Your Oxford Medical Benefits Plan Information.

UnitedHealthcare®
Oxford

OXFORD EPO

Oxford

12053

UnitedHealthcare Oxford

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.

Network access.
We have a large network of hospitals and providers located throughout the tristate region.[1] Network doctors, mental health professionals, hospitals, clinics and laboratories charge discounted rates, which typically save you money. If your plan offers out-of-area coverage, you may also have national network access outside of the Oxford tristate service area through the UnitedHealthcare Choice Plus network.[2]

Your personal member website.
A self-service health plan member website allows you convenient, around-the-clock access to important information about your health benefits, the ability to request a health plan ID card, update your personal information and more.

Oxford On-Call®.
Get health care guidance 24 hours a day, seven days a week, from registered nurses through Oxford On-Call®. Call 800-201-4911 for support.

Rally®.
Rally is a digital health and wellness experience built into your health plan member website that provides personalized lifestyle plans you can adopt as you work toward achieving and maintain good health.

Sweat Equity Program.
A wellness program that offers you reimbursement toward your physical fitness expenses—up to $200 two times per year—after meeting the program requirements.[3]

Cancer support.
A program led by highly experienced cancer nurses with assistance from a board-certified medical oncologist, a hematologist and other doctors, as well as social workers, that was created to support members who are affected by cancer. Call 1-866-936-6002 for support.

Centers of Excellence.
For bariatric surgery and transplants, these providers are identified for meeting our quality assessment criteria and being in good standing with us and national accreditations.

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Schedule of Benefits

How Do You Access Benefits?

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this Schedule of Benefits, Benefits are not available for services provided by out-of-Network providers. This Benefit plan does not provide an out-of-Network level of Benefits.

Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to out-of-Network providers who have agreed to discount their billed charges for Covered Health Care Services. Refer to the definition of Shared Savings Program in *Section 9: Defined Terms* of the *Certificate* for details about how the Shared Savings Program applies.

You must show your identification card (ID card) or have your provider verify your eligibility by calling us every time you request health care services from a Network provider. If you do not show your ID card or have your provider verify your eligibility, Network providers have no way of knowing that you are enrolled under an Oxford Policy. As a result, they may bill you for the entire cost of the services you receive. If you have not received your ID card from us, or if you have lost your ID card, please contact us as soon as possible. If you need to seek services and do not have your ID card, please direct your provider to verify your eligibility by calling us to ensure proper payment of claims.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits.*

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Group, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?
In general health care terminology, prior authorization may also be referred to as precertification. We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

When a prior authorization is requested, the utilization review process starts. The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits.* You are not required to obtain authorization before receiving Covered Health Care Services.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a Calendar year basis.

Out-of-Pocket Limits are calculated on a Calendar year basis.

Benefit limits are calculated on a Calendar year basis unless otherwise specifically stated.

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Payment Term And Description	Amounts
Annual Deductible The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not apply to Preventive Care Services or services provided by capitated providers.	$2,500 per Covered Persons, not to exceed $5,000 for all Covered Persons in a family.
Out-of-Pocket Limit The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this Schedule of Benefits, including Covered Health Care Services provided under the Outpatient Prescription Drug Rider. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: ● Any charges for non-Covered Health Care Services. ● The amount you are required to pay if you do not obtain prior authorization as required. ● Charges that exceed Allowed Amounts.	$6,350 per Covered Person, not to exceed $12,700 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

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Payment Term And Description	Amounts

Co-payment
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of:

- The applicable Co-payment.
- 50% of the Allowed Amount.

Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.

Co-insurance
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount) each time you receive certain Covered Health Care Services.

Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
1. Ambulance Services			
Emergency Ambulance	*Ground Ambulance* 50%	Yes	Yes
	Air Ambulance 50%	Yes	Yes
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	*Ground Ambulance* 50%	Yes	Yes
	Air Ambulance 50%	Yes	Yes
2. Autism Spectrum Disorder and Other Developmental Disabilities - Rehabilitative Services			
Inpatient services limited per year as follows: Limit will be the same as those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services.*	*Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Outpatient: Limited per year as follows: Network benefits for any combination of physical therapy, occupational therapy and speech therapy are limited to 60 visits per year. Limits do not apply to the treatment of Autism Spectrum Disorder.	*Outpatient* None after you pay a Co-payment of $50 per visit	Yes	No
3. Cellular and Gene Therapy			
Cellular or Gene Therapy services must be received from a Designated Provider.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
4. Clinical Trials Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
5. Dental Services - Accident Only	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
6. Dental Services - Other	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
7. Diabetes Services **Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care**	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of DME are not subject to the limit stated under *Durable Medical Equipment* (*DME), Orthotics and Supplies.*	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider.*		
8. Donated Human Breast Milk	50%	Yes	Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
9. Durable Medical Equipment (DME) and Supplies You must purchase, rent, or obtain the DME from the vendor we identify or purchase it directly from the prescribing Network Physician.	None	Yes	No
10. Emergency Health Care Services - Outpatient **Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible.	50% after you pay $100 per visit.	Yes	No

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
11. Gender Dysphoria			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider.*		
12. Habilitative Services			
Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services.*	*Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Outpatient therapies: ● Physical therapy. ● Occupational therapy. ● Manipulative Treatment. ● Speech therapy. ● Post-cochlear implant aural therapy. ● Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*	*Outpatient* $30 per visit for Manipulative Treatment $50 per visit for all other habilitative services	Yes	No
13. Hearing Aids			
For Covered Persons up to age 16, Benefits are limited to one hearing aid per hearing impaired ear every 24 months. For Covered Persons age 16 and older, Benefits are limited to $5,000 per hearing impaired ear every 24 months.	None	Yes	No

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
14. Hearing Loss Screening	None	Yes	No
15. Hemophilia Services	50%	Yes	Yes
16. Home Health Care Limited to 60 visits per year. One visit equals up to four hours of skilled care services.	$75 per visit	Yes	No
17. Hospice Care Limited to 180 days inpatient and outpatient combined per lifetime.	*Inpatient* Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits.*	Yes	Yes
5 sessions for bereavement counseling are available to the Member's family either before or after the Member's death.	*Outpatient* $75 per visit	Yes	No
	Home Hospice $75 per visit	Yes	No
18. Hospital - Inpatient Stay	50%	Yes	Yes
19. Infertility Services 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.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider.*		

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
20. Lab, X-Ray and Diagnostic - Outpatient			
Lab Testing - Outpatient	None	Yes	No
X-Ray and Other Diagnostic Testing - Outpatient	50%	Yes	Yes
21. Major Diagnostic and Imaging - Outpatient			
	50% at a freestanding diagnostic center	Yes	Yes
	50% at an outpatient Hospital-based diagnostic center	Yes	Yes
22. Medical Foods			
	50%	Yes	Yes
23. Medical Supplies			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
24. Mental Health Care Services			
	Inpatient Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits.*	Yes	Yes
	Outpatient $30 per visit	Yes	No
	None for Partial Hospitalization/Intensive Outpatient Treatment	Yes	No

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
25. New Jersey Early Intervention Family Cost Share Expense			
The Annual Deductible, Co-insurance or Co-payment as applicable to a non-Specialist Physician visit for treatment of a Sickness or Injury will apply to the monthly Family Cost Share expense.	$50 per visit	Yes	No
26. Oral Surgery			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
27. Orthoptic Exercises and Corneal Topographic Procedures			
Orthoptic Exercises Limited to one diagnostic visit and two therapeutic/follow-up visits per year.	50%	Yes	Yes
Corneal Topographic Procedures Limited to two studies per eye per year.			

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
28. Physician's Office Services - Sickness and Injury In addition to the office visit Co-payment stated in this section, the Co-payments/Co-insurance and any deductible for the following services apply when the Covered Health Care Service is performed in a Physician's office: ● Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* ● Major diagnostic and nuclear medicine described under Major *Diagnostic and Imaging - Outpatient.* ● Outpatient surgery procedures described under *Surgery - Outpatient.* ● Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* ● Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.* Habilitative therapy services described under *Habilitative Services.*	$50 per visit for a Primary Care Physician office visit or $75 per visit for a Specialist office visit None for allergy injections when no other service is provided during the office visit	Yes	No

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
29. Pregnancy - Maternity Services	Benefits will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
30. Preventive Care Services			
Physician office services	None	No	No
Lab, X-ray or other preventive tests	None	No	No
Breast pumps	None	No	No
31. Prosthetic Devices and Orthotics			
Please Note: Reimbursement for these items will be at the same rate as under the federal Medicare reimbursement schedule.	None	Yes	No
32. Reconstructive Procedures	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
33. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows: ● 60 visits for any combination of physical therapy, occupational therapy and speech therapy. ● 60 visits of pulmonary rehabilitation therapy.	$30 per visit for Manipulative Treatments $50 per visit for all other rehabilitation services	Yes	No

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
33. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment ● 60 visits of post-cochlear implant aural therapy. ● 60 visits of cognitive rehabilitation therapy. Limits do not apply for the treatment of Autism Spectrum Disorder.			
34. Second and Third Opinions There is no charge to you for second or third opinions requested by us.	$75 per visit	Yes	No
35. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Limited to: ● 30 days per year in a Skilled Nursing Facility. ● 60 days per year in an Inpatient Rehabilitation Facility.	Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits.*	Yes	Yes
36. Specialized Non-Standard Infant Formulas	50%	Yes	Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
37. Substance Use Disorder Services			
	Inpatient Benefits will be the same as those stated under Hospital - Inpatient Stay in this Schedule of Benefits.	Yes	Yes
	Outpatient $30 per visit	Yes	No
	None for Partial Hospitalization/Intensive Outpatient Treatment	Yes	No
38. Surgery - Outpatient			
	50% at an ambulatory surgical center	Yes	Yes
	50% at an outpatient Hospital-based surgical center	Yes	Yes
39. Telehealth/Telemedicine Services Benefits are available only when services are delivered through a Network Provider.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
40. Termination of Pregnancy Elective abortions are limited to one procedure per year.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits.		
41. Therapeutic Treatments - Outpatient			
	$75 per treatment	Yes	No

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
42. Transplantation Services Transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
43. Urgent Care Center Services In addition to the Co-payment stated in this section, the Co-payments/Co-insurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center: ● Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* ● Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* ● Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* ● Outpatient surgery procedures described under *Surgery - Outpatient.*	$75 per visit	Yes	No

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
43. Urgent Care Center Services ● Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.*			
44. Wigs Limited to one wig per lifetime.	None	Yes	No
Fitness Reimbursement Reimbursement to the Subscriber is limited to $200 per 6-month period. Reimbursement to the Subscriber's spouse is limited to $100 per 6-month period.	***Not applicable***	***Not applicable***	***Not applicable***

Allowed Amounts
Allowed Amounts are the amount we determine that we will pay for Benefits. For Network Benefits, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills. Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate.*

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.

