

This Contract has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the HMO health benefits plan.

Cigna HealthCare of New Jersey, Inc. HMO PLAN

INDIVIDUAL HEALTH MAINTENANCE ORGANIZATION (HMO) CONTRACT

Notice of Right to Examine Contract. Within 30 days after delivery of this Contract to You, You may return it to Us for a full refund of any Premium paid, less the cost for services provided. The Contract will be deemed void from the beginning.

EFFECTIVE DATE OF CONTRACT: January 1, 2018

Renewal Provision. Subject to all Contract terms and provisions, including those describing Termination of the Contract, You may renew and keep this Contract in force by paying the premiums as they become due. We agree to arrange or provide services under the terms and provisions of this Contract. In consideration of the application for this Contract and the payment of premiums as stated herein, We agree to arrange or provide services and supplies in accordance with and subject to the terms of this Contract. This Contract is delivered in New Jersey and is governed by the laws thereof.

This Contract takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in its General Provisions.

Cigna HealthCare of New Jersey, Inc.
499 Washington Blvd
Jersey City, NJ 07310

If You require assistance with a claim, or need additional information about the benefits provided in this Agreement, please contact Us at the toll-free number on the back of your Cigna HealthCare ID card, or visit our website at www.myCigna.com.

Please include Your Cigna HealthCare identification number with any correspondence. This number can be found on Your Cigna HealthCare ID card.

NOTICE

Proficiency of Language Assistance Services

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-244-6224 (TTY: Dial 711).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-244-6224 (TTY: 711).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-244-6224 (TTY: 711)

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-244-6224 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-244-6224 (TTY: 711)번으로 전화해 주십시오.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-244-6224 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-244-6224 (телетайп: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-244-6224 (رقم هاتف الصم والبكم: 711).

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-244-6224 (TTY: 711).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-244-6224 (ATS: 711).

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-244-6224 (TTY: 711).

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-244-6224 (TTY: 711).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-244-6224 (TTY: 711) まで、お電話にてご連絡ください。

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-244-6224 (TTY: 711).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-244-6224 (TTY: 711).

Persian (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-244-6224 (TTY: 711) تماس بگیرید.

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SCHEDULE OF PREMIUM RATES

The initial monthly premium rates, in U.S. dollars, for the coverage provided under this Contract are set forth on the rate sheet for this Contract for the effective date shown on the first page of this Contract.

We have the right to prospectively change any Premium rate(s) set forth above at the times and in the manner established by the provision of this Contract entitled "General Provisions."

Monthly Rate Schedule (effective Jan 1, 2018)

Age	Monthly Rate	Age	Monthly Rate
0 - 14	\$550.65	40	\$919.91
15	\$599.59	41	\$937.18
16	\$618.31	42	\$953.74
17	\$637.02	43	\$976.77
18	\$657.18	44	\$1,005.56
19	\$677.33	45	\$1,039.39
20	\$698.21	46	\$1,079.70
21	\$719.80	47	\$1,125.05
22	\$719.80	48	\$1,176.87
23	\$719.80	49	\$1,227.98
24	\$719.80	50	\$1,285.56
25	\$722.68	51	\$1,342.43
26	\$737.08	52	\$1,405.05
27	\$754.35	53	\$1,468.39
28	\$782.42	54	\$1,536.78
29	\$805.46	55	\$1,605.16
30	\$816.97	56	\$1,679.30
31	\$834.25	57	\$1,754.16
32	\$851.52	58	\$1,834.05
33	\$862.32	59	\$1,873.64
34	\$873.84	60	\$1,953.54
35	\$879.60	61	\$2,022.64
36	\$885.36	62	\$2,067.99
37	\$891.11	63	\$2,124.85
38	\$896.87	64 and over	\$2,159.40
39	\$908.39		

If You have more than one (1) Member enrolled, the total rate is the sum of the individual rates, except where there are more than three (3) Dependent children under the age of twenty-one (21) enrolled in this Contract. In that case, the rate will be the sum of the Contract holder, Spouse and all eligible Dependents over the age of twenty-one (21) rates (if applicable), plus the rate for the first three (3) Dependent children under the age of twenty-one (21).

SCHEDULE OF SERVICES AND SUPPLIES

The services or supplies covered under this Contract are subject to the Copayments, Deductible and Coinsurance set forth below and are determined per Calendar Year per Member, unless otherwise stated. Maximums only apply to the specific services provided.

COPAYMENT

Primary Care Provider but not for Preventive Care Visits	\$50, deductible waived
Specialist	\$75, deductible waived
Preventive Care	NONE
Mental Health Outpatient Visits	\$50, deductible waived
Maternity (pre-natal care)	NONE
Inpatient Hospital Facility	50%, after deductible
All other services and supplies	Copayment Not Applicable; Refer to the Deductible and Coinsurance sections

DEDUCTIBLE PER CALENDAR YEAR

• Preventive Care and immunizations and lead screening for children	NONE
• Maternity (pre-natal care)	NONE
• All other Covered Services and Supplies	
• Per Member	\$2,500
• Per Covered Family	\$5,000

COINSURANCE

Preventive Care:	NONE
Prescription Drugs	50%, after deductible per 90-day supply
Pediatric Dental (thru age 18)-Orthodontia	50%
Advance Radiological Imaging	50% per scan, after deductible
All services and supplies to which a Copayment does not apply	50%, after deductible
All services and supplies to which a Copayment applies	NONE

MAXIMUM OUT OF POCKET

Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Covered Services and Supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Covered Services and Supplies for the remainder of the Calendar Year.

The **Maximum Out of Pocket** for this Contract is as follows:

• Per Member per Calendar Year	\$7,350
• Per Family per Calendar Year	\$14,700

Note: The Maximum Out of Pocket cannot be met with Non-Covered Services and Supplies.

LIMITATIONS ON SERVICES AND SUPPLIES

Home Health Care Unlimited days, subject to Pre-Approval.

Hospice Services Unlimited days, subject to Pre-Approval.

Speech Therapy 30 visits per Calendar Year
See below for the separate benefits available under the
Diagnosis and Treatment of Autism or other Developmental
Disabilities provision

Cognitive Rehabilitation Therapy 30 visits per Calendar Year

Physical Therapy 30 visits per Calendar Year
See below for the separate benefits available under the
Diagnosis and Treatment of Autism or other Developmental
Disabilities provision

Occupational Therapy 30 visits per Calendar Year
See below for the separate benefits available under the
Diagnosis and Treatment of Autism or other Developmental
Disabilities provision

Charges for physical, occupational and speech therapy per
Calendar Year provided under the Diagnosis and Treatment
of Autism and Other Developmental Disabilities Provision

Note: These services are habilitative services in that they are provided
to help develop rather than restore a function. The 30-visit limit does not
apply to the treatment of autism.

(limit applies separately to each therapy and is in addition to
the therapy visits listed above) 30 visits

Hearing aids for a Member
age 15 or younger One hearing aid per impaired ear
every 24 months

Therapeutic Manipulation 30 visits per Calendar Year

Skilled Nursing Facility/Extended Care Center Unlimited days, subject to Pre-
Approval

Pediatric Vision Benefits	<u>REIMBURSEMENT</u>
<p>Pediatric Vision Care Performed by an Ophthalmologist or Optometrist for an Insured Person, through the end of the month in which the enrollee turns 19 years of age.</p> <p>Please be aware that the Pediatric Vision network is different than the network of your medical benefits.</p>	
<p>Comprehensive Eye Exam <i>Limited to one exam per year</i></p>	<p>You Pay 40%, deductible waived</p>
<p>Eyeglasses for Children Pediatric Frames</p>	<p>You Pay 40%, deductible waived</p>
<p>Single Vision Lenses,</p>	<p>You Pay 40%, deductible waived</p>
<p>Lined Bifocal Lenses,</p>	<p>You Pay 40%, deductible waived</p>
<p>Lined Trifocal or Standard Progressive Lenses,</p>	<p>You Pay 40%, deductible waived</p>
<p>Lenticular Lenses</p>	<p>You Pay 40%, deductible waived</p>
<p><i>Limited to one pair per year</i></p>	
<p>Contact Lenses for Children Elective</p>	<p>You Pay 40%, deductible waived</p>
<p>Therapeutic</p>	<p>You Pay 40%, deductible waived</p>
<p><i>Limited to one pair or a single purchase of a supply in lieu of Frame and Lenses, per year</i></p>	

NOTE: NO SERVICES OR SUPPLIES WILL BE PROVIDED IF A MEMBER FAILS TO OBTAIN A REFERRAL FOR CARE THROUGH HIS OR HER PRIMARY CARE PROVIDER. READ THE MEMBER PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES" FOR A LIST OF THE SERVICES AND SUPPLIES FOR WHICH A MEMBER IS NOT ELIGIBLE FOR COVERAGE UNDER THIS CONTRACT.

DEFINITIONS

The words shown below have specific meanings when used in this Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help Members understand what services and supplies are provided.

ACCREDITED SCHOOL. A school accredited by a nationally recognized accrediting association, such as one of the following regional accrediting agencies: Middle States Association of Colleges and Schools, New England Association of Schools and Colleges, North Central Association of Colleges and Schools, Northwest Association of Schools and Colleges, Southern Association of Colleges and Schools, or Western Association of Schools and Colleges. An accredited school also includes a proprietary institution approved by an agency responsible for issuing certificates or licenses to graduates of such an institution.

ALLOWED CHARGE. An amount that is not more than the negotiated fee schedule.

AMBULANCE. A certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by applicable state and local law.

AMBULATORY SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:

- a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
- b) have operating and recovery rooms;
- c) be staffed and equipped to give emergency care; and
- d) have written back-up arrangements with a local Hospital for emergency care.

It must carry out its stated purpose under all relevant state and local laws and be either:

- a) accredited for its stated purpose by either The Joint Commission or the Accreditation Association for ambulatory care; or
- b) approved for its stated purpose by Medicare.

A Facility is not an Ambulatory Surgical Center, for the purpose of this Contract, if it is part of a Hospital.

ANNUAL OPEN ENROLLMENT PERIOD. The designated period of time each year during which:

- a) individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and
- b) individuals who already have coverage may replace current coverage with a different standard health benefits plans or standard health benefits plan with rider.

APPROVED CANCER CLINICAL TRIAL. A scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer in human beings that meets the following requirements:

- a) The treatment or intervention is provided pursuant to an approved cancer clinical trial that has been authorized or approved by one of the following: 1) The National Institutes of Health (Phase I, II and III); (2) the United States Food and Drug Administration, in the form of an investigational new drug (IND) exemption (Phase I,

II and III); 3) The United States Department of Defense; or 4) The United States Department of Veteran Affairs.

- b) The proposed therapy has been reviewed and approved by the applicable qualified Institutional Review Board.
- c) The available clinical or pre-clinical data to indicate that the treatment or intervention provided pursuant to the Approved Cancer Clinical Trial will be at least as effective as standard therapy, if such therapy exists, and is expected to constitute an improvement in effectiveness for treatment, prevention and palliation of cancer.
- d) The Facility and personnel providing the treatment are capable of doing so by virtue of their experience and training.
- e) The trial consists of a scientific plan of treatment that includes specified goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of quantitative measures for determining treatment response and methods for documenting and treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval by one of the federal entities identified in item a. A cost-benefit analysis of clinical trials will be performed when such an evaluation can be included with a reasonable expectation of sound assessment.

BIRTHING CENTER. A Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

- a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
- b) be staffed and equipped to give emergency care; and
- c) have written back-up arrangements with a local Hospital for emergency care.

It must:

- a) carry out its stated purpose under all relevant state and local laws; or
- b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
- c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of this Contract, if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CHURCH PLAN. Has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974"

COINSURANCE. The percentage of Covered Services or Supplies that must be paid by a Member. Coinsurance does not include Copayments or Cash Deductible.

COMPLEX IMAGING SERVICES. Any of the following services:

- a) Computed Tomography (CT),

- b) Computed Tomography Angiography (CTA),
- c) Magnetic Resonance Imaging (MRI),
- d) Magnetic Resonance Angiogram (MRA),
- e) Magnetic Resonance Spectroscopy (MRS)
- f) Positron Emission Tomography (PET),
- g) Nuclear Medicine including Nuclear Cardiology.

CONTRACT. This contract, including the application and any riders, amendments or endorsements, between the Contractholder and Cigna HealthCare of New Jersey, Inc.

CONTRACTHOLDER. The person who purchased this Contract.

COPAYMENT. A specified dollar amount which Member must pay for certain Covered Services or Supplies. **NOTE:** The Emergency Room Copayment, if applicable, must be paid in addition to any other Copayments.

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of this Contract. Read the entire Contract to find out what We limit or exclude.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.) The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:

- a) is furnished mainly to help Member meet Member's routine daily needs; or
- b) can be furnished by someone who has no professional health care training or skills.

