment center.

*Routine nursery and preventive Newborn Care does not require Precertification. Circumcision performed by a Licensed Medical Practitioner during the delivery or inpatient stay does not require Precertification. However, services that generally require Precertification (such as surgery) must be Precertified.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- Special foods and diets, supplements and vitamins and enteral feedings are not Covered except as noted under "Food and Food Products for Inherited Diseases" below. Infant formulas are not Covered. However, if the Group has purchased "Outpatient Prescription Drug" coverage, Specialized, Non-Standard, Infant Formulas are Covered. Please check your Summary of Benefits to verify if this coverage has been purchased.

- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

B. Allergy Testing and Treatment

Covered Benefits

* *Precertification is required for inpatient admissions.*

We Cover testing and evaluations to determine the existence of an allergy. Routine allergy injections, including serums are Covered. We only Cover allergy testing and evaluations that are determined by Us to be consistent with current practice guidelines of Board Certified Allergists and Immunologists.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- All serums must be mixed by an Allergist. All testing must be administered by an Allergist.

- We do not Cover self-administration of allergy serums. We do not Cover the administration of allergy serums in a location where emergency resuscitative equipment and trained personnel are not present.

- We only Cover allergy testing and evaluations that are determined by Us to be consistent with current practice guidelines of Board Certified Allergists and Immunologists. On the basis of current studies, The World Health Organization does not recommend and therefore, We do not Cover, serums delivered either; orally, sublingually, or bronchially.

- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

C. Rehabilitation Services

**Precertification required for inpatient rehabilitation.*

Covered Services

Rehabilitation therapy including physical therapy, speech therapy, and occupational therapy, is Covered on an outpatient or inpatient basis. Coverage is limited to the amount of visits shown on the Summary of Benefits.

A "session" is a period of time, up to 45 minutes, in which therapy is performed.

Other than as described below under Habilitative Services, Speech or occupational therapy is Covered only when it is necessary to correct a condition that is the result of a disease, a Mental Illness including Autism Spectrum Disorder, an injury, a congenital physical deformity that inhibits normal function or a Developmental Disability as defined below.

If a Member has chronic, congenital, inherited conditions including, but not limited to, chromosomal abnormalities and degenerative diseases, We will not Cover speech or occupational therapy for such Member if, in Our opinion, the Member has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement. However, Medically Necessary coverage under this limited

benefit is available for Members who have been diagnosed with a Mental Illness as defined by applicable law. Services received for the treatment of such illness will be applied toward the benefit maximum noted in your Summary of Benefits.

Acquired conditions which result in intellectual disability which, in Our determination, lack the probability for improvement will not be Covered. These include, but are not limited to, conditions resulting from severe brain trauma, static encephalopathy and chronic degenerative diseases.

Exception: For Members with a primary diagnosis of Autism Spectrum Disorder or another Developmental Disability as defined below, coverage for physical, occupational and speech therapy will be provided as prescribed through a treatment plan and will not be denied on the basis that the treatment is not restorative.

The treatment plan must include all elements necessary to appropriately provide coverage, including, but not limited to:

- a diagnosis;
- proposed treatment by type, frequency, and duration;
- the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated;
- and the treating Physician's signature.

We may request an updated treatment plan once every six months from your Physician to review medical necessity, unless a more frequent review is agreed upon due to emerging clinical circumstances.

Physical, occupational and speech therapy related to the diagnosis of Autism Spectrum Disorder or another Developmental Disability as defined below, do not reduce the visit limits for therapy otherwise available under this section.

Habilitative Services:

Benefits are provided for habilitative services provided on an outpatient basis for Members with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Member to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Member reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Member's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Member to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Member's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.

An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Member prior to that Member developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- With the exception of treatment for Mental Illness including Autism Spectrum Disorder or another Developmental Disability or as described under Habilitative Services, Covered Services must begin within six months of the later:
    - the date of the injury or illness that caused the need for the therapy;
    - the date the Member is discharged from a Hospital where the surgical treatment was rendered; or
    - the date outpatient surgical care is rendered.
    - and, with the exception of treatment for Mental Illness including Autism Spectrum Disorder or another Developmental Disability, in no event will the therapy continue beyond 365 days after such event.
- With the exception of Medically Necessary treatment for Mental Illness including Autism Spectrum Disorder or another Developmental Disability, Rehabilitation services or physical therapy on a long-term basis is not Covered.
- Speech or occupational therapy to correct a condition that is not the result of a congenital defect, injury or disease for which surgery has been performed is not Covered. This exclusion does not apply to therapeutic services received under this benefit by Members for the Treatment of Mental Illness including Autism Spectrum Disorder or another Developmental Disability or as described under Habilitative Services.
- We do not Cover speech or occupational therapy if a Member has reached maximum level of physical or mental function possible and will not make further significant clinical improvement. This exclusion does not apply to therapeutic services received under this benefit by Members for the treatment of Mental Illness including Autism Spectrum Disorder or another Developmental Disability.
- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

D. Reconstructive and Corrective Surgery

** Precertification is required for inpatient admissions.*

Covered Benefits

Reconstructive and corrective surgery is Covered only when:

1. it is performed to correct a congenital birth defect of an infant or Dependent who was born while Covered under this Certificate;
2. is incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part. The reconstructive or corrective surgery must be performed within two years of the surgery that was necessitated by the trauma, infection or disease. Under no circumstances will We Cover reconstructive or corrective surgery that does not meet this criteria; or
3. it is breast reconstruction (including surgery on the healthy breast to restore and achieve symmetry) or implanted breast prostheses following a Covered mastectomy.

Important: Reconstructive and corrective surgery is not a Covered Service unless it meets the criteria stated in either 1, 2 or 3 above. An appeal of an Adverse Benefit Determination based on Medical Necessity cannot be made unless one of these criteria has been met.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- The following are not Covered: Cosmetic, reconstructive or plastic surgery that is done for a condition that does not meet the specific criteria stated above, including but not limited to: cosmetic surgery, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body including, but not limited to: surgery for sagging skin or extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; rhinoplasty and rhinoplasty done in conjunction with a Covered nasal or Covered sinus surgery.

- The reconstructive or corrective surgery must be performed within two years of the surgery that was necessitated by the trauma, infection or disease.

- Complications of such surgeries are not Covered unless they are Medically Necessary and are otherwise Covered.

- Remedial work is not Covered. Remedial work is any medical procedure to correct either undesired results or an unsuccessful procedure connected to a prior Uncovered Cosmetic surgery/procedure. Please see "Reconstructive and Corrective Surgery" for a description of when plastic or reconstructive surgery is Covered.

- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

E. Oral Surgery

** Precertification is required for inpatient admissions.*

Covered Benefits

The following limited dental and oral surgical procedures are Covered in either an inpatient or outpatient setting:

1. Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair (not replacement) of sound natural teeth that are required due to "accidental injury." Dental services must be obtained within 12 months of the injury. "Accidental injury" does not include damage caused to a tooth while biting or chewing or the intentional misuse of the tooth.

2. Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.

3. Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

All inpatient admissions and all procedures requiring general anesthesia must be Precertified. General anesthesia is Covered only if the Member: 1) has significant cardiovascular disease, or insulin controlled diabetes; or 2) is unable to cooperate with the procedure (i.e., a child under the age of three or a mentally incapacitated child.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- General dental services, including but not limited to the following, are not Covered: Dental services related to the care, filling, removal or replacement of teeth; the treatment of injuries (except as described above); or diseases of the teeth, gums and temporomandibular joint; including, but not limited to: apicoectomy, orthodontics, root canals, soft tissue impaction, temporomandibular joint dysfunction therapy, alveolectomy, treatment of periodontal disease or orthognathic surgery.

- Removal of cysts related to teeth is not Covered.

- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

F. Outpatient Cardiac Rehabilitation

** This benefit requires Precertification.*

Covered Benefits

We Cover outpatient cardiac rehabilitation if a Member has:

1. had an Acute myocardial infarction within the preceding 12 months;
2. chronic angina pectoris, or
3. had coronary bypass surgery within the preceding six months.

Subject to Precertification by Our Medical Director, therapy may be available following: valve surgery or any other major open-heart surgical procedure; angioplasty or atherectomy; heart or lung transplant; congestive heart failure, or if the Member has Peripheral Arterial Disease.

Clinical evidence must show that the Member is able to exercise at least three times a week for at least 20 minutes per session. Additionally, the Member must have the potential to attain at least 70 percent of the age adjusted exercise heart rate goal.

We will Cover up to 36 visits (three visits a week over a 12-week period). Up to 36 additional sessions can be obtained if Our Medical Director determines: 1) there is a clear demonstration that the Member is benefiting from the therapy, 2) the exit criteria established in Our Medical Policy has not been met, and 3) there is a reasonable expectation that the Member can meet Our exit criteria with additional sessions.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- This benefit is limited to a maximum of 72 visits as described above.
- Rehabilitation services or therapy on a long-term basis is not Covered. We will not Cover therapy if a Member has reached maximum level of physical function possible and will not make further significant clinical improvement.
- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

G. Outpatient Pulmonary Rehabilitation

** This benefit requires Precertification.*

Covered Benefits

We Cover outpatient pulmonary rehabilitation for Members with moderate to severe symptomatic, chronic Respiratory Impairment. However, coverage is available only when, despite optimal medical management, the Member is dyspneic, has reduced exercise tolerance and is experiencing a restriction in their daily living activities.

We defined Respiratory Impairment as a loss or abnormality of: psychologic, physiologic, or anatomic structure or function, which is the result of respiratory disease.

Therapy will only be Covered if it contains all of the following components: 1) exercise training consisting of upper and lower extremity training, ventilatory muscle training and breathing exercises; 2) patient education; 3) psychological and behavioral interventions; and 4) outcome assessment.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- This benefit is limited to 24 visits, per Member, per Contract Year.
- All services must be provided by a provider who has expertise in pulmonary rehabilitation.
- Rehabilitation services or therapy on a long-term basis is not Covered. We will not Cover therapy if a Member has reached maximum level of physical or psychological function possible and will not make further significant clinical improvement.
- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

H. Orthoptic Exercises and Corneal Topographic Procedures

** This benefit requires Precertification.*

Covered Benefits

We Cover orthoptic exercises only for the following two indications: 1) convergence insufficiency; and 2) amblyopia penalization patching for children (birth through 19).

- Treatment for amblyopia must be prescribed by an Opthomoligist. *Precertification is required.*
- For convergence insufficiency, We Cover one diagnostic visit and two therapeutic/follow-up visits per Contract Year.

Corneal topographic procedures are Covered only for certain diagnosis. A Network Physician will know when coverage is available. If you are seeing a non-Network Provider, he or she should give Us a call. Coverage is limited to two studies per eye, per Contract Year. *Precertification is required.*

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- This benefit is limited to the diagnosis and the amount of visits described above.
- We do not Cover vision therapy, vision training or perceptual motor training services.
- All other applicable exclusions and limitations as listed in Section VI. “Exclusions and Limitations” apply.

I. Outpatient Diagnostic Services

Major Diagnostic Procedures require Precertification.

1. Laboratory Services

Covered Benefits

Laboratory procedures, services and materials are Covered when performed on an outpatient basis when ordered by a Physician because of specific symptoms and to diagnose a specific condition or disease.

A Physician may arrange for you to have these services. You should not seek these services without the assistance of a provider.

2. Radiology Services

Covered Benefits

We Cover Major Diagnostic Procedures and radiology procedures, services and materials, including, but not limited to, diagnostic X-rays, X-ray therapy, fluroscopy, electrocardiograms, and therapeutic radiology services on an outpatient basis when ordered by a Physician because of specific symptoms and to diagnose a specific condition or disease.

A Physician may arrange for you to have these services. You should not seek these services without the assistance of a provider.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- Please remember, unless you are receiving preadmission testing, Network Hospitals are not Network Providers for laboratory or radiology procedures and tests.
- All other applicable exclusions and limitations as listed in Section VI. “Exclusions and Limitations” apply.

J. Internal and External Prosthetic Devices

Internal devices require Precertification.

Covered Benefits

Internal Prosthesis: Surgically implanted prosthetic devices and special appliances will be Covered if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a Covered mastectomy. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Coverage does not include artificial organs. Replacement of an internal breast prosthesis that was originally inserted for cosmetic purposes is not Covered. If a Member has silicone implants, removal of the implants is Covered only when the Member has specific systemic symptoms.

External Prosthetic Devices: We Cover prosthetic devices that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease, when obtained from a licensed orthotist or prosthetist or any certified pedorthotist.

In accordance with Our Medical Policy, external breast prostheses following a Covered mastectomy are also Covered.

Wigs are Covered when the Member has severe hair loss due to injury, disease or as a side effect of the treatment of a disease (e.g., chemotherapy). Coverage is limited to one synthetic hair wig per Member, per lifetime and may be subject to a dollar amount limitation as shown in your Summary of Benefits.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- Coverage for wigs is limited to one synthetic wig per Member, per lifetime and may be subject to a dollar amount limitation as shown in your Summary of Benefits.
- Wigs are not Covered for male pattern baldness, female pattern baldness, natural aging or premature aging.
- Natural Human Hair Wigs are not a Covered Benefit.
- Coverage does not include artificial organs.

All other applicable exclusions and limitations as listed in Section VI. “Exclusions and Limitations” apply.

K. Durable Medical Equipment, Orthotics and Braces

**Precertification is required for all Durable Medical Equipment rentals and purchases of $500 or more*

Covered Benefits

Durable Medical Equipment. We Cover Durable Medical Equipment. Durable Medical Equipment is equipment which is: 1) designed and intended for repeated use; 2) primarily and customarily used to serve a medical purpose; 3) generally not useful to a person in the absence of disease or injury; and 4) is appropriate for use in the home. ** Precertification is required for all rentals and purchases of $500 or more.*

Coverage is for standard equipment only. We do not Cover customization of any item of Durable Medical Equipment. All maintenance and repairs that result from a Member's misuse are the Member's responsibility. The decision to rent or purchase such equipment will be made at Our discretion.

Orthotics and Braces: We Cover braces and orthotic appliances that are worn externally. The brace or orthotic must temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect.

Orthotic devices must be ordered or provided by, or under the direction of a Physician who deems the device to be Medically Necessary and obtained from a licensed orthotist or prosthetist or any certified pedorthotist. *Precertification is not required for orthotic appliances.*

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- We do not Cover TENS units (except as Covered under Durable Medical Equipment); blood pressure monitoring devices; car seats; arch supports; cervical collars; corrective shoes; false teeth; hearing aids; tilt tables; electronic communication devices; in-flight oxygen for non-emergency travel; special supplies or equipment; or special appliances.

- TENS units when Covered (as stated above) are Covered only when certain medical criteria are met. This benefit requires Precertification.

- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

L. Medical Supplies

Covered Benefits

** Precertification is required for certain services.*

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. Maintenance supplies (e.g., ostomy supplies) are also Covered for conditions Covered under this Certificate. All such supplies must be Medically Necessary and in the appropriate amount for the treatment or maintenance program in progress. Diabetic Supplies are not Covered under this provision.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

M. Treatment of Infertility

**Precertification is required for this benefit.*

Covered Benefits

I. Covered Benefits

We will Cover Medically Necessary expenses incurred in the diagnosis and treatment of infertility. In addition, We may require that certain services will be Covered only when rendered by the most qualified specialist. For example, We may require that you receive Covered Services from a reproductive endocrinologist instead of an OB/GYN.

Covered Services include, but are not limited to:

- Diagnosis and diagnostic testing
- Medications
- Surgery, including microsurgical sperm aspiration
- Ovulation induction
- In vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier.
- Embryo transfer, with fresh and frozen embryos
- Artificial insemination, including intrauterine insemination with no limit as to the number of cycles
- Assisted hatching
- Zygote intra fallopian transfer (ZIFT)
- Intracytoplasmic sperm injection
- Gamete intra fallopian transfer (GIFT)
- Medical costs of egg and sperm donors, including office visits, medications, laboratory and radiology procedures and retrieval until the donor is released from treatment by the reproductive endocrinologist.
- Medical expenses for Gestational Carriers, including office visits, medications, laboratory and radiology procedures and any complications until she is released from treatment by the reproductive endocrinologist.

Coverage for in vitro, GIFT and ZIFT is limited to Members who:

- have used all reasonable, less expensive and medically appropriate treatments (and have not been able to become pregnant or carry a pregnancy);
- have not reached the limit of four completed egg retrievals; and
- are 45 years of age or younger.

All services must be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

Conditions of Coverage:

1. The Member seeking services must be infertile. Applicable New Jersey State law defines infertility as follows:

   The disease or condition that results in the abnormal function of the reproductive system such that:
   - a male is unable to impregnate a female;
   - a female is unable to conceive after two years of unprotected intercourse if the female partner is under 35 years of age, or one year of unprotected intercourse if the female partner is 35 years of age or older;
   - the male or female is medically sterile; or
   - the female is unable to carry a pregnancy to live birth.

The definition of infertility does not include a person who has been voluntarily sterilized regardless of whether the person has attempted to reverse the sterilization. Services will not be Covered for a Member who has successfully reversed sterilization yet is diagnosed as medically infertile (or cannot carry a pregnancy to live birth). However if the partner of such Member is infertile, and is Covered under this Plan, that partner is eligible for coverage.

In addition, coverage will only be provided for same sex couples if the Member seeking coverage is diagnosed as infertile as defined above.

Before obtaining services, Members are encouraged to call Medical Management and speak with an Infertility Case Manager. He or she will verify the Member's eligibility for the Covered Services under this benefit.

2. Members are limited to four completed egg retrievals (and the procedures and treatments associated with such retrievals) while covered under this plan or any plan with the same employer. Unsuccessful completed egg retrievals will count towards the limit. If a live donor is used in the egg retrieval, the medical costs of the donor will also be Covered until the donor has been released from treatment by the Reproductive Endocrinologist.

3. If a Member's infertility meets the definition of a "Pre-existing Condition" as defined in this Certificate, and the Member's coverage under the Plan is subject to a Pre-existing Condition Limitation (all in accordance with N.J.S. 17B:27-55), coverage under this benefit is subject to such limitation.

