AmeriHealth
NEW JERSEY

Everything you need to know about your health plan

AmeriHealth Insurance Company of New Jersey | AmeriHealth HMO, Inc.

How your health plan works

Welcome to AmeriHealth New Jersey

Our goal at AmeriHealth New Jersey is to provide you with health care coverage that can help you live a healthy life. This kit will help you understand your benefits so that you can take full advantage of your membership.

To get the most from your coverage, it's important to become familiar with the benefits and services available to you. You'll find valuable information in this kit on:

- how to use your ID card
- what services are covered and are not covered by your health insurance
- how decisions are made about what is covered
- how to use amerihealthexpress.com
- how to get in touch with us if you have a problem

Register for amerihealthexpress.com, and download the free AmeriHealth New Jersey app, **AHNJ On the Go**, for easy access to your health information 24/7.*

If you have any questions, feel free to call Customer Service at **888-YOUR-AH1** (888-968-7241) and we will be happy to assist you.

Thank you for being an AmeriHealth New Jersey member. We look forward to providing you with quality health care coverage.

*Please have your member ID card ready when you text to sign up. Standard message and data rates may apply. Text STOP to stop and HELP for help. Terms and conditions available at myhelpsite.net/amerihealth. Notification messages within AmeriHealth New Jersey Wire are sent via automated SMS. Enrollment in AmeriHealth New Jersey Wire is not a requirement to purchase goods and services from AmeriHealth New Jersey. Wire is a trademark of Relay Network, LLC.

Introduction to your health plan

What is a primary care physician?
A primary care physician (PCP) helps coordinate the overall medical care for you and your covered dependents. Your PCP is the doctor that will treat you for your basic health care needs.

Anytime you need to see a specialist, such as a cardiologist or dermatologist, your PCP may refer you to a specialist participating in the network. PCPs may choose a radiology, physical therapy, or laboratory site to which they refer their patients. If you need a service your PCP doesn't provide, such as diagnostic testing or hospitalization, your PCP may refer you to an in-network facility.

How to search for a PCP:
Visit **amerihealthnj.com/providerfinder** where you can search by specialty (e.g. internal medicine or pediatrics), location, and gender.

How to choose or change your PCP (HMO, HMO Plus or POS plan members only*):
There are two ways to choose or change your PCP:

- **Online:** To select or change your doctor, visit **amerihealthexpress.com**, our simple, convenient, and secure member website.
- **Phone:** Call **888-YOUR-AH1 (888-968-7241)** and one of our Customer Service associates will assist you with your PCP selection.

Questions? Call
888-YOUR-AH1
(888-968-7241)

*POS Plus and PPO plan members do not need to select a PCP; however, it is always recommended that you consult and seek non-emergency care from your PCP. EPO plan members may be required to select a PCP; please refer to your summary of benefits and coverage.

Using your ID card
You and your covered dependents will each receive an AmeriHealth New Jersey identification (ID) card. It is important to take your ID card with you wherever you go because it contains information including what to pay when visiting your doctor, specialist, or the emergency room (ER). You should present your ID card when you receive care, including doctor visits or when checking in at the ER.

The back of your ID card provides information about medical services, what to do in an emergency, and how to use your benefits. If any information on your ID card is incorrect, you misplace an ID card, or need to print out a temporary ID card, you may do so through **amerihealthexpress.com** or by calling **888-968-7241**. A digital copy of your ID card is also available on the **AHNJ On the Go** app.

How to receive care

Scheduling an appointment
Simply call your doctor's office and request an appointment. If possible, notify your doctor 24 hours in advance if you are unable to make it to a scheduled appointment.

Access after normal business hours
Urgent or emergency medical advice should be available 24 hours a day, 7 days a week. If an urgent issue arises after normal business hours, call your doctor's office for instructions on how to reach your doctor or a covering physician. A physician should call you within 30 minutes.

Referrals
If you have an HMO or POS plan, you are required to get a referral from your PCP for certain specialty services. You may check the status of a referral by logging in to **amerihealthexpress.com,** or on your mobile device through **AHNJ On the Go.**

Please note: referrals are not required for members with HMO Plus, POS Plus, EPO or PPO plans; however, it is always recommended that you consult and seek non-emergency care from your PCP.

Locating a physician or hospital in your network
You have access to our expansive provider network of physicians, specialists, and hospitals. Search for providers at **amerihealthnj.com/providerfinder** and selecting your network and plan from the drop-down list. Provider and facility profiles include location maps and details on specialties, staff languages spoken, patients accepted, and more. Or call Customer Service at **888-968-7241** for assistance.

Using your preventive care benefits
Quality care and prevention are vital to your long-term health and well-being. That's why we cover 100% of certain preventive services, including, but not limited to:

Quality care and **prevention** are vital to your long-term **health** and **well-being.**

- **Screenings for:**
  - breast, cervical, and colon cancer
  - vitamin deficiencies during pregnancy
  - diabetes
  - high cholesterol
  - high blood pressure
- **Routine vaccinations for children, adolescents, and adults as determined by the Centers for Disease Control and Prevention (CDC)**
- **Women's preventive health services, such as:**
  - well-woman visits (annually)
  - screening for gestational diabetes
  - human papillomavirus (HPV) DNA testing
  - counseling for sexually transmitted infections
  - counseling and screening for human immunodeficiency virus (HIV)
  - screening and counseling for interpersonal and domestic violence
  - breastfeeding support, supplies (breast pumps), and counseling
  - generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved over-the-counter female contraceptives with a prescription

Be sure to consult with your PCP for preventive services and/or screenings.

Wellness guidelines

One of the best ways to stay well is to utilize the preventive services covered by your health plan. Our Wellness Guidelines are a list of evidence-based wellness recommendations* for the average-risk person. These recommendations are not a statement of benefits and should not be confused with Preventive Care Benefits identified under Health Care Reform. Some of these services may require cost-sharing. To download our Wellness Guidelines, log on to **amerihealthexpress.com** or call **888-968-7241** to request a hard copy.

Using services that require preapproval and precertification

Certain services may require preapproval prior to receiving care to ensure that the services you seek are medically necessary. For more information, visit **amerihealthnj.com/precert** or call Customer Service for assistance at **888-968-7241**.

Receiving services for mental health or substance use disorder

Magellan Healthcare administers your mental health and substance use disorder benefits. They can be reached by calling Customer Service at **888-968-7241**. Refer to the terms and conditions of your health plan to find out if you have coverage for mental health and substance use disorder benefits.

Laboratory services

Laboratory Corporation of America® Holdings (LabCorp) is AmeriHealth New Jersey's exclusive outpatient laboratory provider. This exclusive partnership with LabCorp enables us to deliver a consistent, high quality experience to all our members.

There are more than 110 LabCorp locations in the state of New Jersey. To find your closest patient service center location, visit **LabCorp.com**.

Please note, if you have a plan with National Access, you should also exclusively utilize LabCorp outside the AmeriHealth New Jersey service area.

*The Wellness Guidelines are a summary of recommendations based on the U.S. Preventive Services Task Force and other nationally recognized sources. These recommendations have been reviewed by our network health care providers. This information is not a statement of benefits. Please refer to your health benefit plan contract/member handbook or benefits handbook for terms, limitations, or exclusions of your health benefits plan. Please contact our Customer Service department with questions about which preventive care benefits apply to you. The telephone number for Customer Service can be found on your ID card.

If you need care outside of normal business hours, the following options are available:

Emergency care

In the event of an emergency, go immediately to the emergency room. If you believe your situation is particularly severe, call 911 for assistance.

A medical emergency is a medical or psychiatric condition in which symptoms are so severe, that the absence of immediate medical attention could place one's health in jeopardy.

For most minor injuries or illness, a hospital emergency room is not the most appropriate place for you to be treated. Hospital emergency rooms provide emergency care and healthcare workers must prioritize patients' needs. The most seriously hurt or ill patients are treated first. If you are not in that category, you may wait a long time.

When to go to the ER:

- Heart attack
- Electrical burn

Urgent care

Urgent care is necessary treatment for a non-life-threatening, unexpected illness or accidental injury that requires prompt medical attention when your doctor is unavailable. Examples include sore throat, fever, sinus infection, earache, cuts, rashes, sprains, and broken bones.

You may visit an urgent care center which offers a convenient, safe, and affordable treatment alternative to emergency room care when you can't get an appointment with your own doctor.

When to go to an urgent care center:

- Sore throat
- Earache

Retail health clinic

Retail health clinics are another alternative when you can't get an appointment with your own doctor for non-emergency care. Retail health clinics use certified nurse practitioners who treat minor, uncomplicated illnesses or injuries. Some retail health clinics may also offer flu shots and vaccinations.

Telemedicine with MDLIVE

Use **MDLIVE*** for 24/7/365 access to on-demand quality health care. Telemedicine provides you with the option to access non-emergency health care by phone or video. You can now visit with a doctor from your home, office, or on-the-go in most states. To activate your **MDLIVE** account, call **888-976-7405** or log in to **MDLIVE.com/amerihealthnj.**

Access to non-emergency health care **24/7/365** via phone or video with **MDLIVE.**

* MDLIVE does not replace the primary care physician. MDLIVE is not an insurance product nor a prescription fulfillment warehouse. MDLIVE operates subject to state regulation and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services. MDLIVE phone consultations are available 24/7/365, while video consultations are available during the hours of 7 a.m. to 9 p.m. ET, 7 days a week or by scheduled availability. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. For complete terms of use visit www.mdlive.com/pages/terms.html

Health insurance that's mobile

Manage your health insurance coverage with AmeriHealth New Jersey online account management systems, personalized tools, and programs, so you get the most out of your benefits.

- **AmeriHealth Express and AHNJ On the Go help you make the most of your health plan.** View your claims and benefit information, download a temporary ID card, email or fax one directly to your doctor, and so much more! Register at **amerihealthexpress.com**, and follow the on-screen directions. Be sure to have your ID card present as it has information that you will need to register. Then, download **AHNJ On the Go** for your iPhone or Android device.

Register to access your benefits online at **amerihealthexpress.com**.

- **Use the Provider Finder to search for a participating doctor**. Provider finder helps you find the participating doctors and hospitals that are equipped to handle your needs. Simple navigation helps you get fast and accurate results. When you select your health plan type, your results are customized based on your network, making it easy to locate a participating doctor, specialist, hospital, or other medical facility nearby. You'll even be able to read patient ratings and reviews, in addition to rating your doctors and writing your own reviews.

- **Estimate costs before you go to the doctor**
  With the Care Cost Estimator* tool, you can estimate your out-of-pocket costs before you schedule a doctor's appointment or medical procedure. All estimates are based on your specific health plan. Knowing your share of medical costs in advance can help you plan your budget for treatment. The Care Cost Estimator helps you find the lowest estimated price of services when comparing doctors in your network. Compare costs for office visits, surgeries, tests, vaccines, and more. To use the Care Cost Estimator, log in at **amerihealthexpress.com** or access it through the **AHNJ On the Go** mobile app for Apple iOS and Android devices.

- **Stay connected and receive updates about your health plan**
  Sign up to receive important account information, benefit updates, and promotions from AmeriHealth New Jersey via text message. Text **MyAHNJ** to **73529** to opt in.

- **Start shopping, start saving with AmeriHealth New Jersey Insider**.
  Find great deals on a wide range of attractions and events; some are even free! Learn how to get discounted movie tickets and so much more from the Insider Discount program at **amerihealthnj.com/discounts.**

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Plan year changes

Throughout your plan year you may qualify to change your health insurance coverage. Depending on your plan, you may qualify if you've had certain life events such as getting married, having a baby, adopting a child, or turning 65.

Having a baby

Children born to active AmeriHealth New Jersey members are automatically covered for their first 60 days of life. During this time, members are encouraged to enroll their child in their current policy. To enroll your newborn, you should contact your plan administrator, or Customer Service at 888-968-7241.

Please note, a child born to a child dependent is not covered under your existing policy, unless the child is eligible to be covered as your dependent.

Becoming eligible for Medicare

If you are turning 65 during this plan year, you will be eligible to enroll in Medicare Parts A and B. AmeriHealth New Jersey members eligible for Medicare Parts A and B should enroll during the Annual Enrollment Period. When you enroll in Medicare, Medicare becomes the primary payer for your claims.

If you are eligible and do not enroll, we will subtract either the amount that Medicare would have paid (usually 80 percent of the Medicare rate) or the applicable plan fee schedule for the services, at our discretion, and pay only the remaining balance of the claim as if you had enrolled in Medicare Parts A and B.

As a result, you may be responsible for the amount that AmeriHealth New Jersey did not pay in addition to any applicable copayments, coinsurance, and deductibles. In your benefit plan, this is referred to as Medicare Primary.

By enrolling in Medicare Parts A and B benefits you will be able to maximize your group benefits and minimize your out-of-pocket costs. For more information or to apply for Medicare Parts A and B, you can:

- Visit a Social Security Administration (SSA) office
- Call the SSA at **1-800-772-1213 (TTY/TDD: 1-800-325-0778)**
- Go to the SSA website at **www.socialsecurity.gov**

Using your prescription drug benefits

The information in this section is only applicable to members who have AmeriHealth New Jersey prescription drug overage.

To find a pharmacy visit **amerihealthexpress.com** or call the number on your ID card.