Even if a Member is in a Hospital or other recognized Facility, We do not provide for that part of the care which is mainly custodial.

DEPENDENT.

Your:

- a) Spouse;
- b) Dependent child who is under age 26.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Eligibility** section of this Contract.

Your "Dependent child" includes:

- a) Your biological child,
- b) Your legally adopted child,
- c) Your foster child from the time the child is placed in the home,
- d) Your step-child,

- e) the child of Your civil union partner,
- f) the child of Your Domestic Partner, and
- g) children under a court appointed guardianship.

We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any other child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent child under this Contract provided the child depends on You for most of the child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)

A Dependent does not include a person who resides in a foreign country. However, this does not apply to a person who is attending an Accredited School in a foreign country who is enrolled as a student for up to one year at a time.

At Our discretion, We can require proof that a person meets the definition of a Dependent.

DEVELOPMENTAL DISABILITY or DEVELOPMENTALLY DISABLED. A severe, chronic disability that:

- a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
- b) is manifested before the Member attains age 26.
- c) is likely to continue indefinitely;
- d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
- e) reflects the Member's need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:

- a) radiology, ultrasound, and nuclear medicine;
- b) laboratory and pathology; and
- c) EKG's, EEG's, and other electronic diagnostic tests.

DISCRETION / DETERMINATION / DETERMINE. Our right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

DOMESTIC PARTNER. As used in this Policy and pursuant to P.L. 2003, c. 246 means an individual who is age 18 or older who is the same sex as the Policyholder, and has established a domestic partnership with the Policyholder by filing an affidavit of domestic partnership and obtaining a certificate of domestic partnership from their local registrar.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

- a) designed and able to withstand repeated use;
- b) used primarily and customarily for a medical purpose;
- c) is generally not useful to a Member in the absence of an Illness or Injury; and
- d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, wheelchairs and hearing aids which are covered through age 15.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Member's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment. Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

EFFECTIVE DATE. The date on which coverage begins under this Contract for You or Your Dependents, as the context in which the term is used suggests.

ELIGIBLE PERSON. A person who is a Resident of New Jersey who is not covered under Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. § 1395 et. seq.) (Medicare).

EMERGENCY. A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of Substance Abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an Emergency exists where: there is inadequate time to effect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn child.

ENROLLMENT DATE. means the Effective Date of coverage under this Contract for the person.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We Determine are:

- a) not of proven benefit for the particular diagnosis or treatment of a Member's particular condition; or

- b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular condition; or
- c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for treatment for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Member's particular condition, as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

- I. The American Hospital Formulary Service Drug Information; or
- II. The United States Pharmacopeia Drug Information.

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with

measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

EXTENDED CARE CENTER. See Skilled Nursing Facility.

FACILITY. A place which:

- a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
- b) provides health care services which are within the scope of its license, certificate or accreditation.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

GOVERNMENTAL PLAN. Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the “Employee Retirement Income Security Act of 1974” and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

GROUP HEALTH PLAN. An employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the “Employee Retirement Income Security Act of 1974” (ERISA) (29 U.S.C. § 1002(1)) to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate or any other similar contract, policy, or plan delivered or issued for delivery in New Jersey not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or more, or any combination

of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance, workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health plan.

HEALTH STATUS-RELATED FACTOR. Any of the following factors: health status; medical condition, including both physical and Mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for terminally Ill or terminally Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

- a) be approved for its stated purpose by Medicare; or
- b) it is accredited for its stated purpose by either The Joint Commission, the Community Health Accreditation Program or the Accreditation Commission for Health Care.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

- a) be accredited as a Hospital by The Joint Commission, or
- b) be approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or Substance Abusers is not a Hospital.

ILLNESS or ILL. A sickness or disease suffered by a Member or a description of a Member suffering from a sickness or a disease.

INJURY or INJURED. Damage to a Member's body, and all complications arising from that damage or a description of a Member suffering from such damage.

INPATIENT. Member if physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such a setting.

LEGEND DRUG. Any drug which must be labeled "Caution – Federal Law prohibits dispensing without a prescription.

MAIL ORDER PROGRAM. A program under which a Member can obtain Prescription Drugs from:

- a) a Participating Mail Order Pharmacy by ordering the drugs through the mail; or
- b) a Participating Pharmacy that has agreed to accept the same terms, conditions, price and services as a Participating Mail Order Pharmacy.

MAINTENANCE DRUG. Only a Prescription Drug used for the treatment of chronic medical conditions.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

- a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
- b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
- c) in accordance with generally accepted medical practice;
- d) not for a Member's convenience;
- e) the most appropriate level of medical care that a Member needs; and
- f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of an Emergency, the fact that a Non-Network Provider prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

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

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

MEMBER. An eligible person who is covered under this Contract.

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

- a) accredited for its stated purpose by The Joint Commission;
- b) approved for its stated purpose by Medicare or
- c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL ILLNESS. A behavioral, psychological or biological dysfunction. Mental Illness includes a biologically-based Mental Illness as well as a Mental Illness that is not biologically-based. With respect to Mental Illness that is biologically based, Mental Illness means a condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

The current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association may be consulted to identify conditions that are considered Mental Illness.

NETWORK PROVIDER. A Provider which has an agreement directly or indirectly with Us to provide Covered Services or Supplies. You will have access to up-to-date lists of Network Providers.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies, or which exceed any of the limitations shown in this Contract.

NON-NETWORK PROVIDER. A Provider which is not a Network Provider.

NON-PREFERRED DRUG. A drug that has not been designated as a Preferred Drug.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

- a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
- b) provides medical services which are within the scope of the nurse's license or certificate.

ORTHOTIC APPLIANCE. 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

OUTPATIENT. Member, if **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such Outpatient settings.

PARTICIPATING MAIL ORDER PHARMACY. A licensed and registered pharmacy operated by Cigna Home Delivery Pharmacy or with whom Cigna Home Delivery Pharmacy has signed a pharmacy service agreement, that is:

- a) equipped to provide Prescription Drugs through the mail; or
- b) is a Participating Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement.

PARTICIPATING PHARMACY. A licensed and registered pharmacy operated by Us or with whom We have signed a pharmacy services agreement.

PHARMACY. A facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

PRACTITIONER. A medical practitioner who:

- a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
- b) provides medical services which are within the scope of the practitioner's license or certificate.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

PRE-APPROVAL or PRE-APPROVED. Specific direction or instruction from a Network Practitioner or from Us in conformance with Our policies and procedures that authorizes a Member to use a Provider for health care services or supplies.

PREFERRED DRUG. A Prescription Drug that: a) has been designated as such by either Us, or a third party with which We contract, as a Preferred Drug; b) is a drug that has been approved under the Federal Food, Drug and Cosmetic Act; and c) is included in the list of Preferred Drugs distributed to Preferred Providers and made available to Members, upon request.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturers label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:

- a) approved for treatment of the Member's Illness or Injury by the Food and Drug Administration;
- b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:
 - The American Hospital Formulary Service Drug Information;
 - The United States Pharmacopeia Drug Information; or
- c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes Medically Necessary and Appropriate services associated with the administration of the drugs. In no event will We pay for:

- a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
- b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PREVENTIVE CARE. Preventive care means:

- a) Evidence based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services task Force with respect to the Member;
- b) Immunizations for routine use for Members of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Member;
- c) Evidence-informed preventive care and screenings for Members who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
- d) Evidence-informed preventive care and screenings for female Members as included in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- e) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, prostate cancer screening, and Nicotine Dependence Treatment.

PRIMARY CARE PROVIDER (PCP). A Network Provider who is a doctor specializing in family practice, general practice, internal medicine, obstetrics/gynecology (for pre and postnatal care, birth and treatment of the diseases and hygiene, or pediatrics or a Network provider who is a nurse practitioner/advanced practice nurse certified in advance practice categories comparable to family practice, internal medicine, general practice, obstetrics/gynecology or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PRIVATE DUTY NURSING. Skilled Nursing Care for Members who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

PROSTHETIC APPLIANCE. Any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

PROVIDER. A recognized Facility or Practitioner of health care.

REFERRAL. Specific direction or instruction from a Member's Primary Care Provider in conformance with our policies and procedures that directs a Member to a Facility or Practitioner for health care.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

- a) be accredited for its stated purpose by either The Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
- b) be approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a “rehabilitation hospital.”

RENEWAL DATE. January 1 of the year immediately following the Effective Date of this Policy and each succeeding January 1 thereafter.

RESIDENT. A person whose primary residence is in New Jersey. We will require a person to provide proof that his or her primary residence is New Jersey.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, and supportive devices for the foot.

SERVICE AREA. A geographic area We define by ZIP codes.

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Nurse, and require the technical skills and professional training of a Nurse.

SKILLED NURSING FACILITY. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:

- a) be accredited for its stated purpose by The Joint Commission; o

b) be approved for its stated purpose by Medicare.

SPECIAL ENROLLMENT PERIOD. A period of time that is no less than 60 days following the date of a triggering event during which:

- a) individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and
- b) individuals who already have coverage are allowed to replace current coverage with a different standard health benefits plans or standard health benefits plan with rider.

SPECIALIST DOCTOR. A doctor who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine or pediatrics or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of the diseases and hygiene.

SPECIALTY PHARMACEUTICALS. Oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These Prescription Drugs may be dispensed through specialty pharmaceutical providers.

Examples of Prescription Drugs that are considered Specialty Pharmaceuticals include some orally administered anti-cancer Prescription Drugs and those used to treat the following conditions: Crohn's Disease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; and Gaucher's Disease. Cigna HealthCare of New Jersey, Inc. will provide a complete list of Specialty Pharmaceuticals. The list is also available on Cigna's website.

SPOUSE. An individual: legally married to the Contractholder under the laws of the State of New Jersey; or the Contractholder's Domestic Partner pursuant to P.L. 2003, c. 246.; or the Contractholder's civil union partner pursuant to P.L. 2006, c. 103, as well as a person legally joined with the Contractholder in a same sex relationship in another jurisdiction if such relationship provides substantially all of the rights and benefits of marriage.

SUBSTANCE ABUSE. Abuse of or addiction to drugs or alcohol.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:

- a) be accredited for its stated purpose by The Joint Commission; or
- b) be approved for its stated purpose by Medicare.

SURGERY.

- a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures;

- b) the correction of fractures and dislocations;
- c) pre-operative and post-operative care;
- d) any of the procedures designated by the Current Procedural Terminology Codes as surgery.

TELEHEALTH. 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. 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.

THE JOINT COMMISSION. The entity that evaluates and accredits or certifies health care organizations or programs.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool, hydrotherapy or other treatment of similar nature.

TRIGGERING EVENT. An event that results in an individual becoming eligible for a Special Enrollment Period. Triggering events are:

- a) The date an Eligible Person loses eligibility for minimum essential coverage, or the Eligible Person's Dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace.
- b) The date a Dependent child's coverage ends as a result of attaining age 26 whether or not the Dependent is eligible for continuing coverage in accordance with federal or state laws.
- c) The date a Dependent child's coverage under a parent's group plan ends as a result of attaining age 31.
- d) The effective date of a marketplace redetermination that an Eligible Person is no longer eligible for a subsidy.
- e) The date an Eligible Person gains or becomes a Dependent due to birth, adoption, placement for adoption, or placement in foster care only the Eligible Person and new Dependents qualify for a triggering event.

- f) The date an Eligible Person gains or becomes a Dependent due to marriage provided at least one spouse demonstrates having minimum essential coverage for one or more days during the 60 days preceding the date of marriage; only the spouses qualify for a triggering event.
- g) The date NJFamilyCare determines an applicant who submitted an application during the Open Enrollment Period or during a Special Enrollment Period is ineligible if that determination is made after the open enrollment period or special enrollment period ends.
- h) The date an Eligible Person and his or her Dependent child(ren) who are victims of domestic abuse or spousal abandonment need to enroll for coverage apart from the perpetrator of the abuse or abandonment.
- i) The date an Eligible Person gains access to plans in New Jersey as a result of a permanent move provided the Eligible Person demonstrates having minimum essential coverage for one or more days during the 60 days preceding the permanent move.
- j) The date of a marketplace or Carrier finding that it erroneously permitted or denied an Eligible Person enrollment in a qualified health plan.
- k) The date of a court order that requires coverage for a Dependent.
- l) The date the Eligible Person demonstrates to the marketplace or a State regulatory agency that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

Exception: A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.

Note: The terms minimum essential coverage, marketplace, qualified health plan and subsidy have the meanings set forth in N.J.A.C. 11:20-1.2.

URGENT CARE. Care for a non-life threatening condition that requires care by a Provider within 24 hours.

VIRTUAL VISIT. A visit with a Provider that has contracted with Us to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the Member and the Provider.