4. In addition to services that generally require Precertification (such as surgical procedures or inpatient admissions), the following services must be Precertified:

   - In vitro fertilization (IVF)
   - Gamete intrafallopian transfer (GIFT)
   - Zygote intrafallopian transfer (ZIFT)
   - Microscopic Epididymal Sperm Aspiration (MESA)
   - Testicular Sperm Aspiration (TESA)
   - Intracytoplasmic sperm injection (ICSI)
   - Assisted oocyte fertilization
   - Embryo hatching and transfer
   - Ovum retrieval
   - Medical costs of ovum or sperm donation
   - Preimplantation Genetic Diagnosis (PGD)
   - Injectible infertility drugs

Network Physicians are responsible for obtaining any required Precertification for Covered Services received in-network. Please feel free to call Us to confirm that Precertification has been obtained.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions

- Non-Medical costs for an ovum donor or sperm donor.
- Sperm storage costs.
- Cryopreservation and storage of embryos and eggs.
- Ovulation predictor kits.
- In vitro services for woman who have undergone tubal ligation.
- Reversal of tubal ligations.
- Any infertility services rendered to a male if the male has undergone a vasectomy.
- All costs for and relating to surrogate motherhood (exception: if the surrogate mother is a Member, the pregnancy is Covered if it would otherwise be Covered under the terms and conditions of the Certificate).
- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

Important: Regardless of whether or not the Group has purchased Outpatient Prescription Drug coverage, all outpatient Prescription Drugs used by a Donor or a Gestational Carrier who are not Members of Oxford with Outpatient Prescription Drug Coverage will be Covered only if the Donor or Carrier submits the claim directly to Us for reimbursement.

Definitions

Artificial Insemination: the introduction of sperm into a woman's vagina or uterus by noncotial methods for the purpose of conception, and includes intrauterine insemination.

Assisted Hatching: a micromanipulation technique in which a hole is artificially created in the outer shell of an embryo to assist with the potential implantation of the embryo.

Completed Egg Retrieval: all office visits, procedures and laboratory and radiological tests performed in preparation for oocyte retrieval; the attempted or successful retrieval of the oocyte(s); and if the retrieval is successful, culture and fertilization of the oocyte(s).

Cryopreservation: the freezing of embryos in liquid nitrogen until such time as required for a frozen embryo transfer. Cryopreservation also refers to the freezing of female gametes (ova) and male gametes (sperm).

Egg Retrieval or Oocyte Retrieval: a procedure by which eggs are collected from a woman's ovarian follicles.

Egg Transfer or Oocyte Transfer: the transfer of received eggs into a woman's fallopian tubes through laparoscopy as part of gamete intrafallopian transfer (GIFT).

Embryo: a fertilized egg that has begun cell division and has completed the pre-embryonic stage.

Embryo Transfer: the placement of an embryo into the uterus through the cervix or, in the case of zygote intrafallopian tube transfer (ZIFT), the placement of an embryo in the fallopian tube. Embryo transfer includes the transfer of cryopreserved embryos and donor embryos.

Fertilization: the penetration of the egg by the sperm.

Gamete: a reproductive cell. In a male, gametes are sperm; in a female, gametes are eggs or ova.

Gamete Intrafallopian Transfer (GIFT): the direct transfer of a sperm/egg mixture into the fallopian tube by laparoscopy. Fertilization takes place inside the fallopian tube.

Gestational Carrier: a woman who has become pregnant with an embryo or embryos that are not part of her genetic or biological entity, and who intends to give the child to the biological parents after birth.

Intracytoplasmic Sperm Injection (ICSI): micromanipulation procedure whereby a single sperm is injected into the center of an egg.

Intra Uterine Insemination: a medical procedure whereby the sperm is placed into a woman's uterus to facilitate fertilization.

In Vitro Fertilization (IVF): an ART procedure whereby eggs are removed from a woman's ovaries and fertilized outside her body. The resulting embryo is then transferred into the woman's uterus.

Microsurgical Sperm Aspiration: the techniques used to obtain sperm for use with the intracytoplasmic sperm injection (ICSI) in cases of obstructive azoopsermia. It can involve the extraction of sperm and fluid from epididymal tubules inside the epididymis ("MESA") or the provision of testicular tissue from which viable sperm may be extracted ("TESE").

Oocyte: the female egg or ovum.

Ovulation Induction: the use of drugs (oral or injected) to stimulate the ovaries to develop follicles and eggs.

Pregnancy-Related Benefits: benefits for normal pregnancy and childbirth.

Sexual Intercourse: the sexual union between a male and a female.

Surrogate: a woman who carries an embryo that was formed from her own egg inseminated by the sperm of a designated sperm donor.

Zygote: a fertilized egg before cell division begins.

Zygote Intrafallopian Transfer (ZIFT): a procedure whereby an egg is fertilized in vitro, and the zygote is transferred to the fallopian tube at the pronuclear stage before cell division takes place.

N. Transplants

**Precertification is required for this benefit.*

Covered Benefits

We Cover only those transplants that We determine to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. When standard chemotherapy is unsuccessful, an autologous bone marrow transplant for the treatment of Wilm's Tumor is Covered.

We will Cover the Hospital and medical expenses, including donor search fees, of the recipient.

We will Cover transplant services required by a Member when the Member serves as an organ donor only if the recipient is a Member.

Dose-Intensive Chemotherapy/Autologous Bone Marrow Transplants

When authorized by the Member's Network Specialist and Precertified by Our Medical Director, services for the treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants are Covered when performed at a provider that is approved by the National Cancer Institute or performed pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- All transplants must be prescribed by your Network Specialist(s) and must be Precertified by Our Medical Director.

- For in-network coverage, all transplants must be received and Precertified at Designated Facilities that We have specifically approved and designated to perform these procedures.
- We do not Cover travel expenses, lodging, meals or other accommodations for donors or guests.
- We do not Cover the cost of bone marrow storage for a Member with a current disease in anticipation of a transplant.
- The medical expenses of a non-Member acting as a donor for a Member are not Covered if the non-Member's expenses will be Covered under another health plan or program.
- Donor fees in connection with organ transplant surgery are not Covered (only donor search fees are Covered).
- Routine harvesting and storage of Stem Cells from newborn cord blood is not Covered.
- Experimental/Investigational Treatments. In general, We will not Cover experimental or investigational treatments. However, We shall Cover an experimental or investigational treatment approved by an External Appeal Agent certified by the State. If an External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a qualifying Clinical Trial, We will only Cover the cost of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this Certificate for non-experimental or non-investigational treatments provided in such Clinical Trial.
- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

O. Clinical Trials

** This benefit requires Precertification.*

Covered Benefits

We will Cover the routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other Life-Threatening Condition or Disease. For purposes of this benefit, a Life-Threatening Condition or Disease is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Covered Services include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Member is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Services for which benefits are typically provided absent a Clinical Trial.
- Covered Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for qualifying Clinical Trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain *Category B* devices.

- Certain promising interventions for patients with terminal illnesses.
- Other items and services that meet specified criteria in accordance with our medical and drug policies.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Conditions or Diseases, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Condition or Disease and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Service and is not otherwise excluded under the Policy.

P. Home Health Care.

**This benefit requires Precertification.*

Covered Benefits

We Cover care provided in your home by a Home Health Service or Agency licensed or certified by the State of New Jersey. The care must be provided by Physician-supervised health professionals pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility.

Home care includes (i) part-time or intermittent nursing care (except when full-time or 24-hour services are needed on a short-time basis) by or under the supervision of a registered professional nurse (RN); (ii) part-time or intermittent services of a home health aide, (iii) physical, occupational, or speech therapy provided by the Home Health Service or Agency, (iv) medical supplies, appliances and equipment, drugs and medications prescribed by a Physician; medical social work; nutritional counseling and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Important: Each visit by a member of the Home Health Care team will count as one visit. Visits are limited in length as follows: Each visit of up to four hours by a home health aide is one visit. Each visit of up to two hours by any other licensed professional (e.g., RN, LPN, physical therapist) is one visit.

Exclusions and Limitations

- Home Health Care is limited to the amount of visits shown in your Summary of Benefits.
- Supervision of home health aides by an RN or LPN is not Covered (home health aids must be supervised by a Physician.
- Services supplied to family members of the Member are not Covered.
- Homemaker services are not Covered.
- We do not Cover comfort or convenience items including, but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. We also do not Cover the purchase or rental of household fixtures or equipment including, but not limited to: escalators; elevators; swimming pools; exercise cycles; treadmills, weight training or muscle strengthening equipment; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.
- We do not Cover custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. We do not Cover nursing care or personal care which is rendered to assist a Member who, in Our opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.
- Any rehabilitation services received under this benefit that is part of the treatment plan and delivered by the Home Health Care Service or Agency will not reduce the amount of services available under the "Rehabilitation Services," Section. Conversely, Rehabilitation Services provided to you in your home that are not part of the treatment plan and are not delivered by the Home Health Care Service or Agency will be treated as Rehabilitation Services.
- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

Q. Services Delivered in the Home

Covered Benefits

* *Precertification is required for certain services.*

If a Member does not qualify for Home Health Care (Hospitalization would not be required if Home Health Care was not available), and the Member is Homebound, certain outpatient Covered Services may be available to the Member in their home. When such services are delivered, they will draw down the day, visit and dollar limit on the Member's benefit. For example, physical therapy delivered in the home will draw down the amount of outpatient Rehabilitation Services available to the Member. Important: We make no assurance that all outpatient Covered Services are available in the home.

A Member will be considered to be "Homebound" if he or she has a condition due to an illness or injury which restricts his or her ability to leave their place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs and walkers; the use of special transportation; or the assistance of another person. Additionally, a Member will be considered Homebound if the Member has a medical condition where leaving the home is medically contraindicated.

The Member will pay the appropriate amount that would have been required had they traveled to the Network Provider to obtain the services.

Exclusions and Limitations

- We make no assurance that all outpatient Covered Services are available in the home.
- The Member must be Homebound as defined above.
- All Covered Services are limited to the amount of day, dollar and visit amounts shown in the Summary of Benefits for the type Covered Service received. For example: If physical therapy is received in the home, the amount of available therapy is limited to the amount of outpatient Rehabilitation Services shown in the Summary of Benefits (minus any therapy actually received on an outpatient basis).
- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

R. Chemotherapy

**Precertification is required for inpatient admissions.*

Chemotherapy is Covered on an inpatient basis in a Hospital or Skilled Nursing Facility. It is also Covered through Home Health Care, on an outpatient basis in an outpatient facility or when provided in a Physician's office. When provided in the office, Precertification is not required.

Chemotherapy drugs that are used to slow or kill the growth of cancerous cells and are administered orally are also Covered. If the Group has purchased coverage for Outpatient Prescription Drugs, chemotherapy drugs will be Covered under the Outpatient Prescription Drug benefit. If the Group has not purchased coverage for Outpatient Prescription Drugs, chemotherapy drugs will be Covered subject to the same cost share as intravenously administered or injected anti-cancer medications, however you will be directed to purchase these drugs through one of Our Designated Specialty Pharmacies. You must submit the claims to Us (as described in Section IX. under "Filing a Claim"). We will reimburse you minus any applicable cost share.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- Experimental/Investigational Treatments. In general, We will not Cover experimental or investigational treatments. However, We shall Cover an experimental or investigational treatment approved by an External Appeal Agent certified by the State. If an External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a qualifying Clinical Trial, We will only Cover the cost of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this Certificate for non-experimental or non-investigational treatments provided in such Clinical Trial.
- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

S. Hemodialysis

**This Benefit requires Precertification.*

Covered Benefits

We Cover hemodialysis when prescribed by a Physician. If you have End Stage Renal Disease (ESRD) and are anemic, We will Cover Proferrin to treat your anemia. However, your provider must obtain Precertification from Us in order for this drug to be Covered.

While traveling outside of Our Service Area, We will Cover up to six treatments per Contract Year that are provided by Non-Network Providers on an in-network basis. *Precertification is required.* You or the Non-Network Provider performing the service must call for Precertification.You must submit the claims to Us (as described in Section IX. under "Filing a Claim"). We will reimburse you minus any applicable cost share.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- Home dialysis nursing services.
- When Medicare is the primary payor, We Cover the Services provided by this benefit only to the extent they are not Covered under Medicare.
- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

T. Home Treatment of Hemophilia

**This benefit requires Precertification.*

Covered Benefits

We Cover the purchase of blood products (including, but not limited to, Factor VIII, Factor IX and cryoprecipitate) and blood infusion equipment (including, but not limited to, syringes and needles) as required for the home treatment of routine bleeding episodes related with hemophilia. The home treatment program must be under the supervision of a state-approved hemophilia treatment center.

The Member must pay the cost share that would have been required had the Member traveled to a Network Provider to receive the Covered Service.

Exclusions and Limitations

- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

U. Second and Third Opinions

Covered Benefits

** Precertification is required for certain services*

At Your Request: There may be instances when you will disagree with a Network Provider's recommended course of treatment. In such cases, you may request that another Network Provider render a second opinion. If the first and second opinions do not agree, you may request that another Network Provider render a third opinion. After completion of the second opinion process, We will Precertify the Covered Services supported by a majority of the Network Providers reviewing your case.

At Our Request: We reserve the right to require a second opinion for any surgical procedure. At the time of Precertification, you may be advised that a second opinion will be required in order for the services to be Covered. If a second opinion is required, We will refer you to a Network Provider for a second opinion. In the event that the first and second opinions differ, a third opinion will be required. We will designate a new Network Provider. The third opinion will determine whether or not the surgery is Precertified and Covered.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

For a second opinion that you request, you must pay the amount shown in your Summary of Benefits. There is no cost to you when We request a second opinion.

Exclusions and Limitations

- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

V. Chiropractic Services

Covered Benefits

**Precertification is required for certain services.*

- We will Cover spinal subluxation and related services when performed by a Doctor of Chiropractic ("Chiropractor"). This includes assessment, manipulation and any modalities.

- Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- We will not Cover any non-medical or non-medical support services including, but not limited to, equipment, clothing, vitamins, supplements or other items and services that may be offered by the Chiropractor.
- Only assessment and manipulation for subluxation of the spine is Covered under this benefit. If a Chiropractor performs a Covered Service other than manipulation, that service will be adjudicated in accordance with applicable Certificate provisions. Example: If a Chiropractor performs physical therapy, that therapy is subject to the "Rehabilitation Services" payment and benefit limitations shown in your Summary of Benefits.
- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

W. Food and Food Products for Inherited Metabolic Diseases

**This benefit requires Precertification.*

Covered Benefits

We Cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula), and low protein modified food products as determined to be Medically Necessary by the Member's Practitioner. Enteral formulas must be proven to be effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, will cause chronic disability, intellectual disability or death.

For the purpose of this benefit:
- "Inherited Metabolic Disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;
- "Low Protein Modified Food Product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and
- "Medical Food" means a food that is intended for the dietary treatment of a disease or condition for or administered enterally under the direction of a Practitioner.

Exclusions and Limitations

- Coverage of special foods, diets and enteral feedings is subject to periodic review for Medical Necessity.

- Nutritional supplements that are taken electively are not Covered.

- Infant formulas are not Covered. However, if the Group has purchased "Outpatient Prescription Drug" coverage, Specialized, Non-Standard, Infant Formulas are Covered. Please check the "Additional Coverage" section of your Summary of Benefits to verify if this coverage has been purchased.

- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

X. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear.

Covered Services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Covered Services are provided for the hearing aid and associated accessories, as well as for charges associated with the fitting, testing and repair of a hearing aid.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

Y. New Jersey Early Intervention Family Cost Share Expense

Covered Services under this section include the Family Cost Share expense incurred by Members for the provision of certain health care services obtained in accordance with a treatment plan developed as a result of, or in conjunction with, an Individualized Family Service Plan (IFSP) for a child determined eligible for early intervention services through the New Jersey Early Intervention System (NJEIS).

In order to be eligible for reimbursement, the Member must:

a) be eligible for early intervention services through the New Jersey Early Intervention System;

b) have been diagnosed with Autism Spectrum Disorder or another Developmental Disability; and

c) received physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services

The portion of the Family Cost Share attributable to such services is a Covered Service under this Certificate. The Deductible, Coinsurance or Copayment as applicable to a non-Specialist Physician visit for treatment of a illness or injury will apply to the monthly Family Cost Share expense.

The therapy services a Member receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under the Certificate.

Z. Nutritional Counseling

**This benefit requires Precertification.*

For certain active, chronic, medical conditions or diseases, We will Cover visits to a Network Registered Dietitian. You or a Network Provider may call Medical Management for more information on the availability of this benefit. This benefit is not available for the treatment of obesity (morbid or otherwise), weight loss or eating disorders.

This section does not apply to diabetes. Please see *Diabetes Equipment and Related Supplies, Self-Management and Education* above.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

AA. Obesity Surgery

* *This benefit requires Precertification.*

We Cover surgical treatment of obesity when provided by or under the direction of a Physician.

Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- The Member has a body mass index (BMI) of greater than 40.
- The Member has a body mass index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.Obesity surgery must be performed at our Designated Facilities in order to be covered on an in-network basis. Please note that not all Network Hospitals are contracted to perform obesity surgery. Please refer to your provider directory or contact us to find out which hospitals are contracted for this service.

Exclusions and Limitations

- Obesity surgery that is not performed at a Designated Facility will not be Covered on an in-network basis.

- All other applicable exclusions and limitations as listed in the "Exclusions and Limitations" Section apply.

3. HOSPITAL AND FACILITY-BASED SERVICES

In order to receive an in-network level of coverage for any facility based Covered Service, you must use a Network Provider. All inpatient based services must be Precertified. Whenever possible, please Precertify at least 14 days in advance of the surgery or treatment.