- When Covered Health Care Services are received from an out-of-Network provider as a result of an Emergency or as arranged by us, Allowed Amounts are an amount negotiated by us or a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible.

Provider Network
We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.oxhp.com or the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits. If you have questions about whether a particular provider is currently participating or accepting new patients, please call us at the telephone number on your ID card.

If you are undergoing an active course of treatment with a provider who leaves the Network, you may be eligible for transition of care Benefits. This means you may continue to receive Covered Health Care Services on a Network basis. This transition period is available for specific medical services and for limited periods of time. Transition of care Benefits are available only if the provider who is leaving the Network agrees to continue to follow our reimbursement policies. If the provider agrees, you will receive Covered Health Care Services on a Network basis. Pregnancies that are affected by this provision are automatically covered on a Network basis.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility when your coverage under the Policy becomes effective, you may be eligible to receive transition of care Benefits for up to 60 days from the effective date of coverage. This coverage is available only if the treatment is for a life-threatening disease or condition, or a degenerative and disabling disease or condition. If you are pregnant when coverage becomes effective and you are in your second or third trimester, you may receive Covered Health Care Services from your out-of-Network provider for the remainder of the Pregnancy, delivery and any post-partum care directly related to the delivery. Transition of care Benefits are available only if the out-of-Network provider agrees to follow our reimbursement policies. If the provider agrees, you will receive Covered Health Care Services on a Network basis.

If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Not all Network Hospitals are contracted to perform transplants. Please refer to your provider directory or contact us to find out which hospitals are contracted for this service.

Continuation of Treatment when a Physician Leaves the Network
If a Covered Person is receiving post-operative follow-up care, oncological treatment, psychiatric treatment or obstetrical care by a Physician who was a Network Physician at the time the treatment was initiated, the Covered Person may continue to be treated by that Physician for the duration of the treatment even if the Physician leaves the Network. The continued treatment is subject to the following time periods:

- Up to six months for post-operative follow-up care.
- Up to one year for oncological treatment and psychiatric treatment.
- Through the duration of a pregnancy and up to six weeks after delivery for obstetrical care.
- Up to four months for other Health Services where it is medically necessary for the Covered Person to continue treatment with that Physician.
- Health Services for the continued treatment are covered as Network Benefits. Reimbursement for Health Services will be made according to the same fee schedule used for Network Services.

During the time a Covered Person receives continued treatment by a Physician who has left the Network, we will provide Network Benefits for any treatment or services provided to the Covered Person in a Hospital, regardless of whether the Hospital is a Network Hospital.

Designated Providers
For Transplants, we may direct you to a Designated Provider chosen by us. If you require certain complex Covered Health Care Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, we may reimburse certain travel expenses.

In both cases, Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify us in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Benefits will not be paid.

Health Care Services from Out-of-Network Providers
If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Primary Care Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Primary Care Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers
If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you do not use the selected Network Physician, Benefits will not be paid.

Dependent Age Limit
The Dependent age limit is 26. Coverage ends on the last day of the year following the date the Dependent reaches the age limit. 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.*

Outpatient Prescription Drugs

When Are Benefits Available for Prescription Drug Products?
Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Co-payments or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

What Happens When a Brand-name Drug Becomes Available as a Generic?
If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment or Co-insurance may change, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?
Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. We will cover up to a consecutive 90-day supply of a Prescription Drug Product, as written by the Physician, subject to the drug manufacturer's packaging size, or based on supply limits.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed.

Note: Some products are subject to additional supply limits other than day limits based on New Jersey State Law or criteria that we have developed. Supply limits are subject, from time to time, to review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.oxhp.com or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?
Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization
When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Certain Prescription Drug Products may be subject to prior authorization due to the following:

- they contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product;
- they contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product;
- there are Therapeutically Equivalent alternatives available; or
- they have an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.oxhp.com or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim.*

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment or Co-insurance, and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.oxhp.com or the telephone number on your ID card.

Approval Process for Prescription Drug Products that the Covered Person wants considered at a Lower Tier Co-payment

The prescribing Physician must request our prior approval for a lower tier Co-payment for a higher tier drug by contacting the *Customer Care* and providing all relevant information. We will respond to the Physician by telephone within one business day after the receipt of all requested documentation from the Physician. If we fail to respond within that time period, the request is deemed approved. The request for approval must be based on the Physician's certification that the Prescription Drug Product is medically necessary as defined below and the current drugs available in the lower Tiers are not effective for the Covered Person.

A Prescription Drug Product which is not on the Prescription Drug List will be considered medically necessary if:

- It is approved by the *U.S. Federal Food and Drug Administration ("FDA")* or its use is supported by one or more citations included or approved for inclusion in The *American Hospital Formulary Drug Information* or the United States Pharmacopeia Drug Information, or it is recommended by a clinical study or review article in a major peer reviewed professional journal; and

- The prescribing Physician states that all Prescription Drug Products on the Prescription Drug List used to treat each disease state has been ineffective in the treatment of your disease or condition, or all such drugs have caused or are reasonably expected to cause you adverse or harmful reactions.

If the request is denied by telephone, we will also provide you and the Physician a written denial within 5 business days of the request. The written denial will include the clinical reason for the denial.

If you are dissatisfied with our decision, you should follow the procedures described in the *Certificate* for questions, complaints and appeals. If you want to contest our decision you may apply to the Independent Health Care Appeals Program for a review. You must make your application within 60 days of the date you were notified of the decision. Your notification of our decision will include specific instructions as to how you or your provider may arrange for an external appeal and will also include any forms required to initiate the appeal.

Extended Coverage during Total Disability

Extended Coverage for Total Disability described in the *Certificate* applies to Prescription Drug Products.

Pharmacy Charges for Additional Services

A pharmacy may charge you for services rendered by the pharmacy that are in addition to charges for the Prescription Drug Product, for dispensing the drug or for prescription counseling. Services rendered by the pharmacy for which additional charges are imposed are subject to the approval of the Board of Pharmacy. A pharmacy must disclose to you the charges for the additional services and your out-of-pocket cost for those services prior to dispensing the Prescription Drug Product. A pharmacy may not impose any additional charges for patient counseling or for other services required by the Board of Pharmacy or State or federal law.

What Do You Pay?

You are responsible for paying the Annual Drug Deductible.

Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.

Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Co-payment or Co-insurance described in the Benefit Information table. You are not responsible for paying a Co-payment or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

The amount you pay for any of the following under the Outpatient Prescription Drug Rider will not be included in calculating any Out-of-Pocket Limit stated in your Certificate:

- The Annual Drug Deductible.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Oxford Health Insurance, Inc.
Liberty EPO Plan
Schedule of Benefits

Payment Information

The Annual Drug Deductibles are calculated on a Calendar year basis.

Payment Term And Description	Amounts
Annual Drug Deductible The amount you pay for covered Tier 1, and Tier 2, and Tier 3 Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products. Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible. Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Drug Deductible.	***Tier 1*** No Annual Drug Deductible. ***Tiers 2 and 3*** $100 per Covered Person.
Co-payment and Co-insurance ***Co-payment*** Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. ***Co-payment and Co-insurance*** Your Co-payment or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. **NOTE:** The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.oxhp.com or the telephone number on your ID card for the most up-to-date tier status.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: ● The applicable Co-payment or Co-insurance. ● The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. ● The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: ● The applicable Co-payment or Co-insurance. ● The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments or Co-insurance stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

Oxford Health Insurance, Inc.
Liberty EPO Plan
Schedule of Benefits

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay?
Specialty Prescription Drug Products The following supply limits apply. ● As written by the provider, up to a consecutive 90-day supply of a Specialty Prescription Drug Product, subject to the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Some products are subject to additional supply limits other than day limits based on New Jersey State Law or on criteria we have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, or a mail order Network Pharmacy or a Designated Specialty Pharmacy.	Your Co-payment or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1 , or Tier 2, or Tier 3. Please contact us at www.oxhp.com or the telephone number on your ID card to find out tier placement. For up to a 31-day supply, we pay: For a Tier 1 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $25 per Prescription Order or Refill. For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $50 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $75 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge per Prescription Order or Refill.

Oxford Health Insurance, Inc.
Liberty EPO Plan
Schedule of Benefits

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay?
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: ● As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, subject to the drug manufacturer's packaging size, or based on supply limits. Some products are subject to additional supply limits other than day limits based on New Jersey State Law or on criteria we have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. ● For a contraceptive up to a three month supply for the first dispensing. For refills of the same contraceptive, up to a six-month supply, regardless of whether coverage under the Policy was in effect at the time of the first dispensing. Coverage will not extend beyond the date your coverage ends under this Policy. The Co-payment or Co-insurance that applies will reflect the number of days dispensed. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed.	Your Co-payment or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, or Tier 2, or Tier 3. Please contact us at www.oxhp.com or the telephone number on your ID card to find out tier status. For up to a 31-day supply, we pay: For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $25 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $50 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $75 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge per Prescription Order or Refill.

Oxford Health Insurance, Inc.
Liberty EPO Plan
Schedule of Benefits

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay?
Prescription Drug Products from a Mail Order Network Pharmacy The following supply limits apply: ● As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, subject to the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products, including Specialty Prescription Drug Products on the List of Preventive Medications. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading Specialty Prescription Drug Products. Some products are subject to additional supply limits other than day limits based on criteria we have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	Your Co-payment or Co-insurance is determined by the PDL Management Committee's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, or Tier 2, or Tier 3. Please contact us at www.oxhp.com or the telephone number on your ID card to find out tier status. For up to a 90-day supply, you pay: For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $50 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $100 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $150 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge per Prescription Order or Refill.

Mental health and substance disorder services support.
A 24/7 substance disorder services treatment help line, as well as **liveandworkwell.com** – a website dedicated to mental health and substance disorder services support. Call the at Substance Use Treatment Helpline 1-855-780-5955 24-hours a day, 7-days a week.

If you have questions about this information or your coverage, or want to learn more about available programs and resources, log in to your health plan member website or call Customer Service. The website address and our phone number are shown on your health plan ID card.