AmeriHealth New Jersey Prescription Drug Program

If you have an AmeriHealth New Jersey Prescription Drug plan, your benefits are administered by FutureScripts®. FutureScripts helps you easily and safely obtain the prescription drugs you need at an affordable price.

Take a look at the advantages:

- **Easy to use.** A national network of retail pharmacies will recognize and accept your member ID card.
- **Low out-of-pocket expenses.** When you use a participating pharmacy, your out-of-pocket costs are based on a discounted price, fixed copayments, or coinsurance.
- **No paperwork.** You don't have to file a claim form or wait for reimbursement when you use a participating pharmacy.
- **High level of safety.** When you fill a prescription at a participating pharmacy, your pharmacy can identify harmful drug interactions and other dangers by viewing your drug history.
- **Mail order.** If you take maintenance drugs for an ongoing or chronic condition, you may be able get your prescriptions delivered to your home through mail order. Mail order purchases allow you to get a larger supply of drugs than what might be available to you at the retail pharmacy. And, depending upon your plan design, your out-of-pocket expenses may be lower and you won't have to visit the pharmacy as often.

How to fill your prescription at a retail pharmacy

Present your member ID card and your prescription at a FutureScripts-participating pharmacy. The pharmacist will confirm your eligibility for benefits and determine your share of the cost for your prescription (e.g. copay). Your doctor may also be able to submit your prescription to your pharmacy electronically.

Participating pharmacies

If a pharmacy is in your plan's network, it is considered to be a participating pharmacy. When you're traveling, you will find that most pharmacies in all 50 states accept your member ID card and can fill your prescription for the same cost that you would pay at your local pharmacy back home. There is no need to select just one pharmacy to fill your prescription needs.

Brand vs. Generic

Generic drugs are as effective as brand drugs and could save you money. However, consult your doctor to find out which drug type is best for you.

Understanding your prescription

Brand drugs are only manufactured by one company, which advertises and sells its product under a unique trade name. In many cases, brand drugs are quite expensive, which is why your share of the cost is higher. Generic drugs are typically manufactured by several companies and are almost always less expensive than the brand drug. Generic drugs are approved by the U.S. Food and Drug Administration (FDA) to ensure they are as safe and effective as their brand counterparts. However, not every brand drug has a generic version.

Using your prescription drug benefits, *continued*

Drug benefit program

Your prescription drug benefit program, administered by FutureScripts®, provides many advantages to help you easily and safely obtain the prescription drugs you need at an affordable cost.

The drug benefit program uses a formulary, which includes generic drugs and a defined list of brand drugs that have been evaluated for their medical effectiveness, positive results, and value. The formulary is reviewed quarterly to ensure its continued effectiveness.

To check the formulary status of drugs, simply log in to **amerihealthexpress.com**.

In addition to the drug formulary, you will also find helpful information on these related topics:

- Prior authorization process
- Formulary exception process
- Age and quantity level limits

If you're not sure if brand or generic drugs are right for you, talk to your doctor. The pharmacist may discuss with your physician whether an alternate drug is appropriate for you. Let your physician know if you have a question about a change in your prescription(s) or if you prefer the original prescription(s).

Certain controlled substances and other prescribed medications may be subject to dispensing limitations. If you have any questions regarding your medication, please call Customer Service at **888-968-7241**.

Preventive drugs for adults and children

AmeriHealth New Jersey's prescription drug plans include 100% coverage for certain preventive medications when received from an in-network pharmacy. This means that you won't have to pay copays, coinsurance, or deductibles for certain preventive medications with a prescription from your doctor. Receiving this preventive care will help you stay healthy and may improve your overall health.

For a list of eligible preventive drugs, please visit **amerihealthexpress.com**, or call the number on the back of your member ID card.

Mail order pharmacy

If your doctor has prescribed a medication that you'll need to take regularly over a long period of time, the mail order service is an excellent way to get a long-lasting supply and reduce your out-of-pocket costs.

Mail order is convenient and safe to use

If you choose mail order, you can get up to 90-day supply without having to go to a retail pharmacy each month. Mail order prescriptions have been safely handled through the mail for many years. When your order is received, a team of registered, licensed pharmacists check your prescription against the record of all drugs dispensed to you by a FutureScripts network pharmacy. This process ensures that every prescription is reviewed for safety and accuracy before it is filled and mailed to you. If there are questions about your prescription, a pharmacist will contact your doctor before your medication is dispensed. Your medication will be sent to your home within ten days from the date your complete, eligible order is received.

Using your prescription drug benefits, *continued*

How to begin using mail order pharmacy:

1. When you are prescribed a chronic or "maintenance" drug therapy, ask your doctor to write the prescription for a 90-day supply, plus refills. Make sure your doctor knows that you have a mail order service so that you get one 90-day prescription and not three 30-day prescriptions, because the cost of the three 30-day prescriptions may be more than the cost for one 90-day prescription. If you're taking medication now and would like to begin using mail order pharmacy, ask your doctor for a new prescription.
2. Complete the *FutureScripts Mail Order Form* with your first order only. Forms are available by calling the number on your member ID card.
3. Be sure to answer all the questions, and include your member ID number. An incomplete form can cause a delay in processing your request. Send the completed *Mail Order Form*, your original 90-day prescription, and the appropriate payment to FutureScripts.
4. Your medication will be sent to you within about 10 business days from the date the completed order is received, along with instructions for future refills. Standard delivery is included at no charge. Narcotic substances and refrigerated medicines will be shipped by FedEx® at no additional cost to you.

Paying for mail order services

Your payment can be in the form of a check or money order (made payable to FutureScripts), or you can complete the credit card portion of the Mail Order Form. FutureScripts accepts Visa, MasterCard®, Discover®, and American Express®. Please do not send cash. If you are uncertain of your payment, call the number on the back of your member ID card. If the payment you enclose is incorrect, you will be sent either a reimbursement check or an invoice, as appropriate.

Mail order refills

When you receive a medication through the mail order service, you will also receive a notice showing the number of refills allowed by your doctor. To avoid the risk of being without your medication, mail the refill notice and your payment two weeks before you expect your present supply to run out. You can also manage and order your refills online through **amerihealthexpress.com**.

your refills at
amerihealthexpress.com.

The refill notice will include the date when you should reorder your medication, as well as the number of refills you have left. Remember, most prescriptions are valid for a maximum of one year.

If you have any questions concerning this program, please contact FutureScripts at **888-678-7012.**

Using your prescription drug benefits, *continued*

Self-administered Specialty Drug Coverage

Self-injectables and other oral specialty drugs that can be administered by you, the patient, or by a caregiver outside of the doctor's office are covered under your AmeriHealth New Jersey prescription drug benefits administered by FutureScripts.

The administration of a self-injectable drug by a medical professional is covered under your AmeriHealth New Jersey medical benefit, even if you obtained the self-injectable drug through the FutureScripts Specialty Pharmacy Program. However, the drug itself will be covered under your AmeriHealth New Jersey prescription drug benefit.

Unless otherwise noted in your Benefit Booklet, the only self-injectable drugs that are covered under AmeriHealth New Jersey medical plans include drugs that:

- are required by law to be covered under both medical benefits and pharmacy benefits (e.g., insulin)
- are required for emergency treatment, such as a self-injectable that counteracts allergic reactions (e.g., EpiPen)

An independent pharmacy benefits management (PBM) company, FutureScripts, administers our prescription drug benefits and is responsible for providing a network of participating pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. AmeriHealth New Jersey anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of pharmacy benefits. Under most benefit plans, prescription drugs are subject to a member copayment.

Using your Vision benefits

The information in this section only applies to members who have AmeriHealth New Jersey Vision coverage.

View your Vision benefits at **amerihealthexpress.com.**

Your Vision benefits

Vision problems are among the most widespread health issues in the United States. An eye exam can help prevent vision problems and help to spot more serious chronic health conditions, such as diabetes, hypertension, and heart disease.

Your vision plan gives you access to timely treatment and covered services like refraction, glaucoma screenings, and dilation that can help paint a picture of your overall health. Please review your Benefit Booklet to confirm if you have vision coverage, as well as applicable benefits and limitations.

Freedom of provider choice

You have access to the Davis Vision® provider network, which includes more than 84,000 points of access.

Choose from an extensive frame collection*

You can select any frame from the Exclusive Frame Collection of stylish, contemporary frames covered in full, or with a minimal copay. You also have the freedom to use your frame allowance toward any frame on the market at any in-network location.

Accidents happen and they are covered. All glasses provided by Davis Vision laboratories are warranted against breakage for one year from the original date of dispensing.

*Additional Pairs: Members will receive 30% off complete pairs of eyeglasses at independent participating provider locations on the same transaction. Otherwise, a 20% discount off the providers usual and customary rate is available.

Coverage for laser vision correction

If you're interested in Laser Vision Correction, you may qualify to receive up to 25% off a participating provider's usual and customary fees, or 5% off any participating provider's advertised specials on laser vision correction services.

Hearing Aid discounts

Davis Vision members now have access to a routine hearing test and name brand hearing aid technology at reduced prices through Your Hearing Network, an industry leader.

All services, provider referrals and discounts are coordinated through Your Hearing Network. In order for members to access their discounted pricing and see a YHN provider, they will first need to contact YHN directly at 1 (888) 809-0044 or **davisvision.yourhearing.com**.

Using your Vision benefits, *continued*

Visionworks retail centers offer affordability, choice, and convenience.
Visionworks optical retail centers are a cornerstone of the provider network and support AmeriHealth New Jersey's commitment to choice.

To find a **Visionworks** location near you, visit **visionworks.com.**

Visionworks has high-quality eyeglasses, designer frames, and a wide variety of contact lenses, reading glasses, and specialty lenses all at great prices. With a dedication to quality, durability, and variety, Visionworks provides you with everything that you need to find the right look. Visionworks also has one of the largest selections of fun and fashionable children's eyeglasses in the eyewear industry. Children 13 years of age or younger receive free impact and scratch-resistant lenses.

With your AmeriHealth New Jersey Vision Care benefits, you will receive:

- high-quality designer and exclusive brands frames
- eyeglass lenses
- contact lenses
- sunglasses
- vision correction

AmeriHealth New Jersey Vision is administered by Davis Vision, an independent company.

An affiliate of AmeriHealth has a financial interest in Visionworks, a separate company.

Organ and tissue donation

AmeriHealth New Jersey is required by the Senate and General Assembly of the State of New Jersey to provide you with information about organ and tissue donation and registration.

Organ donation in New Jersey

The New Jersey Motor Vehicle Commission (MVC) administers the organ donation registration program. If you are a New Jersey resident 18 years or older you can register as an organ donor. Once you decide to become a donor, you should inform your family of your decision. In the event of your death, the hospital will still have questions about your organ donation wishes, even if you are a registered donor. It is important that your intentions are known, including which organs and tissues you wish to donate.

Ways to register as an organ donor:

- Online with Donate Life at **registerme.org**
- In person at your local NJ MVC office whenever you apply or renew your New Jersey driver's license or state identification card. Find your local NJ MVC office at **dmv.org/nj-new-jersey/dmv-office-finder.php**
- By calling the New Jersey Organ and Tissue Sharing Network at **800-742-7365**
- Or by calling the Gift of Life Donor Program at **800-366-6771**

To change your organ donor information on your NJ driver's license or state identification card you should visit your local New Jersey MVC office. You can also update your information at **organize.org**, or by completing the Change of Status organ and tissue donation form available at **www.state.nj.us/mvc.**

Member support

When you need us, we're here for you. You can contact us to discuss anything pertaining to your health care, including benefits and eligibility, claims status, requesting a new ID card, or wellness programs.

Phone
Call Customer Service at **888-968-7241** Monday - Friday, 8 a.m. to 6 p.m.

Information about your AmeriHealth New Jersey health plan

Your Summary of Benefits and Coverage (SBC) for your plan, which explains any out-of-pocket costs like copayments, coinsurance, and deductibles is available by logging in to amerihealthexpress.com. All AmeriHealth New Jersey Individual SBCs are also available at amerihealthnj.com.

Please contact Customer Service at **888-968-7241** if you have any questions or would like to request a paper copy of any plan documents.

Member Rights & Responsibilities

To obtain a list of your rights and responsibilities, go to **amerihealthnj.com/html/members/quality_management/rights_responsibilities.html** or call the Customer Service number on your ID Card.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih koji' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of rae, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, toher formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grevance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 09F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan.

AMERIHEALTH INSURANCE COMPANY OF NEW JERSEY
INDIVIDUAL HEALTH BENEFITS PLAN EPO
(New Jersey Individual Health Benefits Plan)

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

EFFECTIVE DATE OF POLICY: January 1, 2021

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

In consideration of the application for this Policy and of the payment of premiums as stated herein, We agree to pay benefits in accordance with and subject to the terms of this Policy. This Policy is delivered in New Jersey and is governed by the laws thereof.

This Policy 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 the **General Provisions** section.

Michael A. Munoz
SVP & Market President - AHNJ

Legal Name of Carrier AmeriHealth Insurance Company of New Jersey
Trade Name: AmeriHealth

Carrier Toll free Telephone Number: 1-888-968-7241 (TTY: 711)

Carrier Fax Number: 1-888-457-3013

Carrier E-Mail Address: www.amerihealth.com/inquiry.