A. Hospital Services (Excluding Mental Health Services, Alcohol and Substance Abuse)

**Hospital admissions require Precertification. All Precertified admissions to Network Hospitals are Covered; regardless of whether or not the admitting provider is a Network Provider.*

Covered Benefits

Inpatient Services: Covered Hospital Inpatient services for Medically Necessary, Acute-care includes: semi-private room and board, unlimited days, general nursing care and the following additional facilities, services and supplies: meals and special diets; use of operating room and related facilities; use of intensive care or cardiac care units and related services; X-ray services; laboratory and other diagnostic tests; drugs; medications; biologicals; anesthesia and oxygen services; short-term physical, speech and occupational therapy; radiation therapy; inhalation therapy; chemotherapy; whole blood and blood products; and the administration of whole blood and blood products. Additionally, We Cover:

Inpatient Stay for Lymph Node Dissection or Lumpectomy: We will Cover Hospital inpatient services for Members undergoing a lymph node dissection or lumpectomy. Coverage is available for the period of time determined to be Medically Necessary by you and your Physician. In addition, coverage will be provided for inpatient stays of a minimum of 72 hours after a modified radical mastectomy and a minimum of 48 hours following a simple mastectomy.

Autologous Blood Banking Services: Autologous blood banking services are Covered only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We will Cover storage fees for what We determine to be a reasonable storage period that is Medically Necessary and appropriate for having the blood available when it is needed.

Routine harvesting and storage of Stem Cells from newborn cord blood is not Covered.

Outpatient Services

We Cover the inpatient Hospital services and supplies listed above that can be provided to you while being treated in the outpatient facility. Please remember, unless you are receiving preadmission testing, Network Hospitals are not Network Providers for laboratory procedures and tests.

General Anesthesia for Dental Services

We Cover general anesthesia and hospitalization for dental services or for a medical condition Covered under the Certificate which requires hospitalization or general anesthesia for dental services rendered by a Doctor of Medicine, "M.D.", Doctor of Dental Surgery, "D.D.S.", or Doctor of Medical Dentistry "D.M.D." regardless of where the dental services are provided.

Covered Services are limited to Members who are either under the age of 5 or severely disabled.

Coverage for Physician services are described under Physician Fees for Surgical and Medical Services.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

B. Outpatient Ambulatory Surgical Center

**Precertification is required for certain services.*

Coverage is available for Covered surgical procedures performed at Ambulatory Surgical Centers.

Coverage under this section includes:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- Blood, blood plasma and blood derivatives other than as described above are not Covered. Synthetic blood, apharesis or plasmapheresis, the collection and storage of blood or the cost of securing the services of blood donors other than as described above are not Covered.
- Care for conditions that by federal, state or local law must be treated in a public facility including, but not limited to, commitments for Mental Illness. Additionally, to the extent allowed by law, We do not Cover care or treatment provided in a Non-Network Hospital that is owned or operated by any federal, state or other governmental entity.
- Military service related conditions. Conditions that are connected with a Member's service in the military and for which the Member is legally entitled to receive services at a government facility provided the facilities are reasonably available to the Member (maximum three hour drive time).
- Confinement in an infirmary setting is not Covered. This includes but is not limited to, charges incurred while receiving care aboard a cruise ship.
- All other applicable exclusions and limitations as listed in Section VI. “Exclusions and Limitations” apply.

C. Skilled Nursing Facility

**This benefit requires Precertification and treatment plan.*

Covered Benefits

We Cover non-custodial services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. In addition to Precertification, an admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by a Network Provider and approved by Us.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- Coverage is limited to amount of days shown in your Summary of Benefits.
- Private or special duty nursing is not Covered.
- We do not Cover, custodial care, convalescent care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. We do not Cover room, board, nursing care or personal care which is rendered to assist a Member who, in Our opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.
- We do not Cover rehabilitation services or physical therapy on a long-term basis.
- Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.
- All other applicable exclusions and limitations as listed in Section VI. “Exclusions and Limitations” apply.

D. Hospice

**This benefit requires Precertification for services rendered inpatient or in the home.*

Covered Benefits

Hospice Care is available to Members who have a prognosis of six months or less to live. Coverage consists of palliative care rather than curative treatment. When Certified as part of the Hospice program, We Cover a total of 5 visits for supportive care and guidance for the purpose of helping the Member and the Member's immediate family cope with the emotional and social issues related to the Member's death. For the purpose of this provision, "immediate family" is limited to the Member's parents, Spouse and children and the siblings of terminally ill Members who are children. Hospice Care will be Covered only when provided as part of a Hospice Care program certified by the State of New Jersey. Such certified programs may include Hospice Care delivered by: a Hospital (inpatient or outpatient), Home Health Care Agency, Skilled Nursing Facility or a licensed Hospice facility.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- Supportive Care and guidance for the immediate family is limited to a total of five visits. The family members must be Covered under the Plan.
- We do not Cover: funeral arrangements; pastoral, financial or legal counseling; homemaker, caretaker or respite care.
- All other applicable exclusions and limitations as listed in Section VI. "Exclusions and Limitations" apply.

E. Physician Fees for Surgical and Medical Services

** Precertification is required for certain services.*

We Cover Physician fees for surgical and obstetrical procedures on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care. Deliveries and related services that are performed by a certified nurse midwife are also Covered.

Coverage includes Physician fees for a second opinion, including the review of the results of any laboratory and radiology essential to the second opinion, where another licensed Physician proposes to perform an elective inpatient surgical procedure on a Member. For purposes of this benefit, an inpatient surgical procedure is one which is scheduled at the convenience of the Member or the Member's Physician without jeopardizing the Member's life or causing serious impairment to the Member's bodily functions. If the second surgical opinion does not confirm that the proposed elective surgical procedure is medically advisable, then Physician Fees for a third surgical opinion shall be covered in the same manner as those covered for a second surgical opinion. A Physician providing a second or third surgical opinion shall be a physician who is licensed to practice medicine and surgery who holds the rank of Diplomate of an American Board (M.D.) or Certified Specialist (O.D.) in the surgical or medical specialty for which surgery is proposed. In the event that the Physician who provides a second or third surgical opinion also performs the elective surgical procedure being proposed, then no benefits for the second or third opinion will be paid to that Physician.

4. MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES

A. Mental Health Services

**Precertification is required for Intermediate Care and inpatient admissions.*

Mental Health Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a Physician's office or at an Alternate Facility.

Coverage for Mental Health Services includes:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.

- Treatment and/or procedures.
- Referral services.
- Medication management.
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family and group therapeutic services.
- Crisis intervention.

We will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is Covered on a Semi-private Room basis.

When the primary diagnosis is Autism Spectrum Disorder, benefits are provided for Medically Necessary Behavioral Interventions Based on ABA and Related Structured Behavioral Programs as prescribed through a treatment plan and provided by or under the direct supervision of an experienced individual who is credentialed by the national *Behavior Analyst Certification Board* as either:

- a Board Certified Behavior Analyst – Doctoral (BCBA-D); or
- a Board Certified Behavior Analyst (BCBA)

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Mental Health Services as treatments for R and T-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Mental Health Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
- Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilic disorders and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice.
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
- Learning, motor disorders, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Intellectual disability as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by Us.
- Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

- All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
- Health services and supplies that do not meet the definition of a Covered Service - see the definition in *Section XVI: Definitions*.

B. Substance Use Disorder Services

**Precertification is required for Intermediate Care and inpatient admissions.*

Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a Physician's office or at an Alternate Facility.

Coverage for Substance Use Disorder Services includes:

- Substance Use Disorder and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Detoxification (sub-acute/non-medical).
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Referral services.
- Medication management.
- Individual, family and group therapeutic services.
- Crisis intervention.

We will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is Covered on a Semi-private Room basis.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions & Limitations

- All benefits are subject to the limitations listed in your Summary of Benefits.
- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Substance Use Disorder Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
- Substance Use Disorder Services for the treatment of nicotine or caffeine use.
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by Us.
- Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that are any of the following:
    - Not consistent with Generally Accepted Standards of Medical Practice for the treatment of such conditions.
    - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.

- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on Generally Accepted Standards of Medical Practice and benchmarks.

We may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

5. MEDICAL EMERGENCIES

Covered Benefits

We Cover Medical Emergencies, including coverage of trauma services at any designated level I or II trauma center as Medically Necessary and appropriate, which shall be continued at least until, in the judgment of the attending Physician, the Member is medically stable, no longer requires critical care, and can be safely transferred to another facility. We also provide coverage for a medical screening examination provided upon a Member's arrival in a Hospital, as required to be performed by the Hospital in accordance with Federal law, but only as necessary to determine whether an Medical Emergency condition exists.

In order to obtain Coverage for Medical Emergencies, you should follow these instructions, regardless of whether or not you are in the Service Area at the time of the Medical
Emergency. Medical Emergencies include Covered Services provided by any health care
provider as follows:

We define a Medical Emergency as follows: 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 lay person, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate attention could result in: (a) placing the health of the Member (or, with respect to a pregnant woman, the health of the woman or the unborn child) in serious jeopardy; (b) serious impairment to bodily functions; (c) serious dysfunction of a bodily organ or part; or (d) serious disfigurement of such Member. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to affect 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. Some examples of a Medical Emergency include but are not limited to:

- Severe chest pains
- Severe shortness of breath
- Severe or multiple injuries
- Loss of consciousness
- Convulsions
- Severe bleeding
- Poisonings
- Sudden change in mental status (e.g., disorientation)
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis

We reserve the right to review all appropriate medical records and make the final decision
regarding the existence of a Medical Emergency. Regarding such Respective Reviews, We will Cover only those services and supplies that are Medically Necessary and are performed to treat or stabilize a Medical Emergency condition.

Hospital Emergency Room Visits

In the event of a Medical Emergency, seek immediate care at the nearest emergency room or call 911.

Emergency room care is not subject to Our prior approval. However, only Medical Emergencies, as defined above, are Covered in an emergency room. If you would like assistance assessing the situation, you may call Medical Management or *Oxford-On-Call*. They are available 24 hours a day, 7 days a week.

Follow-up care provided in a Hospital emergency room is not Covered. You should contact a Network Physician or Us to make sure you receive the appropriate follow-up care.

Emergency Hospital Admissions

In the event you are admitted to the Hospital, you or someone on your behalf must notify Us at the number listed on the back of your ID Card within 48 hours of your admission, or as soon as is reasonably possible.

To continue coverage on an in-network basis: If you have been admitted to a Non-Network facility, We may require that you be moved to a Network Hospital or other Network facility as soon as your medical condition permits. If you decline Our request, your hospitalization will be Covered on an out-of-network basis from that time forward.

Please Note: It is important to remember that only those conditions that meet all of the requirements contained in the definition of Medical Emergency will be Covered as a Medical Emergency.

All medical emergencies that meet the criteria of a Medical Emergency will be Covered on an in-network basis regardless of where they are received provided that notification protocols have been followed.

Ambulance Services

**Non-urgent ambulance services require Precertification.*

Ambulance services for life-threatening Medical Emergencies will be Covered. Ambulance services for all other Medical Emergencies will be Covered when Medically Necessary. Inter-facility ambulance transfers will also be Covered if they receive Precertification.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- Improper use of an emergency room or emergency admissions are not Covered. Routine care and treatment for conditions that are not Medical Emergencies, when received in an emergency room, are not Covered.
- Follow-up care provided in a Hospital emergency room is not Covered.
- All other applicable exclusions and limitations as listed in Section VI. “Exclusions and Limitations” apply.

6. URGENT CARE

Covered Benefits

We define Urgent Care as medical care for a condition that needs immediate attention to minimize severity and prevent complications, but which is not a Medical Emergency.

You are encouraged to contact Medical Management at the number on your ID Card, who can provide you with instructions. Medical Management is available around the clock to help you in urgent medical situations.

If an Urgent Care visit results in an emergency admission, please follow the instructions for Emergency Hospital Admissions described above.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions and Limitations

- Routine care is not Covered in an Urgent Care Center.
- Follow-up care is not Covered in an Urgent Care Center.
- All other applicable exclusions and limitations as listed in Section VI. “Exclusions and Limitations” apply.

Section VI. Exclusions and Limitations

Unless coverage is specifically provided under this Certificate or provided under a rider or attachment to this Certificate, the following services and benefits are not Covered.

1. Services which are not Medically Necessary. If there is a dispute between a provider and Us about the Medical Necessity of a service or supply, you or your provider may appeal Our decision. Any disputed service or supply will not be Covered during the appeal process.

   Important: If you and a provider agree that you will be responsible for the cost of Covered Services that We have determined are not Medically Necessary, We will not reimburse you.

2. Acupuncture therapy.

3. An adopted newly born infant's initial Hospital stay if the natural parent has coverage available for the infant's care.

4. Autopsies.

5. Blood, blood plasma and blood derivatives, except as Covered under "Hospital and Other Facility-Based Services". Synthetic blood, apheresis or plasmapheresis, the collection and storage of blood or the cost of securing the services of blood donors are not Covered.

6. Birth control pills, self-injectable contraceptive drugs, condoms, foams, contraceptive jellies and ointments, even if they are being prescribed or recommended for a medical condition other than birth control. Some of these items may be Covered under your pharmacy benefit if your Group has purchased coverage for Outpatient Prescription Drugs. Please check the "Additional Coverage" section of your Summary of Benefits to verify if this coverage has been purchased.

7. Care for conditions that by federal, state or local law must be treated in a public facility including, but not limited to, commitments for Mental Illness. Additionally, to the extent allowed by law, We do not Cover care or treatment provided in a Non-Network Hospital that is owned or operated by any federal, state or other governmental entity.

8. Comfort or convenience items including, but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. We also do not Cover the purchase or rental of household fixtures or equipment including, but not limited to: escalators; elevators; swimming pools; exercise cycles; treadmills, weight training or muscle strengthening equipment; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.

9. Cosmetic, reconstructive or plastic surgery excluding coverage of cosmetic treatment of medically diagnosed congenital birth defects or birth abnormalities in dependents who have been covered under the contract from the moment of birth, that is done for a condition that does not meet the specific criteria stated in "Reconstructive and Corrective Surgery," including but not limited to: cosmetic surgery, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body including but not limited to: surgery for sagging or extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; rhinoplasty and rhinoplasty done in conjunction with Covered nasal or Covered sinus surgery. Complications of such surgeries are Covered only if they are Medically Necessary and are otherwise Covered. Remedial work is not Covered.

10. Court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if We agree that the services are Medically Necessary, are otherwise Covered, the Member has not exhausted their benefit for the Contract/Calendar Year, and the treatment is provided in accordance with Our policies and procedures.

11. Custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. We do not Cover room, board, nursing care or personal care which is rendered to assist a Member who, in Our opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.

12. Dental services related to the care, filling, removal or replacement of teeth and the treatment of injuries or diseases of the teeth, gums and temporomandibular joint, including, but not limited to: apicoectomy, orthodontics, root canals, soft tissue impaction, temporomandibular joint dysfunction therapy, alveolectomy, and treatment of periodontal disease or orthognathic surgery. As described in "Oral Surgery," only dental services required to treat accidental injury of sound, natural teeth are Covered.

13. The following are not Covered as diabetic services or supplies: services or supplies that are not both Medically Necessary and prescribed by the Member's Physician or qualified health professional; membership in health clubs, diet plans or clubs even if recommended by a

Physician or any other provider for purpose of losing weight; any counseling or courses in diabetes management other than as described as Covered under this Certificate; stays at special facilities or spas for the purpose of diabetes education/management; special foods, diet aids and supplements related to dieting.

14. Durable Medical Equipment (other than as specifically Covered under this Certificate. We also do not Cover: TENS units (except as Covered under Durable Medical Equipment); blood pressure monitoring devices; car seats; arch supports; cervical collars; corrective shoes; false teeth; hearing aids; tilt tables; electronic communication devices; in-flight oxygen for non-emergency travel; special supplies or equipment; or special appliances.

15. Experimental, investigational or ineffective surgical or medical treatments, procedures, drugs, or research studies including, but not limited to: transplants, stem cell retrieval, cancer chemotherapy protocols, AIDS Clinical Trials or I.V. therapies that are not recognized as acceptable medical practice and any such services where federal or other governmental agency approval is required but has not been granted. We will make the determination as to whether the requested service is excluded in accordance with this provision. In certain instances, such procedures may be Covered if they are approved in advance by Our Medical Advisory Board and provided in accordance with the provisions of this Certificate.

    Under no circumstances will We Cover autologous bone marrow transplants combined with high dose chemotherapy except, when medically appropriate, for the treatment of: advanced neuroblastoma, second remission acute leukemia, relapsed Hodgkin's disease, relapsed non-Hodgkin's lymphoma, and metastatic breast cancer or any other diagnosis that Our Medical Advisory Board determines to be appropriate. Such treatment must be approved in advance by Our Medical Advisory Board and provided in accordance with the provisions of this Certificate.

16. Improper use of an emergency room or emergency admissions. Routine care and treatment for conditions that We determine were not Medical Emergencies, when received in an emergency room, are not Covered.

17. Infertility treatments and supplies (except as otherwise Covered under this Certificate), even if the treatment or supply is for a purpose other than the correction of infertility. The following services and supplies are not Covered: cost for an ovum donor or donor sperm, sperm storage costs, chromosomal analyses, testicular biopsy, elective abdominal surgeries related to lysis of adhesions or asymptomatic varicoceles, radiographic imaging to determine tubal patency; blood analyses related to immunological diagnosis of infertility, cryopreservation and storage of embryos (unless the Member has not yet reached her lifetime limit of four egg retrievals), in-vitro services for women who have undergone tubal ligation, any infertility services if the male has undergone a vasectomy and all costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers). We also do not Cover services to reverse voluntary sterilization.

18. Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; intellectual disability; developmental and learning disorders or behavioral problems. We also do not Cover behavioral training, visual perceptual or visual motor training related to learning disabilities or cognitive rehabilitation. Behavioral and learning disorders related to congenital abnormalities such as Down's Syndrome are not Covered.

19. When Medicare is the primary payor, We Cover the Services provided by this Certificate only to the extent they are not Covered under Medicare.

20. Military service related conditions. Conditions that are connected with a Member's service in the military and for which the Member is legally entitled to receive services at a government facility provided the facilities are reasonably available to the Member (maximum three hour drive time).

21. Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.

22. Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, injury or a congenital defect for which surgery has been performed. This exclusion does not apply to therapeutic services received by Members for the Treatment of Mental Illness including Autism Spectrum Disorder or another Developmental Disability.

23. No-show charges. If a provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

24. Occupational conditions, ailments, or injuries arising out of and in the course of employment. Such conditions, ailments or injuries are not Covered if they are subject to coverage, in whole or in part, under any workers' compensation, occupational disease or similar law. This applies even if the Member's rights have been waived or qualified.

25. Outpatient Prescription Drugs, unless coverage has been purchased by the Group. Please check the "Additional Coverage" section of the Summary of Benefits to see if this coverage has been purchased.

26. Recreational, educational or sleep therapy and related diagnostic testing.

27. Routine foot care including nail trimming, corn and callous removal, cleaning, soaking or any other hygienic maintenance or care.

28. Sex, marital or religious counseling, including sex therapy and treatment of sexual dysfunction.

29. Sex Transformations. Any procedure or treatment designed to alter the physical characteristics of a Member from the Member's biological sex to those of the opposite sex regardless of any diagnosis of gender role or psychosexual orientation problems.

30. Special foods and diets, supplements, vitamins and enteral feedings, except as what is otherwise outlined in this Certificate. When coverage of special foods, diets and enteral feedings are available, it is subject to periodic review for Medical Necessity. Infant formulas are not Covered. However, if the Group has purchased "Outpatient Prescription Drug" coverage, Specialized, Non-Standard, Infant Formulas are Covered. Please check the "Additional Coverage" section of your Summary of Benefits to verify if this coverage has been purchased.

31. Special medical reports not directly related to treatment. Appearances in court or at a hearing.

32. Temporomandibular joint syndrome. Dental procedures and appliances for the treatment of temporomandibular joint syndrome or craniomandibular pain syndrome. Surgical and nonsurgical medical procedures are Covered if Precertified and approved by Our Medical Director.

33. Third party requests for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; obtaining insurance coverage; foreign travel; school admissions or attendance including examinations required for participation in athletic activities. Court ordered psychological or behavioral evaluations or counseling related to marital disputes, divorce proceedings, or child custody proceedings are not Covered.

34. Transplant services required by a Member when the Member serves as an organ donor are not Covered unless the recipient is a Member. The medical expenses of a non-Member acting as a donor for a Member are not Covered if the non-Member's expenses will be Covered under another health plan or program. Donor fees in connection with organ transplant surgery are excluded. Routine harvesting and storage of Stem Cells from newborn cord blood is not Covered. We do not Cover travel expenses, lodging, meals or other accommodations for donors or guests. Transplants performed in facilities other than those designated by Us for the transplant procedure are not Covered.

35. Coverage outside of the United States. No coverage is available outside of the United States if the Member traveled out-of-the-country to obtain medical treatment, drugs or supplies. Additionally, We will not Cover any treatment, drugs or supplies that are unavailable or illegal in the United States.

    When a Member is traveling for other purposes, only Medical Emergencies and Urgent Care will be Covered outside of the United States (with the exception of Canada, Mexico and U.S. possessions).

36. Unnecessary Care. In general, We will not Cover any health care service that We determine is not Medically Necessary. If an Independent Utilization Review Organization ("IURO") determines that you were improperly denied coverage, it will make a recommendation to you or your designee, Us and the Department of Banking and Insurance as to what should be Covered. If the IURO determines that the denial, reduction or termination of benefits deprived you of medically necessary covered services, it shall convey to you and Us its decision regarding the appropriate, medically necessary health care services that you should received, which shall be binding on the carrier.

37. Any charges by a non-Network Provider for Covered Services that are in excess of Our Out-of-Network Reimbursement Amount are excluded from coverage and are the Member's responsibility.

38. We do not Cover vision correction services and supplies including, but not limited to: eyeglasses (lenses and frames), all manner of contact lenses or corrective lenses and refractions. We do not Cover eye exercises, visual training, vision therapy or orthoptics (exception: orthoptics are Covered for convergence insufficiency and amblyopia penalization patching for children). Refractive eye surgery is not Covered including, but not limited to LASIK, Laser Thermal Keratoplasty, Orthokeratology, Standard Keratomeluesis, Astigmatic Keratotomy, Photoreactive Keratotomy, Radial Keratotomy, Epikeratoplasty, Keratophakia Keratomileusis.

39. Weight Control. All services, supplies, programs and surgical procedures for the purpose of weight control, except as described in Section V. Covered Services under Obesity Surgery.

40. Any service, supply or treatment not specifically listed in this Certificate as a Covered Service, supply or treatment. Any supply or treatment for which the Member has no legal obligation to reimburse the provider. Any supply or treatment provided by a member of the Member's family (mother, step-mother, father, step-father, sister, step-sister, brother, step-brother, any "in-law," aunt, uncle, niece, nephew or cousin).

41. Fraud. We do not Cover any procedures, services or supplies if they have been fraudulently obtained.

Section VII. Termination of Coverage

1. HOW YOUR COVERAGE MAY TERMINATE

Your Coverage under this Certificate will terminate in the event any of the following occur:

A. Where permitted by the Group, upon written notice from you. If you provide written notice at least 15 days prior to the beginning of the following month, coverage will terminate on the last day of the month in which notice is given. If 15 days notice is not received, coverage under this provision will not terminate until the end of the following month.

B. Upon termination of the Agreement. Either We or the Group can terminate the Agreement under certain conditions. Coverage will cease at 12:00 midnight on the date the Agreement terminates. We are not obligated to notify you that the coverage is being terminated. The Group will provide you with this notice. The fact that you did not receive notice from Us will not continue or extend your coverage under this Plan beyond the date of the termination of the Agreement.

C. Upon loss of eligibility. Your coverage will cease on the date you no longer meet the eligibility requirements of your Group or the requirements of this Certificate regarding eligibility for coverage. When a Subscriber loses eligibility, his or her Covered Dependents will also become ineligible on that date.

D. In the case of your failure to pay the required premiums and other applicable charges for coverage, including copayment, coinsurance and deductibles. We will provide you written notice of the violation and a reasonable opportunity to come into compliance.

E. In the case of your failure to abide by Our rules and/or policies and procedures. We will provide you written notice of the violation and a reasonable opportunity to come into compliance.

F. In the case of fraud or material misrepresentation affecting coverage, including misuse of a member ID Card.

2. EFFECTIVE DATE OF TERMINATION

All terminations are effective 31 days from the date the notice is mailed.

3. REINSTATEMENT

A Member will not be reinstated automatically if Coverage is terminated. Re-enrollment is required.

Please note: A HIPAA (Health Insurance Portability and Accountability Act) Certificate is generated for all Members when coverage under the Plan ends. It documents how long each Member was Covered under the Plan. If you seek to obtain coverage under another group's plan, the group or the group's carrier may request this form.

Section VIII. What Happens If I Lose Coverage?

Termination or Loss of Eligibility: Coverage Options

1. COBRA

Federal law provides that, in certain cases, coverage may continue under this Plan. The abbreviation for that law is COBRA. Electing coverage under this provision ends any rights under any applicable state continuation provision. The following is a summary of the terms and conditions.

A. Continuation of Coverage for You and Your Covered Dependents

If you and your Covered Dependents become ineligible under the Certificate due to (a) termination of your employment for any reason (except for gross misconduct on your part), or (b) a reduction in your hours of employment, coverage may be continued under this Certificate for you and/or your Covered Dependents, subject to the following:

1. You and/or your Covered Dependents must elect to continue such coverage by the Plan within the 60-day period described in the Notice of Federal Continuation Rights given by the Group to you and/or your Covered Dependents;
2. You and/or your Covered Dependents make the required contributions; and
3. You and/or your Covered Dependents comply with all other terms and conditions under this Certificate.

The coverage under this subsection will end on the earliest of:

1. The last day of the 18-month period from the date you became ineligible under the Certificate. This 18-month period may be extended to a 29-month period for you or a Covered Dependent who is and remains disabled as determined under Title II or XVI of the Social Security Act;
2. The date any required contribution for a Member on COBRA is not made;
3. The date any Member on COBRA becomes entitled to benefits under Medicare;
4. The date any Member on COBRA becomes covered under another group health plan without limitation or exclusion of a Pre-existing Condition; and
5. The date that coverage under this Certificate is discontinued with respect to all employees of the Group.

B. Continuation of Dependent Coverage Only

Coverage under this Certificate may be continued for Covered Dependents who become ineligible while Covered under this Plan. In addition to your termination of employment or reduction in hours, as described above in subsection 1, this provision applies when your Covered Dependents lose eligibility for any of the following reasons:

1. You die while providing coverage for your Covered Dependents under this Certificate;
2. There is a divorce or legal separation from you; or
3. A Covered Dependent (other than Spouse) ceases to be a Covered Dependent as defined in the Certificate.

Children who are born while the Subscriber is on COBRA Continuation and children placed in the Subscriber's home for adoption while the Subscriber is on COBRA Continuation are eligible for COBRA coverage. They must be enrolled in accordance with the Certificate's terms and conditions for Dependent coverage.

To obtain coverage under this provision, the Member must: notify the Group of the event, elect in writing to continue coverage within the 60-day period described in the Notice of Federal Continuation Rights; make the required contributions; and not be entitled to Medicare or other group coverage.

Coverage under this subsection will end on the earliest of:

1. The last day of the 36-month period from the date the Member became ineligible under the Certificate;
2. The date any required contribution is not made;
3. The date the Member becomes entitled to benefits under Medicare;
4. The date the Member becomes covered under any group health plan without limitation or exclusion of a Pre-existing Condition; or
5. The date coverage under this Certificate is discontinued with respect to all employees of the Group.

C. Other COBRA Information

1. Coverage for Persons on COBRA Under a Prior Plan
   You or your Covered Dependent may have elected COBRA under a prior plan or may be entitled to elect COBRA due to termination under a prior plan. In such a case, this Plan will provide coverage for the period remaining under COBRA, subject to the termination provisions described above and all other terms and conditions of this Certificate. Any benefits paid under the prior plan, whether due to an extension of benefits or otherwise, will be deducted from benefits payable under this Certificate.

2. Increases and Decreases in Coverage
   Any amount of coverage or benefits continued under COBRA is subject to any increases and reductions as set forth in "Increase or Reduction in Benefits."

3. Notification Requirements
   a. Election. The failure to elect coverage within the 60-day period discussed above will result in the loss of the COBRA option.
   b. Benefits. You or your Covered Dependents must notify the Group no later than 60 days after any of the following events occur:
      i. There is a divorce or legal separation between you and your Spouse;
      ii. A child ceases to be a Covered Dependent as defined in this document.
      Failure to provide this notice will result in the loss of the COBRA option.
   c. Disability. If coverage for you or your Covered Dependents is being continued for 18 months under Section A above and it is determined that you or your Covered Dependent was disabled (as determined under Title II or XVI of the Social Security Act) either before or during the first 60 days of coverage under Section A, you or your Covered Dependent must notify the Group of such determination within 60 days after the date of the determination (if you or your Covered Dependent wishes to receive 29 months of COBRA coverage). The Group must also be notified within 30 days after the date of any final determination that you or your Covered Dependent is no longer disabled.

4. Multiple Continuation Periods
   If a Covered Dependent is on an 18-month continuance under Section A, and one of the events listed in Section B occurs, coverage can be extended. Coverage for up to 36 months is available, measured from the date that coverage under Section A began. Any extended coverage is subject to all other terms of the Certificate.

5. Maximums, Deductibles and Copayments
   a. Any benefit maximums, as well as any other limits on benefits under COBRA, will be reduced by any corresponding amounts or limitations previously paid or satisfied, whether in whole or in part, under this Certificate on the date before you became ineligible under this Certificate.
   b. Any Copayments paid for the Calendar Year under this Certificate before you became ineligible under this Certificate will be applied toward the satisfaction of the Copayment limit for that Calendar Year.

6. Conversion
   The Conversion privilege described in Section 3 below is available to Members upon termination of COBRA.

2. EXTENDED BENEFITS FOR THE TOTALLY DISABLED

Please note: If you are Totally Disabled on the date the Agreement is terminated, services for the treatment of your disability can be covered under the Group's new insurer or HMO or, they can be Covered under this Certificate as described below. Either way, there may be an advantage to you. If you decide to elect Extended Benefits, you must notify Us, in writing, within 30 days of your loss of coverage.

A. Eligibility for Extended Benefits

If a Member is Totally Disabled on the date his or her coverage under this Certificate ends, the Plan will, at Member's option, continue to pay for Covered Services that are for treatment of the particular injury or sickness that caused the Total Disability.

B. Termination of Extended Benefit

Extended Benefits will end on the earliest of the following:

a. Twelve months from the date the Extended Benefits Provision began;
b. The date the Member is no longer Totally Disabled as determined by the Member's Network Physician; or
c. The date the contractual benefit limit has been reached.

C. Limits on Extended Benefits

We will not pay Extended Benefits:

a. For any Member who is not Totally Disabled on the date his or her coverage under this Certificate ends;
b. For any child born as the result of a pregnancy for which benefits are being extended; and
c. Beyond the extent to which We would have paid benefits under the Certificate if coverage had not ended.

Continuation of coverage under either COBRA or Conversion Coverage is not available if Extended Benefits has been elected or exhausted.

3. CONTINUATION DUE TO TOTAL DISABILITY

If your coverage would otherwise cease due to Total Disability, and you have been insured for at least three consecutive months under the Plan, and if you pay the Group the required Premium, your coverage will be continued until the earliest of:

- The last day for which you have paid the required Premiums;
- The date you become employed and eligible for similar coverage under another group policy for medical benefits; or
- The date the Agreement is cancelled.

Within 31 days after the date coverage would otherwise cease, you may elect such continuation by completing and submitting a continuation notification and by paying the required Premium to the Group.

If your coverage is being continued as outlined above, coverage for any of your Covered Dependents on the date your coverage would otherwise cease may be continued subject to the above provisions. Dependent coverage will be continued until the earliest of:

- The date the Subscriber's coverage ceases; or
- With respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent.

This provision will not operate to reduce any continuation of coverage otherwise provided.

4. CONVERSION PRIVILEGE

In the event you cease to be eligible for coverage under this Certificate, you may, within 45 days after termination of coverage under this Certificate convert to individual membership. The individual coverage will become effective as of the date of the termination. In order to be eligible for conversion coverage, your coverage, or the coverage of your Covered Dependents, must terminate for one of the following reasons:

1. The Agreement between the Group and Us is terminated and the Group does not replace the coverage provided by this Certificate with continuous and similar coverage;

2. A Subscriber ceases to meet the eligibility requirements of this Certificate. In this instance, the Subscriber and his or her then Covered Dependents are eligible to convert;

3. A Covered Dependent ceases to meet the eligibility requirements of this Certificate because of attaining the limiting age, death of the Subscriber or divorce or annulment; or

4. Continuation of coverage under COBRA, or State Continuation expires and the Member is not eligible for coverage under any other group health plan or Medicare.

In order to be eligible for conversion coverage, a Subscriber must have been continuously Covered under this Certificate for at least three months immediately prior to the termination. Conversion coverage is not available if:

1. The Member is, or is eligible, to be Covered for similar benefits under: another group plan, medical services subscriber contract, medical practice or other prepaid plan regardless of whether the coverage is on an insured or self-funded basis; or any governmental program and such coverage combined with the conversion coverage would result in over-insurance (as defined by Our over-insurance rules which are filed with the State).

2. Coverage was terminated for cause as described in the "Termination of Coverage" section of this Certificate.

To obtain conversion coverage, you or your Covered Dependents must do three things:

First, you must continue to reside in the Service Area or return to the Service Area for non-Emergency and non-Urgent Care. Second, you must submit a completed application for conversion to Us within 45 days after the date of termination. This 45-day period will be extended for an extra 45 days (90 days total) if your employer does not give you timely notice of your conversion rights. Finally, you must submit the required Premium payments. We will not ask for evidence of good health.

Please note that the Premium under conversion will differ from that under the Group coverage. In addition, the terms of the conversion plan will be different. You or your Covered Dependents will be issued the conversion plan that is being offered by Us at the time of your application. This plan will offer benefits at the same level as are available to Our conversion subscribers in general.

Application for conversion is not initiated by Us. You or your Covered Dependents must initiate the application procedure. In accordance with its usual notification procedures, the Group is responsible for giving notice of your eligibility for conversion coverage. However, if coverage under this Certificate has ended due to the exhaustion of your or your Covered Dependents COBRA coverage, the Group must give you notice of your conversion rights. The Group must do this during the 180-day period prior to the expiration of the COBRA coverage.

5. OTHER AVAILABLE COVERAGE

A. Leave of Absence or Lay-off

If your coverage would terminate because you are temporarily laid-off or receive an approved leave of absence, coverage may be continued for up to 60 days, or as otherwise agreed upon by the Group and Us; if the Group: (1) pays the Premium for the continued coverage; and (2) requires all participating carriers to provide continued coverage to employees whose coverage would otherwise terminate because of a temporary lay-off or approved leave of absence.

B. Family and Medical Leave Act

Federal law provides that certain employees can take up to 12 weeks of unpaid leave in a 12-month period for:

- the birth or adoption of a child,
- a serious health condition affecting the employee or a family member,
- for any qualifying exigency arising out of the fact that the employee's Spouse, child or parent is on or has been called to active duty in the Armed Forces, or
- up to 26 weeks of unpaid leave in a 12-month period to care for an injured servicemember.

Employers subject to this law are required to keep an employee's medical coverage in force to the same extent as if no leave had been taken. Your obligations, including any Premium contributions and compliance with Plan provisions, do not change during a leave.

If your employer is subject to this law, and you are eligible for leave under the Act, We will continue your coverage during a qualified leave. Coverage will terminate for failure to comply with Plan provisions, including the failure to pay Premium. You should check with your employer regarding family or medical leaves.

C. A Dependent's Right to Continue Group Health Benefits

If an employee dies, any of his or her Dependents who were covered under the Certificate may elect to continue coverage. Subject to the payment of the required Premium, coverage may be continued until the earlier of:

a) 180 days following the date of the employee's death; or
b) the date the Dependent is no longer eligible under the terms of the Certificate.