Wishing you the best of health,

Oxford Health Plans

[1] Tri-state area includes Connecticut, New Jersey and certain New York counties (Ulster, Sullivan, Dutchess, Orange, Putnam, Rockland, Westchester, Bronx, New York, Queens, Kings, Richmond, Nassau and Suffolk). Network access may vary by plan.

[2] National network may not be available for all groups.

[3] Reimbursement is generally limited to the lesser of $200 (subscriber)/$100 (covered spouse/partner) or the actual amount of the qualifying fitness costs per six-month period, but the reimbursement may vary by plan. Refer to your benefits documents or check with your benefits administrator to find out how much you may be reimbursed. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you.

Rally Health provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the health survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

Disease Management programs and services may vary on a location-by-location basis and are subject to change with written notice. UnitedHealthcare does not guarantee availability of programs in all service areas and provider participation may vary. Certain items may be excluded from coverage and other requirements or restrictions may apply. If you select a new provider or are assigned to a provider who does not participate in the Disease Management program, your participation in the program will be terminated. Self-Funded or Self-Insured Plans (ASO) covered persons may have an additional premium cost. Please check with your employer.

The Centers of Excellence (COE) program providers and medical centers are independent contractors who render care and treatment to health plan members. The COE program does not provide direct health care services or practice medicine, and the COE providers and medical centers are solely responsible for medical judgments and related treatments. The COE program is not liable for any act or omission, including negligence, committed by any independent contracted health care professional or medical center.

Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Oxford HMO products are underwritten by Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. Administrative services provided by Oxford Health Plans LLC.

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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'dę́ę́' 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.

UnitedHealthcare Oxford

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.

Disclosures to Covered Persons Regarding Out-of-Network Treatment

This summary only provides an overview of how a covered person's health benefits plan covers out-of-network treatment. It is only guidance to help a covered person understand their out-of-network benefits. This summary does not alter your coverage in any way.

The covered person should refer to their Certificate of Coverage and Schedule of Benefits for more information about your out-of-network benefits and about coverages and costs for in-network treatment.

For additional information—including whether a health care professional or facility is in-network or out-of-network—please visit oxfordhealth.com or contact us at 1-866-280-1412 . For examples of out-of-network costs and estimates for specific health care services, visit https://oxhp-member.uhc.com/secure/materials/member/DisclosuresToNJMbrsFullyInsuredPlans.pdf.

Your Policy Covers:	What this Means:	How Am I Protected by NJ law?
Medically Necessary Treatment on an Emergency or Urgent Basis by Out-of-Network Health Care Professionals/Facilities	Emergency - You are covered for out-of-network treatment for 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 Use Disorder such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual or unborn child in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. This includes any further medical examination and such treatment as may be required to stabilize the medical condition. This also includes if there is inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery or such transfer may pose a threat to the health or safety of the woman or unborn child. Urgent – You are covered for out-of-network treatment of a non-life-threatening condition that requires care by a health care professional within 24 hours.	Except as discussed below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, Co-payment, or Co-insurance amounts (also known as "cost- sharing") applicable to the same services when received in-network. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: www.state.nj.us/dobi/consumer.htm. We and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the emergent/urgent Covered Health Care Services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of-pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled. If an agreement cannot be reached, we or the out-of-network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the Covered Health Care Services. The amount awarded by the

		arbitrator may exceed what we have already paid to the out-of-network health care professional/facility; however, any additional amount paid by us pursuant to the arbitration award will not increase your cost-sharing liability above the amount indicated as your responsibility on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total Allowed Amount for the service(s).

Your Policy Covers:	**What this Means:**	**How Am I Protected by NJ law?**
Inadvertent Out-of- Network services	You are covered for treatment by an out-of-network health care professional for Covered Health Care Services when you use a network health care facility (e.g. hospital, ambulatory surgery center, etc.) and, for any reason, in-network Covered Health Care Services are unavailable or provided by an out-of-network health care professional in that network facility. This includes laboratory testing ordered by an in-network health care professional and performed by an out-of-network bio-analytical laboratory (e.g., imaging, x-rays, blood tests, and anesthesia).	Except as provided below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, Co-payment, or Co-insurance amounts (also known as "cost- sharing") applicable to the same Covered Health Care Services when received in-network. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: https://www.state.nj.us/dobi/consumer.htm We and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the inadvertent out-of-network Covered Health Care Services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of-pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled.

		If an agreement cannot be reached, we or the out-of-network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the inadvertent out-of-network Covered Health Care Services. The amount awarded by the arbitrator may exceed what we have already paid to an out-of-network health care professional/facility; however, any additional amount paid by us pursuant to the arbitration award will not increase your cost-sharing liability above the amount indicated as your responsibility on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total Allowed Amount for the service(s).

Your Policy Covers:	**What this Means:**	**How Am I Protected by NJ law?**
Treatment from out-of-Network health care professionals/ facilities if Network health care professionals/facilities are unavailable.	Plans are required to have adequate networks to provide you with access to professionals/facilities within certain time/distance requirements so you can obtain Medically Necessary treatment of all illnesses or injuries covered by your plan.	You can request treatment from an out-of-network health care professional/facility when a network health care professional/facility is unavailable through an appeal, often called a request for an "in-plan exception." Please see the Department of Banking and Insurance's guide at: https://nj.gov/dobi/appeal/.

Your Policy DOES NOT Cover:	**What this Means:**	**How Am I Protected by NJ law?**
Voluntary Out-of-Network services	You are not covered for treatment by an out-of-network health care professional/facility when you knowingly, voluntarily and specifically select an out-of-network professional/facility for treatment when you have the opportunity to be serviced by a network healthcare professional/facility.	As discussed above, you can request treatment from an out-of-network health care professional/facility when an in-network health care professional/facility is unavailable through an appeal, called a request for "in-plan exception."

Certificate of Coverage

Oxford Health Insurance, Inc.

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between Oxford Health Insurance, Inc. and the Group. The *Certificate* describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate,* the Policy includes:

- The *Schedule of Benefits*.
- The Group's *Application*.
- Riders, including the *Outpatient Prescription Drug Rider* if purchased by the Group.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When this happens we will send you a new *Certificate*, Rider or Amendment.

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

We are delivering the Policy in New Jersey. The Policy is governed by ERISA unless the Group is not an employee health and welfare plan as defined by ERISA. To the extent that state law applies, New Jersey law governs the Policy.

Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to Oxford Health Insurance, Inc. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *Certificate* at www.oxhp.com.

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Certificate* and any summaries provided to you by the Group, this *Certificate* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact Us?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

Be Aware the Policy Does Not Pay for All Health Care Services

The Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

We understand that there are many variables that influence the decisions you make regarding your care, including the coverage available under this plan. However, final care decisions are between you and your Physician. Your Physicians are solely responsible for all health services that you receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver your care. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Co-payment or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds the Allowed Amount.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

Show Your ID Card

You should show your ID card or have your provider verify your eligibility by calling us every time you request health care services. If you do not show your ID card or have your provider verify your eligibility, the provider may fail to bill the correct entity for the services delivered. If you have not received your ID card from us, or if you have lost your ID card, please contact us as soon as possible. If you need to seek services and do not have your ID card, please direct your provider to verify your eligibility by calling us to ensure proper payment of claims.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, the out-of-Network provider is responsible for requesting payment from us. You may also request payment on your own behalf at your option. Claims must be filed in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health care services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under the Policy for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

Subject to your appeal rights set forth under *Section 6: Questions, Complaints and Appeal*, we will do the following:

- Make an initial interpretation of Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Care Services

We pay Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your or your Out-of-Network provider's request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with

Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at www.oxhp.com or the telephone number on your ID card.

We may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, we will use a comparable methodology(ies). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.oxhp.com for information regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

We may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or pharmaceutical products, is only a Covered Health Care Service if it is Medically Necessary or medically appropriate. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Policy is in effect or during any extension of benefits period.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Policy.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance use disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Policy.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Co-payment and/or Co-insurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

2. Autism Spectrum Disorder and Other Developmental Disabilities – Rehabilitative Services

For Covered Persons with a primary diagnosis of Autism Spectrum Disorder or another Developmental Disability, Benefits under this section include:

- Physical therapy provided by a licensed physical therapist.
- Speech and language pathology services provided by a licensed speech and language pathologist.
- Occupational therapy provided by a licensed occupational therapist.

Benefits for these therapies 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 Benefits, 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.

3. Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

4. Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) 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 meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet 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 taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It 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* if the study or investigation has been reviewed and approved through a system of

peer review. The peer review system 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 takes place 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. It must have been approved by all relevant institutional review boards (*IRBs*) before you 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 Health Care Service and is not otherwise excluded under the Policy.

5. Dental Services - Accident Only

Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair (not replacement) of sound natural teeth when both of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Medicine, "M.D.", Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.".

Please note that dental damage that happens as a result of normal activities of daily living (such as biting or chewing) or intentional misuse of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

Benefits for treatment of accidental Injury include the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

6. Dental Services - Other

Services including surgery, general anesthesia and associated Hospital or Alternate Facility charges when the dentist and Physician determine that the services are necessary for the safe and effective treatment of one of the following:

- A dental condition.
- A medical condition covered under the Policy 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.

Services are limited to Covered Persons who are one of the following:

- A child under 5 years of age.
- A person who is severely disabled.

Services for the diagnosis or treatment of a dental disease are not Covered Health Care Services.

7. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services to ensure that a person with diabetes is educated regarding the proper self-management and treatment of their diabetic condition, including information on proper diet. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Covered Health Care Services for self-management and diet education are limited to the following:

- Visits as Medically Necessary upon the diagnosis of diabetes.
- Visits as Medically Necessary upon diagnosis by a Physician or nurse practitioner/clinical nurse specialist of a significant change in the person's symptoms or conditions which necessitate changes in that person's self-management.
- Visits as Medically Necessary upon the determination of a Physician or nurse practitioner/clinical nurse specialist that reeducation or refresher education is necessary.

Diabetes self-management education must be provided by one of the following:

- A dietitian who is registered by a nationally-recognized professional association of dietitians.
- A health care professional recognized as a certified diabetes educator by the *American Association of Diabetes Educators*.

A registered pharmacist qualified regarding management education for diabetes by any institution recognized by the *Board of Pharmacy* of the State of New Jersey.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps, supplies and medications for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME) and Supplies.*
- Insulin.
- Oral agents such as glucose tablets and gels.
- Glucagon for use with injection to increase blood glucose concentration.
- Blood glucose meters and blood glucose monitors for the legally blind including continuous glucose monitors.
- Insulin syringes with needles.
- Test strips for blood glucose monitors and visual reading and urine test strips.