POLICY INDEX

SECTION **PAGE(S)**

PREMIUM RATES

The initial monthly premium rates, in U.S. dollars, for the coverage provided under this Policy are set forth on the rate sheet for this Policy for the effective date shown on the first page of this Policy. The monthly rates may be adjusted as explained in the Premium Rate Changes provision.

Age	Non-Tobacco	Tobacco
0-14	$242.26	$242.26
15	$263.79	$263.79
16	$272.03	$272.03
17	$280.26	$280.26
18	$289.13	$289.13
19	$298.00	$298.00
20	$307.18	$307.18
21	$316.68	$316.68
22	$316.68	$316.68
23	$316.68	$316.68
24	$316.68	$316.68
25	$317.95	$317.95
26	$324.28	$324.28
27	$331.88	$331.88
28	$344.23	$344.23
29	$354.36	$354.36
30	$359.43	$359.43
31	$367.03	$367.03
32	$374.63	$374.63
33	$379.38	$379.38
34	$384.45	$384.45
35	$386.98	$386.98
36	$389.52	$389.52
37	$392.05	$392.05
38	$394.58	$394.58
39	$399.65	$399.65
40	$404.72	$404.72
41	$412.32	$412.32
42	$419.60	$419.60
43	$429.73	$429.73
44	$442.40	$442.40
45	$457.29	$457.29
46	$475.02	$475.02
47	$494.97	$494.97
48	$517.77	$517.77
49	$540.26	$540.26
50	$565.59	$565.59
51	$590.61	$590.61
52	$618.16	$618.16

53	$646.03	$646.03
54	$676.11	$676.11
55	$706.20	$706.20
56	$738.81	$738.81
57	$771.75	$771.75
58	$806.90	$806.90
59	$824.32	$824.32
60	$859.47	$859.47
61	$889.87	$889.87
62	$909.82	$909.82
63	$934.84	$934.84
64+	$950.04	$950.04

SCHEDULE OF INSURANCE – IHC Silver EPO AmeriHealth Advantage Plan

IMPORTANT: Except in case of Emergency, all services and supplies must be provided by a Tier 1 or Tier 2 Network Provider. Some services and supplies are available from network providers for which there is no designation of Tier 1 and Tier 2. For such services and supplies refer to the Tier 2 column.

Calendar Year Cash Deductible does not apply to any of the following services:

SERVICES	**Tier 1**	**Tier 2**
Preventive Care	NONE	NONE
Immunizations and Lead Screening for Children	NONE	NONE
Laboratory	NONE	NONE
Maternity Care (pre-natal visits)	NONE	NONE
Prescription Drugs	NONE	NONE

All other Covered Charges for Tier 1 and 2:	
Per Covered Person	$2,500
Per Covered Family	$5,000

Copayment or Coinsurance (as defined below) may apply after the Cash Deductible is satisfied

Preventive Care	NONE	NONE
Maternity Care (pre-natal visits)	NONE	NONE
Primary Care Provider Visits	$25 Copayment	50%, after deductible

SERVICES	Tier 1	Tier 2
Specialist Visits	$60 Copayment	50%, after deductible
Outpatient Treatment for Mental Health Condition or Substance Use Disorder	$60 Copayment	$60 Copayment
Telemedicine and Telehealth Services:		
Provided by a contracted vendor	$0 Copayment	$0 Copayment
Provided by a Network PCP	$12.50 Copayment	50%, after deductible
Provided by a Network Mental Health Condition or Substance Use Disorder Provider	$30 Copayment	$30 Copayment
Provided by a Network Specialist	$30 Copayment	50%, after deductible
Urgent Care	20%, after deductible	20%, after deductible
Inpatient Treatment for Mental Health Condition or Substance Use Disorder	20%, after deductible	20%, after deductible
Skilled Nursing Facility	20%, after deductible	20%, after deductible
Complex Imaging Services	50%, after deductible	50%, after deductible
All other Radiology Services	50%, after deductible	50%, after deductible
Durable Medical Equipment	50%, after deductible	50%, after deductible
Laboratory	NONE	NONE
Dialysis	50%, after deductible	50%, after deductible
Hospice	50%, after deductible	50%, after deductible
Home Health Care	50%, after deductible	50%, after deductible
Emergency Transportation	50%, after deductible	50%, after deductible
Therapy Services (Speech, Cognitive, Occupational, Physical)	$60 Copayment	$60 Copayment
Therapeutic Manipulations	$60 Copayment	$60 Copayment
Outpatient Cardiac and Respiratory Therapy	$60 Copayment	50%, after deductible
Infusion Therapy	$60 Copayment	50%, after deductible

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

	Tier 1	**Tier 2**
All other Covered Charges	20%, after deductible	50%, after deductible

Prescription Drugs

Retail Pharmacy
For Generic Drugs: $10.00 Copayment per 30 day supply.
For Brand Name Drugs: 50% Coinsurance per 30 day supply, with a maximum Prescription Drug Coinsurance Limit expense of $150.00.

Mail Order Pharmacy
The Copayment or Coinsurance for each prescription or refill which is obtained through the Mail Order Program:
For Generic Drugs: $20.00 Copayment per 31-90 day supply.
For Brand Name Drugs: 50% Coinsurance per 31-90 day supply, with a maximum Prescription Drug Coinsurance limit expense of $300.00.

Vision Benefits: (For Covered Person through the end of the month in which the Covered Person turns age 19)

Eye Exam (once every 12 months):	0%, no deductible for Tier 1 or Tier 2
Eyeglass lenses or Contact lenses (once every 12 months):	0%, no deductible for Tier 1 or Tier 2
Standard frames (once every 12 months):	0%, no deductible for Tier 1 or Tier 2

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person 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 Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.

Maximum Out of Pocket	
Per Calendar Year for Tier 1 and Tier 2:	
Per Covered Person	$8,550
Per Covered Family	$17,100

SCHEDULE OF INSURANCE
Daily Room and Board Limits

During a Period of Hospital Confinement

For semi-private room and board accommodations, We will cover charges up to the Hospital's actual daily semi private room and board rate.

For private room and board accommodations. We will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, We will cover charges up to the Hospital's actual private room charge.

For Special Care Units, We will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

During a Confinement In An Extended Care Center Or Rehabilitation Center

We will cover the lesser of:
a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Nutritional Counseling
- Complex Imaging Services

We will reduce benefits by 50% with respect to charges for treatment, services and supplies which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Payment Limits: For Illness or Injury, We will pay up to the payment limit shown below:

Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech therapy per Calendar Year Note: This limit does not apply to speech therapy covered under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for cognitive therapy per Calendar Year	30 visits
Charges for physical therapy per Calendar Year Note: This limit does not apply to physical therapy covered under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for occupational therapy per Calendar Year Note: This limit does not apply to occupational therapy covered under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for hearing aids for a Covered Person age 15 or younger	one hearing aid per hearing impaired ear per 24-month period
Maximum Benefit (for all Illnesses and Injuries)	Unlimited

DEFINITIONS

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

Accredited School means 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 is always the negotiated fee schedule. No other method is used in this Network only plan.

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

Ambulatory Surgical Center means 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 permanent 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.

We will recognize it 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 either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b) approved for its stated purpose by medicare.

We do not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Annual open enrollment period means 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.

Birthing Center means 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.

We will recognize it if:
a) it carries out its stated purpose under all relevant state and local laws; or
b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) it is approved for its stated purpose by Medicare.

We do not recognize a Facility as a Birthing Center if it is part of a Hospital.

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

Brand Name Drug means: a) a Prescription Drug as determined by the Food and Drug Administration; and b) protected by the trademark registration of the pharmaceutical company which produces them.

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before this Policy pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments and Non-Covered Charges.

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 means the percentage of a Covered Charge that must be paid by a Covered Person. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Charges.

Complex Imaging Services means 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.

Copayment means a specified dollar amount a Covered Person must pay for specified Covered Charges. Note: The Emergency Room Copayment, if applicable, must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.

Cosmetic Surgery or Procedure means 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 Charges are Allowed Charges for the types of services and supplies described in the **Covered Charges** section of this Policy. The services and supplies must be:
a) furnished or ordered by a recognized health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of this Policy, We pay benefits for Covered Charges incurred by a Covered Person while he or she is insured by this Policy. Read the entire Policy to find out what We limit or exclude.

Covered Person means an Eligible Person who is insured under this Policy. Throughout this Policy, Covered Person is often referred to using "You" and "Your."

Current Procedural Terminology (C.P.T.) means 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 means any service or supply, including room and board, which:
a) is furnished mainly to help a person meet his or her routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

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

Dependent means Your:
a) Spouse;
b) Dependent child through the end of the month in which he or she attains age 26.

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

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.

In addition to the Dependent children described above, any other child over whom You have legal custody or legal guardianship may be covered to the same extent as a Dependent child under this Policy provided the child depends on You for most of the child's support and maintenance. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, 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 means 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 Covered Person 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 Covered Person's need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of, lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable intellectual disability, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
a) radiology, ultrasound and nuclear medicine;
b) laboratory and pathology; and
c) EKGs, EEGs and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services are not covered under this Policy if the procedures are ordered as part of a routine or periodic physical examination or screening examination.

Discretion / Determination / Determine means 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 is equipment which is:
a) designed and able to withstand repeated use;
b) primarily and customarily used to serve a medical purpose;
c) generally not useful to a Covered Person in the absence of an Illness or Injury; and
d) suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors and hearing aids which are covered through age 15. Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

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 the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date on which coverage begins under this Policy for the Policyholder, or the date coverage begins under this Policy for Your or Your Dependent, as the context in which the term is used suggests.

Eligible Person means 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). An eligible person must be a U.S. Citizen, National or lawfully present in the United States.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of Substance Use Disorder such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual (or 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 means We determine a service or supply is:

a) not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a 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 primarily to receive 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 particular condition.

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

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

a. 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:
    1. The American Hospital Formulary Service Drug Information; or
    2. 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.
b. 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;
c. 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;
d. 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
e. Proof as reflected in the published peer reviewed medical literature must exist that improvements in health outcomes; as defined in item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. We will recognize it 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; or
b) approved for its stated purpose by Medicare.

In some places, an "Extended Care Center" may be called a "Skilled Nursing Facility."

Facility means a place We are required by law to recognize 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.

Generic Drug means: a) a therapeutically equivalent Prescription Drug, as determined by the Food and Drug administration; b) a drug which is used unless the Practitioner prescribes a Brand Name Drug; and c) a drug which is identical to the Brand Name Drug in strength or concentration, dosage form and route of administration.

Government Hospital means 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. means a policy, program or plan that provides medical benefits to a group of two or more individuals.

Group Health Plan means 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 means 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 means 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 means 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. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. We will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

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

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited as a Hospital by The Joint Commission; or
b) approved as a Hospital by Medicare.

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

Illness or Ill means a sickness or disease suffered by a Covered Person or a description of a Covered Person suffering from a sickness or disease. Illness includes Mental Illness and Substance Use Disorder.

Injury or Injured means all damage to a Covered Person's body and all complications arising from that damage, or a description of a Covered Person suffering from such damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such settings.

Legend Drug means any drug which must be labeled "Caution – Federal Law prohibits dispensing without a prescription.

Mail Order Program means a program under which a Covered Person 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 means only a Prescription Drug used for the treatment of chronic medical conditions.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and We determine at Our Discretion, that it is:
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 the convenience of a Covered Person;
e) the most appropriate level of medical care the Covered Person needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner 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.

With respect to treatment of Substance Use Disorder the determination of Medically Necessary and Appropriate shall use an evidence-based and peer reviewed clinical review tool as designated in regulation by the Commissioner of Human Services.

Medicaid means 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 means 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.

Mental Health Facility means a Facility which mainly provides treatment for people with mental health problems. We will recognize 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 means 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 means 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.

Nicotine Dependence Treatment means "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

Non-Covered Charges are charges which do not meet this Policy's definition of Covered Charges or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Charges or are otherwise not covered by this Policy. Utilization review penalties are also Non-Covered Charges.

Non- Network Provider means a Provider which is not a Network Provider.

Non-Preferred Drug means a drug that has not been designated as a Preferred Drug.

Nurse means 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 he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.

Orthotic Appliance means 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 means a Covered Person who is **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 means a licensed and registered pharmacy operated by Us or with whom We have 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 means a licensed and registered pharmacy operated by Us or with whom We have signed a pharmacy services agreement.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. We determine if the cause(s) of the confinements are the same or related.

Pharmacy means 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.

Policy means this policy, including the application and any riders, amendments, or endorsements, between You and Us.

Policyholder means the person who purchased this Policy.

Practitioner means a person We are required by law to recognize who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her 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 means Our approval using paper or electronic means for specified services and supplies prior to the date charges are incurred. We will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy. For information regarding the services for which We require Pre-Approval, consult our website at **www.ameriHealthnj.com**

Preferred Drug means 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 Covered Persons, upon request.

The list of Preferred Drugs will be revised, as appropriate.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution- Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by Us, such as insulin.

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 Covered Person;

b) Immunizations for routine use for Covered Persons of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Covered Person;
c) Evidence–informed preventive care and screenings for Covered Persons 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 Covered Persons 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) means a Practitioner who is a Network provider who is licensed or otherwise authorized to provide health care services in the state or jurisdiction in which the services are furnished and who supervises, coordinates and maintains continuity of care for Covered Persons. Primary Care Providers include nurse practitioners/clinical nurse specialists, physician assistants and certified nurse midwives.