Section IX . What Happens If a Provider Bills Me?

Either providers or Members can submit claims. This can be done on paper or electronically. Claims that are submitted electronically are referred to as EDI claims. EDI or Electronic Data Interchange is a form of business to business communication which links the provider's computer system with a data clearinghouse. The clearinghouse then forwards the information to Oxford's computer systems to be processed.

1. FILING A CLAIM

Written notice of sickness or injury must be given to us within 20 days after it occurs. Failure to provide such notice will not reduce or invalidate your claim had it not been reasonable for you to provide such notice. Notifications that are received outside this timeframe may require proof that you notified us of such loss within the shortest amount of time that was reasonably possible.

If you receive Covered Services from a Non-Network Provider, you must complete a claim form, sign it, and send it to Us with the original, itemized bill(s). Only original bills will be considered. Itemized bills should contain:

- Patient name
- Type of service
- Name and address of provider making the charge
- CPT-4 codes or HCPCS codes (description of services)
- Date of service
- Individual charge for each service
- ICD-9 codes (diagnosis or symptoms)

Be sure to keep a copy of your claim form and bills for your own records.

Claim forms are available from the Group or from Us by calling the Customer Care telephone number listed on the back of your ID Card. If We do not provide you with a claim form within 15 days after receipt of notice of a sickness or accident, you may still make your claim. Send Us written proof covering the occurrence, character and extent of the loss for which claim is made. Your submission must meet the time requirements for other proofs of loss, as described in this section. Completed forms should be sent to the address listed for "Claims" at the front of this Certificate.

2. PAYMENT OPTIONS

You may request Us to make payment directly to you or to the Non-Network Provider. If you want Us to pay the Non-Network Provider directly (referred to as assignment), you must give the provider a blank claim form to be completed and forwarded with the itemized bill.

If you decide to pay a Non-Network Provider directly, submit the completed claim form with your bill to Us for reimbursement as described above. Although We will generally follow your instructions, We reserve the right to make the final determination.

3. LIMITATIONS

All requests for reimbursement must be made within 90 days of the date Covered Services were rendered. Failure to request reimbursement within the required time will not invalidate or reduce any claim if it was not reasonably possible to provide such proof within the 90-day period. However, such request must be made as soon as reasonably possible thereafter. All reimbursements to Non-Network Providers are subject to Our Out-of-Network Reimbursement Amount unless you were referred to a Non-Network Provider by Us.

4. IF YOU RECEIVE A BILL FROM A NETWORK PROVIDER

The cost of Covered Services provided by Network Providers in accordance with the terms of this Certificate will be billed directly to Us. No claim forms are necessary.

If you should receive a bill from a Network Provider for Covered Services, please contact Us immediately.

5. CLAIM INFORMATION

Complete claims will be paid within 40 days of Our receipt of your written request and within 30 days of your electronic submission. If necessary, Our Claims Department will contact you for more information regarding your claim in order to speed up the processing. If you would like to inquire about the status of a claim, call the telephone number list on the back of your ID Card. Please have the date of service and your ID number ready.

Section X. Summary of Benefits

In order to receive Covered Services under this Certificate, We may require that you pay a set dollar amount (Copayment) or a percentage of charges (Coinsurance) to the provider who supplied the Covered Services. You may also be responsible for meeting a Deductible before coverage under this Certificate is available. In addition, certain other charges may be applied.

The Summary of Benefits outlines all of the applicable cost shares (Copayments, Coinsurance and/or Deductibles) and other similar features of your Plan. It will also list specific limitations on visits, days and dollar amounts for the benefits that are provided by the Plan.

Please check with your Benefits Administrator to make sure you have the most recent documents concerning your coverage under the Plan.

Section XI. General Administrative Policies and Procedures

1. MEDICAL RECORDS: CONFIDENTIALITY AND AUTHORIZATION TO EXAMINE

Your medical records are confidential documents. Access to those records will be limited to persons who need to see them. They will be used to determine appropriate medical care for you, to administer this Plan, and in some cases, to meet state and federal regulatory requirements. Your records will not be released for any other reason without your consent. By participating in the Plan, you agree and authorize Us, Network Physicians, other Network Providers and Non-Network Providers to permit the examination and copying of any portion of your Hospital or medical records, when requested by Us for the reasons discussed above. Additionally, Oxford has the right, without consent of the Member or Group, to review certain documents, including but not limited to; medical records, enrollment records and other information needed to verify services if potential fraud is suspected.

2. COORDINATION OF BENEFITS (COB)

This section describes how Covered Services under the Certificate will be coordinated with those of any other plan that provides benefits to you.

When Coordination of Covered Services Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below. For instance, you may be covered by this Certificate as an employee and by another Plan as a Dependent of your Spouse. If you are covered by more than one Plan, this provision allows Us to coordinate what We pay or provide with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which you are covered.

Definitions

The words shown below have special meanings when used in this provision. Please read these definitions carefully. Throughout this provision, these defined terms appear with their initial letter capitalized.

Allowable Expense - The charge for any Health Care Service, supply or other item of expense for which you are liable when the Health Care Service, supply or other item of expense is Covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this Plan is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

We will not consider the difference between the cost of a private Hospital room and that of a semi-private Hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and appropriate.

When this Plan is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, We will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period - A Calendar Year, or any portion of a Calendar Year, during which a you are covered by this Plan and at least one other Plan and incur one or more Allowable Expense(s) under such plans.

Plan - Coverage with which coordination of benefits is allowed. Plan includes:

- Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
- Group hospital indemnity benefit amounts that exceed $150.00 per day;
- Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

- Individual or family insurance contracts or subscriber contracts;
- Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
- Group or group-type coverage where the cost of coverage is paid solely by you except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
- Group hospital indemnity benefit amounts of $150.00 per day or less;
- School accident-type coverage;
- A State plan under Medicaid.

Primary Plan - A Plan whose benefits for your health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either of the below exist:

- The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
- All Plans which cover you use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Reasonable and Customary - An amount that is not more than the usual or customary charge for the service or supply as determined by Us, based on a standard which is most often charged for a given service by a provider within the same geographic area.

Secondary Plan - A Plan which is not a Primary Plan. If you are covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

Primary and Secondary Plan

We consider each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each claim determination period the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for Medically Necessary and appropriate services or supplies on the basis that Precertification, preapproval, notification or second surgical opinion procedures were not followed.

Order of Benefit Determination Rules

The benefits of the Plan that covers you as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers you as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers you as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers you as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers you as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers you under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

- The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
- If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the plan which covered the other parent for a shorter period of time.
- " Birthday," as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
- If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

- The benefits of the Plan of the parent with custody of the child shall be determined first.
- The benefits of the Plan of the Spouse of the parent with custody shall be determined second.
- The benefits of the Plan of the parent without custody shall be determined last.
- If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Effect on the Benefits of This Plan

In order to determine which procedure to follow it is necessary to consider:

- The basis on which the Primary Plan and the Secondary Plan pay benefits; and
- Whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the provider bills a charge and you may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an " R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a Network Provider, bills a charge, you may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a " Fee Schedule Plan." If you use the services of a Non-Network Provider, the plan will be treated as an R&C Plan even though the plan under which you are covered allows for a fee schedule.

Payment to the provider may be based on a "capitation". This means that the HMO or other plan pays the provider a fixed amount per Member. You are liable only for the applicable Deductible, Coinsurance or Copayment. If you use the services of a Non-Network Provider, the HMO or other plan will only pay benefits in the event of emergency care or Urgent Care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is R&C Plan and Secondary Plan is R&C Plan

The Secondary Plan shall pay the lesser of:

- The difference between the amount of the billed charges and the amount paid by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan and Secondary Plan is Fee Schedule Plan

If the provider is a Network Provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- The amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and you shall not exceed the fee schedule of the Primary Plan. In no event shall you be responsible for any payment in excess of the Copayment, Coinsurance or Deductible of the Secondary Plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a Network Provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

- The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

You shall only be liable for the Copayment, Deductible or Coinsurance under the Secondary Plan if you have no liability for Copayment, Deductible or Coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall you be responsible for any payment in excess of the Copayment, Coinsurance or Deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan

If the provider is a Network Provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- The amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan

If the Primary Plan is an HMO plan that does not allow for the use of Non-Network Providers except in the event of Urgent Care or emergency care and the service or supply you receive from a Non-Network Provider is not considered as Urgent Care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan

If you receive services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

- The amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan

If you receive services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the Deductible, Coinsurance or Copayment imposed by the Primary Plan. You shall not be liable to pay any Deductible, Coinsurance or Copayments of either the Primary Plan or the Secondary Plan.

Primary Plan is an HMO and Secondary Plan is an HMO

If the Primary Plan is an HMO plan that does not allow for the use of Non-Network Providers except in the event of Urgent Care or emergency care and the service or supply you receive from a Non-Network Provider is not considered as Urgent Care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan, except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

3. BENEFITS FOR AUTOMOBILE-RELATED INJURIES

A. Definitions - The following definitions apply to this Section:

i. Automobile-Related Injury means bodily injury sustained by a Member as a result of an accident while occupying, entering into, exiting from or using an automobile. It also means a Member who, as a pedestrian, is injured by an automobile or an object propelled by or from an automobile.

ii. Allowable Expense means a Medically Necessary, Usual, Customary and Reasonable item of expense Covered, at least in part, by this Certificate or PIP.

iii. Eligible Expense means that portion of the expense incurred for treatment of an injury which is Covered under this Certificate without application of any Deductibles or Copayments.

iv. Out-of-State Automobile Insurance Coverage ("OSAIC") means any coverage for medical expenses under an automobile insurance policy other than PIP, including automobile insurance policies issued in another state or jurisdiction.

v. PIP means personal injury protection coverage (specifically those provisions for medical expense coverage) provided as part of an automobile insurance policy issued in New Jersey.

B. Application - When expenses are incurred as the result of an Automobile-Related Injury, and the Member also has coverage under PIP or OSAIC, this section will be used to determine whether this Certificate is primary or secondary to PIP or OSAIC. It will also be used to determine the amount payable, if any, under this Certificate.

C. Determination of Primary or Secondary Coverage - This Certificate is secondary to PIP unless health coverage has been elected as primary by or for the Member. This election is made by the named insured under a PIP policy and affects that person's family members who are not themselves the named insured under another automobile policy. This Certificate may be primary for one Member, but not another, if the persons have separate automobile policies and have made different selections regarding primacy of health coverage.

This Certificate is secondary to OSAIC. However, if the OSAIC contains provisions which make it secondary or excess to this Certificate, then this Certificate will be primary.

If there is a dispute between coverages, this Certificate will pay benefits as if it were primary.

D. Benefits We Will Pay When Primary - If this Certificate is primary to PIP or OSAIC, We will pay benefits for Eligible Expenses in accordance with the terms of this Certificate. Where several health benefit plans are determined to be primary to automobile insurance, this Certificate's Coordination of Benefits rules will apply.

E. Benefits We Will Pay When Secondary - If this Certificate is secondary to PIP, We will pay the lesser of: (a) the remaining uncovered Allowable Expenses after PIP has provided coverage after application of Deductibles and Copayments; or (b) the actual benefits that would have been payable had We been primary to PIP.

F. Medicare - To the extent that this Certificate supplements Medicare coverage, We will be primary to automobile insurance only insofar as Medicare is primary to automobile insurance.

4. WORKERS' COMPENSATION - Injuries and diseases covered under any Workers' Compensation program are excluded from coverage under this Plan.

5. MEDICARE AND OTHER GOVERNMENT PROGRAMS

This Plan is not intended to duplicate any coverage for which Members are, or could be eligible for, such as Medicare or any other federal or state government programs. Any benefits payable under any such programs for Covered Services provided or benefits paid under this Certificate shall be payable to and retained by Us. You agree to complete and submit to Us any documentation reasonably necessary for Us to receive or assure reimbursement under Medicare or any other government programs for which you or your Covered Dependents are eligible.

Benefits for Medicare Eligibles Who are Covered Under this Certificate

1. If your Group has 20 or more employees, any active employee or Spouse of an employee who becomes or remains a member of the Group Covered by this Certificate, after becoming eligible for Medicare due to reaching age 65, will receive the benefits of this Certificate as primary unless such Member elects Medicare as his or her primary coverage. However, the Member must notify Us of the election by signing and submitting to Us an election card which indicates his or her choice. He or she must also pay any required Premium. Any Member who elects Medicare as primary shall not be eligible for coverage under this Certificate as of the date of election.

2. If your Group has 100 or more employees or your group is an association or similar organization which includes an employer with 100 or more employees, any active employee, Spouse of an active employee or Dependent child of an active employee who becomes or remains a member of the Group Covered under this Certificate, after becoming eligible for Medicare due to disability, will receive the benefits of this Certificate as primary unless the Member elects Medicare as his or her primary coverage. However, the Member must notify Us of his or her election by signing an election card which indicates his or her choice. He or she must also pay any required Premium. Any Member who elects Medicare as primary will not be eligible for coverage under this Certificate as of the date of this election.

3. Any Members who are not subject to subsections 1 and 2 of this Section and who are Medicare eligible will receive the benefits of this Certificate as secondary, reduced by any benefits available under Medicare Part B. This applies even if the Member fails to enroll in Medicare or does not claim the benefits available under Medicare.

Medicare Part D

If Medicare Part D has been purchased, We will coordinate benefits with Part D regardless of whether you are subject to subsection 1, 2 or 3.

6. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply those COB rules. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts it needs to pay the claim.

7. FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable monetary value of the benefits provided in the form of services.

8. RIGHT OF RECOVERY

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;
- Insurance companies; or
- Other organizations.

The amount of the payments made includes the reasonable monetary value of any benefits provided in the form of services.

Section XII. General Provisions

1. Entire Agreement. This Certificate, Summary of Benefits, the Agreement, and the individual Enrollment Forms of you and your Covered Dependents, if any, constitute the entire contract between the parties, and as of the effective date, supersede all other agreements between the parties. The Group application will be attached to the Agreement when it is issued. Any and all statements made to Us by the Group and any Subscriber or Covered Dependent will, in the absence of fraud, be deemed representations and not warranties, and no such statement, unless it is contained in a written Enrollment Form for coverage under this Certificate, shall be used in defense of a claim under this Certificate.

2. Form or Content of Certificate. No agent or employee of Us is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by one of Our officers or by amendment to the Agreement signed by the policyholder and Us.

3. Identification Cards. Cards issued by Us to Members pursuant to this Certificate are for identification only. Possession of an identification card confers no right to Covered Services or other benefits under this Certificate. To be entitled to such services or benefits the holder of the card must, in fact, be a Member on whose behalf all applicable Premiums under this Certificate have actually been paid. Any person receiving services or other benefits to which he is not then entitled pursuant to the provision of this Certificate will be liable for the actual cost of such services or benefits.

4. Notice. Any notice required under this Certificate may be given to Us by U.S. Mail, first class, postage prepaid to the address listed on the back of your ID Card. Notice to a Member will be sent to the last address We have for that Member. The Member agrees to provide Us with notice, within 31 days, of any change of address.

5. Interpretation of Certificate. The laws of the State of New Jersey shall be applied to interpretations of this Certificate.

6. Assignment. This Certificate is not assignable by Group without Our written consent. Any benefits under this Certificate are not assignable by any Member without Our written consent. In addition, This Agreement shall not confer any rights or obligations on third parties except as specifically provided herein.

7. Gender. The use of any gender in this Certificate is deemed to include the other gender and, whenever appropriate, the use of the singular is deemed to include the plural (and vice versa).

8. Modifications. By this Certificate, the Group makes Our coverage available to Members who are eligible under the terms of the Certificate. However, this Certificate is subject to amendment, modification, and termination in accordance with this provision, the Agreement or by mutual agreement between Us and Group's Board of Directors without the consent or concurrence of any Member. By enrolling in this Plan, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all its terms, conditions, and provisions.

9. Clerical Error. Clerical error, whether by the Group or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. Further, a clerical error will not entitle a Member to benefits that were not purchased by the Group nor will it be used to deny benefits that were validly purchased by the Group.

10. Policies and Procedures. We may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which Members shall comply.

11. Waiver. The waiver by any party of any breach of any provision of the Agreement will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

12. Termination of the Agreement. The Agreement will continue in effect for the period of time specified in the Agreement, and may be canceled in accordance with the terms of the Agreement.

13. Incontestability. Except as to a fraudulent misstatement: No statement made by the Group or any Member will be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing. No statement made by the Group will be the basis for voiding the Agreement after it has been in force for two years from its effective date.

14. Significant Change in Circumstances. If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Network Providers' personnel or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Network Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

15. Independent Contractors. Network Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Network Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by any Member while receiving care from any Network Provider or in any Network Provider's facility.

16. Legal Action. No action at law or in equity may be maintained against Us for any expense or bill prior to the expiration of 60 days after the proof of loss has been filed in accordance with all applicable protocol as defined in your Member materials and unless brought within three years from the expiration of the time within which proof of loss is required under this Certificate.

17. Right to Review. Oxford reserves the right and opportunity to examine any Member at a time and within a frequency determined by Us to be appropriate during the pending of a claim submitted for reimbursement under this Certificate. This right includes the right and opportunity to request an autopsy in case of death where it is not prohibited by law.

18. Administrative Fees. Oxford does not prohibit Pharmacies from charging Members who have outpatient prescription drug coverage, for services that are in addition to charges for the drug, for dispensing the drug or for prescription counseling. Services for which additional charges may be imposed are subject to approval by the Board of Pharmacy and must be disclosed to all Members. A pharmacy shall not impose any additional charges for patient counseling or for other services required by the Board of Pharmacy or state or federal law.

19. Issuance of Certificates: Oxford will issue for delivery to employers, policyholders, or other person or association whose name such policy is issued, benefit information for delivery to each employee or member. Such information will be delivered in a manner that is required pursuant to applicable law and will be in the form of a Certificate which includes a Summary of Benefits and all supplemental riders in a manner that is required pursuant to applicable law.