WE, US, OUR. Cigna HealthCare of New Jersey, Inc.

YOU, YOUR, AND YOURS. The Contractholder or any Member, as the context in which the term is used suggests.

ELIGIBILITY

Types of Coverage

The Contractholder who completes an application for coverage may elect coverage just for him/herself and may add one or more eligible Dependents for coverage. The possible types of coverage listed below:

- **Single Coverage** - coverage under this Contract for only one person.
- **Family Coverage** - coverage under this Contract for You, Your Spouse and Your Dependent child(ren).
- **Adult and Child(ren) Coverage** - coverage under this Contract for You and all Your Dependent child(ren) or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.
- **Single and Spouse Coverage** - coverage under this Contract for You and Your Spouse.

Who is Eligible

The Contractholder - You, if You are an Eligible Person, who lives in the designated Service Area in the State of New Jersey.

Spouse - Your Spouse who lives in the designated Service Area in the State of New Jersey, who is an Eligible Person **except:** a Spouse need not be a Resident.

Child - Your child who lives in the designated Service Area in the State of New Jersey, who is an Eligible Person and who qualifies as a Dependent, as defined in this Contract, **except:** a Child need not be a Resident.

You may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Contract, such a child may stay eligible for Dependent health benefits past this Contract's age limit for eligible Dependents.

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

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

The child's coverage ends when Your coverage ends.

In order to obtain and continue health care coverage with Us, the Member, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Member is a Resident.

Adding dependents to this contract:

Spouse - You may apply to add Your Spouse by notifying Us in writing.. If Your application is made and submitted to Us within 60 days of Your marriage or documentation of domestic partnership or civil union, the Spouse will be covered as of the first or fifteenth of the month following the date We receive the application.

In case of a court order, coverage of a Spouse as required by a court order will be effective as of the date specified in the court order.

If You do not submit an application within 60 days of Your Spouse becoming eligible, You may apply to add coverage for Your Spouse during an Annual Open Enrollment Period or during an applicable Special Enrollment Period.

Newborn Children - We will cover Your newborn child for 31 days from the date of birth without additional premium. Coverage may be continued beyond such 31-day period as stated below:

You must: a) give written notice to enroll the newborn child; and b) pay any additional premium required for Dependent child coverage within 60 days after the date of birth for coverage to continue beyond the initial 31 days.

If the notice is not given and the premium is not paid within such 60-day period, the newborn child's coverage will end at the end of such 31-day period. You may apply for coverage for the Child during an Annual Open Enrollment Period or during any applicable Special Enrollment Period.

Child Dependent - If You want to add coverage for an adopted child or foster child and You submit an application to Us within 60 days of the date of placement for adoption or placement in foster care, the adopted or foster child will be covered as of the date of placement for adoption or placement in foster care.

If You do not submit an application within 60 days of the placement for adoption or placement in foster care You may apply to add coverage for adopted or foster Child during an Annual Open Enrollment Period or during an applicable Special Enrollment Period.

Except as stated below with respect to a court order, if You want to add coverage for a Child other than a newborn, adopted or foster Child and You submit an application to Us within 60 days of the date the Child is first eligible, the Child will be covered as of the first or fifteenth of the month following the date We receive the application.

In case of a court order, coverage of a child dependent as required by a court order will be effective as of the date specified in the court order.

If You do not submit an application within 60 days of the date the Child is first eligible, You may apply to add coverage for the Child during an Annual Open Enrollment Period or during an applicable Special Enrollment Period.

Please note: A child born to Your child Dependent is not covered under this Contract unless the child is eligible to be covered as Your Dependent, as defined.

MEMBER PROVISIONS

THE ROLE OF A MEMBER'S PRIMARY CARE PROVIDER

A Member's Primary Care Provider provides basic health maintenance services and coordinates a Member's overall health care. Anytime a Member needs medical care, the Member should contact his or her Primary Care Provider and identify himself or herself as a Member of this program.

In an Emergency, a Member may go directly to the emergency room. If a Member does, then the Member must call his or her Primary Care Provider and Member Services within 48 hours. If a Member does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

SELECTING OR CHANGING A PRIMARY CARE PROVIDER

When You first obtain this coverage You and each of Your covered Dependents must select a Primary Care Provider.

Members select a Primary Care Provider from Our Physician Directory; this choice is solely a Member's. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Provider initially selected cannot accept additional patients, a Member will be notified and given an opportunity to make another Primary Care Provider selection. If a Member fails to select a Primary Care Provider, We will make a selection on behalf of the Member.

After initially selecting a Primary Care Provider, Members can transfer to different Primary Care Providers if the physician-patient relationship becomes unacceptable. The Member can select another Primary Care Provider from Our Physician Directory.

For a discretionary change of PCP, the new PCP selection will take effect no more than 14 days following the date of the request. For a change necessitated by termination of the prior PCP from the Network, the new PCP selection will take effect immediately.

NETWORK

The Member will have access to up-to date lists of Network Providers. Except in the case of Urgent Care or a medical Emergency, a Member must obtain Covered Services and Supplies from Network Providers to receive benefits under this Contract. Services and supplies obtained from Providers that are not Network Providers will generally not be covered.

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such Identification Card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the Contractholder, coverage may be terminated for the Contractholder as well as any of his or her Dependents who are Members. To be eligible for services or benefits under this Contract, the holder of the card must be a Member on whose behalf all applicable premium charges under this Contract have been paid.

Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such Member and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Appeals Procedures.

CONFIDENTIALITY

Information contained in the medical records of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us, may not be disclosed without the Member's written consent, except as required or authorized by law.

INABILITY TO PROVIDE NETWORK SERVICES AND SUPPLIES

In the event that due to circumstances not within Our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Our Network Providers or entities with whom We have arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event. In the event We cannot provide or arrange for any services for three or more days We will refund premium for that period for which no services are available.

REFERRAL FORMS

A Member can be Referred for Specialist Services by a Member's Primary Care Provider.

Except in the case of an Emergency, a Member will not be eligible for any services provided by anyone other than a Member's Primary Care Provider (including but not limited to Specialist Services) if a Member has not been Referred by his or her Primary Care Provider. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the Member's Primary Care Provider.

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT

A Member has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A Member has the right to participate in decision-making regarding the Member's care. Further, a Member may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a Network Practitioner. A Member who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another Network Practitioner. If

such Network Practitioner(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the Network Practitioner shall inform the Member of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the Member and or the Member's family or other person acting on the Member's behalf. If the Member refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the Member in writing that We will not provide further benefits or services for the particular condition or its consequences. The Member's decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Appeals Procedure, and We will continue to provide all benefits covered by the Contract during the pendency of the Appeals Procedure. We reserve the right to expedite the Appeals Procedure. If the Appeals Procedure results in a decision upholding the position of the Network Practitioner(s) and the dispute is unresolved, We will have no further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences unless the Member asks, in writing and within 7 days of being informed of the result of the Appeals Procedure, to terminate his or her coverage under this Contract. In such event, We will continue to provide all benefits covered by this Contract for 30 days or until the date of termination, whichever comes first, and We and the Network Practitioner will cooperate with the Member in facilitating a transfer of care.

REFUSAL OF LIFE-SUSTAINING TREATMENT

A Member has the right under New Jersey law to refuse life sustaining treatment. A Member who refuses life sustaining treatment remains eligible for all benefits including Home Health and Hospice benefits in accordance with this Contract. We will follow a Member's properly executed advance directive or other valid indication of refusal of life sustaining treatment.

TERMINATION FOR CAUSE

If any of the following conditions exist, We may give written notice to the Member that the person is no longer covered under this Contract:

- a) **Untenable Relationship:** After reasonable efforts, We and/or Network Providers are unable to establish and maintain a satisfactory relationship with the Member or the Member fails to abide by our rules and regulations, or the Member acts in a manner which is verbally or physically abusive or the Member abuses the system, including but not limited to; theft, damage to Our Network Provider's property, and consistent failure to keep scheduled appointments.
- b) **Misuse of Identification Card:** The Member permits any other person who is not authorized by Us to use any identification card We issue to the Member.
- c) **Furnishing Incorrect or Incomplete Information:** The Member furnishes material information that is either incorrect or incomplete in a statement made for the purpose of effecting coverage under this Contract. This condition is subject to the provisions of the **Incontestability of the Contract** section.
- d) **Nonpayment:** The Member fails to pay any Copayment or to make any reimbursement to Us required under this Contract.
- e) **Misconduct:** The Member abuses the system through forgery of drug prescriptions.
- f) **Failure to Cooperate:** The Member fails to assist Us in coordinating benefits as described in the **Coordination of Benefits and Services** Section.

If We give the Member such written notice:

- a) that person will cease to be a Member for the coverage under this Contract immediately if termination is occurring due to **Misuse of Identification Card** (b above) or **Misconduct** (e above), otherwise, on the date 31 days after such written notice is given by Us; and
- b) no benefits will be provided to the Member under the coverage after that date.

Any action by Us under these provisions is subject to review in accordance with the Appeal Procedures We establish.

REPORTS AND RECORDS

We are entitled to receive from any Provider of services to a Member, such information We deem is necessary to administer this Contract, subject to all applicable confidentiality requirements as defined in this Contract. By accepting coverage under this Contract, You, for Yourself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to the Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of the Member and render reports pertaining to same to Us, upon request, and to permit copying of a Member's records by Us.

MEDICAL NECESSITY

Members will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and We have the option to select the appropriate Network Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by Our quality assessment committee or its physician designee. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Provider or a Provider referred in writing by the Primary Care Provider without notifying the Member that such benefit would not be covered under this Contract.

LIMITATION ON SERVICES

Except in cases of Emergency, services are available only from Network Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

PROVIDER PAYMENT

Different providers in Our Network have agreed to be paid in different ways by Us. A Member's Provider may be paid each time he or she treats the Member ("fee for service"), or may be paid a set fee for each month for each Member whether or not the Member actually receives services ("capitation"), or may receive a salary. These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Member satisfaction, quality of care, and control of costs and use of services among them. If a Member desires additional information about how Our Primary Care Providers or any

other Provider in Our Network are compensated, please call Us at 1-800-244-6224 or write Cigna HealthCare of New Jersey, Inc., 499 Washington Blvd., Jersey City, NJ 07310.

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make Referrals to other health care Providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care Provider or Facility when making a Referral to that health care Provider or Facility. If a Member wants more information about this the Member, the Member should contact his or her physician, chiropractor or podiatrist. If a Member believes he or she is not receiving the information to which the Member is entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.

APPEAL PROCEDURE

When You Have a Concern or Complaint

(For the purposes of this section, any reference to “you”, “your” or “Member” also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.)

We want you to be completely satisfied with the care you receive. That’s why we’ve established a process for addressing your concerns and solving your problems.

Complaints and Administrative Appeals Regarding Contractual Benefits, Quality of Care and Services, and Adverse Benefit Determinations.

Start with Customer Services

We’re here to listen and help. If you have a specific concern or complaint regarding a person, a service, the quality of care, choice of or access to providers, provider network adequacy, or contractual benefits, you or your designated representative (including your treating Provider) can call us at our toll-free number and explain your concern to one of our Customer Services representatives. You can also express that concern in writing. Please call or write to us at the following:

Cigna HealthCare of New Jersey, Inc.

National Appeals Unit (NAO)

P.O. Box 188011

Chattanooga, TN 37422

Customer Services can be contacted at the Toll-Free Number that appears on your Cigna HealthCare ID card or Benefit Identification card

We’ll do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we’ll get back to you as soon as possible, but in any case within thirty (30) calendar days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure

Administrative Appeals “Complaint” Procedure

The two step appeal process for complaints only apply to unresolved complaints regarding quality of care, choice and accessibility of providers, network adequacy and adverse benefit determinations of group or member ineligibility, including rescission, or the application of contract exclusion or limitation not related to medical necessity.

You may proceed to the process described under “Appeals Regarding Adverse Benefit Determinations for Medical Necessity and Utilization Review Determinations” if the adverse benefit determination is not resolved during the 30 day complaint process and is not related to a determination of group or member ineligibility, including rescission, or the application of a contract exclusion or limitation not related to medical necessity

To initiate an Administrative appeal, you must submit a request for an appeal in writing at the address shown above within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your Cigna HealthCare ID card or Benefit Identification card. If you choose to designate a representative to appeal on your behalf, including your provider, all correspondence related to your appeal will be sent to your designated representative and you. If you do not want such representative to pursue the appeal on your behalf, you must notify Cigna HealthCare that you do not want this representative appealing this issue on your behalf.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision.

For level one appeals, we will acknowledge in writing that we have received your request within ten (10) business days and respond in writing with a decision within thirty (30) calendar days after we receive an appeal for a post-service coverage determination, or within fifteen (15) days for a pre-service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to fifteen (15) calendar days and to specify any additional information needed to complete the review.