Private Duty Nursing means Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

Prosthetic Appliance means 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 means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy. Tribal Provider means those providers listed in 25 U.S.C. 1603, including the Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization.

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. We will recognize it 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 either The Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

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

Resident means 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 means 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.

Routine Nursing Care means the appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule means the Schedule of Insurance contained in this Policy.

Skilled Nursing Care means 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 (see Extended Care Center.)

Special Care Unit means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

Specialist Doctor means a doctor who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Special enrollment period means 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 Services mean 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 diseases and hygiene).

Specialty Pharmaceuticals are 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 must 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. AmeriHealth will provide a complete list of Specialty Pharmaceuticals. The list is also available on AmeriHealth's website.

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

Substance Use Disorder is as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and any subsequent editions. Substance Use Disorder includes substance use withdrawal.

Substance Use Disorder Facility means a Facility that mainly provides treatment for people with Substance Use Disorder problems. We will recognize such a Facility 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 by the Commission on Accreditation of Rehabilitation Facilities (CARF); or
d) credentialed by AmeriHealth.

Surgery means:

a) the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
b) the correction of fractures and dislocations;
c) reasonable and customary preoperative and post-operative care; or
   any of the procedures designated by Current Procedural Terminology codes as Surgery.

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

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

The Joint Commission means the entity that evaluates and accredits or certifies health care organizations or programs.

Therapeutic Manipulation means the 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, hydro therapy or other treatment of similar nature.

Triggering event means 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 of an Eligible Person's subsidy, including a determination that an Eligible Person is newly eligible or 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 NJ FamilyCare 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 or 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 court order that requires coverage for a Dependent.
k) The date of a marketplace or Carrier finding that it erroneously permitted or denied an Eligible Person enrollment in a qualified health plan.
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 means care for a non-life threatening condition that requires care by a Provider within 24 hours.

We, Us, Our and **Carrier** mean AmeriHealth Insurance Company of New Jersey.

You, Your and Yours mean the Policyholder and/or any Covered Person, as the context in which the term is used suggests.

ELIGIBILITY

Types of Coverage

The Policyholder who completes an application for coverage may elect coverage just for him/her self or may add one or more eligible Dependents for coverage. The possible types of coverage are listed below.

- **Single Coverage** - coverage under this Policy for only one person.
- **Family Coverage** - coverage under this Policy for You, Your Spouse and Your Dependent Child(ren)
- **Adult and Child(ren) Coverage -** coverage under this Policy for You and 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.
- **Two Adults Coverage** - coverage under this Policy for You and Your Spouse.

Who is Eligible

The Policyholder -You, if You are an Eligible Person.
Spouse - Your Spouse who is an Eligible Person **except:** a Spouse need not be a Resident but must be a U.S. Citizen, National or lawfully present in the United States.
Child - Your child who is an Eligible Person and who qualifies as a Dependent, as defined in this Policy, **except**: a child need not be a Resident but must be a U.S. Citizen, National or lawfully present in the United States.

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 Policy, such a child may stay eligible for Dependent health benefits past this Policy's age 26 limit for eligible Dependents.

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

But, for the child to stay eligible, You must send Us written proof that the child is 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 Covered Person, who is not covered as either a Dependent Spouse or as a Dependent child, must be a Resident and a U.S. Citizen, National or lawfully present in the United States. We reserve the right to require proof that such Covered Person is a Resident and a U.S. Citizen, National or lawfully present in the United States.

Adding dependents to this Policy

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 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 60 days from the date of birth without additional premium. Coverage may be continued beyond such 60-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 60 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 60-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 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 Policy unless the child is eligible to be covered as Your Dependent, as defined.

EXCLUSIVE PROVIDER ORGANIZATION (EPO) PROVISIONS

Definitions

a) ***Primary Care Provider*** (PCP) Under this Policy a Covered Person does not have to select a PCP, but is encouraged to do so. If selected, the PCP will supervise and coordinate the Covered Person's health care in the AmeriHealth Network for example, by providing referrals to specialists. Even if a PCP is selected, a Covered Person can choose any specialist he or she wants to use. Whether or not a PCP is selected any office visit to a PCP who qualifies as a PCP is subject to the applicable

PCP copayment. Carrier will supply the Covered Person with a list of PCPs who are members of the AmeriHealth Provider Organization.

b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Service Area*** means the geographical area which is served by the Practitioners in the AmeriHealth Provider Organization.

Provider Organization (PO)
The Provider Organization for this Policy is the AmeriHealth Provider Organization. The Covered Person will periodically be given up-to date lists of AmeriHealth PO Providers. The up-to date lists will be furnished automatically, without charge. Except in the case of Urgent Care or a medical Emergency, a Covered Person must obtain covered services and supplies from Network PO Providers to receive benefits under this Policy. Services and supplies obtained from Providers that are not Network PO Providers will generally not be covered.

Some of the Providers are classified as Tier 1 and Tier 2. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of Tier 1 Providers than for Tier 2 Providers.

The Primary Care Provider (PCP)
Under this Policy a Covered Person does not have to select a PCP, but is encouraged to do so. The PCP is available to supervise and coordinate the Covered Person's health care in the AmeriHealth PO.

As long as services or supplies are obtained from AmeriHealth Providers, the Covered Person will be eligible for Network Benefits.

A Covered Person may change his or her PCP to another PCP. He or she may select another PCP from the list of Practitioners, and notify AmeriHealth PO by phone or in writing. For a discretionary change, 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.

When a Covered Person uses the services of a network provider, he or she must present his or her ID card and pay the applicable Copayment, if any. Most AmeriHealth PO Practitioners will prepare any necessary claim forms and submit them to Us.

Emergency Services

In the case of Urgent Care or an Emergency, a Covered Person may go to a AmeriHealth Health Care Network provider or a non-AmeriHealth Health Care Network provider. If a Covered Person receives Urgent Care or care and treatment for an Emergency from a non-AmeriHealth Health Care Network provider, and the Covered Person calls Carrier within 48 hours, or as soon as reasonably possible, so We will have the information necessary to provide benefits for the Urgent Care or Emergency care and treatment to the same extent as would have been provided if care and treatment were provided by a AmeriHealth Health Care Network provider. However, follow-up care or treatment by a non-AmeriHealth Health Care Network provider will be treated as Network Benefits only to the extent it is Medically Necessary and Appropriate care or treatment rendered before the Covered Person can return to the AmeriHealth Health Care Network service area.

Service Area
As applicable to Network services and supplies, the geographic area AmeriHealth defines as county.

A Provider may be paid each time he or she treats a Covered Person ("fee for service". If a Covered Person desires additional information about how Carrier's Primary Care Providers or any other Provider in Carrier's Network are compensated, please call Carrier at 1-888-968-7241. or write:

AmeriHealth Correspondence
P.O. Box 7930
Philadelphia, Pa. 19101-7930

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 Covered Person wants more information about this, contact the Covered Person's physician, chiropractor or podiatrist. If a Covered Person believes he or she is not receiving the information to which he or she 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.

APPEALS PROCEDURE

Covered Person Complaints

A Complaint is an expression of dissatisfaction regarding any aspect of the coverage, operations, or management of the CARRIER Plan, including but not limited to the CARRIER Plan's health care services, quality of care and service, choice and accessibility of Providers, and network adequacy. Administrative Complaints typically revolve around dissatisfaction with some aspect of the CARRIER Plan's coverage, operations or management, including but not limited to choice of network providers, network adequacy, CARRIER Plan policy, procedure, administrative service or decisions pertaining to enrollment and disenrollment. Quality Complaints typically revolve around dissatisfaction with the quality of care or service delivered by Participating Providers, including but not limited to office wait times, office environment, lack of courtesy, difficulty obtaining Referrals, accessibility, or any incident which may have or could potentially result in an adverse occurrence.

Complaints may be brought by you or by another individual, such as your physician, acting on your behalf, with your consent/authorization (Covered Person Designee). To submit a Complaint, you or your Covered Person Designee may call Customer Service at the telephone number listed on the back of your ID Card. Most Administrative Complaints are resolved informally at this level. Covered Persons Services staff will refer Quality Complaints to clinical staff within the Quality Management Department for investigation and resolution. Complaints are resolved as quickly as possible. Processes and procedures have been established to ensure that Complaints are resolved within thirty (30) calendar days and that timeliness standards take into consideration the clinical urgency of the situation. When the subject of a Complaint involves a decision made by the CARRIER Plan and you or your Covered Person Designee is dissatisfied with the resolution reached through the Complaint process, Plan staff will ensure that you or your Covered Person Designee is given Appeal rights, as appropriate (see the Appeals information in this section). The complaint process is voluntary and is separate from the Appeals process. Please note that Quality Complaints are peer protected and are not subject to the Appeal process.

If you or your Covered Person Designee is dissatisfied with the outcome reached through the CARRIER Plan's internal complaint system, he or she may contact the New Jersey Department of Banking and Insurance at the following address:

Consumer Protection Services
Department of Banking and Insurance
Managed Care Complaints and Appeals

20 West State Street, 9th floor
P.O. Box 329
Trenton, NJ 08625-0329
Main Phone: (609) 292-5316
Fax: (609) 633-0807

Utilization Management Appeals

The CARRIER maintains a Utilization Management Appeals process for any Covered Person who is dissatisfied with any CARRIER Utilization Management coverage decision. The Utilization Management Appeals process provides the Covered Person the opportunity to discuss the decision with a Plan Medical Director/peer reviewer and Appeal the adverse benefit determination. A Utilization

Management coverage decision is defined as any decision to deny, terminate, or limit the provision of Covered Services that is based primarily on Medical Necessity or appropriateness, or any other coverage request based on the exclusions for Experimental/Investigational or cosmetic services. Each Appeal stage will be completed promptly, based on your health condition, within the applicable timeframes described below.

Covered Person Representatives

A Provider or another individual may Appeal on your behalf as your authorized representative if a valid consent/authorization form from the Covered Person ("Covered Person Designee") is provided to the CARRIER. However, in Expedited or Urgent Care Appeals, a valid Covered Person consent/authorization form is not required if a health care professional with knowledge of your medical condition (e.g., a treating physician) acts as the Covered Person Designee. Also, the CARRIER has staff that are available to assist and/or represent you in the Appeals process.

Appeal Classifications

Appeals of Utilization Management coverage decisions are also sometimes called "Pre-service Appeals" or "Post-service Appeals." A Pre-service Appeal is for benefits that are only covered if Pre-certified or Pre-approved before medical care is obtained; all other Appeals are Post-service. Utilization Management Appeals are usually considered Pre-service Appeals.

Appeal Stages

As described below, you or your Covered Person Designee has two opportunities to appeal a Utilization Management coverage decision. There is one internal Appeals Stage conducted by the CARRIER. After the internal review is completed, the external Appeal process becomes available to the extent mandated by the State of New Jersey or as determined by other applicable authorities (see External section). In addition, in certain circumstances you or your Covered Person Designee may pursue a civil action against the CARRIER for losses resulting from the CARRIER's denial of Medically Necessary Covered Services.

Matched Specialist Consultation

Decision makers for Utilization Management Appeals obtain input from a matched specialist—a licensed physician, psychologist, or other health care professional in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the initial adverse benefit determination at issue in the Appeal and cannot be a subordinate of the person who made that determination.

Information for the Appeal Review At the internal Appeal Stage, all information gathered for the Appeal review will be considered by the decision makers. This consist of information obtained from the CARRIER's investigation, as well as any additional information submitted by you or your Covered Person Designee. You or your designee are entitled to a full and fair review. Upon request at any time during the Appeals process, the CARRIER will provide you or your Covered Person Designee a copy of the correspondence, documents, medical records, and other information provided to the decision makers for internal Appeal review. The CARRIER may redact or delete from the copy provided to you

or your Covered Person Designee certain information that the CARRIER considers confidential and/or proprietary. The Plan will provide you with any new or additional evidence considered, relied upon, or generated by your plan in connection with the appeal, which is used to formulate the rationale. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. This information is provided to you or your designee at no charge.

The Plan will not terminate or reduce an ongoing course of treatment without providing you with advance notice and the opportunity for advance review.

Stage 1 Appeal (Internal)

You, a Provider, or your Covered Person Designee may initiate a Stage I Appeal with a Plan Medical Director/peer reviewer by calling or writing the CARRIER's New Jersey Appeals Unit as outlined in the initial CARRIER denial letter or contacting Customer Service at the telephone number listed on the back of your ID Card. The Appeal must be filed within one hundred-eighty (180) days of receipt of the initial Utilization Management determination letter.

A Stage I Appeal consists of an opportunity for a discussion and/or review of a Utilization Management coverage decision based on review of available information. Within the time periods that apply to the Stage I Appeal review (see below), a Plan Medical Director or physician designee will conduct a review and a decision will be issued. A Plan Medical Director or physician designee who has not been previously involved in the decision-making on the case, and who is not a subordinate of the decision maker, will be the decision maker for each Stage I Appeal—whether it is Expedited or non-Expedited. Input from a matched specialist will be obtained either through the participation of a Stage I Appeal decision maker who qualifies as a matched specialist or through the opinion that a qualified, independent consultant provides to the Stage I Appeal decision maker.