20. Hold Harmless. Network Providers have contractually agreed that Members will not be held financially liable for any sums owed to Network Providers for Covered Services (with the exception of required Copayments, Coinsurance and Deductibles) in the event that We fail to pay for Covered Services.

21. Application of Deductibles, Limitations and Maximums. Calculations of annual Deductibles, benefit limitations, Out-of-Pocket Maximums and lifetime maximums under this plan, will take into consideration as applicable payments made by you and benefits provided by Us and/or Our affiliate, Oxford Health Insurance, Inc. (collectively “Oxford”), pursuant to any Agreement between Group and Oxford.

Section XIII. Living Wills and Advance Directives

You have the right to participate in decisions relating to your health care. Working with your doctor, you can decide whether to accept or reject proposed medical treatments. That right extends to situations where, because of your medical condition, you are unable to communicate with your doctor or the Hospital. This is done by the creation of an advance directive.

An advance directive is a written, signed document that provides instructions for your care if you are unable to communicate your wishes directly. Depending on the state where you reside or are receiving treatment, the most common forms of advance directives are living wills and durable powers of attorney. These documents instruct your health care providers how to proceed if you are not able to communicate with them.

If you decide to execute an advance directive you should notify all of your regular providers and a copy of the item should be placed in your medical files. In addition, you should have some way of notifying police and emergency medical personnel that you have made an advance directive. For example, you may want to keep a card in your wallet or purse.

You are not required to make an advance directive. If you do decide to make one, please note that you are free to amend or cancel it at any time.

Section XIV. Member Rights and Responsibilities

WHAT ARE MY RIGHTS AS A MEMBER?

As a Member you have the following rights:

1. The right to obtain complete and current information concerning a diagnosis, treatment and prognosis from any Network Provider in terms that you or your authorized representative can readily understand. You have the right to be given the name, professional status and function of any personnel delivering Covered Services to you.

   You also have the right to receive all information from a Network Provider necessary for you to give your informed consent prior to the start of any procedure or treatment.

   Finally, You have the right to refuse treatment to the extent permitted by law. We and, when appropriate, the Network Provider will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended treatment and We and the Network Provider believe no professionally acceptable alternative exists, We will not be responsible for the cost of further treatment for that condition. You will be notified accordingly.

   If a Member is not capable of understanding any of this information, an explanation will be provided to his or her guardian, designee or a family member.

2. The right to be provided with information about Our services, policies, procedures, Complaint and appeal procedures and Our Network Providers that accurately provides relevant information in a manner that is easily understood. This means you have a right to and will be provided with; a Certificate, a Summary of Benefits, any applicable riders and a directory of Network Providers. Upon request, you may receive a listing of Our Network Providers who accept Members who do not speak English.

3. You have the right to be informed of changes in benefits, services or Our provider network on a timely basis.

4. The right to quality health care services, provided in a professional manner that respects your dignity and protects your privacy. You also have the right to participate in decision-making regarding your health care.

5. You have the right to formulate an Advance Directive.

6. The right to privacy and confidentiality of your health records, except as otherwise provided by law or contract. You have the right to all information contained in your medical records unless access is specifically restricted by the attending Physician for medical reasons.

7. The right to initiate disenrollment from the Plan.

8. The right to file a formal appeal if Complaints or concerns arise about Our medical or administrative services or policies. You also have the right to file a complaint with the New Jersey Department of Banking and Insurance and to receive an answer to those complaints within a reasonable period of time.

9. You have, when Medically Necessary, the right to medical services without unnecessary delay. This includes Emergency Care and Urgent Care 24 hours a day, seven days a week.

10. You have the right to be advised if any of the Network Providers participating in your care propose to engage in or perform human experimentation or research affecting your care or treatment. You or a legally responsible party on your behalf may, at any time, refuse to participate in or to continue in any experimentation or research program to which you have previously given informed consent.

11. You have the right to be free from "balance billing" by Our Network Providers. However, you are responsible for any applicable cost share.

12. The right to sign-language interpreter services in accordance with applicable laws and regulations, when such services are necessary to enable you as a person with special communication needs to communicate effectively with your provider.

    Should you have any difficulty in arranging for such services, please contact your Oxford Customer Care associate. We can also arrange for TTY services. To receive payment for said service(s), please have your provider mail Oxford an invoice from the translation service.

13. The right, upon request, to be promptly informed if a Network Physician is board certified and whether a Network Physician is currently accepting new patients.

14. The right, upon request, to be provided with information about the provider network, including hospital affiliations.

WHAT ARE MY RESPONSIBILITIES?

Your Responsibilities Include:

1. To enter into this Plan with the intent of following the policies and procedures as outlined in this Certificate.

2. To take an active role in your health care through maintaining good relations with Network Providers and following prescribed treatments and guidelines.

3. To provide, to the extent possible, information that professional staff needs in order to care for you as a Member.

4. To use the emergency room for Medical Emergencies only as described in this Certificate.

5. To notify the proper Plan representative of any change in name, address or any other important information.

Section XV. Information Available to Members Upon Request

As an Oxford Member, you automatically receive a Certificate, a Summary of Benefits and a directory of Network Providers. The directory of Network Providers is a tool to assist you in locating Network Providers should you chose to obtain services from them. Upon your written request, Oxford will furnish you with the following additional information.

- Our Annual Report which contains: a list of the names, business addresses and official positions of Our Board of Directors, officers, controlling persons, and owners;

- Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements;

- A description of Our procedures for maintaining confidentiality of medical records and other enrollee information;

- A copy of Our Medical Policy regarding an experimental or investigational drug, medical device or treatment in qualifying Clinical Trials;

- A copy of Our Medical Policy regarding a specific disease or course of treatment. You may also request how this information, and any applicable Utilization Review guidelines, may be used during the Utilization Review process.

To obtain Medical Policy information, please send Us a letter indicating the information you require. Please address your letter to: Policy Requests and Information, 4 Research Dr. Shelton, CT 06484.

Please note: requests for Medical Polices are limited to two per letter and must relate to a valid need on your part to assess your coverage under this Certificate.

For all other information requests please contact Us at the number on the back of your ID Card.

Section XVI. Definitions

Defined terms will appear capitalized throughout the Agreement.

Acute: The sudden onset of disease or injury, or a sudden change in the Member's condition that would require prompt medical attention.

Adverse Benefit Determination: A denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any Utilization Review, as well as a failure to Cover an item or service for which benefits are otherwise provided because We determine the item or service to be Experimental or Investigational, cosmetic, dental rather than medical, excluded as a Pre-existing Condition or due to a rescission of coverage.

Group Enrollment Agreement: The Group Enrollment Agreement between Oxford Health Insurance, Inc. and the Group including this Certificate, any riders, and attachments.

Alternate Facility: a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:
- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

Ambulatory Surgical Centers: A facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Autism Spectrum Disorder: a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Behavioral Interventions Based on ABA - interventions or strategies based upon learning theory that are intended to improve socially important behavior of an individual using instructional and environmental modifications that have been evaluated through scientific research using reliable and objective measurements, including the empirical identification of functional relations between behavior and environmental factors. Behavior intervention strategies based on ABA include, but are not limited to:

(1) chaining;

(2) functional analysis;

(3) functional assessment;

(4) functional communication training;

(5) modeling, including video modeling (also known as imitation training);

(6) procedures designed to reduce challenging and dangerous behaviors (e.g. differential reinforcement, extinction, time out, and response cost);

(7) prompting; and

(8) reinforcement systems, including differential reinforcement, shaping and strategies to promote generalization

Biologically Based Mental Illness: a condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizo-affective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; and pervasive developmental disorder or autism.

Calendar Year: January 1st through December 31st.

Certificate: This Certificate of Coverage issued by Oxford Health Insurance, Inc., the Summary of Benefits and any attached riders.

Civil Union Partner/Partnership: An individual who is a partner in a civil union. A "civil union" is defined as, the legally recognized union of two eligible individuals, of the same sex, established pursuant to (or otherwise compliant with) New Jersey law. A civil union also includes relationships entered into under the laws of other jurisdictions provided such relationships provide substantially all of the rights and benefits of marriage.

Clinical Peer Reviewer: For internal UR appeals, a Clinical Peer Reviewer is either:

- a Physician with a current and valid non-restricted license to practice medicine; or
- a health care professional (other than a licensed Physician) with a current and valid non-restricted license, certificate or registration or, who is appropriately credentialed. This health care professional must be in the same profession and same or similar specialty as the provider who typically manages the medical condition or disease, or provides the Health Care Service or treatment under review.

For external UR appeals, a Clinical Peer Reviewer is either:

- a Physician who meets the following criteria:
    - possesses a current and valid non-restricted license to practice medicine, and where applicable, is board certified or board eligible in the same or similar specialty as the provider who typically manages the medical condition or disease, or provides the Health Care Service or treatment under appeal; and
    - has been practicing in such area of specialty for a period of at least five years and is knowledgeable about the Health Care Service or treatment under appeal.
- a health care professional (other than a licensed Physician) who:
    - has a current and valid non-restricted license, certificate or registration (if applicable); and
    - is credentialed by the national accrediting body (if applicable) appropriate to the profession and is in the same profession and same or similar specialty as the provider who typically manages the medical condition or disease or provides the Health Care Service or treatment under appeal; and
    - has been practicing in such area of specialty for a period of at least five years and is knowledgeable about the Health Care Service or treatment under appeal; and
    - is clinically supported by a Physician who possesses a current and valid non-restricted license to practice medicine (as applicable).

Clinical Trial: A peer-reviewed study plan which has been reviewed and approved by a qualified institutional review board, and approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or an NIH center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the U.S. Department of Veteran Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by NIH for center support grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

As used in this section, the term "cooperative groups" means formal networks of facilities that collaborate on research projects and have established NIH-approved peer review programs operating within their groups; and that include, but are not limited to, the National Cancer Institute (NCI) Clinical Cooperative Groups, the NCI Community Clinical Oncology Program (CCOP), the AIDS Clinical Trials Groups (ACTG), and the Community Programs for Clinical Research in AIDS (CPCRA).

Coinsurance: The percentage of Charges for Covered Services that you are required to pay a provider once you have met your Deductible.

Complaint: An expression of dissatisfaction with any aspect of Our operations or a Network Provider's business operations, activities or behavior regardless of whether any remedial action is required.

Contract Year: That 12-month period commencing on the effective date of the Agreement or any anniversary date thereafter, during which the Agreement is in effect.

Copayment: The amount you are required to pay directly to a Network Provider at the time Covered Services are rendered.

Cover, Covered or Covered Services: Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Service in this Certificate under Section V: Covered Services and in the Summary of Benefits.
- Not otherwise excluded in this Certificate under Section VI: Exclusions and Limitations.

Covered Dependents: Dependents, as defined in this Certificate, who are Members.

Deductible: The Deductible is the amount of dollars in claims for Covered Services you are responsible for before coverage under this Certificate is available.

Dependents: Your Spouse, and children as described in the "Eligibility" section of this Certificate.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Specialty Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Specialty Pharmacy.

Detoxification Facility: A health care facility licensed by the State of New Jersey as a Detoxification Facility for the treatment of alcoholism.

Developmental Disability- a severe, chronic disability of a person which:

(1) is attributable to a mental or physical impairment or combination of mental or physical impairments;

(2) is manifested before age 22;

(3) is likely to continue indefinitely;

(4) results in substantial functional limitations in three or more of the following areas of major life activity, that is, self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living or economic self-sufficiency; and

(5) reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

Disabling Condition or Disease: A condition or disease which, according to the current diagnosis of your Physician, is consistent with the definition of "disabled person" pursuant to the social services law.

Durable Medical Equipment: Durable Medical Equipment is equipment which: (a) is designed and intended for repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) is generally not useful to a person in the absence of disease or injury; and is appropriate for use in the home.

Enrollment Date: The Enrollment Date is the Member's first day of coverage with the Group. (i.e. the date the member first became Covered under healthcare coverage offered through the Group including any waiting period, which may or may not be the same date as the Effective Date of coverage under this plan.)

Enrollment Form: Our form which Members must complete to enroll in the Plan.

Experimental and Investigational Treatment Review Plan: A description of the process for developing the written clinical review criteria used in rendering an Experimental and Investigational treatment review determination. The Experimental and Investigational Treatment Review Plan also includes a description of the qualifications and experience of the Clinical Peers who developed the criteria, who are responsible for periodic evaluation of the criteria, and who use the written clinical review criteria in the process of reviewing proposed Experimental and Investigational Health Care Services.

External Appeal: An appeal conducted by an External Appeal Agent.

External Appeal Agent: An entity certified by the State of New Jersey to conduct External Appeals.

Family Cost Share: The New Jersey Early Intervention System (NJEIS) Family Cost Share is a progressive co-payment per hour of direct services provided in accordance with an Individualized Family Service Plan (IFSP) that is based upon family size and NJEIS determined income along the federal poverty level guidelines.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination which has been upheld by Us at the completion of the appeals process, an Adverse Benefit Determination to which We have, in any way, waived Our rights to an internal review of the appeal, and an Adverse Benefit Determination for which a Member or provider has applied for an expedited External Appeal at the same time as applying for an expedited internal appeal.

Generally Accepted Standards of Medical Practice: standards that are based on:

- credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
- Physician and health care provider specialty society recommendations;
- the views of Physicians and health care providers practicing in relevant clinical areas; and
- any other relevant factor as determined by the commissioner by regulation.

Group: The employer or party that has entered into an Agreement with Us.

Group Open Enrollment Period: A period of time, established by the Group and Us, during which eligible persons may be enrolled. Your employer or plan sponsor will have the dates for each period.

Health Care Service: For purposes of UR determinations and appeals, Health Care Service includes health care procedures, treatments, services, Prescription Drugs, or Durable Medical Equipment. Additionally, for purposes of External Appeals, Health Care Services are Experimental or Investigational procedures, treatments or services, including the following (to the extent the services are prohibited from being excluded under the Plan):

- services provided within a qualifying Clinical Trial, and
- the provision of a Prescription Drug for a use other than those uses which have been approved for marketing by the federal Food and Drug Administration.

A Health Care Service is not necessarily a Covered Service under this Plan.

Homebound: A Member will be considered to be "Homebound" if he or she has a condition due to an illness or injury which restricts his or her ability to leave their place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs and walkers; the use of special transportation; or the assistance of another person. Additionally, a Member will be considered Homebound if the Member has a medical condition where leaving the home is medically contraindicated.

Home Health Care Agency: An organization currently certified or licensed as a home health care agency by the State of New Jersey.

Hospital: An institution rendering inpatient and outpatient services for the medical care of the sick or injured. It must be accredited as a Hospital by either the Joint Commission on Accreditation of Health Care Facilities or the Bureau of Hospitals of the American Osteopathic Association. A Hospital may be a general, Acute care, or a specialty institution, provided that it is appropriately accredited as such, and currently licensed by the proper state authorities.

Individualized Family Service Plan (IFSP): The IFSP is both a plan and a process. The plan is a written document that identifies the outcomes, services and supports needed for the child and family. The process is ongoing assessment to gather, share, and exchange information between the family and the early intervention practitioners to help parents make informed choices about early intervention services and other needed services for the child and family.

Intermediate Care: Mental Health or Substance Use Disorder treatment that encompasses the following:

- Care at a Residential Treatment Facility.
- Care at a Partial Hospitalization/Day Treatment program.
- Care through an Intensive Outpatient Treatment program.

Intensive Outpatient Treatment: a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Life-Threatening Condition or Disease: A condition or disease which, according to the current diagnosis of your Physician, has a high probability of causing your death.

Major Diagnostic Procedures: Major Diagnostic Procedures are procedures requiring the use of Magnetic Resonance Imaging, Positron Emission Tomography, Computerized Axial Tomography, Nuclear Imaging or diagnostic services performed inpatient or outpatient at a Hospital, Ambulatory Care Facility, or facility other than Physician's office.

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 lay person, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate attention could result in: (a) placing the health of the Member (or, with respect to a pregnant woman, the health of the woman or the unborn child) in serious jeopardy; (b) serious impairment to bodily functions; (c) serious dysfunction of a bodily organ or part; or (d) serious disfigurement of such Member. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to affect 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. Some examples of a Medical Emergency include, but are not limited to, the following conditions:

- Severe chest pains
- Severe shortness of breath
- Severe or multiple injuries
- Loss of consciousness
- Convulsions
- Severe bleeding
- Poisonings
- Sudden change in mental status (e.g., disorientation)
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis

Medically Necessary: Health Care Services that a health care provider, exercising his prudent clinical judgment, would provide to a Member for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is in accordance with the Generally Accepted Standards of Medical Practice:

- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Member's illness, injury or disease;
- not primarily for the convenience of the Member 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 Member's illness, injury or disease.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: Subscribers and Covered Dependents for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to an appeal or Complaint or emergency room visit or admission, "Member" also means the Member's designee.

Mental Health Services: Covered Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Service.

Mental Illness: those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Certificate. Mental Illness includes Biologically Based Mental Illness as defined by New Jersey State Law.

Network Physician: A Physician who, at the time of providing Covered Services, is contracted with Us to provide Covered Services to Members.

Network Provider: A Physician, Certified Nurse Midwife, Hospital, Skilled Nursing Facility, Home Health Care Agency, or any other duly licensed or certified institution or health professional under contract with Us to provide Covered Services to Members. A list of Network Providers and their locations is available to you upon enrollment or upon request. The list will be revised from time to time by Us.

Non-Network Provider: A person or entity that does not have a contract with Us to provide Covered Services to Members.

Network Specialist: A Network Provider who has limited his or her practice to certain areas of medicine, and who is contracted with Us to provide Covered Services to Members. A list of Network Specialists and their locations is available to you upon enrollment or upon request.

New Jersey Early Intervention System (NJEIS): The New Jersey Early Intervention System (NJEIS), under the Division of Family Health Services, implements New Jersey's statewide system of services for infants and toddlers, birth to age three, with developmental delays or disabilities, and their families. The Department of Health and Senior Services is appointed by the Governor as the state lead agency for the NJEIS.