We will respond in writing with a decision as soon as possible in accordance to the medical needs of the case, not to exceed 72 hours in the case of appeals from determination regarding 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.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal, except that such request must be submitted within sixty (60) days from your receipt of a Level One Appeal decision.

Requests for a second review will be acknowledged in writing within ten (10) business days, noting that we have received your request. Post-service requests will be completed within thirty (30) calendar days, while most pre-service requests will be completed within fifteen (15) calendar days.

If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to fifteen (15) calendar days and to specify any additional information needed to complete the review. You will be notified in writing of the decision.

We will respond in writing with a decision as soon as possible in accordance to the medical needs of the case, not to exceed 72 hours in the case of appeals from determination regarding 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.

Appeal to the State of New Jersey

For appeals regarding a person, a service, the quality of care, choice of or access to providers, provider network adequacy, the contractual benefits, or a rescission of coverage, you may appeal to the State of New Jersey Department of Banking and Insurance at the following address and telephone number:

New Jersey Department of Banking and Insurance
Consumer Protection Services
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
1-888-393-1062

You may also wish to access an online New Jersey complaint form at:
http://www.state.nj.us/dobi/division_insurance/managedcare/mcfaqs..htm.

You may seek the assistance of the State of New Jersey's Consumer Protection Services at any time if you are dissatisfied with the resolution reached through our internal complaints system.

Appeals Regarding Adverse Benefit Determinations for Medical Necessity and Utilization Review Determinations

Initial Determination

The Healthplan is responsible for making decisions about the appropriateness, medical necessity and efficiency of health care services provided to Members under this Agreement. All decisions to deny or limit coverage for an inpatient admission, a service, a procedure or an extension of inpatient stay are made by a Physician.

The health care determinations made by the Healthplan are directly communicated to the treating Provider on a timely basis appropriate to the Member's medical needs. The Healthplan will not reverse its initial determination of medical necessity or appropriateness unless misrepresented or fraudulent information was submitted to the Healthplan as part of the request for health care services.

You or your designated representative (including a provider acting on your behalf with your consent) will receive a written notice of any determination to deny coverage or authorization for service within two (2) business days of the determination. The written notice includes an explanation of the appeal process.

Adverse Benefit Determination Appeals Procedure

You or your provider acting on your behalf, with your consent, may appeal all levels of Appeals Regarding Adverse Benefit Determinations, except where the adverse benefit determination was based on a determination of member or group ineligibility, including rescission, or the application of a contract exclusion or limitation not related to medical necessity.

To initiate a Medical Necessity appeal, you must submit a request for an appeal in writing at the address shown above within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your Cigna HealthCare ID card or Benefit Identification card. If you choose to designate a representative to appeal on your behalf, including your provider, all correspondence related to your appeal will be sent to your designated representative and you. If you do not want such representative to pursue the appeal on your behalf, you must notify Cigna HealthCare that you do not want this representative appealing this issue on your behalf.

You have the right to receive any new or additional evidence or rationale we use to review your appeal, free of charge and sufficiently in advance of the date on which a notice of a Stage 1 or Stage 2 appeal determination is required, in order to give you a reasonable opportunity to respond prior to that date.

Informal Internal Utilization Management Appeal Process (Stage 1)

You have the opportunity to speak with, and may request appeal review by, the Healthplan Medical Director and or physician designee who rendered the determination.

For Stage 1 appeals, we will respond in writing with a decision as soon as possible in accordance to the medical needs of the case, not to exceed 72 hours in the case of appeals from determination regarding 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 and 10 calendar days in the case of all other appeals.

Formal Internal Utilization Management Appeal Process (Stage 2)

If you are dissatisfied with the Stage 1 appeal decision, you have the right to proceed to a Stage 2 appeal. To initiate a Stage 2 appeal, follow the same process required for a Stage 1 appeal, except that such request must be submitted within sixty (60) days from your receipt of a Stage 1 Appeal decision. Provide all relevant documentation with your Stage 2 level appeal request.

Most requests for a Stage 2 review will be conducted by the Appeals Committee, which consists of at least one Physician reviewer and two other Physicians/health care professionals. Anyone involved in the prior decision may not vote on the Appeals Committee. The committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by the Healthplan Medical Director. You may present your situation to the committee in person or by conference call.

For Stage 2 appeals we will acknowledge in writing that we have received your request within ten (10) business days and schedule a committee review. The Healthplan's review will be completed within twenty (20) business days. In the event, any new or additional information (evidence) is considered, relied upon or generated by the Healthplan in connection with the Stage 2 appeal, the Healthplan will provide this information to you free of charge, as soon as possible and sufficiently in advance of the a final internal adverse decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the Healthplan, the Healthplan will provide the rationale to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond.

We will respond in writing with a decision as soon as possible in accordance to the medical needs of the case, not to exceed 72 hours in the case of appeals from determination regarding 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.

External Appeals Process

After exhausting the Healthplan's internal Appeal procedure, if you remain dissatisfied with the Healthplan's health care determination, you may initiate a review by an independent utilization review organization (IURO) within four (4) months from the receipt of the Healthplan's final written decision. To initiate a review, you or your Provider, on your behalf, should complete the State of New Jersey IURO forms provided by Healthplan and mail the completed forms to:

Consumer Protection Services
New Jersey Department of Banking and Insurance
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
(888) 393-1062

along with a check or money order for twenty-five dollars (\$25.00) payable to the "New Jersey Department of Banking and Insurance" (this fee may be waived in cases of financial hardship, cannot exceed \$75 for all appeals submitted annually, and will be refunded if the original adverse benefit determination is overturned). If a Provider is appealing to the IURO on your behalf, the Provider is responsible for paying your portion of the cost of the IURO appeal. The Healthplan will bear the remaining costs of the review.

You or your Provider, on your behalf, may also request review of your appeal by the IURO if the Healthplan has missed any timeframes associated with the processing of your medical necessity appeal. If this is the case, you must certify to the IURO that you or your Provider, on your behalf, did not hinder the Healthplan from making a timely determination by failing to provide the information required for the Healthplan to make its decision.

A review by the IURO may also be requested before exhaustion of the internal appeal process if we expressly waive our requirement of an internal review of any appeal, or if you have or your Provider has applied for expedited external review at the same time as applying for an expedited internal appeal request. Expedited external review may be requested for any of the following: cases that involve care for an urgent or emergency case; an admission; availability of care; continued stay; health care services for which you've received emergency services but have not yet been discharged from a facility; or a medical condition for which the standard review time frame would seriously jeopardize your life or health or ability to regain maximum function.

Once the IURO communicates its decision, the Healthplan will respond within ten (10) business days to you (or the Provider on your behalf), the IURO and the Department of Banking and Insurance with a written report describing how the Healthplan will implement the IURO's decision.

The External Appeals Program is a voluntary program. The decision of the IURO is binding on the Healthplan.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) a statement describing: (a) the procedure to initiate the next level of appeal; (b) any voluntary appeal procedures offered by the plan ; and (c) the claimant's right to bring an action under ERISA section 502(a); (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (7) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the Level Two Appeal decision (or with the Level One Appeal decision if expedited). You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was (a) relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action Following Appeals

If your plan is governed by ERISA, you have the right to bring a civil action in federal court under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against the Healthplan until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action in federal court.

If your plan is governed by New Jersey P.L.2001, c.187 (2A:53A-30 et seq), you have the right to bring action in state court accordance with that statute. You must exhaust the Independent Health Care Appeals Program procedures created pursuant to section 11 of P.L.1997, c.192 (C26:2S-11), before filing an action in state court, unless serious or significant harm to the covered person has occurred or will imminently occur, before filing an action in state court for economic and non-economic loss that occurs as a result of the Healthplan's negligence with respect to the denial of or delay in approving or providing medically necessary covered services, which denial or delay is the proximate cause of a covered person's: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment; (6) a physical condition resulting in chronic and significant pain; or (7) substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay or care.

CONTINUATION OF CARE

We shall provide written notice to each Member at least 30 business days prior to the termination or withdrawal from Our Provider Network of a Member's PCP and any other Provider from which the Member is currently receiving a course of treatment, as reported to Us. The 30-day prior notice may be waived in cases of immediate termination of a health care professional based on a breach of contract by the health care professional, a determination of fraud, or where Our medical director is of the opinion that the health care professional is an imminent danger to the patient or the public health, safety or welfare.

We shall assure continued coverage of covered services at the contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the Member to continue treatment with the terminated health care professional and in certain cases of active treatment for up to 90 days, as described below.

In case of a Member in active treatment for a health condition for which the Provider attests that discontinuing care by the Provider would worsen the Member's condition or interfere with anticipated outcomes, coverage of the terminated Provider shall continue for the duration of the treatment, or up to 90 days, whichever occurs first.

In case of pregnancy of a Member, coverage of services for the terminated health care professional shall continue to the postpartum evaluation of the Member up to six weeks after the delivery. With respect to pregnancy, Medical Necessity and Appropriateness shall be deemed to have been demonstrated.

For a Member who is receiving post-operative follow-up care, We shall continue to cover the services rendered by the health care professional for the duration of the treatment or for up to six months, whichever occurs first.

For a Member who is receiving oncological treatment or psychiatric treatment, We shall continue to cover services rendered by the health care professional for the duration of the treatment or for up to 12 months, whichever occurs first.

For a Member receiving the above services in an acute care Facility, We will continue to provide coverage for services rendered by the health care professional regardless of whether the acute care Facility is under contract or agreement with Us.

Services shall be provided to the same extent as provided while the health care professional was employed by or under contract with Us. Reimbursement for services shall be pursuant to the same schedule used to reimburse the health care professional while the health care professional was employed by or under contract with Us.

If a Member is admitted to a health care Facility on the date this Contract is terminated, We shall continue to provide benefits for the Member until the date the Member is discharged from the Facility.

We shall not continue services in those instances in which the health care professional has been terminated based upon the opinion of Our medical director that the health care professional is an imminent danger to a patient or to the public health, safety and welfare, a determination of fraud or a breach of contract by a health care professional. The Determination of the Medical Necessity and Appropriateness of a Member's continued treatment with a health care professional shall be subject to the appeal procedures set forth in this Contract. We shall not be liable for any inappropriate treatment provided to a Member by a health care professional who is no longer employed by or under contract with Us.

If We refer a Member to a Non-Network provider, the service or supply shall be covered as a Network service or supply. We are fully responsible for payment to the health care professional, and the Member's liability shall be limited to any applicable Network Copayment or Coinsurance for the service or supply.

COVERAGE PROVISION

The Cash Deductible

Each Calendar Year, each Member must incur charges for Covered Services or Supplies that exceed the Cash Deductible before We provide coverage for Covered Services or Supplies to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Services or Supplies. Only charges for Covered Services or Supplies incurred by the Member while covered by this Contract can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We provide coverage for other Covered Services or Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Member is covered by this Contract. What We cover is based on all the terms of this Contract.

Family Deductible Limit

This Contract has a family deductible limit of two Cash Deductibles for each Calendar Year. Once Members in a family meet the family Cash Deductible in a Calendar Year, We provide coverage for Covered Services and Supplies for all Members who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Contract.

Maximum Out of Pocket

Maximum out of pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all Covered Services or Supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Covered Services or Supplies for the remainder of the Calendar Year.

Once Members in a family meet the family Maximum Out of Pocket, no other Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for Covered Services and Supplies for the remainder of the Calendar Year.

COVERED SERVICES & SUPPLIES

Members are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by Members of applicable copayments as stated in the applicable Schedule of Services and Supplies and subject to the terms, conditions and limitations of this Contract. Read the entire Contract to determine what treatment, services and supplies are limited or excluded.

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Provider's office selected by a Member, or elsewhere upon prior written Referral by a Member's Primary Care Provider:

1. **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2. **Practitioner's Charges for Telehealth and/or Telemedicine.** If a Network Practitioner 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 Practitioner's charges for services provided through Telehealth and/or Telemedicine.
3. **Home visits** by a Member's Primary Care Provider.
4. **Preventive Care, including but not limited to Periodic health examinations** such as:
 - a. Well child care from birth including immunizations;
 - b. Routine physical examinations, including eye examinations;
 - c. Routine gynecologic exams and related services;
 - d. Routine ear and hearing examination; and
 - e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a Member's employment).
5. **Diagnostic Services.**
6. **Casts and dressings.**
7. **Ambulance service** when certified in writing as Medically Necessary and Appropriate by a Member's Primary Care Provider and Pre-Approved by Us.
8. **Orthotic or Prosthetic Appliances.** We cover charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Member's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a PCP visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any Network licensed orthotist or prosthetist or any certified pedorthist.

Coverage for the appliances will be provided to the same extent as other charges under the Contract.