- Ketone test strips and tablets.
- Insulin.
- Injection aids.
- Oral agents for controlling blood sugar.
- Lancets and lancet devices.

The equipment and supplies must be recommended or prescribed by a Physician or nurse practitioner/clinical nurse specialist.

If your Benefit plan includes an *Outpatient Prescription Drug Rider*, Benefits for diabetic medications and supplies may be provided as described in the Outpatient Prescription Drugs section of the *Schedule of Benefits*.

8. Donated Human Breast Milk

Benefits are provided for donated human breast milk for Covered Persons under the age of six months subject to the following conditions:

- The Covered Person is medically or physically unable to receive maternal breast milk or participate in breast feeding, or the Covered Person's mother is medically or physically unable to produce breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; and
- The Covered Person's practitioner issued an order for the donated human breast milk.

We also cover pasteurized donated human breast milk as ordered by the Covered Person's practitioner for Covered Persons under the age of six months if the Covered Person meets any of the following conditions:

- A body weight below healthy levels determined by the Covered Person's practitioner;
- A congenital or acquired condition that places the Covered Person at a high risk for development of necrotizing enterocolitis; or
- A congenital or acquired condition that may benefit from the use of donor breast milk as determined by the *New Jersey Department of Health*.

As used in this provision, pasteurized donated human breast milk means milk obtained from a human milk bank that meets the quality guidelines established by the *New Jersey Department of Health*. If there is no supply of human breast milk that meets such guidelines there will be no coverage under this provision.

The pasteurized donated human breast milk may include human milk fortifiers if indicated by the Covered Person's practitioner.

9. Durable Medical Equipment (DME) and Supplies

Benefits are provided for DME and certain supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.

- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services.*
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998.*

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits.*

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations,* under *Devices, Appliances, Medical Equipment and Prosthetics.*

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.

10. Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits do not include follow-up care provided in a Hospital Emergency room.

11. Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

12. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn or improve skills and functioning for daily living. We will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a congenital, genetic or early acquired disorder when both of the following conditions are met:

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.
  - Licensed physical therapist.
  - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

- Treatment plan.
- Medical records.
- Clinical notes.
- Other necessary data to allow us to prove that medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, we may request a treatment plan that includes:

- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.

- Frequency of treatment plan updates.

Habilitative services provided in your home by a Home Health Agency are provided as described under Home Health Care. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME) and Supplies* and *Prosthetic Devices and Orthotics.*

Please note that Benefits under this section do not include physical therapy, occupational therapy or speech therapy for the diagnosis of Autism Spectrum Disorders or other Developmental Disabilities. Benefits for these services payable as described in *Autism Spectrum Disorder and Other Developmental Disabilities - Rehabilitative Services* above.

13. 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). These are electronic amplifying devices designed to bring sound more effectively into the ear.

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid, associated accessories, and associated fitting charges, testing and repair of a hearing aid.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *Certificate*. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

14. Hearing Loss Screening

Covered Health Care Services include screening for newborn hearing loss by appropriate electro physiologic screening measures and periodic monitoring of infants for delayed onset hearing loss. No Co-payment amount or Annual Deductible applies to these Benefits.

15. Hemophilia Services

Covered Health Care Services include home treatment of routine bleeding episodes due to hemophilia. The treatment must be supervised by a state-approved hemophilia treatment center. Benefits are provided for blood products including, but not limited to Factor VIII, Factor IX and Cryoprecipitate as well as blood infusion equipment including, but not limited to, syringes and needles.

16. Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required or when continued hospitalization would otherwise be required.

Benefits are available for full-time nursing care and full-time care by an aide on a short-term basis if needed. Home Health Agency services include physical, occupational, or speech therapy, medical social work and nutritional services.

Benefits are available for the following items to the extent that they would have been available if the Covered Person were confined in a Hospital:

- Medical supplies.
- Drugs and medications ordered by a Physician.
- Laboratory services given or ordered in a Hospital.
- Special meals.
- Diagnostic, therapeutic or surgical services provided on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office..

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

17. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call us at the telephone number on your ID card for information about our guidelines for hospice care.

18. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay, including autologous blood banking services.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services including radiologists, anesthesiologists, pathologists and Emergency room Physicians.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours following a simple mastectomy.
- 72 hours following a modified radical mastectomy.

If you agree, the attending provider may discharge you earlier than these minimum time frames.

Your cost share for Covered Health Care Services rendered during a hospitalization in a Network Hospital will be limited to the Co-payment, deductible or Co-insurance applicable to Network services as long as all request for prior authorization requirements have been met. Please refer to your *Schedule of Benefits* for the Co-payment, deductible, Co-insurance and prior authorization requirements that apply to your plan. This applies to Covered Health Care Services received at a Network Hospital regardless of whether the admitting Physician is a Network or out-of-Network provider. However, although the inpatient services will be treated as Network services, the services of the out-of-Network admitting Physician will be treated as out-of-Network services.

19. Infertility Services

Benefits for Infertility will be paid at the same level as Benefits for any other maternity-related procedure. Diagnosis and treatment of Infertility including but not limited to:

- Diagnosis and diagnostic tests.
- Medications.
- Surgery.
- In vitro fertilization.
- Embryo transfer.
- Zygote intrafallopian transfer.
- Intracytoplasmic sperm injection.
- Gamete intrafallopian transfer.
- Four completed egg retrievals per Covered Person while covered under this plan or any plan with the same employer.
- Medical costs of egg and sperm donors.
- Benefits for gamete intrafallopian transfer, in vitro fertilization, and zygote intrafallopian transfer are limited to a Covered Person who meets all of the following conditions:
- The Covered Person has used all reasonable, less expensive and medically appropriate treatments and is still unable to become pregnant or carry a pregnancy.
- The Covered Person has not reached the limit of four completed egg retrievals.
- The Covered Person is 45 years of age or younger.

Services must be performed at facilities that conform to standards established by the *American Society for Reproductive Medicine* or the *American College of Obstetrics and Gynecologists*.

20. Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services including radiologists, anesthesiologists and pathologists.
- Prostate cancer screening which includes an annual 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.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

21. Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services, including digital tomosynthesis, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services including radiologists, anesthesiologists and pathologists.

22. Medical Foods

Benefits for Medical Foods and Low Protein Modified Food Products when prescribed for the therapeutic treatment of Inherited Metabolic Diseases and administered under the direction of a Physician.

23. Medical Supplies

Benefits for medical supplies for Covered Health Care Services required for the treatment of Sickness or Injury. This includes maintenance supplies, such as ostomy supplies.

Benefits for diabetic supplies are described under *Diabetes Services*. Benefits for supplies associated with DME are described under *Durable Medical Equipment (DME) and Supplies.*

24. Mental Health Care Services

Mental Health Care 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.

Benefits include 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.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA))* that are the following:
    - Focused on the treatment of core deficits of Autism Spectrum Disorder.
    - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
    - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *Certificate*.

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

Benefits under this section include Biologically Based Mental Illness as required by New Jersey insurance law.

The Mental Health/Substance Use Disorders Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance Use Disorders Designee for referrals to providers and coordination of care.

25. New Jersey Early Intervention Family Cost Share Expense

Benefits under this section include the Family Cost Share expense incurred by Covered Persons 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 Covered Person 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 Health Care Service under the Policy. The deductible, Co-insurance or Co-payment as applicable to a non-Specialist Physician visit for treatment of a Sickness or Injury will apply to the monthly Family Cost Share expense.

The therapy services a Covered Person received through New Jersey Early Intervention do not reduce the therapy services otherwise available under the Policy.

26. Oral Surgery

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

- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Removal of cysts related to teeth is not covered.
- Surgical and nonsurgical medical procedures for temporomandibular joint disorders (TMJ) and orthognathic surgery.

27. Orthoptic Exercises and Corneal Topographic Procedures

Orthoptic exercises for the treatment of the following conditions:

- Amblyopia for Covered Persons up to age 19. Treatment includes patching and penalization therapies.
- Convergence insufficiency.

Corneal topographic procedures for the treatment of certain conditions.

28. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy testing and treatment, including routine allergy injections.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient.*

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, whether performed in or out of the Physician's office, are described under *Lab, X-ray and Diagnostic - Outpatient.*

29. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. If the mother and newborn are discharged earlier than the above time frames, Home Health Care visits are available at the mother's request. The visits will not apply to the Home Health Care Benefit.

30. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include 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 (and the duration of any rental).
  - Timing of purchase or rental.

Benefits for the services below are required under New Jersey law:

- Screening and diagnostic mammography.
- Screening for colorectal cancer as follows:
  - Annual guaiac-based fecal occult blood test (gFOBT) with high test sensitivity for cancer.
  - Annual immunochemical-based fecal occult blood test (FIT) with high test sensitivity for cancer.
  - Stool DNA (sDNA) test with high test sensitivity for cancer.
  - Screening colonoscopy or Flexible sigmoidoscopy every five years.
  - Colonoscopy every ten years.
  - Double contract barium enema every five years.
  - Computed tomography colonography (virtual colonoscopy) every five years.
- A Pap smear including all laboratory costs associated with the pap smear and any confirmatory test.
- Cervical cancer screening.
- Screening for blood lead measurement for lead poisoning for children. Screening for blood lead measurement includes confirmatory blood lead testing and medical evaluation and any necessary medical follow-up and treatment of lead-poisoned children.
- Bone mineral density tests.

Health Wellness Exams

Benefits are provided for health wellness examinations which include the following tests and services:

- For Covered Persons 20 years of age and older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density liporotein (LDL) level and blood high-density lipoprotein (HDL) level.
- For Covered Persons 35 years of age or older, a glaucoma eye test every five years.
- For Covered Persons 40 years of age or older, an annual stool examination for presence of blood.
- For Covered Persons 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years.
- For women 20 years of age or older, a pap smear.
- For women 40 years of age or older, one baseline mammogram and annual mammogram examination.Benefits include coverage for digital tomosynthesis when used for the detection and screening of breast cancer.

- For women under 40 years of age who have a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed Medically Necessary by the woman's health care provider.
- For adult Covered Persons, recommended immunizations.
- Other tests and services recommended as medically appropriate by a Physician.

For all persons 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.