The New Jersey Early Intervention System (NJEIS), under the Division of Family Health Services, implements New Jersey's statewide system of services for infants and toddlers, birth to age three, with developmental delays or disabilities, and their families. The Department of Health and Senior Services is appointed by the Governor as the state lead agency for the NJEIS.

Non-Occupational Disease or Non-Occupational Injury: A disease or injury that does not:

1. Arise out of (or in the course of) any work for pay or profit; or

2. Result in any way from an injury that does.

Out-of-Network Reimbursement Amount: The Out-of-Network Reimbursement Amount is the maximum allowable reimbursement for the medical service, supply or pharmaceutical. The maximum allowed amount will be the lesser of:

- the amount charged;
- the Fee(s) that are negotiated with the provider;
- If fee(s) have not been negotiated with the provider;
    - a percentile of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or
        - When a rate is not published by CMS for the service, We use an available gap methodology to determine a rate for the service as follows –
            - For services other than Physician-administered pharmaceuticals, We use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by FAIR Health, Inc. (“FAIR”). If the FAIR relative value scale becomes no longer available, We will use a comparable scale.
            - For Physician-administered pharmaceuticals, We use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or Us based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a Physician-administered pharmaceutical or We decide that special circumstances support an upward adjustment to the other pricing methodology.
    - When there is not an available or applicable CMS rate and a gap methodology does not apply to the service, the Out-of-Network Reimbursement Amount is based on 50 percent of the provider’s billed charge.

We update Out-of-Network Reimbursement Amounts on a regular basis when updated data from CMS becomes available. Updates to the Out-of-Network Reimbursement Amount are typically implemented within 30 to 90 days after CMS updates its data.

There may be times when you receive Network Benefits from a Non-Network Provider, such as in an emergency situation or when Our Medical Director determines that a Network Provider is not available. In such cases, if a negotiated rate is not available, We will seek to reimburse the Non-Network Provider using the Out-of-Network Reimbursement Amount. If the Non-Network Provider seeks to charge more and bills you for a Network service, call Our [1][Customer Care Department] using the toll-free phone number on your identification card. Tell Us the claim number and that you are being "balance billed". You are only financially responsible to pay your applicable in-network cost-share as shown on your Summary of Benefits and We will resolve the billing issue with the Non-Network Provider.

Out-of-Pocket Maximum: The Out-of-Pocket Maximum limits the amount of Copayments, Coinsurance and Deductible you will pay in any Calendar or Contract Year. Once the Out-of-Pocket Maximum has been reached, We pay 100% of Covered Services for the remainder of that year, with the exception of Outpatient Prescription Drug costs. Once the Out-of-Pocket Maximum has been met, you will still be responsible for Outpatient Prescription Drug costs as outlined in your Summary of Benefits.

Partial Hospitalization/Day Treatment: a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Physician: A currently licensed doctor of medicine or osteopathy.

Please Note: Any audiologist, podiatrist, dentist, psychologist, chiropractor, chiropodist, optometrist, nurse midwife, physical therapist, psychologist, registered professional nurse, speech-language pathologist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that We describe a provider as a Physician does not mean that benefits for services from that provider are available to you under this Certificate.

Plan: Coverage under the Group's health benefits program as provided under this Certificate by Oxford Health Insurance, Inc.

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

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

Precertification: An authorization given by Us that you must receive before you can obtain certain Covered Services. We indicate which Covered Services require Precertification in the "Covered Services" section of this Certificate as well as in your Summary of Benefits.

Precertify/Precertified: The process of obtaining Precertification.

Pre-existing Condition: For a Member age 19 or older, a Pre-existing Condition is a physical or medical condition (regardless of the cause of the condition); for which treatment, diagnosis or medical advice was actually recommended or received within the prior six months ending on the Enrollment Date. Individuals who are enrolled under the Plan or Prior Continuous Creditable Coverage within 30 days of birth are not subject to the Preexisting Condition Limitation exclusion.

In the absence of a diagnosis of a condition related to such information, genetic information will not be treated as Pre-existing Condition. Pregnancy is not a Pre-existing Condition.

Premium: The total payment made, including any contributions by Subscribers, by the Group to Us for coverage.

Primary Care Physician: A Network Physician who provides initial care and basic medical services and is listed in Our directory of Network Providers as a Primary Care Physician.

Prior Continuous Creditable Coverage:

1. Group health plans (including self-funded plans); health insurance coverage (including individual policies);

2. Insured and non-insured public health plans including plans established or maintained by a state or the federal government (including S-Chip plans, state high risk pools, Indian Health Service or tribal organization programs, a health benefit plan under Section 5(e) of the Peace Corps Act, Medicare Part A and Part B and Medicaid); and public health plans established and maintained by a foreign country or political subdivision;

3. Military or veterans benefits;

are all “creditable” coverage.

Creditable coverage is “continuous” only if the gap between the new coverage and the prior coverage is less than 63 days. Therefore, if there is a gap of 63 or more days between the prior creditable coverage and new coverage, the prior creditable coverage is not “continuous.” The Member does not receive credit for their prior creditable coverage.

Rare Disease: A Life-Threatening Condition or Disease or Disabling Condition or Disease that:

- is currently or has been subject to a research study by the NIH Rare Diseases clinical research network or affects fewer than two hundred thousand United States residents per year, and
- for which there does not exist a standard health service or procedure Covered by the health care plan that is more clinically beneficial than the requested health service or treatment.

A Physician, other than your treating Physician, must certify in writing that the condition is a Rare Disease. The certifying Physician must be a licensed, board-certified or board-eligible Physician who specializes in the area of practice appropriate to treat the Rare Disease. The certification must provide either:

- that your Rare Disease is currently or has been subject to a research study by the NIH Rare Diseases clinical research network; or
- that your Rare Disease affects fewer than two hundred thousand United States residents per year.

The certification must rely on medical and scientific evidence to support the requested health service or procedure, if such evidence exists, and must include a statement that, based on the Physician's credible experience, there is no standard treatment that is likely to be more clinically beneficial than the requested health service or procedure and the requested health service or procedure is likely to benefit you in the treatment of the Rare Disease and that such benefit outweighs the risks of such health service or procedure. The certifying Physician must disclose any material financial or professional relationship with the provider of the requested health service or procedure as part of the application for External Appeal of denial of a Rare Disease treatment. If the provision of the requested health service or procedure at a health care facility requires prior approval of an institutional review board, you or your Designee must also submit such approval as part of the External Appeal application.

Referral: An authorization given to one Network Provider from another Network Provider (usually from a PCP to a Network Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by completing a paper Referral Form.

Rehabilitation Facility: A currently licensed and accredited facility which primarily provides physical therapy treatment. Such facilities must be contracted with Us in order for Members to receive Covered Services.

Related Structured Behavioral Programs - services delivered by a qualified practitioner that are comprised of multiple intervention strategies (that is, behavioral intervention packages) based upon the principles of ABA. These packages may include but are not limited to:

(1) activity schedules;

(2) discrete trial instruction;

(3) incidental teaching;

(4) natural environment training;

(5) picture exchange communication system;

(6) pivotal response treatment;

(7) script and script-fading procedures; and

(8) self-management

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with subdivision ten of section 1.03 of the mental hygiene law.

- It provides a program of treatment under the active participation and direction of a Physician and approved by Us.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Retrospective Review: A review of services after such services have already been provided. We may reverse Our determination of a Precertified service, treatment or supply after Retrospective Review only when:

- the relevant medical information presented to Us upon Retrospective Review is materially different from the information that was presented during the Precertification review; and
- such relevant information presented to Us existed at the time of the Precertification but was withheld from or not made available to Us; and
- We were not aware of the existence of the information at the time of the Precertification review; and

had We been aware of the information, the service, treatment or supply that was requested would not have been Precertified. This determination will be made using the same specific standards, criteria or procedures as were used during the Precertification review.

Service Area: The geographical area, designated by Us and approved by the State of New Jersey, in which an individual must live or work in order to be eligible to enroll.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare law; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist Physician: A fully licensed Physician who:
1. Is a diplomat of a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association;
2. Is a fellow of the appropriate American specialty college or a member of an osteopathic specialty college;
3. Is currently admissible to take the examination administered by a specialty board approved by the America Board of Medical Specialties or the Advisory Board of the American Osteopathic Association, or has evidence of completion of an appropriate qualifying residency approved by the American Medical Association or American Osteopathic Association;
4. Holds an active staff appointment with specialty privileges in a voluntary or governmental Hospital which is approved for training in the specialty in which the Physician has privileges; or
5. Is recognized in the community as a specialist by his or her peers.

Specialized Rehabilitation Facility: A Hospital or other facility that is certified by the State of New Jersey for the treatment of alcohol or drug dependent individuals, respectively. It provides nursing, medical counseling and therapeutic services to such individuals according to individualized treatment plans. Such facilities must be contracted with Us in order for Members to receive in-network Covered Services. Transitional living facilities are excluded from this definition.

Spouse: A person's partner (husband or wife) in a legal marriage. For purposes of Dependent eligibility under this Certificate, Spouse includes same sex partners who are married in jurisdictions that recognize same sex marriages. It also includes Civil Union Partners as defined by, and in accordance with New Jersey law and the valid laws of another jurisdiction under which a civil union relationship was created.

Subscriber: An employee or member of the Group 1) who meets all applicable eligibility requirements of this Certificate, 2) whose Enrollment Form has been accepted by Us, and 3) on whose behalf the Group has paid any applicable Premium.

Substance Use Disorder Services: Covered Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Service.

Totally Disabled: A Subscriber who is prevented because of injury or disease from performing their regular or customary occupational duties and is not engaged in any work or other gainful activity for pay or profit. A Covered Dependent, who is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

Urgent Care: Urgent Care is medical care for a condition that needs immediate attention to minimize severity and prevent complications, but is not a Medical Emergency. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent Care Center: A licensed facility (except a Hospital), which provides Urgent Care.

Urgent Care Claim: Any claim for medical care or treatment with respect to which application of the time periods for making non-urgent determinations, in the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or that, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Utilization Review (UR): The review to determine whether Health Care Services that have been provided (Retrospective), are being provided (Concurrent) or are proposed to be provided (Precertification) are Medically Necessary.

UR Plan: A UR Plan includes the following:

- a description of the process for developing the written clinical review criteria;
- a description of the types of written clinical information We might consider in Our review, including but not limited to, a set of specific written clinical review criteria;
- a description of the practice guidelines and standards We use in carrying out a determination of Medical Necessity;
- the procedures for scheduled review and evaluation of the written clinical review criteria; and
- a description of the qualifications and experience of the health care professionals who developed the criteria, who are responsible for periodic evaluation of the criteria and of the health care professionals or others who use the written clinical review criteria in the process of Utilization Review.

Us, We, Our: Oxford Health Insurance, Inc.

[1] The correct name will appear here.

OXFORD HEALTH INSURANCE, INC.

Gender Dysphoria Amendment

Your Certificate of Coverage has been modified as follows:

1. Section V, Covered Services, Subsection 2 has been amended by adding the following:

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under *Mental Health Services* in your *Certificate*.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is described under *Pharmaceutical Products - Outpatient* in your *Certificate*.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided as described in the *Outpatient Prescription Drug Rider,* if purchased by your Group.
  - Puberty suppressing medication is not cross-sex hormone therapy.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment of Gender Dysphoria, including the surgeries listed below.

  Male to Female:

  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)

  Female to Male:

  - Bilateral mastectomy or breast reduction
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of male urethra)

- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

2. The exclusion for Sex Transformations in Section VI. Exclusions and Limitations of the Certificate, has been deleted.

3. Definitions

The following definition of Gender Dysphoria is added to the Certificate under Section XVI. Definitions:

Gender Dysphoria - a disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association:*

- *Diagnostic criteria for adults and adolescents:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- *Diagnostic criteria for children:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.

- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
- In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
- A strong dislike of ones' sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

4. Miscellaneous Provisions

This Amendment forms a part of the Agreement between the Group and Us. Unless otherwise agreed to in writing between the Group and Us, this Amendment becomes effective on the date the Agreement becomes effective.

This Amendment supersedes any amendment or rider providing coverage for treatment of Gender Dysphoria previously issued by Us. In the event of a conflict between the provisions of this Amendment and the Certificate, the provisions of this Amendment will prevail. All other terms and conditions of the Certificate remain in full force and effect.

Nothing contained in this Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

Oxford Health Insurance, Inc.
Out-of-Network Reimbursement Amendment

Your Certificate of Coverage has been modified as follows:

In Section XVI, Definitions, the definition of Out-of-Network Reimbursement Amount is deleted and replaced with the following:

Out-of-Network Reimbursement Amount: The Out-of-Network Reimbursement Amount is the maximum allowable reimbursement for the medical service, supply or pharmaceutical. The maximum allowed amount will be

- The negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
- If rates have not been negotiated, then the lesser of:
    - the amount charged;
    - a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market,
    - When a rate is not published by CMS for the service, We use an available gap methodology to determine a rate for the service as follows –
        - For services other than Physician-administered pharmaceuticals, We use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by FAIR Health, Inc. ("FAIR"). If the FAIR relative value scale becomes no longer available, We will use a comparable scale.
        - For Physician-administered pharmaceuticals, We use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or Us based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a Physician-administered pharmaceutical or We decide that special circumstances support an upward adjustment to the other pricing methodology. When there is not an available or applicable CMS rate and a gap methodology does not apply to the service, the Out-of-Network Reimbursement Amount is based on 50 percent of the provider's billed charge.
    - For Mental Health Services and Substance Use Disorder Services the Out-of-Network Reimbursement Amount will be reduced by 25% for Covered Services provided by a psychologist and by 35% for Covered Services provided by a masters level counselor.

We update Out-of-Network Reimbursement Amounts on a regular basis when updated data from CMS becomes available. Updates to the Out-of-Network Reimbursement Amount are typically implemented within 30 to 90 days after CMS updates its data.

There may be times when you receive Network Benefits from a Non-Network Provider, such as in an emergency situation or when Our Medical Director determines that a Network Provider is not available. In such cases, if a negotiated rate is not available, We will seek to reimburse the Non-Network Provider using the Out-of-Network Reimbursement Amount. **You are only financially responsible to pay your applicable in-network cost-share as shown on your Summary of Benefits. Please contact us if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any Deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.**

OXFORD HEALTH INSURANCE, INC.

Benefit Update Rider

Your Certificate of Coverage has been modified as follows:

1. Substance Use Disorder Services

Substance Use Disorder Services under subsection 4. MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES in Section V, Covered Services of your Certificate is deleted and replaced with the following:

Substance Use Disorder Services

For Non-Network Benefits, Precertification is required for Intermediate Care and inpatient admissions. For Network Benefits, Precertification is required for Intermediate Care and Inpatient admissions after the first 180 days of treatment during the plan year.

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Coverage includes the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

Coverage is provided for treatment at Network facilities subject to the following:

- the prospective determination of Medically Necessary is made by the Covered Person’s practitioner for the first 180 days of treatment during each year and for the balance of the year the determination of Medically Necessary is made by Us;
- Precertification is not required for the first 180 days of inpatient and/or outpatient treatment during each year but is required for Intermediate Care and inpatient admissions for the balance of the year;

- Concurrent review and Retrospective Review are not required for the first 28 days of inpatient treatment during each year but concurrent and Retrospective Review may be required for the balance of the year;
- Retrospective Review is not required for the first 28 days of Intermediate Care during each year but retrospective review may be required for the balance of the year;
- Retrospective Review is not required for the first 180 days of outpatient treatment including outpatient prescription drugs, during each year but Retrospective Review may be required for the balance of the year; and
- If no Network facility is available to provide inpatient services, we shall approve an exception and provide benefits for inpatient services at a Non-Network facility.

The Mental Health/Substance Use Disorder Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Please see your Summary of Benefits for applicable cost share information as well as any benefit limitations.

Exclusions & Limitations

- All benefits are subject to the limitations listed in your Summary of Benefits.
- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Substance Use Disorder Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
- Substance Use Disorder Services for the treatment of nicotine or caffeine use.
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by Us.
- Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that are any of the following:
    - Not consistent with Generally Accepted Standards of Medical Practice for the treatment of such conditions.
    - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
    - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
    - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on Generally Accepted Standards of Medical Practice and benchmarks.

  We may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

The following paragraph is added to Part 1 – Utilization Review (UR) Appeals, under Appeals and Complaints in Section III. Initial Coverage Determination Timeframes and Appeals and Complaints Processes:

If a decision is made that continued inpatient care in a Network facility for Substance Use Disorder Services is no longer Medically Necessary and you disagree with the decision, you and/or your physician can request an expedited internal appeal. Within 24 hours of receipt of your expedited internal appeal request, we will review, make a determination and communicate the determination to you and your physician. If the determination is to uphold the denial, you and/or your physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program in the Department of Banking and Insurance. An independent utilization review organization shall make a determination within 24 hours. If Our determination is upheld and it is determined continued inpatient care is not Medically Necessary, We will remain responsible to provide benefits for the inpatient care through the day following the date the determination is made and the covered person will be responsible for any applicable Copayment, Deductible and Coinsurance for the stay through that date as applicable under the policy. For any costs incurred after the day following the date of determination until the day of discharge, you will be responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

2. Treatment of Infertility

Treatment of Infertility in Section V. Covered Services of your Certificate is deleted and replaced with the following:

Treatment of Infertility

***Precertification is required for this benefit.**

I. Covered Benefits

OHI will cover Medically Necessary expenses incurred in the diagnosis and treatment of infertility.

Covered services include, **but are not limited to**:

- Diagnosis and diagnostic testing
- Medications
- Surgery, including microsurgical sperm aspiration
- Ovulation induction
- Gamete intra fallopian transfer (GIFT)
- Medical costs of egg and sperm donors, including office visits, medications, laboratory and radiology procedures and retrieval until the donor is released from treatment by the reproductive endocrinologist.
- Medical expenses for Gestational Carriers, including office visits, medications, laboratory and radiology procedures and any complications until she is released from treatment by the reproductive endocrinologist.