9. Durable Medical Equipment when ordered by a Member's Primary Care Provider and arranged through Us. Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

10. Subject to Our Pre-Approval, as applicable, **Prescription Drugs** including **contraceptives which require a Practitioner's prescription**, and insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Network Provider.

A prescription or refill will not include a prescription or refill that is more than:

a) the greater of a 90 day supply or 100 unit doses for each prescription or refill;

or

b) the amount usually prescribed by the Member's Network Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

We have identified certain Prescription Drugs, including Specialty Pharmaceuticals, for which Pre-Approval is required. We will provide the list of Prescription Drugs for which Pre-Approval is required to You. We will give at least 30 days advance written notice to You before revising the list of Prescription Drugs to add a Prescription Drug to the list.

If a Member brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, the Member must contact Us to request Pre-Approval. The Pharmacy will dispense a 96-hour supply of the Prescription Drug. We will review the Pre-Approval request within the time period allowed by law. If We give Pre-Approval, We will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of this Contract. If We do not give Pre-Approval, the Member may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Member paying for the Prescription Drug. The Member may submit a claim for the Prescription Drug, subject to the terms of this Contract. The Member may appeal the decision by following the Appeals Procedure process set forth in this Contract.

We cover Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the prescription drug.

If a Member purchases a Brand Name Drug when there is a Generic Prescription Drug alternative, We will cover the Generic Prescription Drug subject to the applicable cost sharing, whether Deductible, Coinsurance or Copayment. Except as stated below, the Member is responsible for the difference between the cost of the Brand Name Drug and the Generic Prescription Drug. Exception: If the provider states “Dispense as Written” on the prescription, the Member will be responsible for the applicable cost sharing for the Brand Name Prescription Drug.

A Member must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy. The Copayment must be paid before the Contract pays any benefit for the Prescription Drug. The Copayment for each prescription or refill which is not obtained through the Mail Order Program is shown in the Schedule.

After the Copayment is paid, We will cover the Covered Service and Supply in excess of the Copayment for each Prescription Drug dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy while the Member is insured. What We pay is subject to all the terms of the Contract.

A Member and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable copayment for a Preferred Drug. We will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

- a) It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia-Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed journal; and
- b) The Practitioner states that all Preferred Drugs used to treat the Illness or Injury have been ineffective in the treatment of the Member's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the Member.

We shall respond to the request for approval of a Non-Preferred Drug within one business day and shall provide written confirmation within 5 business days. Denials shall include the clinical reason for the denial. The Member may follow the Appeals Procedure set forth in the Contract. In addition, the Member may appeal a denial to the Independent Health Care Appeals Program.

The Contract only pays benefits for Prescription Drugs which are:

- a) prescribed by a Practitioner (except for insulin)
- b) dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy; and

c) needed to treat an Illness or Injury covered under this Contract.

Such charges will not include charges made for more than:

- a) a 90-day supply for each prescription or refill which is not obtained through the Mail Order Program where the copayment is calculated based on the multiple of 30-day supplies received;
- b) a 90-day supply of a Maintenance Drug obtained through the Mail Order Program where the copayment is the copayment specified for a 90-day supply; and
- c) the amount usually prescribed by the Member's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

We will arrange for audits that will take place at a time mutually agreeable to the Participating Pharmacy and the Participating Mail Order Pharmacy or the pharmacist and the auditor. The audits shall only include the review of documents relating to persons and prescription plans reimbursable by Us.

We will not restrict or prohibit, directly or indirectly, a Participating Pharmacy or a Participating Mail Order Pharmacy from charging the Member for charges that are in addition to charges for the Prescription Drug, for dispensing the Prescription Drug or for prescription counseling provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and the purchaser's out-of-pocket cost for those services has been disclosed to the Member prior to dispensing the drug.

Specialty Pharmaceuticals Split Fill Program: Select Specialty Drugs will be eligible for a split fill when a new prescription that will be filled at a specialty pharmacy is prescribed. Under the split fill program an initial prescription will be dispensed in two separate amounts. The first shipment will be for a 15-day supply. The Member will be contacted prior to dispensing the second 15-day supply in order to evaluate necessary clinical intervention due to medication side effects that may require a dose modification or discontinuation of the medication. The split-fill process will continue for the first 90 days the Member takes the medication. The Member's cost share Copayment amounts will be prorated to align with the quantity dispensed with each fill. If the Member does not wish to have a split fill of the medication, he or she may decline participation in the program. For those Members the Specialty Pharmacy will ship the full prescription amount and charge the Member the cost share for the medication dispensed. Alternatively, the Member may obtain the medication at a retail pharmacy.

11. **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Member's Primary Care Provider and Pre-Approved by Us.
12. **Dental x-rays** when related to Covered Services.
13. **Oral surgery** in connection with bone fractures, removal of tumors and orthodontogenic cysts, and other surgical procedures, as We approve.
14. **Food and Food Products for Inherited Metabolic Diseases:** We cover charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by a Member's Practitioner.

For the purpose of this benefit:

"inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;

"low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and

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

15. **Specialized non-standard infant formulas** are covered to the same extent and subject to the same terms and conditions as coverage is provided under this Contract for Prescription Drugs. We cover specialized non-standard infant formulas provided:
 - a) The child's Practitioner has diagnosed the child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
 - b) The child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

We may review continued Medical Necessity and Appropriateness of the specialized infant formula.

16. Unless otherwise provided in the Charges for the Treatment of Hemophilia section below, **Blood, blood products, blood transfusions** and the cost of testing and processing blood. But We do not cover blood which has been donated or replaced on behalf of the Member.
17. **Charges for the Treatment of Hemophilia.** The Providers in Our Network providing Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia shall comply with standards adopted by the

Department of Health and Senior Services in consultation with the Hemophilia Association of New Jersey.

We will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a Network Provider if the Member's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for Our network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by Our Network clinical laboratory.

We will pay the Hospital's clinical laboratory for the laboratory services at the same rate We would pay a Network clinical laboratory for comparable services.

18. **Colorectal Cancer Screening** We provide coverage for colorectal cancer screening provided to a Member age 50 or over and to younger Members who are considered to be high risk for colorectal cancer. Coverage will be provided, subject to all the terms of this Contract, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the Member's Practitioner in consultation with the Member regarding methods to use, We will cover:

- a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
- b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
- c) Stool DNA (sDNA) test with high sensitivity for cancer;
- d) flexible sigmoidoscopy;
- e) colonoscopy;
- f) contrast barium enema;
- g) Computed Tomography (CT) Colonography;
- h) any combination of the services listed in items a-g above; or
- i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

We will provide coverage for the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the Member's practitioner in consultation with the Member.

High risk for colorectal cancer means a Member has:

- a) A family history of: familial adenomatous polyposis, hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
- b) Chronic inflammatory bowel disease; or

- c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

19. **Newborn Hearing Screening** We provide coverage up to a maximum of 28 days following the date of birth for screening for newborn hearing loss by appropriate electrophysiologic screening measures. In addition, We provide coverage between age 29 days and 36 months for the periodic monitoring of infants for delayed onset hearing loss.

20. **Hearing Aids** We cover charges for medically necessary services incurred in the purchase of a hearing aid for a Member age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modification and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment as applicable to Durable Medical Equipment will apply to the purchase of a hearing aid. The deductible, coinsurance or copayment as applicable to a PCP visit for treatment of an Illness or Injury will apply to the medically necessary services incurred in the purchase of a hearing aid. Hearing aids are habilitative devices.

21. **Mammogram Screening** We will provide coverage for:

- a) one baseline mammogram for a female Member, who is 40 years of age;
- b) one mammogram, every year, for a female Member age 40 and older; and
- c) in the case of a woman who is under 40 years of age and has 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 Practitioner.

In addition, if the conditions listed below are satisfied after a baseline mammogram, We will cover charges for:

- a) an ultrasound evaluation;
- b) a magnetic resonance imaging scan;
- c) a three-dimensional mammography; and
- d) other additional testing of the breasts.

The above additional charges will be covered if one of following conditions is satisfied:

- 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 female Member 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 female Member's Practitioner.

Please note that mammograms and the additional testing described above, when warranted as described above, are included under the Preventive Care provision.

22. **Orally Administered Anti-Cancer Prescription Drugs** As used in this provision, orally administered anti-cancer prescription drugs means Prescription Drugs that are used to slow or kill the growth of cancerous cells and are administered orally. Such anti-cancer Prescription Drugs does not include those that are prescribed to maintain red or white cell counts, those that treat nausea or those that are prescribed to support the anti-cancer prescription drugs. Any such Prescription Drugs are covered under the Prescription Drugs provision of the Contract.

Anti-cancer prescription drugs are covered subject to the terms of the **Prescription Drugs** provision of the Contract as stated above. The Member must pay the Coinsurance required for Prescription Drugs. Using the receipt from the pharmacy, the Member may then submit a claim for the anti-cancer prescription drug under this Orally Administered Anti-Cancer Prescription Drugs provision of the Contract. Upon receipt of such a claim We will compare the coverage for the orally-administered anti-cancer prescription drugs as covered under the Prescription Drugs provision to the coverage the Contract would have provided if the Member had received intravenously administered or injected anti-cancer medications from the Network Practitioner to determine which is more favorable to the Member in terms of Copayment, deductible and/or Coinsurance. If the Contract provides different Copayment, deductible or Coinsurance for different places of service, the comparison shall be to the location for which the Copayment, deductible and Coinsurance is more favorable to the Member. If a Member paid Coinsurance under the Prescription Drug provision that exceeds the Copayment, deductible and/or Coinsurance that would have applied for intravenously administered or injected anti-cancer medications, the Member will be reimbursed for the difference.

23. **Procedures and Prescription Drugs to Enhance Fertility** Subject to Pre-Approval, We cover charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Contract.
24. **Vision Benefit** We cover the vision benefits described in this provision for Members through the end of the month in which the Member turns age 19. We cover one comprehensive eye examination by a Network ophthalmologist or optometrist in a 12 month period. When purchased from a Network provider, We cover one pair of standard lenses, for glasses or contact lenses, in a 12 month period. We cover one

pair of standard frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

We cover charges for a one comprehensive low vision evaluation every 5 years. We cover low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

- (b) **SPECIALIST DOCTOR BENEFITS.** Services are covered when rendered by a Network specialist doctor at the doctor's office or any other Network Facility or a Network Hospital outpatient department during office or business hours upon prior written Referral by a Member's Primary Care Provider.
- (c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following services are covered when hospitalized by a Network Provider upon prior written referral from a Member's Primary Care Provider, only at Network Hospitals and Network Providers (or at Non-Network facilities subject to Our Pre-Approval); however, Network Skilled Nursing Facility services and supplies are limited to those which constitute Skilled Nursing Care and Hospice services are subject to Our Pre-Approval:

1. Semi-private room and board accommodations

Except as stated below, We provide coverage for Inpatient care for:

- a) a minimum of 72 hours following a modified radical mastectomy; and
- b) a minimum of 48 hours following a simple mastectomy.

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the Member, in consultation with the Network Provider, determines that a shorter length of stay is Medically Necessary and Appropriate.

As an exception to the Medically Necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:

- a) up to 48 hours of inpatient care in a Network Hospital following a vaginal delivery; and
- b) a minimum of 96 hours of Inpatient care in a Network Hospital following a cesarean section.

We provide childbirth and newborn coverage subject to the following:

- a) the attending Practitioner must determine that Inpatient care is medically necessary; or
- b) the mother must request the Inpatient care.

As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by Us.

- 2. Private accommodations will be provided only when Pre-Approved by Us. If a Member occupies a private room without such certification Member shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center

or Skilled Nursing Facility of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Network Hospice, Network Hospital, Network Rehabilitation Center or Network Skilled Nursing Facility and the private room rate.

3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services. We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts. We also cover treatment of the physical complications of mastectomy, including lymphedemas.
20. The following transplants: Cornea, Kidney, Lung, Liver, Heart, heart-lung, heart valve, Pancreas and Intestines.

21. Allogeneic bone marrow transplants.
22. Autologous bone marrow transplants and associated dose intensive chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when Pre-Approved by Us, if the Member is participating in a National Cancer Institute sponsored clinical trial.
23. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.
24. Donor's costs associated with transplants if the donor does not have health coverage that would cover the medical costs associated with his or her role as a donor. We do not cover costs for travel, accommodations, or comfort items.

(d) **BENEFITS FOR MENTAL ILLNESS OR ALCOHOL ABUSE.**

We cover treatment for Mental Illness or Substance Abuse the same way We would for any other illness, if such treatment is prescribed by a Network Provider upon prior written referral by a Member's Primary Care Provider. We do not pay for Custodial care, education or training.

Inpatient or day treatment may be furnished by any Network Provider that is licensed, certified or State approved facility, including but not limited to:

- a) a Hospital;
- b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
- c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of The Joint Commission;
- d) a Mental Health Center; or
- e) a Substance Abuse Center.