In addition to the mammogram examinations listed above, we will cover an ultrasound evaluation, an MRI, a three-dimensional mammography, or other additional testing of an entire breast or breasts, after a baseline mammogram examination if one of the following conditions is met:

a) The mammogram demonstrates extremely dense breast tissue;

b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or

c) If the Covered Person has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the *Breast Imaging Reporting and Data System* established by the *American College of Radiology* or other indications as determined by the Covered Person's practitioner.

32. Prosthetic Devices and Orthotics

Prosthetics

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME) and Supplies.*

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Orthotics

Orthotics that straighten or re-shape a body part. For the purpose of this Benefit this refers to a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

The prosthetic device or orthotic must be ordered or provided by, or under the direction of a Physician who deems the device to be Medically Necessary and must be obtained from a licensed orthotist or prosthetist, or any certified pedorthist.

Benefits are available for repairs and replacement, if deemed to be Medically Necessary by a Physician.

Reimbursement for these items will be at the same rate as under the federal Medicare reimbursement schedule.

33. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly.

Reconstructive procedures include the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children. These procedures that correct an anatomical Congenial Anomaly are not considered Cosmetic Procedures.

Cosmetic Procedures are excluded from coverage. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury or Sickness does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

34. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care.* Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for

cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

35. Second and Third Opinions

Second and third opinions requested by you or by us.

At your request:

- If you disagree with a Network provider's recommended course of treatment, you may request that another provider render a second opinion.
- If the first and second opinions do not agree, we will designate a Network provider to render a third opinion at no cost to you.
- After reviewing the third opinion, we will cover the Covered Health Care Services supported by a majority of the providers reviewing your case.
- If the first opinion concerns a diagnosis of cancer (either negative or positive) or treatment for cancer, you may obtain a second opinion from an out-of-Network provider on a Network basis.

At our request:

- We reserve the right to require a second opinion for any surgical procedure.
- If a second surgical opinion is required, we will refer you to a Network provider for the second opinion at no cost to you.
- In the event that the first and second surgical opinions differ, a third opinion will be required. We will designate another Network provider for a third opinion at no cost to you.
- The third opinion will determine whether the procedure will be covered. The providers who render the second or third opinion are not eligible to perform the procedure.

36. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services including radiologists, anesthesiologists and pathologists.

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

37. Specialized Non-Standard Infant Formulas

Benefits are provided for specialized non-standard infant formulas when the following conditions are met:

- The covered infant's Physician has diagnosed the infant as having multiple food protein intolerance.
- The covered infant's Physician has determined specialized non-standard infant formulas to be Medically Necessary.
- The covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

Benefits are provided to the same extent as for other medical foods as described under *Medical Foods* in this Section.

38. Substance Use Disorders Services

Substance Use 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.

Benefits include 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.

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

Benefits for Substance Use Disorders are provided at Network Facilities subject to the following:

- the prospective determination of medical necessity 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 medical necessity is made by us;
- Prior Authorization is not required for the first 180 days of inpatient and/or outpatient treatment during each year but may be required for inpatient treatment for the balance of the year;
- concurrent 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 intensive outpatient and partial hospitalization services 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 in-patient services, we shall approve an in-plan exception and provide benefits for in-patient services at an Out-of-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.

39. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services including radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury.*

40. Telehealth/Telemedicine Services

Benefits are provided for Telehealth and/or Telemedicine.

If a Network Provider provides Medically Necessary and appropriate services through Telehealth and/or Telemedicine that are consistent with the requirements of P.L. 2017, c. 117, We cover such Network Provider's charges for services provided through Telehealth and/or Telemedicine.

For purposes of this benefit, the following definitions apply:

“Telehealth” means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, practitioner consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L. 2017, c. 117.

“Telemedicine” means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the physical distance between a practitioner and a Covered Person, either with or without the assistance of an intervening practitioner, and in accordance with the provisions of P.L. 2017, c.117. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

41. Termination of Pregnancy

Therapeutic abortions and abortions in the case of rape, incest or fetal malformation. Elective abortions are covered. Benefits are limited as stated in the *Schedule of Benefits*.

42. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services including anesthesiologists, pathologists and radiologists.

43. Transplantation Services

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Benefits are available for the treatment of Wilms' tumor, including autologous bone marrow transplants when standard chemotherapy is unsuccessful, even when such treatment is considered Experimental or Investigational.

Treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants are a Covered Health Care Service for which Benefits are payable 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*.

Treatment of sickle cell anemia by dose-intensive chemotherapy, bone marrow transplants and umbilical cord blood transplants are a Covered Health Care Service for which Benefits are payable when

performed by institutions approved by the *National Heart, Lung, and Blood Institute* or pursuant to protocols consistent with the guidelines of the *National Health, Lung, and Blood Institute* or any other nationally recognized professional medical specialty academy or organization.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Policy, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

Transplantation services must be performed at our Designated Facilities in order to receive Network Benefits. Refer to the *Schedule of Benefits* for applicable prior authorization requirements. Please note that not all Network Hospitals are contracted to perform transplants. Please refer to your provider directory or contact us to find out which Hospitals are contracted for this service.

If you reside more than 50 miles from the Designated Facility and are required to travel to obtain transplantation services from the Designated Facility, we will provide for reimbursement of travel and lodging expenses for the Covered Person and one companion. Coverage is limited to $50-$100 lodging per day, up to a maximum Benefit of $10,000 per lifetime.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for transplant services.

44. Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

45. Wigs

Wigs when you have severe hair loss due to Injury, Sickness or as a side effect of the treatment of a disease, such as chemotherapy.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

To help you find exclusions, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
7. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses). This exclusion does not apply to services for which Benefits are provided as described under *Dental Services - Accident Only and Dental Services - Other* in *Section 1: Covered Health Care Services*.

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Removal of teeth (including wisdom teeth).
   - Restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA) requirement.* This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only and Dental Services - Other* in *Section 1: Covered Health Care Services*.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only and Dental Services - Other* in *Section 1: Covered Health Care Services.*

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly except for treatment of medically diagnosed congenital birth defects and birth abnormalities in Dependents that have been covered under the *Certificate* from the moment of birth.

6. Removal of cysts related to teeth.

C. Devices, Appliances, Medical Equipment and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.

2. Cranial molding helmets and cranial banding except when required for surgery.

3. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

4. Devices and computers to help in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME) and Supplies* in *Section 1: Covered Health Care Services.*
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
8. Powered and non-powered exoskeleton devices.
9. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME) and Supplies* in *Section 1: Covered Health Care Services.*
10. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
11. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to medications covered under *Section 1: Covered Health Care Services.*
2. Self-injectable medications. This exclusion does not apply to medications covered under *Diabetes Services* in *Section 1: Covered Health Care Services.*
3. Over-the-counter drugs and treatments. This exclusion does not apply to diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
4. Growth hormone therapy.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services* or to the treatment for Wilm's tumor as described under *Transplantation Services* in *Section 1: Covered Health Care Services*.

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services* or if you are at risk of neurological or vascular disease arising from diseases such as diabetes.
2. Nail trimming, cutting, or debriding. This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Arch supports.

G. Mental Health Care Services

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care Services* in *Section 1: Covered Health Care Services.*

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
7. Transitional Living services.

H. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is a part of treatment.
   - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk. This exclusion does not apply to Benefits that are provided under *Donated Human Breast Milk, Medical Foods* and *Specialized Non-Standard Infant Formulas* in *Section 1: Covered Health Care Services*.

3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

I. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
   - Exercise equipment.
   - Home modifications such as elevators, escalators, handrails and ramps.
   - Hot and cold compresses.
   - Hot tubs.
   - Humidifiers or water purifiers.
   - Jacuzzis.
   - Mattresses or waterbeds.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Safety equipment.
   - Saunas.
   - Stair lifts and stair glides.
   - Strollers.
   - Swimming pools.
   - Treadmills.
   - Vehicle modifications such as van lifts.
   - Video players.
   - Whirlpools.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.

   We pay Benefits for the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight control. All services, supplies, programs and surgical procedures for the purpose of weight control, except surgical procedures that are Medically Necessary for the treatment of morbid obesity.
6. Wigs, except as described under *Wigs* in *Section 1: Covered Health Care Services.*

K. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
3. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
4. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
5. Habilitative services for maintenance/preventive treatment.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
7. Biofeedback.
8. The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.
9. Non-surgical treatment of obesity.

10. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of* 1998 for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*

11. Intracellular micronutrient testing.

L. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal address.

3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

   - Has not been involved in your medical care prior to ordering the service; or
   - Is not involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

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

M. Reproduction

1. The following infertility treatment-related services:

   - Cryo-preservation and other forms of preservation of reproductive materials.
   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Infertility treatment for infertility resulting from voluntary sterilization procedures.

2. The following services related to a gestational carrier or surrogate:

   - Fees for the use of a gestational carrier or surrogate.
   - Pregnancy services for a gestational carrier or surrogate who is not a Covered Person.

3. The reversal of voluntary sterilization.

7. In vitro fertilization that is not used as an Assisted Reproductive Technology for the treatment of infertility.

N. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

3. Health care services for treatment of military service-related disabilities:

   - as a result of war or an act of war, if the illness or Injury occurs while you are serving in the military, naval or air forces of any country, combination of countries or international organization; and
   - as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the illness or Injury occurs while you are serving in such forces and are outside the United States and Canada.

4. Health care services during active military duty:

   - as a result of war or an act of war, if the illness or Injury occurs while you are serving in the military, naval or air forces of any country, combination of countries or international organization; and
   - as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the illness or Injury occurs while you are serving in such forces and are outside the United States and Canada.

O. Substance Use Disorders Services

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Substance Use Disorders Services* in *Section 1: Covered Health Care Services.*

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*

6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7. Transitional Living services.

P. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.

2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)

3. Health care services for transplants involving animal organs.
4. Transplant services not received from a Designated Provider will not be paid on a Network basis. Out-of-Network Benefits will apply, if applicable. This exclusion does not apply to cornea transplants.

Q. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back as determined by us. Refer to *Transplantation Services* in *Section 1: Covered Health Care Services* for more information. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.*

R. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care regardless of whether provided in a home setting or in a facility.
3. Private Duty Nursing.
4. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
5. Rest cures.
6. Services of personal care aides.
7. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

S. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Routine vision exams, including refractive exams to determine the need for vision correction.
3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
5. Bone anchored hearing aids except when either of the following applies:
   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

   Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

T. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or pharmaceutical products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war:
   - as a result of war or an act of war, if the illness or Injury occurs while you are serving in any civilian non-combatant unit supporting or accompany any military, naval or air forces of any country, combination of countries or international organization; and
   - as a result of the special hazards incident to service in any civilian non-combatant unit supporting or accompanying such forces, provided the illness or Injury occurs while you are serving in such unit and are outside the United States and Canada.