Coverage for is limited to Members who:

- have used all reasonable, less expensive and medically appropriate treatments (and have not been able to become pregnant or carry a pregnancy);
- have not reached the limit of four completed egg retrievals; and
- are 45 years of age or younger.

All services must be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

Conditions of Coverage:

1. The Member seeking services must be infertile. Applicable New Jersey State law defines infertility as follows:

The disease or condition that results in the abnormal function of the reproductive system, as determined pursuant to the *American Society for Reproductive Medicine* practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology or that the patient has met one of the following conditions:
(1) A male is unable to impregnate a female;
(2) A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
(3) A female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;
(4) A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
(5) A female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;
(6) Partners are unable to conceive as a result of involuntary medical sterility;
(7) A person is unable to carry a pregnancy to live birth; or
(8) A previous determination of infertility pursuant to New Jersey state law.

The definition of infertility does not include a person who has been voluntarily sterilized regardless of whether the person has attempted to reverse the sterilization. Services will not be covered for a Member who has successfully reversed sterilization yet is diagnosed as medically infertile (or cannot carry a pregnancy to live birth). However if the partner of such Member is infertile, and is covered under this Plan, that partner is eligible for coverage.

In addition, coverage will only be provided for same sex couples if the Member seeking coverage is diagnosed as infertile as defined above.

2. Members are limited to four completed egg retrievals (and the procedures and treatments associated with such retrievals) while covered under this plan or any plan with the same employer. Unsuccessful completed egg retrievals will count towards the limit. If a live donor is used in the egg retrieval, the medical costs of the donor will also be covered until the donor has been released from treatment by the Reproductive Endocrinologist.

3. In addition to services that generally require Precertification (such as surgical procedures or inpatient admissions), the following services must be Precertified:

- In vitro fertilization (IVF)
- Gamete intrafallopian transfer (GIFT)
- Zygote intrafallopian transfer (ZIFT)
- Microscopic Epididymal Sperm Aspiration (MESA)
- Testicular Sperm Aspiration (TESA)
- Intracytoplasmic sperm injection (ICSI)
- Assisted oocyte fertilization
- Embryo hatching and transfer
- Ovum retrieval
- Medical costs of ovum or sperm donation
- Preimplantation Genetic Diagnosis (PGD)
- Injectible infertility drugs

OHI will reduce benefits by 50% with respect to charges for infertility services which are not Precertified by OHI provided that benefits would otherwise be payable under the plan.

Network Physicians are responsible for obtaining any required Precertification for covered services received in-network. Please feel free to call Us to confirm that Precertification has been obtained.

Exclusions

- Non-Medical costs for an ovum donor or sperm donor.
- Sperm storage costs.
- Cryopreservation and storage of embryos and eggs.
- Ovulation predictor kits.
- In vitro services for woman who have undergone tubal ligation.
- Reversal of tubal ligations.
- Any infertility services rendered to a male if the male has undergone a vasectomy.
- All costs for and relating to surrogate motherhood (exception: if the surrogate mother is a Member, the pregnancy is covered if it would otherwise be covered under the terms and conditions of the Certificate).

Important: Regardless of whether or not the Group has purchased Outpatient Prescription Drug coverage, all outpatient Prescription Drugs used by a Donor or a Gestational Carrier who are not Members of Oxford with Outpatient Prescription Drug Coverage will be covered only if the Donor or Carrier submits the claim directly to Us for reimbursement.

Please see your **Summary of Benefits** for applicable cost share information as well as any benefit limitations.

Definitions

Artificial Insemination: the introduction of sperm into a woman's vagina or uterus by noncotial methods for the purpose of conception, and includes intrauterine insemination.

Assisted Hatching: a micromanipulation technique in which a hole is artificially created in the outer shell of an embryo to assist with the potential implantation of the embryo.

Completed Egg Retrieval: all office visits, procedures and laboratory and radiological tests performed in preparation for oocyte retrieval; the attempted or successful retrieval of the oocyte(s); and if the retrieval is successful, culture and fertilization of the oocyte(s).

Cryopreservation: the freezing of embryos in liquid nitrogen until such time as required for a frozen embryo transfer. Cryopreservation also refers to the freezing of female gametes (ova) and male gametes (sperm).

Egg Retrieval or Oocyte Retrieval: a procedure by which eggs are collected from a woman's ovarian follicles.

Egg Transfer or Oocyte Transfer: the transfer of received eggs into a woman's fallopian tubes through laparoscopy as part of gamete intrafallopian transfer (GIFT).

Embryo: a fertilized egg that has begun cell division and has completed the pre-embryonic stage.

Embryo Transfer: the placement of an embryo into the uterus through the cervix or, in the case of zygote intrafallopian tube transfer (ZIFT), the placement of an embryo in the fallopian tube. Embryo transfer includes the transfer of cryopreserved embryos and donor embryos.

Fertilization: the penetration of the egg by the sperm.

Gamete: a reproductive cell. In a male, gametes are sperm; in a female, gametes are eggs or ova.

Gamete Intrafallopian Transfer (GIFT): the direct transfer of a sperm/egg mixture into the fallopian tube by laparoscopy. Fertilization takes place inside the fallopian tube.

Gestational Carrier: a woman who has become pregnant with an embryo or embryos that are not part of her genetic or biological entity, and who intends to give the child to the biological parents after birth.

Intracytoplasmic Sperm Injection (ICSI): micromanipulation procedure whereby a single sperm is injected into the center of an egg.

Intra Uterine Insemination: a medical procedure whereby the sperm is placed into a woman's uterus to facilitate fertilization.

In Vitro Fertilization (IVF): an ART procedure whereby eggs are removed from a woman's ovaries and fertilized outside her body. The resulting embryo is then transferred into the woman's uterus.

Microsurgical Sperm Aspiration: the techniques used to obtain sperm for use with the intracytoplasmic sperm injection (ICSI) in cases of obstructive azoopsermia. It can involve the extraction of sperm and fluid from epididymal tubules inside the epididymis ("MESA") or the provision of testicular tissue from which viable sperm may be extracted ("TESE").

Oocyte: the female egg or ovum.

Ovulation Induction: the use of drugs (oral or injected) to stimulate the ovaries to develop follicles and eggs.

Pregnancy-Related Benefits: benefits for normal pregnancy and childbirth.

Sexual Intercourse: the sexual union between a male and a female.

Surrogate: a woman who carries an embryo that was formed from her own egg inseminated by the sperm of a designated sperm donor.

Zygote: a fertilized egg before cell division begins.

Zygote Intrafallopian Transfer (ZIFT): a procedure whereby an egg is fertilized in vitro, and the zygote is transferred to the fallopian tube at the pronuclear stage before cell division takes place.

3. Miscellaneous Provisions

This Amendment forms a part of the Agreement between the Group and Us. Unless otherwise agreed to in writing between the Group and Us, this Amendment becomes effective on the date the Agreement becomes effective.

This Amendment supersedes any amendment or rider providing coverage previously issued by Us. In the event of a conflict between the provisions of this Amendment and the Certificate, the provisions of this Amendment will prevail. All other terms and conditions of the Certificate remain in full force and effect.

Nothing contained in this Amendment will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Amendment is attached, other than as specifically stated herein.

Gym Reimbursement

The only thing better than staying in shape is getting reimbursed for it.

Healthier members are happier members.

Starting or staying with an exercise routine isn't always easy. To help you stay motivated and achieve your fitness goals, we provide reimbursement toward fitness center membership fees.[1] You can get reimbursed for going to the gym an average of two to three times per week. We know that staying with an exercise routine isn't always easy, and this can help you stay motivated and healthy.

Note: This reimbursement is not available to all Oxford plan members, including members of any Connecticut plan, and some New York and New Jersey plans. Please refer to your Certificate of Coverage, Summary Plan Description or other governing member document that applies to your plan, for benefit availability.

It's easy. First, select a gym.

To receive reimbursement, you must participate in a gym and/or program that promotes cardiovascular wellness. (Memberships in sports clubs, country clubs, weight loss clinics, spas or other similar facilities are not eligible.) For a gym to be considered eligible, it must provide at least two pieces of equipment or activities that promote cardiovascular wellness from the following list:

- Elliptical cross-trainer
- Group exercise
- Pool
- Rowing machine
- Squash/tennis/ racquetball courts
- Stationary bicycle
- Step machine/climber
- Treadmill
- Walking/running group

How much can you get reimbursed?

Please check your benefits documents or check with your benefits administrator to determine how much you (and your spouse or domestic partner) may be reimbursed.[2]

The reimbursement period begins on the date of your initial visit to the gym and ends six months from that date. Subsequent reimbursement periods begin one day after your previous reimbursement period ended.[3]

You should follow the steps below to receive reimbursement for your fitness participation:

1. **Visit the gym** – You must complete a minimum of 50 visits per six-month period. Reimbursements will not be issued until six months have passed, even if 50 visits are completed sooner than six months.
2. **Collect paperwork** – You need to collect three things: a copy of your current gym bill, showing the monthly cost of your membership; proof of payment for each of the six months you are submitting for reimbursement (i.e., credit card statement, payroll deduction, automatic bank withdrawal, etc.);[4] and a copy of the brochure that outlines the services the gym offers.
3. **Complete the form** – Fill out and submit a Gym Reimbursement Form, which is shown on the reverse side of this page. Remember to provide the dates of your gym visits completed within the six-month period for which you are making a claim. Also, a representative from your gym must sign the form. You can get extra forms from your benefits administrator, from our website oxfordhealth.com or by calling Customer Service at the telephone number on your health plan ID card.
4. **Mail everything** – The Gym Reimbursement Form, along with a copy of your current gym bill, proof of payment and a copy of the gym's brochure, should be submitted within six months (180 days) to the following address:

   Oxford Gym Reimbursement
   P.O. Box 29130
   Hot Springs, AR 71903
   Call the telephone number on your health plan ID card

Important: Please complete the form in its entirety, or the processing of your claim may be delayed or denied. Please complete one form per member, for each six-month period for which you are making a claim.

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[1] Check your Certificate of Coverage, Summary Plan Description or other governing member document to determine eligibility for this reimbursement.

[2] The reimbursement benefit is limited to you and your spouse or domestic partner; no other dependents are eligible. For your spouse or domestic partner to be eligible for this benefit, he or she must also be enrolled in an Oxford product. Reimbursement amounts may vary depending upon your plan. Please refer to your Certificate of Coverage/health benefits plan documents to confirm your policy's benefit.

[3] Please refer to your Certificate of Coverage, Summary Plan Description or other governing member document to confirm your policy's benefit and for applicable filing deadlines. Claim must be filed upon completion of the six-month period being submitted in order to obtain reimbursement.

[4] On your proof of payment, please be sure to cross out your personal account identification information and other information not relevant to your gym payment so it is not legible.

Gym Reimbursement Form

Member name:_____ Member address:_____

Oxford member ID number:_____ Date of birth:_____

Six-month period requested: Start date:_____ End date:_____

Dates of your 50 gym visits*:

1.	18.	35.
2.	19.	36.
3.	20.	37.
4.	21.	38.
5.	22.	39.
6.	23.	40.
7.	24.	41.
8.	25.	42.
9.	26.	43.
10.	27.	44.
11.	28.	45.
12.	29.	46.
13.	30.	47.
14.	31.	48.
15.	32.	49.
16.	33.	50.
17.	34.	

*As a substitute for filling in the dates of your 50 gym visits on this form, you may submit one of the pieces of documentation that are listed below as an attachment to this form. Your documentation must include a signature from a gym representative for verification purposes.

- A computer printout of your visits to the fitness center;
- Receipts that indicate each time you have visited the gym; or
- Verification from your employer that indicates your use of the employer's gym.

Name of facility:_____ Facility employee's signature:_____

Facility employee's signature above constitutes agreement that the facility promotes cardiovascular wellness for members. False statements will result in the denial of reimbursement. My signature below affirms that all of the information listed above is full, complete and true to the best of my knowledge.

Member signature:_____ Date:_____

If you have any questions regarding gym reimbursement, please call Customer Service at 1-800-444-6222.

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ACCESS REQUEST FORM

Purpose: This Form is intended for use by an individual to exercise his/her right to access his/her protected health information in Oxford's designated record sets or the designated record sets of Oxford's business associates.

Individual Seeking Access

Name: _____

Address: _____

Oxford I.D. Number: _____

Telephone: _____

Scope of Access

You have the right to inspect and obtain a copy of your protected health information maintained by Oxford and its business associates. You are not, however, entitled to inspect or obtain a copy of any psychotherapy notes we may have or any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding.

Please specify the records you wish to inspect or obtain copies of:

_____

_____

_____

We may charge you to make copies and mail your protected health information. Oxford will notify you in advance of these charges. If you want to pick the copies up at our Shelton, CT office please check here _____

Signature: _____ **Date**: _____

Personal Representative

If this request is being made by a personal representative on behalf of the individual, please provide a description and any available documentation of authority to act as the individual's personal representative and sign below.

_____

_____

Print name _____

Signature _____

Please send completed form to:

Oxford Health Plans
Attn: HIPAA Member Rights Unit
P.O. Box 29135
Hot Springs, AR 71903

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

OXFORD HEALTH INSURANCE, INC.

DOMESTIC PARTNER/LIFE PARTNER RIDER

Your Certificate is revised to add the following:

The Eligibility Section I, "Who Can Join?" Subsection 1(B), Dependents has been revised to provide the following coverage:

3. A Domestic Partner

The definition of "Dependent" also includes Domestic Partners.

A Domestic Partner is an individual of the same or opposite sex who lives with the Subscriber in a Domestic Partnership. A Domestic Partnership is defined as two persons who:

- have a common residence and are otherwise jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, which shall be demonstrated to the State of New Jersey and pursuant to New Jersey law;
- agree to be jointly responsible for each other's basic living expenses during the domestic partnership and neither person is in a marriage recognized by New Jersey law, or is a member of another domestic partnership;
- are not related to each other by blood or affinity up to and including the fourth degree of consanguinity;
- have chosen to share each other's lives in a committed relationship of mutual caring and both are at least 62 years of age, except that Domestic Partners who formed their Domestic Partnership prior to February 19, 2007 may continue to renew /purchase coverage;
- have filed jointly on Affidavit of Domestic Partnership pursuant to New Jersey state law; and
- have not been a partner in a domestic partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except if one of the partners died, and in all cases in which a person registered a prior domestic partnership, that domestic partnership shall have been terminated in accordance with New Jersey law.

We will consider a Domestic Partnership to exist if the Subscriber complies with the eligibility requirements listed above.

Domestic Partner Coverage

1. An individual who qualifies as a Domestic Partner shall have all of the rights and benefits of a Subscriber's lawful spouse subject to all of the terms and conditions of this Certificate.
2. Children of the Domestic Partner, who are financially dependent upon the Domestic Partner, are eligible for coverage subject to all of the terms and conditions of this Certificate.
3. Same sex Domestic Partners who entered into a Domestic Partnership prior to February 19, 2007 have the right to enter into a civil union pursuant to New Jersey Law. Entry into a civil union will terminate the Domestic Partnership.

4. A Life Partner.

The definition of "Dependent" also includes Life Partners. "Life Partner" is defined as follows:

A Life Partner is an individual who lives with the Subscriber in a Life Partnership. A Life Partnership is defined as:

- Two individuals who are both under age 62 years of age;
- Two individuals of the same gender (and opposite gender if allowed by Group) who live together in a long-term relationship of indefinite duration with an exclusive mutual commitment similar to that of marriage;
- In which the Partners have agreed to be responsible for each other's welfare; and
- The Partners are financially interdependent.

We will consider a Life Partnership to exist if the Subscriber complies with the eligibility requirements listed below and any additional requirements required by the Group.

Life Partner Eligibility
To be eligible for coverage, the Subscriber and his or her Life Partner must comply with each of Paragraphs 1 and 2 below:

1. Present Us with a notarized affidavit attesting to the following:

   a. They are not married (or legally separated), to each other or anyone else;

   b. They meet the marriage age requirements for the State of New Jersey and are mentally competent to consent to contract;

c. are not related to each other by blood or affinity up to and including the fourth degree of consanguinity;

d. They are currently sharing a household and have been doing so, on a continuous basis, for at least twelve months (or other period of time as specified by the Group) prior to the request for coverage and intend to continue sharing a household indefinitely; and

e. They are each other's sole Life Partner and neither individual has been registered as a member of another partnership or has been in a partnership (as described in this section) within the last twelve months.

2. Demonstrate cohabitation and joint responsibility for each other's common welfare and financial obligations by:

a. Providing proof of cohabitation in the form of one of the following:

i. the driver's licenses of both Partners;
ii. the tax returns of both Partners; or
iii. the bank records of both Partners.

and

b. Providing proof of joint responsibility for each other's common welfare and financial interdependence in the form of two of the following:

i. a joint mortgage or lease;
ii. a joint bank account or joint credit account;
iii. joint ownership of real property or of financial instruments;
iv. designation of the Life Partner as the primary beneficiary in the Subscriber's will, life insurance policy or retirement program.
v. assignment of durable power of attorney or health care power of attorney to a Life Partner.

Life Partner Coverage

1. An individual who qualifies as a Life Partner shall have all of the rights and benefits of a Subscriber's lawful spouse subject to all of the terms and conditions of this Certificate.

2. Children of the Life Partner, who are financially dependent upon the Life Partner, are eligible for coverage subject to all of the terms and conditions of this Certificate.

Please Note: This Plan will not Cover an individual as both a Subscriber and a Dependent.

Any employee or Dependent who is eligible for Medicare is not eligible for coverage under this Certificate unless he or she is eligible for coverage in accordance with the conditions stated in this Certificate under “Medicare and Government Programs.”

Miscellaneous Provisions

This Rider forms a part of the Agreement between the Group and Us. Unless otherwise agreed to in writing between the Group and Us, this Rider becomes effective on the date the Agreement becomes effective.

This Rider supersedes any amendment or rider providing coverage for treatment of infertility previously issued by Us. In the event of a conflict between the provisions of this Rider and the Certificate, the provisions of this Rider will prevail. All other terms and conditions of the Certificate remain in full force and effect.

Nothing contained in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Rider is attached, other than as specifically stated herein.

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