(e) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE**

AREA. The following services are covered without prior written Referral by a Member's Primary Care Provider in the event of an Emergency as Determined by Us.

1. A Member's Primary Care Provider is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a Member's health, Member shall call a Member's Primary Care Provider prior to seeking Emergency treatment.
2. We will cover the cost of Emergency medical and hospital services performed within or outside our service area without a prior written Referral only if:

- a. Our review Determines that a Member's symptoms were severe and delay of treatment would have been detrimental to a Member's health, the symptoms occurred suddenly, and Member sought immediate medical attention.
 - b. The service rendered is provided as a Covered Service or Supply under this Contract and is not a service or supply which is normally treated on a non-Emergency basis; and
 - c. We and the Member's Primary Care Provider are notified within 48 hours of the Emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the Emergency services within 30 days. A Member shall be responsible for payment for services received unless We Determine that a Member's failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event a Member is Hospitalized in a Non-Network Facility, coverage will only be provided until the Member is medically able to travel or to be transported to a Network Facility. If the Member elects to continue treatment with Non-Network Providers, We shall have no responsibility for payment beyond the date the Member is Determined to be medically able to be transported.

In the event that transportation is Medically Necessary and Appropriate, We will cover the amount We Determine to be the Allowed Charge cost. Reimbursement may be subject to payment by Members of all Copayments which would have been required had similar benefits been provided upon prior written Referral to a Network Provider.

4. Coverage for Emergency services includes only such treatment necessary to treat the Emergency. Any elective procedures performed after a Member has been admitted to a Facility as the result of an Emergency shall require prior written Referral or the Member shall be responsible for payment.
5. The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if a Member is admitted as an Inpatient to the Hospital as a result of the Emergency.
6. Coverage for Emergency and Urgent Care include coverage of trauma services at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgment of the attending physician, the Member is medically stable, no longer requires critical care, and can be safely transferred to another Facility. We also provide coverage for a medical screening examination provided upon a Member's arrival in a Hospital, as required to be performed by the Hospital in accordance with Federal law, but only as necessary to determine whether an Emergency medical condition exists. Please note that the "911" Emergency response system may be used whenever a Member has a potentially life-threatening condition. Information on the use of the "911" system is included on the identification card.

- (f) **THERAPY SERVICES.** The following Services are covered when rendered by a Network Provider upon prior written Referral by a Member's Primary Care Provider. Subject to the stated limits, We cover the Therapy Services listed below. We cover other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.
- a. *Chelation Therapy* - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
 - b. *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
 - c. *Dialysis Treatment* - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
 - d. *Radiation Therapy* - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
 - e. *Respiration Therapy* - the introduction of dry or moist gases into the lungs.
 - f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
Coverage for Cognitive Rehabilitation Therapy is limited to 30 visits per Calendar Year.
 - g. *Speech Therapy* -except as stated below, treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes. Exception: For a Covered Person who has been diagnosed with a biologically-based Mental Illness, speech therapy means treatment of a speech impairment. Coverage for Speech Therapy is limited to 30 visits per Calendar Year.
 - h. *Occupational Therapy* - except as stated below, treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living. Exception: For a Covered Person who has been diagnosed with a biologically-based Mental Illness, occupational therapy means treatment to develop a Member's ability to perform the ordinary tasks of daily living. Coverage for Occupational Therapy is limited to 30 visits per Calendar Year.
 - i. *Physical Therapy* - except as stated below, the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb. Exception: For a Member who has been diagnosed with a biologically-based Mental Illness, physical therapy means treatment to develop a Member's physical function. Coverage for Physical Therapy is limited to 30 visits per Calendar Year.
 - j. *Infusion Therapy* - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Note: The limitations on Therapy Services contained in this Therapy Services provision do not apply to any Therapy Services that are received under the Home Health Care provision or to services provided while a Member is confined in a Facility or to Therapy Services received under the Diagnosis and Treatment of Autism or Other Developmental Disabilities provision.

- (g) **Diagnosis and Treatment of Autism and Other Developmental Disabilities** We provide coverage for charges for the screening and diagnosis of autism and other Developmental Disabilities.

If a Member's primary diagnosis is autism or another Developmental Disability, We provide coverage for the following medically necessary therapies as prescribed through a treatment plan. These are habilitative services in that they are provided to develop rather than restore a function. The therapy services are subject to the benefit limits set forth below:

- a) occupational therapy where occupational therapy refers to a treatment to develop a Member's ability to perform the ordinary tasks of daily living.
- b) physical therapy where physical therapy refers to treatment to develop a Member's physical function; and
- c) speech therapy where speech therapy refers to treatment of a Member's speech impairment .

Coverage for occupational therapy is limited to 30 visits per Calendar Year. Coverage for physical therapy is limited to 30 visits per Calendar Year. Coverage for speech therapy is limited to 30 visits per Calendar Year. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision.

If a Member's primary diagnosis is autism, and the Member is under 21 years of age, in addition to coverage for the therapy services as described above, We also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan(s) referred to above must be in writing, signed by the treating physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. We may request additional information if necessary to determine the coverage under the Contract. We may require the submission of an updated treatment plan once every six months unless We and the treating physician agree to more frequent updates.

If a Member:

- a) is eligible for early intervention services through the New Jersey Early Intervention System; and

- b) has been diagnosed with autism or other Developmental Disability; and
- c) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services

The portion of the family cost share attributable to such services is a covered service under this Contract. The deductible, Coinsurance or Copayment as applicable to a PCP visit for treatment of an Illness or Injury will apply to the family cost share.

The therapy services a member receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Disabilities provision.

(h) **HOME HEALTH CARE.** The following Services are covered upon prior written referral from a Member's Primary Care Provider. When home health care can take the place of Inpatient care, We cover such care furnished to a Member under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:

- 1) Routine Nursing Care furnished by or under the supervision of a registered Nurse;
- 2) physical therapy;
- 3) occupational therapy;
- 4) medical social work;
- 5) nutrition services;
- 6) speech therapy;
- 7) home health aide services;
- 8) medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Contract if the Member had been in a Hospital; and
- 9) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Contract if performed as Inpatient Hospital services.

Payment is subject to all of the terms of this Contract and to the following conditions:

- a. The Member's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. Home health care is covered **only** in situations where continuing hospitalization or confinement in a Skilled

Nursing Facility or Rehabilitation Center would otherwise have been required if home health care were not provided.

- b. The services and supplies must be:
 - 1. ordered by the Member's Practitioner;
 - 2. included in the home health care plan; and
 - 3. furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term (no more than three-day) basis.

- c. The home health care plan must be set up in writing by the Member's Practitioner within 14 days after home health care starts. And it must be reviewed by the Member's Practitioner at least once every 60 days.
- d. We do not pay for:
 - 1. services furnished to family members, other than the patient; or
 - 2. services and supplies not included in the home health care plan.

Any visit by a member of a home health care team on any day shall be considered as one home health care visit.

We **only** cover services by a Nurse for Medically Necessary and Appropriate private duty nursing care if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under this **Home Health Care** section. Any other services for private duty nursing care are Non-Covered Services.

- (i) **Hospice Care** if Members are terminally Ill or terminally Injured with life expectancy of six months or less, as certified by the Member's Primary Care Provider. Services may include home and Hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other home health care benefits listed above.
- (j) **DENTAL CARE AND TREATMENT.** This Dental Care and Treatment provision applies to all Members. The following services are covered when rendered by a Network Practitioner upon prior Referral by a Member's Primary Care Provider. We cover:
 - 1) the diagnosis and treatment of oral tumors and cysts; and
 - 2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:

- 1) the Injury was not caused, directly or indirectly by biting or chewing; and
- 2) all treatment is finished within 6 months of the later of:
 - a) the date of the Injury; or
 - b) The effective date of the Member's coverage under this Contract.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

(k) **Dental Benefits**

Subject to the applicable deductible, Coinsurance or Copayments shown on the Schedule of Insurance and Premium rates, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for Members through the end of the month in which the Member turns age 19 when services are provided by a Network provider.

- Dental services are available from birth with an age one dental visit encouraged.
- A second opinion is allowed.
- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available, radiographs needed to diagnose and treat will be allowed.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

Diagnostic Services

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

- a) *Clinical oral evaluations once every 6 months **
 1. Comprehensive oral evaluation— complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation.
 2. Periodic oral evaluation – subsequent thorough evaluation of an established patient*.
 3. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*.
 4. Limited oral evaluations that are problem focused.

5. Detailed oral evaluations that are problem focused.
- b) Diagnostic Imaging with interpretation
 1. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
 2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
 3. Additional films/views needed for diagnosing can be provided as needed.
 4. Bitewings, periapicals, panoramic and cephalometric radiographic images.
 5. Intraoral and extraoral radiographic images.
 6. Oral/facial photographic images.
 7. Maxillofacial MRI, ultrasound.
 8. Cone beam image capture.
 - c) Tests and Examinations
 - d) Viral culture
 - e) Collection and preparation of saliva sample for laboratory diagnostic testing
 - f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
 - g) Oral pathology laboratory
 1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
 2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
 3. Other oral pathology procedures, by report

Preventive Services

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

- a) Dental prophylaxis once every 6 months*
- b) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*
- c) Fluoride varnish once every 3 months for children under the age of 6
- d) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.
- e) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
 1. fixed – unilateral and bilateral
 2. removable – bilateral only
 3. re-cementation of fixed space maintainer
 4. removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

- a) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
- b) Gold foil - Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program.

- c) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
- d) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
 - 1. Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
 - 2. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
 - 3. Provisional crowns are not covered.
- e) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
- f) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
- g) Core buildup including pins
- h) Pin retention
- i) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
- j) Additional fabricated (custom fabricated/cast) and prefabricated post
- k) Post removal
- l) Temporary crown (fractured tooth)
- m) Additional procedures to construct new crown under existing partial denture
- n) Coping
- o) Crown repair
- p) Protective restoration/sedative filling

Endodontic Services

- Service includes all necessary radiographs or views needed for endodontic treatment.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
- Emergency services for pain do not require prior authorization.
- Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:

- a) Therapeutic pulpotomy for primary and permanent teeth
- b) Pulpal debridement for primary and permanent teeth
- c) Partial pulpotomy for apexogenesis
- d) Pulpal therapy for anterior and posterior primary teeth
- e) Endodontic therapy and retreatment
- f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation

- g) Apexification: initial, interim and final visits
- h) Pulpal regeneration
- i) Apicoectomy/Periradicular Surgery
- j) Retrograde filling
- k) Root amputation
- l) Surgical procedure for isolation of tooth with rubber dam
- m) Hemisection
- n) Canal preparation and fitting of preformed dowel or post
- o) Post removal

Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

- a) Surgical services
 1. Gingivectomy and gingivoplasty
 2. Gingival flap including root planning
 3. Apically positioned flap
 4. Clinical crown lengthening
 5. Osseous surgery
 6. Bone replacement graft – first site and additional sites
 7. Biologic materials to aid soft and osseous tissue regeneration
 8. Guided tissue regeneration
 9. Surgical revision
 10. Pedicle and free soft tissue graft
 11. Subepithelial connective tissue graft
 12. Distal or proximal wedge
 13. Soft tissue allograft
 14. Combined connective tissue and double pedicle graft
- b) Non-Surgical Periodontal Service
 1. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
 2. Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
 3. Full mouth debridement to enable comprehensive evaluation
 4. Localized delivery of antimicrobial agents
- c) Periodontal maintenance

Prosthodontic Services

- All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
- New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

- a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
- b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
 1. Resin base and cast frame dentures including any conventional clasps, rests and teeth
 2. Flexible base denture including any clasps, rests and teeth
 3. Removable unilateral partial dentures or dentures without clasps are not considered
- c) Overdenture – complete and partial
- d) Denture adjustments –6 months after insertion or repair
- e) Denture repairs – includes adjustments for first 6 months following service
- f) Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service
- g) Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service
- h) Precision attachment, by report
- i) Maxillofacial prosthetics - includes adjustments for first 6 months following service
 1. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
 2. Obturator prosthesis: surgical, definitive and modifications
 3. Mandibular resection prosthesis with and without guide flange
 4. Feeding aid
 5. Surgical stents

6. Radiation carrier
 7. Fluoride gel carrier
 8. Commissure splint
 9. Surgical splint
 10. Topical medicament carrier
 11. Adjustments, modification and repair to a maxillofacial prosthesis
 12. Maintenance and cleaning of maxillofacial prosthesis
- j) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
Covered services include: implant body, abutment and crown.
- k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
 2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
 3. Considerations and requirements noted for single crowns apply.
 4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
 5. Abutment teeth must be periodontally sound and have a good long term prognosis.
 6. Repair and re-cementation.
- l) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