Non-Expedited Stage I Appeals

Non-Expedited (or standard) Stage I Appeals will be completed and a decision letter providing written notice of the decision with an explanation of the Appeal rights, as appropriate, will be sent within five (5) business days of the CARRIER's receipt of the original Appeal request.

Expedited Stage I Appeals

An urgent expedited appeal is any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. The Stage I Appeal will be processed as an Expedited or Urgent Care Appeal when the above criteria are met or whenever the Covered Person is confined in an Inpatient facility. Expedited Appeal review will be completed within seventy-two (72) hours after the CARRIER's receipt of the Appeal.

You, your Covered Person Designee, and other Providers, as appropriate, will be notified of the Medical Director's decision on the Stage I Expedited Appeal verbally or via fax within seventy-two (72) hours after receipt of the Expedited Appeal. At that time the CARRIER will also provide notice of the opportunity to go forward with an External Appeal, if you have not already filed an expedited External Appeal. The letter with written confirmation of the Expedited Stage I decision will include an explanation of Appeal rights, as appropriate. That decision letter will be sent to you, your Covered Person Designee and other Providers, as appropriate, within seventy-two (72) hours after receipt of the original Expedited Appeal request.

For urgent care appeals, you may also file an expedited External Appeal at the same time as filing an internal Expedited Appeal.

External Appeal/Review

If not satisfied with the outcome of the Stage 1 Appeal, you or your Covered Person Designee may initiate an External Appeal/Review. For most health plans, External Review is conducted by an Independent Utilization Review Organization (IURO) consistent with processes mandated by New Jersey state laws.

For plans subject to New Jersey state-mandated requirements, you or your Covered Person Designee may initiate the External Appeal/Review within one hundred twenty (120) days of receipt of the Stage 1 determination to an IURO. If the IURO accepts the Appeal/Review, it will issue a decision within forty-five days of receiving all necessary documentation to complete the review. The IURO may extend its review period for a reasonable period of time due to circumstances beyond its control. In such an event, the IURO must provide written notice to you and/or your Covered Person Designee prior to the end of the original thirty (30) business-day review period setting forth the reasons for the delay. A decision reached by an IURO that is adverse to the CARRIER is binding on the CARRIER. You Covered Person or your Covered Person Designee may Appeal directly to the IURO if the plan waives its right to an internal review or fails to meet the timeframes for completing Stage 1 internal Appeals process.

To request an External Review, follow the instructions in the decision letter for the Stage 1 Appeal.

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Also, please note that the Appeal Procedures stated above may change due to changes in the applicable state and federal laws and regulations, to satisfy standards of certain recognized accrediting organizations or to otherwise improve the Covered Person Appeals process. For additional information, contact Covered Person Services at the telephone number listed on the back of your ID Card.

Covered Person Administrative Appeals

The CARRIER maintains an Administrative Appeals process for any Covered Person who is dissatisfied with a plan decision regarding claims or non-covered benefits. The Administrative Appeals process gives you the opportunity to appeal adverse claims and non-covered benefit determinations. The internal level of Appeal is completed within the applicable timeframes outlined below. Substance Use Disorder appeals are not applicable; these are handled under Medical Necessity appeals.

Covered Person Representatives

While decisions regarding claims and non-covered benefits may be appealed by you, such decisions may also be appealed by a Provider or other individual acting on behalf of you as your authorized representative (“Covered Person Designee”) if a valid consent/authorization form from the Covered Person is provided to the CARRIER. The CARRIER also has staff available to assist and/or represent Covered Persons in the Appeals process.

Appeal Classifications

Appeals of decisions regarding claims or non-covered benefits may also be referred to as “Pre-service Appeals” or “Post-service Appeals.” A Pre-service Appeal is for benefits that are only covered if Pre-certified or Pre-approved before medical care is obtained; all other Appeals are Post-service Appeals.

Appeal Stages

As described below, you or your Covered Person Designee has access to one internal stage of Appeal.

Appeals Decision Makers and Appeals Timeframes

Decision makers for Administrative Appeals are individuals with no previous involvement in the decision at issue and are not subordinates of such individuals. Review of an Administrative Appeal is completed and a written decision letter issued for the internal level of Appeal within 15 calendar days of receipt of a first level request for a Pre-service Administrative Appeal and within 30 calendar days of receipt for a request for a Post-service Administrative Appeal.

Information for the Appeal Review

You or your designee are entitled to a full and fair review. Specifically, at all administrative appeal levels you or your designee may submit additional information pertaining to your case, to your health plan. You or your designee may specify the remedy or corrective action being sought. At your request, your plan will provide access to and copies of all relevant documents, records, and other information that are not confidential, proprietary, or privileged. The Plan will automatically provide you with any new or additional evidence considered, relied upon, or generated by your plan in connection with the appeal. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. Additionally, the decision rationale is provided to you or your designee in advance of the date the adverse notification is issued. This information is provided to you or your designee at no charge. Individuals with urgent care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

The Plan will not terminate or reduce an-ongoing course of treatment without providing you with advance notice and the opportunity for advanced review.

Stage I Appeal

You or your Covered Person Designee must request a Stage I Appeal within one hundred eighty (180) days of receipt of notice of a denied claim or a non-covered service. Instructions for filing a Level I Appeal are included in the notice letter. You or your Covered Person Designee may call Customer Service at the telephone number listed on the back of your ID Card or send a written Appeal to:

AmeriHealth Appeals
359 Prospect Plains Rd. Bldg. M
Cranbury, NJ 08512

The Stage I decision maker will review all information obtained for the Appeal from you and other sources. The CARRIER will issue a written decision letter according to the timeframes outlined above.

External Review

If not satisfied with the outcome of the Stage I appeal, the Covered Person or Covered Person designee may initiate an external review. The process described below is for all appeals concerning:

- Rescission of coverage;
- UM Denials for the following:
    - Not medically necessary to treat the covered person's illness or injury
    - Experimental or investigational
    - Cosmetic
    - In Plan Exception

Standard External Review Procedures

External appeals may be filed up to four (4) months after receipt of the notice of adverse determination or final adverse determination for appeals involving the above stated issues.

To File an Appeal

- Send electronically completed forms to dobi.ihcap@dobi.nj.gov;
- Mail requests to:

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

- Claimant may call toll free at 888-393-1062 x 50998 or 609-292-5316 x 50998 with any questions/concerns;
- Final external review decisions are made within 45 days and forwarded in writing to the claimant and the Plan;
- External review decision is binding on the Plan and covered person.

Expedited External Review Process

- Claimant may make written or oral request for external review;
- Urgent care reviews may be initiated by calling toll free at 877-549-8152;
- External examiner provides the decision within 72 hours of request for external review.
- External review decision is binding on the Plan and covered person;

Urgent Expedited Appeals

An urgent appeal is any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Substance Use Disorder Appeals
If a Covered Person is admitted to an in network facility and meets the applicable effective dates of the mandate, the appeal is turned around within twenty-four (24) hours. The Stage 2 appeal process is bypassed and the Covered Person may request an External Review, which is also completed in twenty-four (24) hours. Effective May 16, 2017, precertification is required for Substance Use Disorder treatment up until the plan renewal date due to the recent Opioid Mandate. Upon renewal, precertification is dependent upon the Covered Persons coverage. Services must be prescribed by a licensed provider and **Substance Use Disorder** appeals are only permitted to begin a **Medical Necessity** review after the **first 28 days**.

Claimants with urgent care conditions or who are currently receiving on-going treatment may file an external expedited review at the same time they file an internal expedited review by calling 877-549-8152.

CONTINUATION OF CARE

We shall provide written notice to each Covered Person at least 30 business days prior to the termination or withdrawal from Our Provider network of a Covered Person's PCP and any other Provider from which the Covered Person 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 Covered Person 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 Covered Person in active treatment for a health condition for which the Provider attests that discontinuing care by the Provider would worsen the Covered Person'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 Covered Person, coverage of services for the terminated health care professional shall continue to the postpartum evaluation of the Covered Person, up to six weeks after the delivery. With respect to pregnancy, Medical Necessity and Appropriateness shall be deemed to have been demonstrated.

For a Covered Person 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 Covered Person 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 Covered Person 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 contact 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 Covered Person is admitted to a health care Facility on the date this Policy is terminated, We shall continue to provide benefits for the Covered Person until the date the Covered Person 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 Covered Person's continued treatment with a health care professional shall be subject to the appeal procedures set forth in this Policy. We shall not be liable for any inappropriate treatment provided to a Covered Person by a health care professional who is no longer employed by or under contract with Us.

If We refer a Covered Person 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 Covered Person's liability shall be limited to any applicable Network Copayment, Coinsurance or Deductible for the service or supply.

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: Our payments will be reduced if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in this Policy.

BENEFIT PROVISION

The Schedule lists Copayments, Deductible Amounts, and/or Coinsurance as well as Maximum Out of Pocket Amounts. These terms are explained below. The Copayments, Deductible Amounts, Coinsurance and Maximum Out of Pocket amounts for some Network services are listed under Tier 1 and Tier 2. The Copayment, Deductible and/or Coinsurance) is lower for use of Tier 1 Providers than for Tier 2 Providers.

Copayment

The Schedule lists the Copayment(s) that apply to specific services and supplies. The applicable Copayment must be paid each time a Covered Person receives a service or supply for which a Copayment is required.

The Cash Deductible

Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before We pay any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, We pay benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what We pay is based on all the terms of this Policy.

Family Deductible Limit

This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once Covered Persons in a family meet the family Cash Deductible in a Calendar Year, We pay benefits for other Covered Charges incurred by any member 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 Policy.

Deductible Credit: For the first Calendar Year of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same Calendar Year that Your first Calendar Year starts under this Policy provided there has been no lapse in coverage between the previous coverage and this Policy.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

NOTE: There is no Coinsurance credit from previous coverage unless the Covered Person is entitled to a cost sharing reduction under Federal law and as a result of an eligibility change replaces a prior policy issued by Us with this Policy where both policies have the same classification of coverage and provided there has been no lapse in coverage between the previous policy and this Policy. In addition, there is no Deductible or Coinsurance carryover into the next Calendar Year.

Tier 1 and Tier 2 Maximum Out of Pocket

Tier 1 and Tier 2 Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Tier 1 and Tier 2 Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Tier 1 and Tier 2 Maximum Out of Pocket. Once the Tier 1 and Tier 2 Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Tier 1 and Tier 2 Network covered services and supplies for the remainder of the Calendar Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the Tier 1 and Tier 2 individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for Tier 1 and Tier 2 covered services and supplies for the remainder of the Calendar Year.

Benefits From Other Plans
The benefits We will pay will be affected by a Covered Person's being covered by or eligible for Medicare. Read the provision **Coordination of Benefits and Supplies with Medicare** to see how this works.

COVERED CHARGES

This section lists the types of charges We will consider as Covered Charges. But what We will pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Hospital Charges

We cover charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But We limit what We pay each day to the room and board limit shown in the Schedule. And We cover other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

Except as stated below, We cover charges 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 Covered Person, in consultation with the Practitioner, determines that a shorter length of stay is Medically Necessary and Appropriate.

As an **exception** to the Medically Necessary and Appropriate requirement of this Policy, We also provide coverage for the mother and newly born child for:
a) a minimum of 48 hours of Inpatient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of Inpatient Hospital care following a cesarean section.

We provide childbirth and newborn care coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the in-patient 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.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, We cover the charges up to the daily room and board limit for a Special care Unit shown in the Schedule.

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non- Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what We pay for Hospital charges.

Emergency and Urgent Care Services

Coverage for Emergency and Urgent Care includes 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 judgement of the attending physician, the Covered Person 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 Covered Person’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.

Pre-Admission Testing Charges

We cover pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. We only cover these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, We will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

Extended Care or Rehabilitation Charges
Subject to Our Pre-Approval We cover charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are a Non-Covered Charge.

And We cover all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:
a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

We will reduce benefits by 50% with respect to charges for treatment, services and supplies for Extended Care or Rehabilitation which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Home Health Care Charges
Subject to Our Pre-Approval, when home health care can take the place of Inpatient care, We cover such care furnished to a Covered Person under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:
a) Routine Nursing care furnished by or under the supervision of a registered Nurse;
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) 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 Policy if the Covered Person had been in a Hospital; and
i) 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 Policy if performed as Inpatient Hospital services.

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

a. The Covered Person'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 Covered Person'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 Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person'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 will reduce benefits by 50% with respect to charges for treatment, services and supplies for Home Health Care which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Private Duty Nursing Care
We **only** cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care if such care is authorized as part of a written home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

Practitioner's Charges for Non-Surgical Care and Treatment
We cover Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury.

Practitioner's Charges for Surgery
We cover Practitioner's charges for Medically Necessary and Appropriate Surgery.

We do not pay for Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

We 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.

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.

Second Opinion Charges
We cover Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. We cover such charges if the Practitioners who give the opinions:

a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges
We cover charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges
We cover charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges
Subject to Our Pre-Approval, We cover charges made by a Hospice for palliative and supportive care furnished to a terminally Ill or terminally Injured Covered Person under a Hospice care program.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain

or symptoms; it makes no attempt to cure the Covered Person's terminal Illness or terminal Injury.

"Terminally Ill" or "terminally Injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally Ill or terminally Injured Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies including Prescription Drugs, to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
a) needed for palliative and supportive care;
b) ordered by the Covered Person's Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

We do not pay for:
a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services;
d) treatment not included in the Hospice care plan; or
e) services supplied to family persons who are not Covered Persons.