   Health services received as a result of war or any act of war, while you are not in the military, naval or air forces of any country, combination of countries or international organization or in any civilian non-combatant unit supporting or accompanying such forces, if the illness or Injury occurs outside the United States and Canada.
4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Charges in excess of the Allowed Amount or in excess of any specified limitation.
7. Follow-up care provided in a Hospital Emergency room.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Blood, blood plasma, blood derivatives and synthetic blood. This exclusion does not apply to services that are covered in *Section 1: Covered Health Care Services.* Apheresis or plasmapheresis, the collection and storage of blood or the cost of securing the services of blood donors are not covered.
10. Routine harvesting and storage of stem cells from newborn cord blood.
11. Autopsy.
12. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
13. Services or supplies that have been fraudulently obtained.

14. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for health care services that you receive before your effective date of coverage.

What If You Are Hospitalized When Your Coverage Begins?

We will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Policy.

These Benefits will be paid by us unless they are being paid by a prior carrier under such prior carrier's obligations with respect to extension of benefits under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network providers unless rendered to treat an Emergency as described in the Emergency Health Care Services Benefit in *Section 1: Covered Health Care Services* section. Covered Health Care Services received in accordance with the Emergency Health Care Services Benefit will be treated as Network Benefits regardless of whether the services were rendered by a Network or an out-of-Network provider.

Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent. Please contact the Benefits administrator of the Group for information on who they have determined is eligible to enroll under this Policy.

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms*.

Eligible Persons must live within the United States.

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

The term spouse 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.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

For a description of the *State of New Jersey Continuation for Over-Age Dependents*, see *Section 4: When Coverage Ends*.

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth. Coverage for a newborn child begins at the moment of birth and continues for 60 days as if the child were enrolled, without additional Premium for these 60 days.
- Legal adoption.
- Placement for adoption.
- Marriage or civil union.
- Legal guardianship.
- Court or administrative order.

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage or civil union.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (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.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including legal separation, divorce, dissolution of a civil union or death).
    - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.
    - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
    - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
    - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Unless you are entitled to *Extended Coverage for Total Disability*, your right to Benefits automatically ends on the date that coverage ends, even if you are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, we will still pay claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Please note that if you are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the date or the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent." The Group can provide you with specific information on which of these dates apply.

- **We Receive Notice to End Coverage**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the date or the last day of the calendar month in which we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later. The Group can provide you with specific information on which of these dates apply.

- **Subscriber Retires or Is Pensioned**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the date or the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Group's pension or retirement plan. The Group can provide you with specific information on which of these dates apply.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's *Application*, and only if the Subscriber continues to meet any applicable eligibility requirements. The Group can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 31 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. In this case, we will also refund the Premiums that were paid to us for your coverage.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of intellectual disability or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental or physical handicap or disability.
- The Enrolled Dependent child depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent child is medically incapacitated and dependent unless coverage otherwise ends in accordance with the terms of the Policy.

You must furnish us with proof of the incapacity and dependency within 31 days of the date coverage would have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year.

If you do not provide proof of the child's incapacity and dependency within 31 days of our request as described above, coverage for that child will end.

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Policy ends will not end automatically. We will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Twelve months from the date coverage would have ended when the entire Policy ends.
- The date maximum Benefits under the Policy have been received.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Policy on the day before a qualifying event:

- An employee (also referred to as "Subscriber").
- An Enrolled Dependent spouse of a Subscriber.
- An Enrolled Dependent child of the Subscriber. NOTE: if a covered Subscriber has a new child or adopts a new child during the continuation period, such new child will also be treated as a Qualified Beneficiary.
- Per federal law, Civil Union Partners and their Eligible Dependents are prohibited from obtaining COBRA continuation.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

The events listed below constitute “Qualifying Events” under COBRA. This means that if such event occurs and results in a loss of coverage to the Qualified Beneficiary under the group health plan the Qualified Beneficiary may be entitled to continue coverage for a certain period of time beyond the normal termination date. In order to continue coverage under this section, the appropriate Premium contributions must be made by (or on behalf of) the Qualified Beneficiary. Terminating Events for Continuation Coverage under Federal Law (COBRA) to determine the length of the continuation period). The Qualifying Events for an employee are as follows:

A. For Subscribers, the termination of employment with the Group (termination can be voluntary or involuntary but, if involuntary must be for any reason(s) other than gross misconduct), or loss of coverage as a result of a reduction of hours; or

B. For Enrolled Dependents, the death of the Subscriber; or

C. For the Enrolled Dependent spouse, the divorce or legal separation from the Subscriber; or

D. For the Enrolled Dependent children, the loss of eligibility under the terms of the group health plan (e.g., reaching the maximum age); or

E. For Enrolled Dependents, the Subscriber's entitlement to Medicare benefits that results in a loss of coverage for the Enrolled Dependents.

NOTE: Special rules apply for Groups filing for bankruptcy, under *Title XI, United States Code*. Please contact your Group's plan administrator for additional details regarding COBRA rights in the event of bankruptcy.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Subscriber or other Qualified Beneficiary must notify the Group's designated plan administrator within 60 days of the Subscriber's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Subscriber or other Qualified Beneficiary fails to notify the designated plan administrator of these events within the 60 day period, the Group and its plan administrator are not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under federal law, the Subscriber must notify the Group's designated plan administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Group's designated plan administrator.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial Premium due to the Group's designated plan administrator must be paid on or before the 45th day after electing continuation.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Policy will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required Premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D).

C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Subscriber's Medicare entitlement. For Enrolled Dependents of a Subscriber who becomes eligible for Medicare after the Subscriber’s qualifying event due to either termination of employment or reduction in work hours, may be entitled to 36 months of continuation coverage from the date of the Subscriber’s first qualifying event (subject to certain group health plan restrictions).

D. The date coverage terminates under the Policy for failure to make timely payment of the Premium.

E. The date, after electing continuation coverage that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Group filed for bankruptcy, (i.e. qualifying event F.)

G. The date the entire Policy ends.

H. The date coverage would otherwise terminate under the Policy as described in this section under the heading Events Ending Your Coverage.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Group filed for bankruptcy, (i.e. qualifying event F) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Subscriber's death. Terminating events B through G described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time (see section "C" above). Such Qualified Beneficiaries should contact the Group's designated plan administrator for information regarding the continuation period.

New Jersey Continuation Rights for Over-Age Dependents (NJCROD)

A dependent who has elected to continue his or her coverage under the group policy 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:

- Has reached the limiting age as described in this *Certificate of Coverage*, under *Section 9: Defined Terms*, but is less than 31 years of age;
- Is not married or part of a civil union or part of a domestic partnership;
- Has no Dependents of his or her own;
- Is either a resident of New Jersey or in enrolled as a full-time Student at an accredited school; and
- 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.

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 limiting age described in this *Certificate of Coverage*, 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.

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:

- 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.
- The Subscriber 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.

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

- The date the Over-Age Dependent gives written notice to us;
- The date the Over-Age Dependent pays the first premium; or
- The date the Dependent would otherwise lose coverage due to the attainment of the limiting age.

For a Dependent whose coverage has not yet terminated due to reaching the limiting age stated in this *Certificate of Coverage, Section 9: Defined Terms - Dependent*, the written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age.

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 or part of a civil union, 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 her 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 a 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 another 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.

Application of a Pre-Existing Conditions 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 credible coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy.

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 must be consistent with the requirements of P.L. 2005, c.375.

Continued Benefits

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

When Continuation Ends

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

The date the Over-Age Dependent:

- Attains age 31;
- Marries or enters a civil union;
- Acquires a Dependent;
- Is no longer either a resident of New Jersey or enrolled as a full-time Student at an accredited school; or
- 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.

- The end of the period for which Premium has been paid for the Over-Age Dependent, subject to the grace period for such payment;
- The date the Policy ceases to provide coverage to the Over-Age Dependent's Subscriber who is the employee under the Policy.
- The date the Policy under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
- The date the Over-Age Dependent's Subscriber who is covered as an Employee under the Policy waives Dependent coverage. Except if the Subscriber has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Subscriber waiving Dependent coverage.

State Continuation of Coverage for Totally Disabled Subscribers

If a Subscriber's coverage stops because his or her employment ends and the Subscriber meets the conditions shown below, the Subscriber may choose to continue the coverage then in effect. The Subscriber must meet the following conditions:

- The Subscriber's employment ended because he or she is Totally Disabled.
- The Subscriber must have been covered under the Policy for at least three months before his or her coverage would have stopped.
- The Subscriber must choose to continue coverage within 31 days after the date his or her coverage would have stopped.
- The Subscriber will have to make payments to the Group for the coverage.

Coverage will stop on the earliest of the following:

- The date the Subscriber becomes employed and eligible for another plan of group health coverage.
- The date coverage ends for failure to make timely payment of the Premium.
- The date the Policy ends.

"Totally Disabled" for the purpose of this state continuation means the Subscriber's complete inability due to Injury or Sickness to engage in any and every gainful occupation for which the Subscriber is or becomes reasonably fitted by education, training or experience and that the Subscriber is not engaged in any gainful occupation.

Optional State Continuation of Coverage After the Subscriber's Death

If the Subscriber dies while covered, his or her Dependents' coverage may continue. It will continue with the same benefits and provisions that the Subscriber's Dependents had while the Subscriber was alive. It will continue only while the Policy is in force. It will stop on the earlier of the following:

- The date of the Subscriber's widow's or widower's death, or the date the last child stops being an eligible Dependent, whichever happens later.
- 180 days after the date of the Subscriber's death.

The Subscriber's Dependents will have to make payments to the Group for the coverage.

After the Subscriber's widow's or widower's death, coverage for the Subscriber's Dependent children may be continued. It will continue with the same Benefits and provisions that the Subscriber's Dependents had while the Subscriber's widow or widower was alive. It will continue according to the rules and time limits described above.

Conversion

If your coverage Ends for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

If your marriage or civil union is dissolved, the Subscriber's former spouse may buy conversion coverage. The conversion coverage will be an individual policy. The Subscriber's former spouse may apply for conversion coverage at either of the following times:

- The date the marriage or civil union is dissolved.
- At the end of any period of continuation of coverage under the Policy, but only if the Policy is in force on that date.