- a) Extraction of teeth:
 1. Extraction of coronal remnants – deciduous tooth,
 2. Extraction, erupted tooth or exposed root
 3. Surgical removal of erupted tooth or residual root
 4. Impactions: removal of soft tissue, partially bony, completely bony and completely bony with unusual surgical complications
- b) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
- c) Other surgical Procedures

1. Oroantral fistula
 2. Primary closure of sinus perforation and sinus repairs
 3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
 4. Surgical access of an unerupted tooth
 5. Mobilization of erupted or malpositioned tooth to aid eruption
 6. Placement of device to aid eruption
 7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
 8. Surgical repositioning of tooth/teeth
 9. Transseptal fiberotomy/supra crestal fiberotomy
 10. Surgical placement of anchorage device with or without flap
 11. Harvesting bone for use in graft(s)
- d) Alveoloplasty in conjunction or not in conjunction with extractions
 - e) Vestibuloplasty
 - f) Excision of benign and malignant tumors/lesions
 - g) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
 - h) Destruction of lesions by electrosurgery
 - i) Removal of lateral exostosis, torus palatinus or torus mandibularis
 - j) Surgical reduction of osseous tuberosity
 - k) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
 - l) Surgical Incision
 1. Incision and drainage of abscess - intraoral and extraoral
 2. Removal of foreign body
 3. Partial ostectomy/sequestrectomy
 4. Maxillary sinusotomy
 - m) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
 - n) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
 1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
 2. Manipulation under anesthesia
 3. Condylectomy, discectomy, synovectomy
 4. Joint reconstruction
 5. Services associated with TMJD treatment require prior authorization
 - o) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
 - p) Arthroscopy
 - q) Occlusal orthotic device – includes placement and removal to same provider
 - r) Surgical and other repairs
 1. Repair of traumatic wounds – small and complicated
 2. Skin and bone graft and synthetic graft
 3. Collection and application of autologous blood concentrate

4. Osteoplasty and osteotomy
5. LeFort I, II, III with or without bone graft
6. Graft of the mandible or maxilla – autogenous or nonautogenous
7. Sinus augmentations
8. Repair of maxillofacial soft and hard tissue defects
9. Frenectomy and frenoplasty
10. Excision of hyperplastic tissue and pericoronal gingiva
11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
12. Emergency tracheotomy
13. Coronoidectomy
14. Implant – mandibular augmentation purposes
15. Appliance removal – “by report” for provider that did not place appliance, splint or hardware

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions, and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

- a) Limited treatment for the primary, transitional and adult dentition
- b) Interceptive treatment for the primary and transitional dentition
- c) Minor treatment to control harmful habits
- d) Continuation of transfer cases or cases started outside of the program
- e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
- f) Orthognathic Surgical Cases with comprehensive orthodontic treatment
- g) Repairs to orthodontic appliances
- h) Replacement of lost or broken retainer
- i) Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Adjunctive General Services

- a) Palliative treatment for emergency treatment – per visit
- b) Anesthesia
 1. Local anesthesia NOT in conjunction with operative or surgical procedures.
 2. Regional block
 3. Trigeminal division block.
 4. Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires hospitalization or general anesthesia. 2 hour maximum time
 5. Intravenous conscious sedation/analgesia – 2 hour maximum time
 6. Nitrous oxide/analgesia
 7. Non-intravenous conscious sedation – to include oral medications
- c) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
 - One unit equals 15 minutes of additional time
 - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
 - Office or Clinic maximum – 2 units

- Inpatient/Outpatient hospital – 4 units
- Skilled Nursing/Long Term Care – 2 units
- d) Consultation by specialist or non-Primary Care Provider
- e) Professional visits
 - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
 - Hospital or ambulatory surgical center call
 - For cases that are treated in a facility.
 - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
 - General anesthesia and outpatient facility charges for dental services are covered
 - Dental services rendered in these settings by a dentist not on staff are considered separately
 - Office visit for observation – (during regular hours) no other service performed
- f) Drugs
 - Therapeutic parenteral drug
 - Single administration
 - Two or more administrations - not to be combined with single administration
 - Other drugs and/or medicaments – by report
- g) Application of desensitizing medicament – per visit
- h) Occlusal guard – for treatment of bruxism, clenching or grinding
- i) Athletic mouthguard covered once per year
- j) Occlusal adjustment
 - Limited - (per visit)
 - Complete (regardless of the number of visits), once in a lifetime
- k) Odontoplasty
- l) Internal bleaching

Additional benefits for a child under age 6

For a Member who is severely disabled or who is a child under age 6, We cover:

- a) general anesthesia and Hospitalization for dental services; and
- b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Contract which requires Hospitalization or general anesthesia.

(1) TREATMENT FOR TEMPOROMANDIBULAR JOINT DISORDER (TMJ)

The following services are covered when rendered by a Network Practitioner upon prior Referral by a Member's Primary Care Provider. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Member. However, with respect to treatment of TMJ, We do not cover any services or supplies for orthodontia, crowns or bridgework.

(m) **THERAPEUTIC MANIPULATION** Therapeutic manipulation is covered when rendered by a Network Practitioner upon prior Referral by a Member's Primary Care Provider. We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Services and supplies beyond 30 visits are not covered.

(n) **Cancer Clinical Trial** We cover practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the Member during the course of treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever a Member receives medical care associated with an Approved Cancer Clinical Trial. We will cover charges for such items and services only if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.

We do not cover the cost of investigational drugs or devices themselves, the cost of any non-health services that might be required for a Member to receive the treatment or intervention, or the costs of managing the research, or any costs which would not be covered under this Contract for treatments that are not Experimental or Investigational.

(o) **Clinical Trial.** The coverage described in this provision applies to Members who are eligible to participate in an approved clinical trial, Phase I, II, III and/or IV according to the trial protocol with respect to the treatment of cancer or another life threatening condition. We provide coverage for the clinical trial if the Member's practitioner is participating in the clinical trial and has concluded that the Member's participation would be appropriate; or the Member provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.

We provide coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.

We will not deny a qualified Member participation in an approved clinical trial with respect to the treatment of cancer or another life threatening disease or condition. We will not deny or limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. We will not discriminate against the Member on the basis of the Member's participation in the clinical trial.

(p) **Surgical Treatment of Morbid Obesity** Coverage is provided for surgical treatment of morbid obesity for one surgical procedure within a two-year period, measured from the date of the first surgical procedure to treat morbid obesity, unless a multi-stage procedure is planned and We authorize coverage for such multi-stage procedure. In addition, We will cover surgery required as a result of complications that may arise from surgical treatment of morbid obesity.

For the purpose of this coverage, morbid obesity means a body mass index that is greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid condition. Body mass index is calculated by dividing the weight in kilograms by the height in meters squared.

NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS CONTRACT.

Care or treatment by means of **acupuncture**, except when used as a substitute for other forms of anesthesia.

The amount of any charge, which is greater than the **Allowed Charge**.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless Member is being transferred to another Inpatient health care Facility.

Blood or blood plasma which is replaced by or for a Member.

Broken Appointments.

Care and/or treatment by a **Christian Science Practitioner**.

Completion of claim forms.

Services or supplies related to **Cosmetic Surgery**, except as otherwise stated in this Contract; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes

Services related to **Custodial or domiciliary** care.

Dental care or treatment, including appliances and dental implants, except as otherwise stated in this Contract.

Care or treatment by means of **dose intensive chemotherapy**, except as otherwise stated in this Contract.

Services or supplies, the primary purpose of which is **educational** providing the Member with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for behavior problems or learning disabilities, except as otherwise stated in this Contract.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this Contract.

Extraction of teeth, except for bony impacted teeth and as otherwise stated in this Contract.

Services or supplies for or in connection with:

- a) except as otherwise stated in this Contract for Members through the end of the month in which he or she turns age 19, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
- b) except as otherwise stated in this Contract for members through the end of the month in which he or she turns age 19, eyeglasses or lenses of any type; this exclusion does not apply to initial replacements for loss of the natural lens; or
- c) eye surgery such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of Your **family**: Spouse, child, parent, in-law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following:

- a) procedures: invitro fertilization; embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); donor sperm, surrogate motherhood;
- b) Prescription Drugs not eligible under the Prescription Drugs section of the Policy; and
- c) ovulation predictor kits. See also the separate Exclusion addressing sterilization reversal.

Except as otherwise stated in this Contract, services or supplies related to **hearing aids and hearing examinations** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to **herbal medicine**.

Services or supplies related to **hypnotism**.

Services or supplies necessary because the Member engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.

Except as stated below, Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

Exception: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who

actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to **marriage, career or financial counseling, sex therapy or family therapy, and related services.**

Charges for **missed appointments.**

Any **Non-Covered Service or Supply** specifically limited or not covered elsewhere in this Contract, or which is not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except;

- a) insulin needles and insulin syringes and glucose test strips and lancets;
- b) colostomy bags, belts, and irrigators; and
- c) as stated in this Contract for food and food products for inherited metabolic diseases.

Services provided by a **pastoral counselor** in the course of his or her normal duties as a religious official or practitioner.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.

The following exclusions apply specifically to *Outpatient* coverage of **Prescription Drugs:**

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents;
 - allergens and allergy serums;
 - biological sera, blood or blood plasma, unless they can be self-administered.
- c) Charges for a Prescription Drug which is: labeled "Caution — limited by Federal Law to Investigational use"; or experimental.
- d) Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.

- e) Charges for refills dispensed after one year from the original date of the prescription.
- f) Charges for Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, misused, stolen, broken or destroyed.
- g) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- h) Charges for a Prescription Drug which is to be taken by or given to the Member, in whole or in part, while confined in:
 - a Hospital;
 - a rest home;
 - a sanitarium;
 - an Extended Care Facility;
 - a Hospice;
 - a Substance Abuse Center;
 - an alcohol abuse or mental health center;
 - a convalescent home;
 - a nursing home or similar institution;
 - a provider's office.
- i) Charges for:
 - therapeutic devices or appliances;
 - hypodermic needles or syringes, except insulin syringes;
 - support garments; and
 - other non-medical substances, regardless of their intended use.
- j) Charges for vitamins, except Legend Drug vitamins.
- k) Charges for drugs for the management of nicotine dependence.
- l) Charges for topical dental fluorides.
- m) Charges for any drug used in connection with baldness.
- n) Charges for drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the
- o) Member taking part in the commission of a felony.
- p) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

- q) Charges for drugs dispensed to a Member while on active duty in any armed force.
- r) Charges for drugs for which there is no charge. This usually means drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and We are legally required to pay it, We will.
- s) Charges for drugs covered under Home Health Care; or Hospice Care section of the Contract.
- t) Except as stated below, charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws. **Exception:** This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.
- u) Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.
- v) Prescription Drugs or new dosage forms that are used in conjunction with a treatment or procedure that is determined to not be a Covered Service.
- w) Drugs when used for cosmetic purposes. This exclusion is not applicable to Members with a medically diagnosed congenital defect or birth abnormality who have been covered under the policy from the moment of birth.
- x) Drugs used solely for the purpose for weight loss.
- y) Life Enhancement Drugs for the treatment of sexual dysfunction, (e.g. Viagra).
- z) Prescription Drugs dispensed outside of the United States, except as required for Emergency treatment.

Any service provided without prior written Referral by the Member's **Primary Care Provider**, except as specified in this Contract.

Services related to **Private Duty Nursing**, except as provided under the Home Health Care section of this Contract.

Services or supplies related to **rest or convalescent cures**.

Room and board charges for a Member in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Services or supplies related to **Routine Foot Care, except:**

- a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
- b) the removal of nail roots; and
- c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services or supplies:

- a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Member asserts his or her rights to obtain this coverage or payment for these services;
- b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
- c) for which a Member would not have been charged if he or she did not have health care coverage;
- d) for which the Member has no legal obligation to reimburse the Provider;
- e) provided by or in a Government Hospital except as stated below, or unless the services are for treatment:
 - of a non-service Emergency; or
 - by a Veterans' Administration Hospital of a non-service related Illness or Injury;

Exception: This exclusion does not apply to military retirees, their Dependents and the Dependents of active duty military personnel who are covered under both this Contract and under military health coverage and who receive care in facilities of the Uniformed Services.

Stand-by services required by a Provider.

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Telephone consultations, except as stated in the Outpatient Services provision.

Charges for **third party requests** for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining a license issued by a municipality, state or federal government; obtaining insurance coverage; foreign travel; school admissions; or attendance including examinations required for participation in athletic activities.

Transplants, except as otherwise listed in the Contract.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a **war**, or an act of war, if the Illness or Injury occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Member is serving in such forces and is outside the home area.

Weight reduction or control, including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, except as otherwise provided in the Surgical Treatment of Morbid Obesity section of this Contract.