We will reduce benefits by 50% with respect to charges for treatment, services and supplies for Hospice Care which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Mental Illness or Substance Use Disorder
Except as stated below for the treatment of Substance Use Disorder, We cover treatment for Mental Illness or Substance Use Disorder the same way We would for any other illness, if such treatment is prescribed by a Network Provider.

We provide benefits for the treatment of Substance Use Disorder at Network Facilities subject to the following:
a) the prospective determination of Medically Necessary and Appropriate is made by the Covered Person’s Practitioner for the first 180 days of treatment during each Calendar Year and for the balance of the Calendar Year the determination of Medically Necessary and Appropriate is made by Us;
b) pre-authorization or Pre-Approval are not required for the first 180 days of inpatient and/or outpatient treatment during each Calendar Year but may be required for inpatient treatment for the balance of the Calendar Year;
c) concurrent and retrospective review are not required for the first 28 days of inpatient treatment during each Calendar Year but concurrent and retrospective review may be required for the balance of the Calendar Year;
d) retrospective review is not required for the first 28 days of intensive outpatient and partial hospitalization services during each Calendar Year but retrospective review may be required for the balance of the Calendar Year

e) retrospective review is not required for the first 180 days of outpatient treatment including outpatient prescription drugs, during each Calendar Year but retrospective review may be required for the balance of the Calendar Year; and
f) If no Network Facility is available to provide in-patient services We shall approve an in-plan exception and provide benefits for in-patient services at a non-Network Facility.

The first 180 days per Calendar Year assumes 180 inpatient days whether consecutive or intermittent. Extended outpatient services such as partial hospitalization and intensive outpatient are counted as inpatient days. Any unused inpatient days may be exchanged for two outpatient visits.

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 Facility;
e) a Substance Use Disorder Facility; or
f) a combination Mental Health Facility and Substance Use Disorder Facility.

Pregnancy
This Policy pays for pregnancies the same way We would cover an Illness. The charges We cover for a newborn child are explained below.

Birthing Center Charges
We cover Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a Covered Person's pregnancy. We cover charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

We cover all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child
We cover charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.
Subject to all of the terms of this Policy, We cover the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

Anesthetics and Other Services and Supplies
We cover anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. We cover the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches We cover Medically Necessary and Appropriate replacements or repairs for braces, trusses, orthopedic footwear and crutches.

Blood
Unless otherwise provided in the **Charges for the Treatment of Hemophilia** section below, We cover blood, blood products, blood transfusions and the cost of testing and processing blood. But We do not pay for blood which has been donated or replaced on behalf of the Covered Person.

Charges for the Treatment of Hemophilia
We cover Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia including the purchase of blood products and blood infusion equipment.

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 Covered Person'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.

Ambulance Charges
We cover Medically Necessary and Appropriate charges for transporting a Covered Person to:
a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a Covered Person to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But We do not pay for chartered air flights. And We will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
Subject to Our Pre-Approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. At Our option, and with Our Pre-Approval, We may cover the purchase of such items when it is less costly and more practical than rental. But We do not pay for:
a) replacements or repairs; or
b) the rental or purchase of items such as air conditioners, exercise equipment, saunas and air humidifiers which do not fully meet the definition of Durable Medical Equipment.

Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

We will reduce benefits by 50% with respect to charges for Durable Medical Equipment which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Orthotic or Prosthetic Appliances
We pay benefits for Covered Charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Covered Person'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 licensed orthotist or prosthetist or any certified pedorthist.

Benefits for the appliances will be provided to the same extent as other Covered Charges under the Policy.

Treatment of Wilm's Tumor
We pay benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Covered Person. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We pay benefits for this treatment even if it is deemed Experimental or Investigational. What We pay is based on all of the terms of this Policy.

Procedures and Prescription Drugs to Enhance Fertility
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 Policy.

Nutritional Counseling
Subject to Our Pre-Approval, We cover charges for 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 Practitioner, and provided by a Practitioner.

We will reduce benefits by 50% with respect to charges for Nutritional Counseling which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

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 the Covered Person'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.

Specialized Infant Formulas
We cover specialized non-standard infant formulas to the same extent and subject to the same terms and conditions as coverage is provided under this Policy 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.

Donated Human Breast Milk
AmeriHealth covers pasteurized donated human breast milk for Covered Persons under the age of six months subject to the following conditions:
a) The Covered Person is medically or physically unable to receive maternal breast milk or participate in breast feeding, or the Covered Person's mother is medically or physically unable to produce

breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; and

b) The Covered Person's Practitioner issued an order for the donated human breast milk

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

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

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

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

X-Rays and Laboratory Tests

We cover x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this Policy's Preventive Care section, We do not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs

Subject to Our Pre-Approval, for certain Prescription Drugs We cover drugs to treat an Illness or Injury which require a Practitioner's prescription. Under this Policy We only cover drugs which are:

a. approved for treatment of the Covered Person'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 Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
    1. The American Hospital Formulary Service Drug Information;
    2. 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 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, except as stated above.

And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.

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 prior to enforcing the Pre-Approval requirement. We will give at least 30 days advance written notice to You before adding a Prescription Drug to the list.

If a Covered Person 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 Pharmacy will contact the Practitioner to request that the Practitioner contact Us to secure 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 Policy. If We do not give Pre-Approval, the Covered Person may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Covered Person paying for the Prescription Drug. The Covered Person may submit a claim for the Prescription Drug, subject to the terms of this Policy. The Covered Person may appeal the decision by following the Appeals Procedure process set forth in this Policy.

A Covered Person must pay the appropriate Copayment 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 Policy 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, AmeriHealth will pay the Covered Charge in excess of the Copayment for each Prescription Drug dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy while the Covered Person is insured. What AmeriHealth pays is subject to all the terms of the Policy.

A Covered Person and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable Copayment for a Preferred Drug. AmeriHealth 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 Covered Person's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the Covered Person.

AmeriHealth 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 Covered Person may follow the Appeals Procedure set forth in the Policy. In addition, the Covered Person may appeal a denial to the Independent Health Care Appeals Program.

The Policy 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 Policy.

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 Covered Person's Practitioner.

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

AmeriHealth will not restrict or prohibit, directly or indirectly, a Participating Pharmacy or a Participating Mail Order Pharmacy from charging the Covered Person 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 Covered Person 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 Covered Person 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 Covered Person takes the medication. The Covered Person's cost share (Copayment) amounts will be prorated to align with the quantity dispensed with each fill. If the Covered Person does not wish to have a split fill of the medication, he or she may decline participation in the program. For those Covered Persons the Specialty Pharmacy will ship the full prescription amount and charge the Covered Person the cost share for the medication dispensed. Alternatively, the Covered Person may obtain the medication at a retail pharmacy.

We will reduce benefits by 50% with respect to charges for Prescription Drugs which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Supplies to Administer Prescription Drugs
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.

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 Policy.

We cover orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Network Services and Supplies if the Covered Person is receiving care and treatment from a Network Practitioner who writes the prescription for such Prescription Drugs.

The Carrier will cover orally administered anti-cancer prescription drugs that are Medically Necessary and Appropriate as Network Services and Supplies if the Covered Person is receiving care and treatment form a Network Practitioner who writes prescriptions for such Prescription Drugs. See your Prescription Drug benefits description for information on obtaining Prescription Drugs. The Carrier will compare the coverage for orally-administered anti-cancer prescription drugs as covered under non-preferred or specialty Prescription drugs to the coverage the booklet would have provided if the Covered Person had received intravenously administered or injected anti-cancer medications from a Network Practitioner to determine which is most favorable to the Covered Person in terms of copayment, deductible and/or coinsurance. If the Policy provides different copayment, deductible and coinsurance for different places of service, the applicable copayment, deductible and coinsurance will be the copayment, deductible and coinsurance that is most favorable to the Covered Person. If a Covered Person paid a deductible and/or 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 Covered Person will be reimbursed for the difference.

Contraceptives
AmeriHealth covers prescription female contraceptives which require a Practitioner's prescription, and which are approved by the Food and Drug Administration for that purpose. Prescription female contraceptives are covered as Preventive Care which means they are covered without application of any copayment, deductible or coinsurance.

As used in this provision, prescription female contraceptive means any drug or device used for contraception by a female. Examples include but are not limited to birth control pills and diaphragms.

With respect to the first dispensing of a specific contraceptive, coverage is provided for a three-month period. For a subsequent dispensing of that same contraceptive, coverage is provided for a six-month period, except as stated below.

Exception: If the six-month period would extend beyond December 31, coverage will be reduced such that the period ends as of December 31.

Cancer Clinical Trial
We cover practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the Covered Person 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 Covered Person 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 Covered Person to receive the treatment or intervention, or the costs of managing the research, or any costs which would not be covered under this Policy for treatments that are not Experimental or Investigational.

Clinical Trial
The coverage described in this provision applies to Covered Persons 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 Covered Person’s practitioner is participating in the clinical trial and has concluded that the Covered Person’s participation would be appropriate; or the Covered Person 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 Covered Person 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 Covered Person on the basis of the Covered Person’s participation in the clinical trial.

Dental Care and Treatment
This Dental Care and Treatment provision applies to all Covered Persons.

We cover:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury was not caused, directly or indirectly by biting or chewing; and
b) all treatment is finished within 6 months of the later of:
    1. the date of the Injury; or
    2. the effective date of the Covered Person's coverage under this Policy.

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

Additional benefits for a child under age 6
For a Covered Person 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 Policy which requires Hospitalization or general anesthesia.

Treatment for Temporomandibular Joint Disorder (TMJ)
We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, with respect to treatment of TMJ We do not cover any charges for orthodontia, crowns or bridgework.

Mammogram Charges
We cover charges made for mammograms provided to a Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

We will cover charges for:
a) one baseline mammogram for a Covered Person– who is 40 years of age
b) one mammogram, every year, for a Covered Person age 40 and older; and
c) in the case of a Covered Person 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 Covered Person'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 Covered Person has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the Covered Person's Practitioner.

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

Digital Tomosynthesis Charges

AmeriHealth covers charges for digital tomosynthesis to detect or screen for breast cancer and for diagnostic purposes as follows:

a) When used for detection and screening for breast cancer in a Covered Person age 40 years and older, AmeriHealth covers charges for digital tomosynthesis as Preventive Care which means they are covered without application of any copayment, deductible or coinsurance.
b) When used for diagnostic purposes for a Covered Person of any age, AmeriHealth covers charges for digital tomosynthesis as a diagnostic service subject to the applicable copayment, deductible and coinsurance.

Colorectal Cancer Screening Charges
We cover charges made for colorectal cancer screening provided to a Covered Person age 50 or over and to younger Covered Persons who are considered to be high risk for colorectal cancer. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the Covered Person's Practitioner in consultation with the Covered Person regarding methods to use, We will cover charges for:
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 cover 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 Covered Person's practitioner in consultation with the Covered Person.

High risk for colorectal cancer means a Covered Person has:
a) A family history of: familial adenomatous polyposis, hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or
c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

Please note that colorectal cancer screening is included under the Preventive Care provision.

Therapy Services
Therapy Services mean services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

Subject to the stated limits, We cover the Therapy Services listed below when such services are provided to a Covered Person as an Outpatient 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* - 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.

We cover the Therapy Services listed below, subject to stated limitations:

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 Covered Person'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 Covered Person who has been diagnosed with a biologically-based Mental Illness, physical therapy means treatment to develop a Covered Person's physical function.

   Coverage for Physical Therapy is limited to 30 visits per Calendar Year.

j. *Infusion Therapy* **-** subject to Our Pre-Approval, the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion. **We will reduce benefits by 50% with respect to charges for Infusion Therapy which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.**

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 Covered Person is confined in a Facility or to therapy services received under the Diagnosis and Treatment of Autism or Other Developmental Disabilities provision.

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 Covered Person'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 treatment to develop a Covered Person's ability to perform the ordinary tasks of daily living;
b) physical therapy where physical therapy refers to treatment to develop a Covered Person's physical function; and

c) speech therapy where speech therapy refers to treatment of a Covered Person's speech impairment.

Coverage for occupational therapy is limited to 30 visits per Calendar Year for treatment of conditions other than autism. Coverage for physical therapy is limited to 30 visits per Calendar Year for treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per Calendar Year for treatment of conditions other than autism. 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 Covered Person's primary diagnosis is autism, 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 Policy. 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 Covered Person:

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 Charge under this Policy. 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 Covered Person 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.

Preventive Care

We cover charges for routine physical examinations including related laboratory tests and x-rays. We also cover charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, lead screening, bone density testing, colorectal cancer screening, and Nicotine Dependence Treatment.

These charges are not subject to the Cash Deductible or Coinsurance or Copayment, if any.

Immunizations and Lead Screening

We will cover charges for:

a) screening by blood measurement for lead poisoning for children, including confirmatory blood lead testing and medical evaluation as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey Department of Health and Senior Services.

These charges are not subject to any Cash Deductible, Coinsurance or Copayment.

Newborn Hearing Screening
We cover charges 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 cover charges between age 29 days and 36 months for the periodic monitoring of infants for delayed onset hearing loss.

Hearing Aids
We cover charges for medically necessary services incurred in the purchase of a hearing aid for a Covered Person 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, modifications 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 medically necessary services incurred in the purchase of a hearing aid.