Application and payment of the first Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, contact us. However, you are required to meet any applicable deductible and to pay any required Co-payments and Co-insurance to a Network provider.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, the out-of-Network provider is responsible for requesting payment from us. The out-of-Network provider must file the claim on the standard claim form prescribed by New Jersey that contains all of the information we require, as described below. At your option, you may also submit the claim to us directly.

A request for payment of Benefits should be submitted within 90 days after the date of service. If this information is not provided to us within 180 days of the date of service, Benefits for that health care service will be denied or reduced, subject to the appeal provisions in *Section 6, Questions, Complaints and Appeals*. This time limit does not apply if it was not reasonably possible to submit the request in the time required and the request was submitted as soon as reasonably possible. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, we will provide you with the appropriate forms to submit proof of loss. You must submit the completed form to us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

If your Benefit plan includes an *Outpatient Prescription Drug Rider* and you need to file a claim, your claim should be submitted to:

Optum RX

PO Box 29077

Hot Springs, AR 71903

If you do not receive the forms for proof of loss within 15 days of our receipt of notice of a claim, you may submit written proof of loss describing the occurrence, character and extent of the loss for which the claim is being made.

Payment of Benefits

We will pay Benefits within the time frames shown below after we receive a request for payment that includes all required information.

- 30 days after we receive a request submitted by electronic means.
- 40 days after we receive a request submitted by other than electronic means.

Requests for payment that include all required information which are not paid within these time frames will include an overdue payment of simple interest at the rate of 12% per annum.

When an assignment is not obtained, we will send the reimbursement directly to the Subscriber for reimbursement to an out-of-Network provider. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to an out-of-Network provider, and the out-of-Network provider submits a claim for payment, you and the out-of-Network provider represent and warrant the following:

- The Covered Health Care Services were actually provided.
- The Covered Health Care Services were medically appropriate.

In accordance with New Jersey law, a consumer may request a review from the Ombudsman of any disputed insurance claim settlement where there is reasonable cause to believe than an insurer has failed or refused to settle a claim in accordance with the provisions of the policy. Consumers seeking a review must file a complaint with the Ombudsman in any form, which indicates that the complainant is seeking review of a disputed claim. All complaints must be sent to:

The Office of Insurance Claims Ombudsman

20 West State Street

P.O. Box 472

Trenton, NJ 08625-0472

Telephone: (800)446-7467

Telefax: (609)292-2431

Email: ombudsman@dobi.state.nj.us

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the appropriate address.

If the representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

If you are not satisfied with our decision, you have the right to take your complaint to the *New Jersey Department of Banking and Insurance*.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a Rescission of Coverage determination, you can contact us in writing to request an appeal. You may also designate a representative (like your Physician) to appeal on your behalf.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the Adverse Benefit Determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below. For procedures associated with inpatient Substance Use Disorder Benefits, see *Appeals for Inpatient Substance Use Disorder Services* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 10 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 180 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 20 business days from receipt of a request for review of the first level appeal decision. The second level appeal process will provide you (or your provider, if applicable) the opportunity to pursue your appeal before a panel of Physicians and/or other providers that we select who have not been previously involved in the decision being appealed. This will be considered our Final Internal Adverse Benefit Determination.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 10 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 180 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 20 business days from receipt of a request for review of the first level appeal decision. This will be considered our Final Internal Adverse Benefit Determination.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

If an 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 the next level of 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 information on how to file the next level of appeal, if applicable, and any new or additional evidence or rationale, which we relied upon, considered or used in making our decision. We will provide this information, when applicable, in advance of our Final Internal Adverse Benefit Determination.

The notice will also include information on the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists covered persons with claims, internal appeals and external reviews.

You may have the right to external review through an *Independent Utilization Review Organization (IURO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

For appeals of benefit determinations concerning an Urgent Care Claim:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for Urgent Care Claims does not apply to prescheduled treatments, therapies or surgeries.

Appeals for Inpatient Substance Use Disorder Services

Benefits for *Substance Use Disorder Services* are provided as described in *Section 1: Covered Health Care Services.*

In the case of an Adverse Benefit Determination of an inpatient stay beyond the first 28 days during each plan year at a Network Facility, we will provide you and your Physician written notice within 24 hours. You or your Physician will then have the right to file an internal appeal of our decision. We will provide you with a written or electronic determination of your appeal within 24 hours following receipt of your request for review of the determination.

You may have the right to external review through an *Independent Utilization Review Organization (IURO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

External Review Program

If you are not satisfied with the results of our internal appeal process, you may pursue an external review 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 of Coverage, 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 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 review, 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 covered person 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 the 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 Health Care Service under the Certificate;

3.Unless we have failed to comply with the deadlines for completion of the internal appeals process without good cause; we have expressly waived our rights to an internal review; or you have 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 Health Care 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 Covered Health Care 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 covered person or jeopardize the covered person'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 Health Care Services, it shall advise to you, your Provider, the Department of Banking and Insurance and us its decision regarding the appropriate, 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 Covered Health Care 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 review process. Any member or any Provider acting on behalf of a member with the member's 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 appeal or external review

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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 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 provision; or
- All Plans which cover you use order of benefit determination rules consistent with those contained in the Coordination of Benefits 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 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 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.

What Are the Rules for Determining the Order of Benefit Payments?

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 Covered Person. You are liable only for the applicable deductible, Co-insurance or Co-payment. 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, Co-insurance or Co-payment 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 Co-payment, Co-insurance 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 Co-payment, deductible or Co-insurance under the Secondary Plan if you have no liability for Co-payment, deductible or Co-insurance 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 Co-payment, Co-insurance 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, Co-insurance or Co-payment 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, Co-insurance or Co-payment 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, Co-insurance or Co-payment imposed by the Primary Plan. You shall not be liable to pay any deductible, Co-insurance or Co-payments 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.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Care Services, which are more fully described in this *Certificate*.
- The Policy may not pay for all treatments you or your Physician may believe are needed. If the Policy does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.

We do not provide health care services or supplies, or practice medicine. We arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. We are not responsible for any act or omission of any provider unless:

- It is determined by a court of law under the provisions of the *New Jersey Health Care Carrier Accountability Act, 2001* that the provider acted as our agent and that we had the right to exercise influence or control, or actually exercised influence or control over the health care treatment decisions of that provider.
- The other elements for establishing our liability under the Act are proven..

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Groups?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy unless it is contained in a written application signed by the Group. No such statement shall void or reduce coverage under the Policy or be used in defense of a legal action unless it is contained in a written application signed by the group or a Subscriber, as applicable.

Do We Pay Incentives to Providers?

We pay Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

An example of a financial incentive for Network providers is capitation. Capitation is when a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage our members to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-

Oxford entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. When programs are available, we will provide materials to you with detailed information and how to access them. Contact us at www.oxhp.com or the telephone number on your ID card if you have any questions.

Do We Receive Rebates and Other Payments?

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed onto you, they may be taken into account in determining your Co-payment and/or Co-insurance.

Who Interprets Benefits and Other Provisions under the Policy?

Subject to your appeal rights set forth in the Questions, Complaints and Appeals Procedures Section, we will do the following:

- Make the initial interpretations of Benefits under the Policy.
- Make the initial interpretations of the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

This discretionary authority to interpret Benefits, other terms, conditions, limitations and exclusions under the Policy is subject to modification or reversal by a court or regulatory agency with appropriate jurisdiction.

It does not alter or affect your rights under state or federal statutes or regulations, including the right to bring legal action against us. It does not alter or affect your rights to make a complaint or appeal a denial, including use of the *Independent Health Care Appeals Program*.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and the Group and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group’s next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.

- No one has authority to make any oral changes or amendments to the Policy.

Any subsequent changes in Benefits will be shown in a Rider or Amendment issued to Subscribers.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Is Workers' Compensation Affected?

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.

- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

Except in cases of fraudulent claims, we will make a written request for the reimbursement no later than 18 months after the date the first payment of the claim was made. The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

In seeking reimbursement for the overpayment from the health care provider, we will not collect or attempt to collect:

- the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;
- the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal are exhausted; or
- a monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee.

We may collect the funds for the reimbursement request by assessing them against payment of any future claims submitted by the health care provider after the 45th calendar day following the submission of the reimbursement request to the health care provider or after the health care provider's rights to appeal have been exhausted if we submit an explanation in writing to the provider in sufficient detail so that the provider can reconcile each Covered Person's bill.

If we determine that the overpayment to the health care provider is a result of fraud committed by the health care provider and we have conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, we may collect an overpayment by assessing it against payment of any future claim submitted by the health care provider.

Is There a Limitation of Action?

No legal action may be brought against us prior to the expiration of 60 days after proof of loss has been filed. Additionally, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Benefits*, the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.

Section 9: Defined Terms

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on: a determination of an individual's eligibility to participate in a plan or health insurance coverage; a determination that a benefit is not a covered benefit; the imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; a determination that a benefit is experimental, investigational, or not medically necessary or appropriate; a denial of a request for an In-plan Exception; or a Rescission of Coverage.

Allowed Amounts - for Covered Health Care Services, incurred while the Policy is in effect, Allowed Amounts are determined by us as shown in the *Schedule of Benefits*.

Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines. We develop these guidelines, as we determine, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance Use Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us and the Group. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - the total of the Allowed Amount you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Assisted Reproductive Technology (ART) - the term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

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:

- chaining;
- functional analysis;
- functional assessment;
- functional communication training;
- modeling, including video modeling (also known as imitation training);
- procedures designed to reduce challenging and dangerous behaviors (e.g. differential reinforcement, extinction, time out, and response cost);
- prompting; and

reinforcement systems, including differential reinforcement, shaping and strategies to promote generalization.

Benefits - your right to payment for Covered Health Care Services that are available under the Policy.

Biologically-Based Mental Illness - a mental or nervous 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, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

Civil Union Partners - 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 all of the rights and benefits of marriage.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Co-insurance - the charge, stated as a percentage of the Allowed Amount, that you are required to pay for certain Covered Health Care Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Co-payment.
- The Allowed Amount.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or pharmaceutical products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorders, condition, disease or its symptoms.
- Medically Necessary or medically appropriate.
- Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - the Subscriber's legal spouse, Civil Union Partner or a child of the Subscriber or the Subscriber's spouse, Civil Union Partner. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above who is under age 26.
- A Dependent includes an unmarried child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age 26.

If we are not notified that a child no longer meets the above requirements, the Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

The Dependent age limit will be specified in your *Schedule of Benefits*, including if your Group has chosen a Dependent age above 26.