Wigs, toupees, hair transplants, hair weaving or any drug, if such drug is used in connection with baldness.

COORDINATION OF BENEFITS AND SERVICES

Purpose of This Provision

A Member may be covered under this Contract and subsequently become covered by or eligible for coverage under Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan. This provision allows Us to coordinate the services and supplies We provide with what Medicare pays or what Medicare would pay. This provision also allows us to coordinate benefits with what a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan pays. 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 the Member is covered.

Please note: The ONLY circumstance in which a person may be covered under both this Contract and under Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan occur when a Member is already covered under this Contract and subsequently becomes eligible for Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan.

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 the Member is 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.

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.

Allowable Charge: An amount that is not more than the allowance 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.

Claim Determination Period: A Calendar Year, or portion of a Calendar Year, during which a Member is covered by this Contract and covered by or eligible to be covered by Medicare and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:
a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;

- b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- c) 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;
- d) Group hospital indemnity benefit amounts that exceed \$150 per day;
- e) 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.

For purposes of determining plans with which this plan can coordinate, Plan does not include:

- a) Individual or family insurance contracts or subscriber contracts;
- b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
- c) Group or group-type coverage where the cost of coverage is paid solely by the Member, except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
- d) Group hospital indemnity benefit amounts of \$150 per day or less;
- e) School accident-type coverage;
- f) A State plan under Medicaid.

PRIMARY AND SECONDARY PLAN

We consider each plan separately when coordinating payments.

For the purpose of coordinating benefits with this individual Contract, Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan is always the Primary Plan and this Contract is always the Secondary Plan. Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan or Church Plan pays or provides services or supplies first, without taking into consideration the existence of this Contract.

This Contract takes into consideration the benefits provided by Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan. During each Claim Determination Period, this Contract will pay up to the remaining unpaid allowable expenses, but this Contract will not pay more than it would have paid if it had been the Primary Plan. The method this Contract 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.

This Contract shall not reduce Allowable Expenses for Medically Necessary and Appropriate services or supplies on the basis that precertification, pre-approval, notification or second surgical opinion procedures were not followed.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow, it is necessary to consider:

- a) the basis on which the Primary Plan and the Secondary Plan pay benefits; and
- b) 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 Allowed Charge (AC) or some similar term. This means that the provider bills a charge and the Member may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on an allowed charge is called an “AC 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, the Member 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.” An HMO and Exclusive Provider Organization (EPO) are examples of network only plans that could use a fee schedule. If the Member uses the services of a non-network provider, the plan will be treated as an AC Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a “capitation”. This means that then HMO or other plans pays the provider a fixed amount per Member. The Member is liable only for the applicable deductible, coinsurance or copayment. If the Member uses the services of a non-network provider, the HMO, EPO or other plans 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, and “EPO” refers to Exclusive Provider Organization.

Primary Plan is AC Plan and Secondary Plan is AC Plan

The Secondary Plan shall pay the lesser of:

- a) the difference between the amount of the billed charges and the amount paid by the Primary Plan; or
- b) 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 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:

- a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- b) 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 the Member shall not exceed the fee schedule of the Primary Plan. In no event shall the Member be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is AC 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:

- a) the difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
- b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

The Member shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the Member has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the primary and Secondary Plans are less than the provider's billed charges. In no event shall the Member be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is AC 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:

- a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- b) 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 AC Plan or Fee Schedule Plan

If the Primary Plan is an HMO or EPO 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 the Member receives 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 AC Plan

If the Member receives 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:

- a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- b) 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 the Member receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The Member shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

Primary Plan is an HMO and Secondary Plan is an HMO or EPO

If the Primary Plan is an HMO or EPO 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 the Member receives 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.

SERVICES FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a Member's coverage under this Contract when services are provided as a result of an automobile related Injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Member as a result of an accident:

- a) while occupying, entering, leaving or using an automobile; or
 - b) as a pedestrian;
- caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:

- a) this Contract;
- b) PIP; or
- c) OSAIC.

"Eligible Services" means services provided for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.

This Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Member under this Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Contract may be primary for one Member, but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

This Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Contractholder's plan. In that case this Contract will be primary.

If there is a dispute as to which policy is primary, this Contract will pay benefits or provide services as if it were primary.

Services this Contract will provide if it is primary to PIP or OSAIC.

If this Contract is primary to PIP or OSAIC it will provide benefits for eligible expenses in accordance with its terms.

Benefits this Contract will pay if it is secondary to PIP or OSAIC.

If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

- a) the Allowable Expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
- b) the equivalent value of services if this Contract had been primary.

GENERAL PROVISIONS

AMENDMENT

We may make amendments to the Contract upon 30 days' notice to the Contractholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Contract will be made without the approval of the Board.

Only Our officers have authority: to waive any conditions or restrictions of the Contract, to extend the time in which a premium may be paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received.

No change in the Contract is valid unless the change is shown in one of the following ways:

- a) it is shown in an endorsement on it signed by one of Our officers.
- b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of this Contract called **Conformity With Law**, it is shown in an amendment to it that is signed by one of Our officers.
- c) if a change is required by Us, it is accepted by the Contractholder, as evidenced by payment of a premium on or after the effective date of such change.
- d) if a written request for a change is made by the Contractholder, it is shown in an amendment to it signed by the Contractholder and by one of Our officers.

ASSIGNMENT

No assignment or transfer by the Contractholder of any of the Contractholder's interest under this Contract or by a Member of any of his or her interest under this Contract is valid unless We consent thereto.

CLERICAL ERROR - MISSTATEMENTS

No clerical error nor programming or systems error by the Contractholder or by Us in keeping any records pertaining to coverage under this Contract will reduce a Member's Coverage. Neither will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the Contractholder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If Your age, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by Us, subject to this Contract's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Contract.

CONFORMITY WITH LAW

Any provision of this Contract which, is in conflict with the laws of the State of New Jersey, or with Federal law, shall be construed and applied as if it were in full compliance with the minimum requirements of such State law or Federal law.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Contract.

GOVERNING LAW

This entire Contract is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE CONTRACT

There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contractholder or by a Member covered under this Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

LIMITATION ON ACTIONS

No action at law or in equity shall be brought to recover on the Contract until 60 days after a Member files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record with the Contractholder.

If to the Contractholder: To the last address provided by the Contractholder on an enrollment or change of address form actually delivered to Us.

If to a Member: To the last address provided by the Member on an enrollment or change of address form actually delivered to Us.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any claims payment previously made to You in error.

OTHER RIGHTS

We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in Your application may not be used by Us to void this Contract or in any legal action unless the application or a duplicate of it is attached to this Contract or has been furnished to You for attachment to this Contract.

PAYMENT OF PREMIUMS - GRACE PERIOD

The following paragraph only applies to Members who are NOT recipients of the premium tax credit and Members who are recipients of the premium tax credit but have not paid at least one full month's premium during the calendar year

Premiums are to be paid by You to Us. They are due on each premium due date. You may pay each premium other than the first within 31 days of the premium due date. Those days are known as the grace period. You are liable to pay premiums to Us from the first day the Contract is in force in order for this Contract to be considered in force on a premium paying basis. You will be liable for the payment of the premium for the time the Contract stays in effect. If any premium is not paid by the end of the grace period coverage will end as of the end of the period for which premium has been paid. You may be responsible for the payment of charges incurred for services or supplies received during the grace period.

The following paragraph only applies to Members who ARE recipients of the premium tax credit who have paid at least one full month's premium during the calendar year.

Premiums are to be paid by You to Us. They are due on each premium due date. While each premium is due by the premium due date there is a grace period for each premium other than the first that runs for 3 consecutive months from the premium due date. We will pay all appropriate claims for services and supplies received during the first month of the grace period. We will pend the payment of claims for services beyond the first month through the end of the 3 month grace period. We will send You a notice if You do not make payment by the premium due date and if payment is not made, the Contract will end 30 days following the date of the notice. You will be liable for the payment of the premium for the time coverage stays in effect. We will notify the Federal Department of Health and Human Services that You have not paid the required premium by the premium due date. We will also notify the Providers for the pended claims that the claims may be denied.

REINSTATEMENT

If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Contract. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Contract will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the forty-fifth day following the date for the conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law. The reinstated Contract shall cover only loss resulting from Injury or Illness that begins more than 10 days after the date of reinstatement. In all other respects, We and the Member shall have the same rights under the Contract as before the end of the grace period.

PREMIUM RATE CHANGES

The premium rates in effect on the Effective Date are shown in the Contract's Schedule of premium Rates. We have the right to prospectively change premium rates as of any of these dates:

any premium due date;

any date that the extent or nature of the risk under the Contract is changed:

- by amendment of the Contract; or
- by reason of any provision of law or any government program or regulation;

at the discovery of a clerical error or misstatement as described in the General Provisions section of this Contract.

We will give You 30 days written notice when a change in the premium rates is made.

STATEMENTS

No statement will void the coverage, or be used in defense of a claim under this Contract, unless it is contained in a writing signed by a Member, and We furnish a copy to the Member.

All statements will be deemed representations and not warranties.

RENEWAL PRIVILEGE – TERMINATION

All Contract Years and Contract Months will be calculated from the Effective Date. All periods of insurance hereunder will begin at 12:01 a.m. and end at midnight Eastern Standard Time.

The Contractholder may renew this Contract for a term of one (1) year, on the first and each subsequent Renewal Date. All renewals are subject to the payment of premiums then due, computed as provided in this Contract's **Premium Rates** section and to the provisions stated below.

We have the right to non-renew this Contract on the Renewal Date following written notice to the Contractholder for the following reasons:

- a) subject to 180 days advance written notice, We cease to do business in the individual health benefits market;
- b) subject to 90 days advance written notice, We cease offering and non-renew a particular type of Health Benefits Plan in the individual market provided We act uniformly without regard to any Health Status-Related Factor of Members or persons who may become eligible for coverage; or
- c) subject to 90 days advance written notice the Board terminates a standard plan or a standard plan option.

The advance written notice for non-renewal for the reasons stated in items a, b and c above shall comply with the requirements of N.J.A.C. 11:20-18.

During or at End of Grace Period - Failure to Pay Premiums: If any premium is not paid by the end of its grace period, the Contract will end as described in the Grace Period provision.

Termination by Request - If You want to replace this Contract with another Individual Health Benefits Plan, You must give us notice of the replacement within 30 days after the effective date of the new Plan. This Contract will end at midnight on the day before the effective date of the new Plan and any unearned premium will be refunded. If You want to end this Contract and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Contract be terminated at the end of any period for which premiums have been paid. Then the Contract will end on the date requested.

This Contract will be renewed automatically each year on the Renewal Date, unless coverage is terminated on or before the Renewal Date due to one of the following circumstances:

- a) You have failed to pay premiums in accordance with the terms of the Contract, or We have not received timely premium payments; (Coverage will end as described in the Grace Period provision).
- b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract; (Coverage will end as of the effective date.)
- c) with respect to a Member other than a Dependent, termination of eligibility if You are no longer a Resident; (We will give You at least 30 days written notice that coverage will end.)
- d) You become covered under another individual Health Benefits Plan; (Coverage will end at midnight on the day before the date the individual Health Benefits Plan takes effect, provided We receive notice of the replacement within 30 days after the effective date of the new plan.)
- e) You no longer live in the Service Area, or in an area for which We are authorized to do business, provided that coverage is terminated uniformly without regard to any Health Status-Related Factor of Members.
- f) with respect to a catastrophic plan, the date of a marketplace redetermination of exemption eligibility that finds the Member is no longer eligible for an

exemption, or until the end of the plan year in which the Member attains age 30, whichever occurs first.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends at midnight on the date the Dependent is no longer a Dependent, as defined in the Contract. However, for a Dependent child who is no longer a dependent due to the attainment of age 26 coverage ends at midnight on the last day of the month in which the Dependent attains age 26..

Also, Dependent coverage ends when the Contractholder's coverage ends.

THE CONTRACT

This Contract, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance.

WORKERS' COMPENSATION

The health benefits provided under this Contract are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF YOUR MARRIAGE OR DOMESTIC PARTNERSHIP OR CIVIL UNION ENDS

If Your marriage ends by legal divorce or annulment, or Your domestic partnership or civil union dissolves, the individual coverage for Your former Spouse ends. The former Spouse may convert to an individual contract during the conversion period. The former Spouse may cover under his or her individual contract any of his or her Dependent children who were covered under this Contract on the date this coverage ends. See **Exceptions** below.

Exceptions

No former Spouse may use this conversion right:

- a) if he or she is eligible for Medicare;
- b) if it would cause him or her to be excessively covered. This may happen if the Spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage; or
- c) if he or she permanently relocates outside the Service Area.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date this coverage ends. The former Spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT

The individual contract will provide the medical benefits that We are required to offer. The individual contract will take effect on the day after coverage under this Contract ends.