Hearing aids are habilitative devices.

Vision Screening
We cover vision screening for Dependent children, through age 17, to determine the need for vision correction. The vision screening is generally performed by the pediatrician during the course of a routine physical examination. The vision screening may suggest that the Covered Person should undergo a vision examination.

Vision Benefit
We cover the vision benefits described in this provision for Covered Persons through the end of the month in which the Covered Person 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.

Therapeutic Manipulation
We cover therapeutic manipulation up to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge.

Transplant Benefits
We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:
a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Heart-lung
g) Heart Valve
h) Pancreas

i) Intestine
j) Allogeneic Bone Marrow
k) Autologous Bone Marrow and Associated Dose Intensive Chemotherapy **only** for treatment of:

- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
- SCID
- WISCOT Aldrich

l) Subject to Our Pre-Approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. **We will reduce benefits by 50% with respect to charges for such treatment of breast cancer which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.**
m) Autologous Bone Marrow transplant and Associated Dose-Intensive Chemotherapy, 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;
n) 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.

If the donor does not have health coverage that would cover the costs associated with his or her role as donor, this Policy will cover the donor's costs associated with the donation. We do not cover costs for travel, accommodations or comfort items.

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.

IMPORTANT NOTICE

This Policy has utilization review features. Under these features, The Carrier's Utilization Department reviews Hospital and other Facility admissions and Surgery performed outside of a Practitioner's office for Us. These features must be complied with if a Covered Person:

a) is admitted as an Inpatient to a Hospital or other Facility, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the **Utilization Review Features** section for details.

What We pay is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

This Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review, Specialty Case Management or Centers of Excellence Features.

UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.

Compliance with this Policy's utilization review features does not guarantee what We will pay for Covered Charges. What We pay is based on:

a) the Covered Charges actually incurred;
b) the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of this Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital or other Facility as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

By "covered professional charges for Surgery" We mean Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means Monday through Friday from 8:15am. to 9 pm. Eastern Time, not including legal holidays.

REQUIRED FACILITY STAY REVIEW

Important Notice: If a Covered Person does not comply with these Facility stay review features, he or she will not be eligible for full benefits under this Policy.

Notice of Facility Admission Required

Except as explained below for certain admissions to treat Substance Use Disorder, We require notice of all Facility admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section We reduce what We pay for covered Facility charges as a penalty.

Pre-Admission Review
Except as explained below for certain admissions to treat Substance Use Disorder, all non-Emergency Hospital or other Facility admissions must be reviewed by Carrier's Utilization Department before they occur. The Covered Person or the Covered Person's Practitioner must notify Carrier's Utilization Department and request a pre-admission review. Carrier's Utilization Department must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or the Covered Person's Practitioner must notify Carrier's Utilization Department and request a pre-admission review at least 60 days before the expected date of delivery, or as soon as reasonably possible.

When Carrier's Utilization Department receives the notice and request, they evaluate:
a) the Medical Necessity and Appropriateness of the admission
b) the anticipated length of stay and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

Carrier's Utilization Department notifies the Covered Person's Practitioner by phone, of the outcome of their review. And they confirm the outcome of their review in writing.

If Carrier's Utilization Department authorizes an admission, the authorization is valid for:
a) the specified Hospital or named Facility;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by Carrier's Utilization Department again if:
a) he or she enters a Facility other than the specified Facility
b) he or she changes attending Practitioners; or
c) more than 60 days elapse between the time he or she obtains authorization and the time he or she enters the Hospital or other Facility, except in the case of a maternity admission.

Emergency Admission
Except as explained below for certain admissions to treat Substance Use Disorder, Carrier's Utilization Department must be notified of all Emergency admissions by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day or as soon as possible after the admission occurs.
When Carrier's Utilization Department is notified by phone, they require the following information:
a) the Covered Person's name, social security number and date of birth;
b) the Covered Person group plan number;
c) the reason for the admission
d) the name and location of the Hospital or other Facility
e) when the admission occurred; and
f) the name of the Covered Person's Practitioner.

Continued Stay Review
Except as explained below for certain admissions to treat Substance Use Disorder, the Covered Person or his or her Practitioner, must request a continued stay review for any Emergency admission. This must be done at the time Carrier's Utilization Department is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital or other Facility stay. This must be done before the end of the previously authorized length of stay.

Carrier's Utilization Department also has the right to initiate a continued stay review of any Hospital or other Facility admission. And Carrier's Utilization Department may contact the Covered Person's Practitioner or Hospital or other Facility by phone or in writing.

In the case of an Emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b) the appropriateness of health care alternatives.

Carrier's Utilization Department notifies the Covered Person's Practitioner by phone, of the outcome of the review. And Carrier's Utilization Department confirms the outcome of the review in writing.The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance
Except as explained below for certain admissions to treat Substance Use Disorder, in the case of a non-Emergency admission, as a penalty for non-compliance. We reduce what We pay for covered Facility charges, by 50% if**:**
a) the Covered Person or his or her Practitioner does not request a pre-admission review; or
b) the Covered Person or his or her Practitioner does not request a pre-admission review as soon as reasonably possible before the admission is scheduled to occur; or
c) Carrier's authorization becomes invalid and the Covered Person or his or her Practitioner does not obtain a new one; or
d) Carrier's Utilization Department does not authorize the admission.

In the case of an Emergency admission, as a penalty for non-compliance, We reduce what We pay for covered Facility charges by 50%, if:
a) Carrier's Utilization Department is not notified of the admission at the times and in the manner described above;
b) the Covered Person or his or her Practitioner does not request a continued stay review; or
c) the Covered Person or his or her Practitioner does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital or other Facility admission, if a Covered Person stays in the Hospital or other Facility longer than Carrier's Utilization Department authorizes, We reduce what We pay for covered charges incurred after the authorized length of stay ends by 50% as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's Maximum Out of Pocket, Cash Deductible or Coinsurance.

Admissions for the Treatment of Substance Use Disorder – Network Only

This section applies during the first 180 days of network treatment per Calendar Year whether the treatment is inpatient or outpatient. Thereafter, inpatient treatment of Substance Use Disorder is subject to the above provisions governing Hospital and other Facility admissions.

If a Covered Person is admitted to a Facility for the treatment of Substance Use Disorder, whether for a scheduled admission or for an emergency admission, the Facility must notify Us of the admission and initial treatment plan within 48 hours of the admission.

We will not initiate continued stay review, also known as concurrent review, with respect to the first 28 days of the inpatient stay. Continued stay review may be required for any subsequent days, but not more frequently than at two-week intervals. If We determine continued stay is no longer Medically Necessary and Appropriate We shall provide written notice within 24 hours to the Covered Person and his or her Practitioner along with information regarding appeal rights.

REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Policy.

We require a Covered Person to get a pre-surgical review for any non-Emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section We reduce what We pay for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from Carrier's Utilization Department. Carrier's Utilization Department must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When Carrier's Utilization Department receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

Carrier's Utilization Department notifies the Covered Person's Practitioner, by phone, of the outcome of the review. Carrier's Utilization Department also confirms the outcome of the review in writing.

Second Surgical Opinion

If AmeriHealth's review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person may obtain a second surgical opinion. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

Carrier's Utilization Department will give the Covered Person a list of Practitioners in his or her area who will give a second opinion. The Covered Person may get the second opinion from a Practitioner on the list, or from a Practitioner of his or her own choosing, if the Practitioner:
a) is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b) is not a business associate of the Covered Person's Practitioner; and
c) does not perform the Surgery if it is needed.

Carrier's Utilization Department gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to Carrier's Utilization Department.

We cover charges for additional surgical opinions, including charges for related x-ray and tests. But what We pay is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Coinsurance.

Pre-Hospital Review

If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, We reduce what We pay for covered professional charges for Surgery by 50% if:
a) the Covered Person does not request a pre-surgical review; or
b) Carrier's Utilization Department is not given at least 24 hours to review and evaluate the proposed Surgery; or

c) Carrier’s Utilization Department requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d) Carrier’s Utilization Department does not confirm the need for Surgery.

Penalties cannot be used to meet this Policy's Maximum Out of Pocket, Cash Deductible or Coinsurance.

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Abortion, except this exclusion shall not apply if the pregnancy is the result of an act of rape or incest or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

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 the Covered Person is being transferred to another Inpatient health care Facility.

Blood or blood plasma which is replaced by or for a Covered Person.

Services or supplies for which the Provider has not obtained a ***certificate of need*** or such other approvals as required by law.

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 Policy; 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 Policy.

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

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person 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 Policy.

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

Extraction of teeth, except as otherwise stated in this Policy. Services or supplies for or in connection with:

a) except as otherwise stated in this Policy for Covered Persons 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 Policy for Covered Persons 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;
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 stated in the Newborn Hearing Screening and Hearing Aids provisions, Services or supplies related to ***hearing aids and hearing exams*** 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 Covered Person 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, nutritional counseling and related services***, except as otherwise stated in this Policy.

Charges for ***missed appointments***.

Nicotine Dependence Treatment, except as otherwise stated in the Preventive Care section of this Policy.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in this Policy, or which are not Medically Necessary and Appropriate, except as otherwise stated in this Policy.

Non-prescription drugs or supplies, except
a) insulin needles and syringes and glucose test strips and lancets;
b) colostomy bags, belts and irrigators; and
c) as stated in this Policy 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 person.

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, 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 Covered Person, in whole or in part, while confined in:

- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Hospice
- a Substance Use Disorder Facility
- Mental Health Facility
- 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 Covered Person taking part in a riot or other civil disorder; or the

o) Covered Person 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 Covered Person 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 Covered Person'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 Carrier is legally required to pay it, Carrier will.

s) Charges for drugs covered under Home Health Care; or Hospice Care section of the Policy.

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 Covered Persons 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) Prescription Drugs dispensed outside of the United States, except as required for Emergency treatment.

Services or supplies that are not furnished by an eligible ***Provider.***

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

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

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

Except as stated in the Preventive Care section, ***Routine examinations*** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; premarital or similar examinations or tests not required to diagnose or treat Illness or Injury.

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 provided by a ***social worker***, except as otherwise stated in this Policy.

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Covered Person 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 Covered Person would not have been charged if he or she did not have health care coverage;
d) for which the Covered Person 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 Policy and under military health coverage and who receive care in facilities of the Uniformed Services.
- provided outside the United States other than in the case of Emergency and except as provided below with respect to a full-time student.

Subject to Our Pre-Approval, eligibility for full-time student status, provided the Covered Person is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. Charges in connection with full-time students in a foreign country for which eligibility as a full-time student has not been Pre-Approved by Us are Non-Covered Charges. Travel to obtain medical treatment, drugs or supplies is not covered. In addition, We will not cover treatment, drugs or supplies that are unavailable or illegal in the United States.

Stand-by services required by a Provider.

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

Telephone consultations except as stated in the Practitioner's Charges for Telehealth and/or Telemedicine 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 this Policy.

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 Covered Person 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 Policy.

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 Covered Person may be covered under this Policy 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 Covered Person is covered.

Please note: The ONLY circumstances in which a person may be covered under both this Policy and under Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan occur when a Covered Person is already covered under this Policy 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 Covered Person 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.

Allowed Charge: An amount that is not more than 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 Covered Person is covered by this Policy 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 Covered Person, 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 policy, Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan is always the Primary Plan and this Policy 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 Policy.

This Policy 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 Policy will pay up to the remaining unpaid allowable expenses, but this Policy will not pay more than it would have paid if it had been the Primary Plan. The method this Policy 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 Policy shall not reduce Allowable Expenses for Medically Necessary and Appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

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 Covered Person 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 Covered Person 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 Covered Person 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 the HMO or EPO or other plan pays the provider a fixed amount per Covered Person. The Covered Person is liable only for the applicable deductible, coinsurance or copayment. If the Covered Person 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, “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 Covered Person shall not exceed the fee schedule of the Primary Plan. In no event shall the Covered Person 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 Covered Person shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the Covered Person 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 Covered Person 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 Covered Person 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 Covered Person 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 AC Plan and Secondary Plan is Capitation Plan

If the Covered Person 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 Covered Person 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 or EPO 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 Covered Person 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 Covered Person's coverage under this Policy when services are provided as a result of an automobile related Injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Covered Person 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 Policy;
b) PIP; or
c) OSAIC.

"Eligible Services" means services provided for treatment of an Injury which is covered under this Policy 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 Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under this Policy. 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 Policy may be primary for one Covered Person, but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

This Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or

excess to the Policyholder's plan. In that case this Policy will be primary.

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

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

Benefits this Policy will pay if it is secondary to PIP or OSAIC.
If this Policy 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 Policy had been primary.

GENERAL PROVISIONS

AMENDMENT

We may make amendments to the Policy upon 30 days' notice to the Policyholder, 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 Policy will be made without the approval of the Board.

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

No change in the Policy 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 Policy, as provided in the section of this Policy 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 Policyholder, 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 Policyholder, it is shown in an amendment to it signed by the Policyholder and by one of Our officers.

ASSIGNMENT

No assignment or transfer by the Policyholder of any of the Policyholder's interest under this Policy or by a Covered Person of any of his or her interest under this Policy is valid unless We consent thereto.

CLERICAL ERROR - MISSTATEMENTS

No clerical error nor programming or systems error by the Policyholder or by Us in keeping any records pertaining to coverage under this Policy will reduce a Covered Person'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 Policyholder 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 any 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 Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Policy.