For a description of the State of New Jersey Continuation for Over-Age Dependents, see *Section 4: When Coverage Ends.*

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that we have identified as Designated Providers. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or condition; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting us at www.oxhp.com or the telephone number on your ID card.

Developmental Disability - a severe, chronic disability of a person which:

- is attributable to a mental or physical impairment or combination of mental or physical impairments;
- is manifested before age 22;
- is likely to continue indefinitely;
- 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
- 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 mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy. An Eligible Person must live within the United States.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

Emergency Health Care Services - with respect to an Emergency:

- A medical screening exam (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use; except that coverage is provided for a drug which has been prescribed for a treatment for which the drug has not been approved by the *FDA* provided the drug is recognized for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: (1) the *U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USPDI)*; (2) the *American Medical Association's Drug Evaluations (AMADE)*; or (3) The *American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHES-DI)* or, it is recommended by a clinical study or review article in a major peer reviewed professional journal. However, there is no coverage for any drug which the *FDA* has determined to be contraindicated for the specific treatment for which the drug has been prescribed.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
  - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*; and
  - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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 means an Adverse Benefit Determination that has been upheld by a plan or issuer at the completion or exhaustion of the internal appeals process.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Home Health Agency - a program or organization authorized by law to provide health care services in the home or is Medicare certified.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

In-plan Exception means a request by a Covered Person or provider to obtain Medically Necessary Covered Health Care Services from an out-of-network provider, with the Covered Person's liability limited to network level cost sharing, because the carrier's network does not have providers who are qualified, accessible, and available to perform the Medically Necessary Covered Health Care Services the Covered Person requires.

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.

Infertility - 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:

- A male is unable to impregnate a female;
- A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
- A female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;

- 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;
- 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;
- Partners are unable to conceive as a result of involuntary medical sterility;
- A person is unable to carry a pregnancy to live birth; or
- A previous determination of infertility pursuant to New Jersey state law.

Inherited Metabolic Disease - a disease caused by an inherited abnormality of body chemistry.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment - a structured outpatient mental health or substance use disorders treatment program. The program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Low Protein Modified Food Product - a food product that is specifically formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease, but does not include a natural food that is naturally low in protein.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medical Food - a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary - health care services that are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

With respect to treatment of Substance Use Disorder the determination of medical necessity shall use an evidence-based and peer reviewed clinical tool as designated in regulation by the *Commissioner of Human Services in consultation with the Department of Health*.

With respect to Pharmaceutical Products, no prescribed drug shall be excluded on the basis that the drug has not been approved by the *United States Food and Drug Administration (USFDA)* for the use for which the drug has been prescribed, if such drug is recognized as medically appropriate for the specific treatment for which it has been prescribed by the *American Hospital Formulary Service Drug Information,* the *United States Pharmacopoeia Drug Information* or a clinical study or review article in a major peer reviewed professional journal.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.oxhp.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Care Services - Covered Health Care Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance Use Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance Use Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association.* The fact that a condition is

listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service. Mental Illness includes Biologically Based Mental Illnesses.

Network - a provider of health care services that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services by way of their participation in the Shared Savings Program. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

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*.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: 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 the Policy.

Policy - the entire agreement issued to the Group that includes all of the following:

- *Group Policy*.
- *Certificate*.
- *Schedule of Benefits*.
- Group *Application*.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Group.

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

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:

- activity schedules;
- discrete trial instruction;
- incidental teaching;
- natural environment training;
- picture exchange communication system;
- pivotal response treatment;
- script and script-fading procedures; and
- self-management.

Rescission of Coverage means a retroactive cancellation or discontinuance of coverage, e.g., policy void from enrollment, or benefits previously paid that are declared void, due to fraud or intentional misrepresentation of material fact. Please note that we will provide 30 days advance written notice to the Subscriber of a Rescission of Coverage and that coverage will end on the date we identify in the notice if any form of fraud or intentional misrepresentation of a material fact.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance Use Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the Mental Health/Substance Use Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance Use Disorder Designee.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
  - 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.

Rider - any attached written description of additional Covered Health Care Services not described in this *Certificate*. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. (Note that if you have Benefits for Outpatient Prescription Drugs, while presented in Rider format, they are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.) Riders are effective only when signed by us and the Group and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Shared Savings Program - a program in which we may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider. When this happens, you may experience lower out-of-pocket amounts. Co-insurance and any applicable deductible would still apply to the reduced charge. Policy provisions or administrative practices supersede the scheduled rate, and a different rate is determined by us. In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by us. If this happens, you should call the telephone number shown on your ID card. Shared Savings Program providers are not Network providers and are not credentialed by us.

To determine whether a provider is part of the Shared Savings Program, contact us at the telephone number on your ID card.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* includes Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

Substance Use Disorders Services - Covered Health Care Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Living - Mental Health Care Services and Substance Use Disorders Services provided through transitional living facilities, group homes and supervised apartments which provide 24-hour supervision and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

These include:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.oxhp.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Care Services that are non-life-threatening but that require care by a provider within 24 hours.

Urgent Care Claim means 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 covered person or the ability of the covered person to regain maximum function or that, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Kidney Donor Travel and Lodging Program Rider

Oxford Health Insurance Inc.

This Rider to the Policy provides a donor travel and lodging allowance related to living kidney transplantation.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to Oxford Health Insurance, Inc.

Kidney Donor Travel and Lodging Program

The *Kidney Donor Travel and Lodging Program* provides support for living kidney donors when the intended recipient of the kidney is a Covered Person under the Policy. The program provides an allowance for travel and lodging expenses for an approved living kidney donor and travel companion. The living kidney donor is not required to be a Covered Person under the Policy.

Donors must be approved by us for participation in this program. This program provides an allowance for incurred travel and lodging expenses only and is independent of any existing medical coverage available for the donor or Covered Person. Once approved, an allowance of up to $5,000 per donor will be provided for travel and lodging expenses incurred as a part of the entire kidney donation process, based on the *U.S. General Services Administration* travel rates. Expenses incurred will include travel and lodging expenses for the donor's first evaluation through follow-up evaluation(s) up to two years after donor surgery.

If you would like additional information regarding the *Kidney Donor Travel and Lodging Program*, you may contact us at www.oxhp.com.

Wellness Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group as described below.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms.*

This Rider describes the health and wellness tool that applies digital experiences, tools, games and rewards and is designed to engage Covered Persons in managing their health.

Who Is Eligible?

Participation is available to Covered Persons age 13 years and older; however, wellness rewards are only available to Covered Persons age 18 years and older.

What Are the Wellness Opportunities?

The health and wellness tool includes a wide range of wellness engagement opportunities. Engagement opportunities include the following:

- Interactive social media and games, which may include taking part in wellness challenges and health communities.
- *Health Survey*.
- *Online Personal Health Record*.
- An *Invite* to create personal missions.
- Integration with a variety of wellness devices (for example, wearable wireless trackers and mobile tools).

What Are the Rewards?

Covered Persons, age 18 years and older, receive wellness rewards for taking part in health and wellness opportunities as described above. When you take part in a health and wellness opportunity, you earn "coins" as a reward. For example, you may earn 40 coins for completing a *Health Survey*. Coins can be saved up and you use the coins to enter into sweepstakes.

If you cannot meet a standard for certain wellness rewards, then you might qualify to earn the same reward by different means. You may call us at 1-877-818-5826 and we will work with you (and, if needed, with your doctor) to find another way for you to earn the same reward.

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.

Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc. and Oxford Health Plans (NJ), Inc.
Oxford insurance products are underwritten by Oxford Health Insurance, Inc.

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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.

Domestic Partner Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group and provides coverage for Domestic Partners.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the Certificate of Coverage (*Certificate)* in *Section 9: Defined Terms* and in this Rider below.

When we use the words "we", "us", and "our" in this document, we are referring to Oxford Health Insurance, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

Coverage for Domestic Partners

The provisions below replace the provision shown in the *Certificate* in order to add coverage for Domestic Partners and Life Partners when they are enrolled as Dependents of Subscribers.

Section 3: When Coverage Begins

The section titled Adding New Dependents in the Certificate, Section 3: When Coverage Begins, is replaced with the following:

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth. Coverage for a newborn child begins at the moment of birth and continues for 60 days as if the child were enrolled, without additional Premium for these 60 days.
- Legal adoption.
- Placement for adoption.
- Marriage or civil union.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.
- Addition of Life Partner

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event.

The section titled Special Enrollment Period in the Certificate, Section 3: When Coverage Begins, is replaced with the following:

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage or civil union.
- Registering a Domestic Partner.
- Addition of Life Partner

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (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.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including legal separation, divorce, dissolution of a civil union, dissolution of Domestic Partnership or Life Partnership or death).
    - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.
    - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
    - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
    - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 9: Defined Terms

The definition of Dependent in the Certificate under Section 9: Defined Terms is replaced with the following:

Dependent - the Subscriber's legal spouse, Civil Union Partner or a child of the Subscriber or the Subscriber's spouse or Civil Union Partner. All references to the spouse of a Subscriber shall include a Domestic Partner or Life Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above who is under the age 26.
- A Dependent includes an unmarried child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age 26.

If we are not notified that a child no longer meets the above requirements, the Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

For a description of the State of New Jersey Continuation for Over-Age Dependents, see *Section 4: When Coverage Ends.*

The following definitions are added to the Certificate under Section 9: Defined Terms:

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has a Domestic Partnership under either statutory or common law.

Domestic Partnership - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same permanent residence and the common necessities of life.
- They must be financially interdependent and they have furnished documents to support one of the following conditions of such financial interdependence:
    - They have a single dedicated relationship of at least 12 months.
    - They have joint ownership of a residence.
    - They have at least two of the following:
        - A joint ownership of an automobile.
        - A joint checking, bank or investment account.
        - A joint credit account.
        - A lease for a residence identifying both partners as tenants.

- A will and/or life insurance policies which designates the other as primary beneficiary.

The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

Life Partner - a person of the opposite or same sex with whom the Subscriber has established a Life Partnership.

Life Partnership - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, in a Civil Union Partnership or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be financially interdependent and they have furnished documents to support one of the following conditions of such financial interdependence:
- They have joint ownership of a residence.
- They have at least two of the following:
  - A joint ownership of an automobile.
  - A joint checking, bank or investment account.
  - A joint credit account.
  - A lease for a residence identifying both partners as tenants.
  - A will and/or life insurance policies which designates the other as primary beneficiary.

Oxford HMO products are underwritten by Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Administrative services provided by Oxford Health Plans LLC.

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