CONFORMITY WITH LAW

Any provision of this Policy 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 Policy.

GOVERNING LAW

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

INCONTESTABILITY OF THE POLICY
There will be no contest of the validity of the Policy, 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 Policyholder or by a Covered Person covered under this Policy 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 Policy until 60 days after a Covered Person 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 Policy may be sent by United States Mail, postage prepaid, addressed as follows:

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

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

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

PAYMENT OF PREMIUMS - GRACE PERIOD
The following paragraph only applies to Covered Persons who are NOT recipients of the premium tax credit and Covered Persons 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 Policy is in force in order for this Policy to be considered in force on a premium paying basis. You will be liable for the payment of the premium for the time the Policy 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 Covered Persons 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 Policy 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.

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

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 Policy. 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 Policy 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. The reinstated Policy 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 Covered Person shall have the same rights under the Policy as before the end of the grace period.

PREMIUM RATE CHANGES
The premium rates in effect on the Effective Date are referenced in the Premium Rates section of the Policy. We have the right to prospectively change premium rates as of any of these dates:
a) any premium due date;
b) any date that the extent or nature of the risk under the Policy is changed:
    - by amendment of the Policy; or
    - by reason of any provision of law or any government program or regulation;
c) at the discovery of a clerical error or misstatement as described in the General Provisions section of this Policy.

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 Policy, unless it is contained in a writing signed by a Covered Person, and We furnish a copy to the Covered Person.

All statements will be deemed representations and not warranties.

RENEWAL PRIVILEGE – TERMINATION

All periods of insurance hereunder will begin at 12:01 a.m. and end at midnight Eastern Standard Time.

The Policyholder may renew this Policy 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 Policy's **Premium Rates** section and to the provisions stated below.

We have the right to non-renew this Policy on the Renewal Date following written notice to the Policyholder 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 Covered Persons or persons who may become eligible for coverage;
c) subject to 90 days advance written notice, the Board terminates a standard plan or a standard plan option; or
d) with respect to coverage issued through the marketplace, decertification of the plan.

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. Any notice provided in the event of item d above will be subject to marketplace requirements, if any.

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 Policy will end as described in the Grace Period provision.
Termination by Request - If You want to replace this Policy 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 Policy will end as of 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 Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which premiums have been paid. Then the Policy will end on the date requested.

This Policy 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 Policy, 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 Policy; (Coverage will end immediately.)
c) with respect to a Covered Person 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) With respect to a catastrophic plan, the date of a marketplace redetermination of exemption eligibility that finds the Covered Person is no longer eligible for an exemption, or until the end of the plan year in which the Covered Person 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 Policy 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 Policyholder's coverage ends.

THE CONTRACT

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

WORKERS' COMPENSATION

The health benefits provided under this Policy 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 Policy 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.

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 Policy ends.

CLAIMS PROVISIONS

A claimant's right to make a claim for any benefits provided by this Policy is governed as follows:

PROOF OF LOSS

Proof of loss must be sent to Us within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, We will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

We will pay all benefits to which the claimant is entitled as soon as We receive written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as We receive due proof of the death to one of the following:
a) his or her estate;
b) his or her Spouse;
c) his or her parents;
d) his or her children;
e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

When You file proof of loss, he or she may direct Us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. For covered services from an eligible Facility or Practitioner, We will determine to pay either the Covered Person or the Facility or the Practitioner. You may not assign his or her right to take legal action under this Policy to such provider.

PHYSICAL EXAMS

We, at our expense, have the right to examine the insured. This may be done as often as reasonably needed to process a claim. We also have the right to have an autopsy performed, at Our expense.

IHC Optional Benefit Rider

This optional Policy Rider is intended for use with the IHC Plan EPO and adds the following benefits..

AmeriHealth Insurance Company of New Jersey
(hereafter called "the Carrier")

Benefit Rider

Policyholder:
Effective Date: January 1, 2019

Your AmeriHealth IHC EPO Policy is hereby amended as follows:

1 The following is added to the Schedule of Insurance for **Prosthetic and Orthotic Devices**:

	The Plan will pay for:
Prosthetic Devices	50%
Orthotic Devices	50%

2 The following **Prosthetic and Orthotic Device definitions** have been added to the Definition Section:

PROSTHETICS (or PROSTHETIC DEVICES) – devices (except dental prosthetics or Prosthetic Appliances), which replace all or part of: (a) an absent body organ including contiguous tissue; or (b) the function of a permanently inoperative or malfunctioning body organ

ORTHOTIC DEVICES – means the following orthotics that are not Orthotic Appliances: arch supports where required for the prevention or treatment of complications associated with diabetes ; elastic knee braces; prefabricated orthotics; cervical collars; over-the-counter corsets; elastic hose; thoracic rib belts; fabric and elastic supports such as socks; dental orthotics; or other similar devices.

3 The following **Prosthetic and Orthotic Device coverage's** have been added to the Coverage Provision section:

Prosthetic Devices

Expenses incurred for Prosthetic Devices (except dental prostheses) required as a result of Illness or Injury. Expenses for Prosthetic Devices are subject to medical review by the Carrier to determine eligibility and Medically Necessary and Appropriate.

Such expenses may include, but not be limited to:

1. The purchase, fitting, necessary adjustments and repairs of Prosthetic Devices which replace all or part of an absent body organ including contiguous tissue or which replace all or part of the function of an inoperative or malfunctioning body organ; and
2. The supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device;

   Breast prostheses required to replace the removed breast or portions thereof as a result of mastectomy and prostheses inserted during reconstructive surgery incident and subsequent to mastectomy. Coverage limitations on external breast prostheses are as follows:
   a. Post mastectomy, four (4) bras per Calendar Year are covered.

3. Benefits are provided for the following visual Prosthetics when Medically Necessary and Appropriate and prescribed for one of the following conditions:
    a. Initial contact lenses prescribed for treatment of infantile glaucoma;
    b. Initial pinhole glasses prescribed for use after Surgery for detached retina;
    c. Initial corneal or scleral lenses prescribed:
        (1) In connection with the treatment of keratoconus; or
        (2) To reduce a corneal irregularity other than astigmatism;
    d. Initial scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
    e. Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of:
        (1) Accidental Injury;
        (2) Trauma; or
        (3) Ocular Surgery.

    Benefits are not provided for:
    a. Lenses which do not require a prescription;
    b. Any lens customization such as, but not limited to, tinting, oversize or progressive lenses, antireflective coatings, U-V lenses or coatings, scratch resistant coatings, mirror coatings, or polarization;
    c. Deluxe frames; or
    d. Eyeglass accessories, such as cases, cleaning solution and equipment.

    The repair and replacement paragraphs set forth below do not apply to this item.

Benefits for replacement of a Prosthetic Device or its parts will be provided: (a) when there has been a significant change in the Covered Person's medical condition that requires the replacement, (b) if the prostheses breaks because it is defective, or (c) if the prostheses breaks because it exceeds its life expectancy, as determined by the manufacturer, or (d) for a Dependent child due to the normal growth process when Medically Necessary and Appropriate. The Carrier will provide benefits to repair Prosthetic Devices when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of a prostheses, replacement means the removal and substitution of the prostheses or one of its components necessary for proper functioning. A repair is a restoration of the prostheses or one of its components to correct problems due to wear or damage. However, the Carrier will not provide benefits for repairs and replacements needed because the prostheses was abused or misplaced.

Orthotic Devices

Benefits are provided for:

1. The initial purchase and fitting (per medical episode) of Orthotic Devices.
2. The replacement of covered Orthotic Devices for Dependent children when required due to natural growth.

This benefit does not apply to Prosthetic Appliances or Orthotic Appliances as mandated by New Jersey law.

4 The following coverage for **Diabetic Education** has been added:

Diabetic Education

Benefits are provided for Outpatient Diabetic Education Program of diabetes self-management education including information on proper diet, provided by a:

A. Dietician registered by a nationally recognized professional association of dieticians;

B. Health care professional recognized as a certified diabetes educator by the American Association of Diabetes Educators; or

C. Registered Pharmacist qualified with regard to management education for diabetes by any institution recognized by the board of pharmacy in the State of Issue.

Benefits are provided for an outpatient Diabetic Education Program when the Primary Care Physician, Participating Specialist or nurse practitioner/clinical nurse specialist determines that such a program is Medically Necessary for the proper self-management and treatment of the Covered Person's diabetic condition at first diagnosis. Benefits are payable for a program Prescribed:

A. At first diagnosis of diabetes;

B. Upon diagnosis by a Physician, or nurse practitioner/clinical nurse specialist of a significant change in the Covered Person's symptoms or conditions which necessitates changes in the Covered Person's self-management; and

C. Upon determination of the Physician or nurse practitioner/clinical nurse specialist that re-education or refresher education is necessary.

A Referral from your Primary Care Physician is not required to obtain services for Diabetic Education.

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.

AmeriHealth Insurance Company of New Jersey

By

Michael A. Munoz
SVP & Market President - AHNJ

AMERIHEALTH
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION[1]

PLEASE REVIEW IT CAREFULLY.

AmeriHealth[2] values you as a customer, and protection of your privacy is very important to us. In conducting our business, we will create and maintain records that contain protected health information about you and the health care provided to you as a member of our health plans.

Note: "Protected health information" or "PHI" is information about you, including information that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We protect your privacy by:

- limiting who may see your PHI;
- limiting how we may use or disclose your PHI;
- informing you of our legal duties with respect to your PHI;
- explaining our privacy policies; and
- adhering to the policies currently in effect.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We also are required by the federal Health Insurance Portability and Accountability Act (or "HIPAA" Privacy Rule to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

[1] If you are enrolled in a self-insured group benefit program, this Notice is not applicable. If you are enrolled in such a program, you should contact your Group Benefit Manager for information about your group's privacy practices. If you are enrolled in the Federal Employee's Service Benefit Plan, you will receive a separate Notice.

[2] For purposes of this Notice, "AmeriHealth' refers to the following companies: AmeriHealth HMO, Inc., AmeriHealth Insurance Company of New Jersey, and QCC Insurance Company d/b/a AmeriHealth Insurance Company.

This revised Notice took effect on July 18, 2017, and will remain in effect until we replace or modify it.

Copies of this Notice
You may request a copy of our Notice at any time. If you want more information about our privacy practices, or have questions or concerns, please contact Member Services by calling the telephone number on the back of your Member Identification Card, or contact us using the contact information at the end of this Notice.

Changes to this Notice
The terms of this Notice apply to all records that are created or retained by us which contain your PHI. We reserve the right to revise or amend the terms of this Notice. A revised or amended Notice will be effective for all of the PHI that we already have about you, as well as for any PHI we may create or receive in the future. We are required by law to comply with whatever Privacy Notice is currently in effect. You will be notified of any material change to our Privacy Notice before the change becomes effective. When necessary, a revised Notice will be mailed to the address that we have on record for the contract holder of your member contract, and will also be posted on our web site at www.amerihealth.com.

Potential Impact of State Law
The HIPAA Privacy Rule generally does not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

How We May Use and Disclose Your Protected Health Information (PHI)
In order to administer our health benefit programs effectively, we will collect, use and disclose PHI for certain of our activities, including payment of covered services and health care operations.

The following categories describe the different ways in which we may use and disclose your PHI. Please note that every permitted use or disclosure of your PHI is not listed below. However, the different ways we will, or might, use or disclose your PHI do fall within one of the permitted categories described below.

Treatment: We may disclose information to doctors, pharmacies, hospitals and other health care providers who take care of you to assist in your treatment or the coordination of your care.

Payment: We may use and disclose your PHI for all payment activities including, but not limited to, collecting premiums or to determine or fulfill our responsibility to provide health care coverage under our health plans. This may include coordinating benefits with other health care programs or insurance carriers, such as Medicare or Medicaid. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors or hospitals which are covered by your health plan(s), or to determine if requested services are covered under your health plan. We may also use and disclose your PHI to conduct business with other AmeriHealth affiliate companies.

Health Care Operations: We may use and disclose your PHI to conduct and support our business and management activities as a health insurance issuer. For example, we may use and disclose your PHI to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to conduct business planning activities, to conduct fraud detection programs, to conduct or arrange for medical review, or to engage in care coordination of health care services.

We may also use and disclose your PHI to offer you one of our value added programs like smoking cessation or discounted health related services, or to provide you with information about one of our disease management programs or other available AmeriHealth health products or health services.

We may also use and disclose your PHI to provide you with reminders to obtain preventive health services, and to inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.

Marketing: Your PHI will not be sold, used or disclosed for marketing purposes without your authorization except where permitted by law. Such exceptions may include: a marketing communication to you that is in the form of (a) a face-to-face communication, or (b) a promotional gift of nominal value.

Release of Information to Plan Sponsors: Plan sponsors are employers or other organizations that sponsor a group health plan. We may disclose PHI to the plan sponsor of your group health plan as follows:

- We may disclose "summary health information" to your plan sponsor to use to obtain premium bids for providing health insurance coverage or to modify, amend or terminate its group health plan. "Summary health information" is information that summarizes claims history, claims expenses, or types of claims experience for the individuals who participate in the plan sponsor's group health plan;
- We may disclose PHI to your plan sponsor to verify enrollment/disenrollment in your group health plan;
- We may disclose your PHI to the plan sponsor of your group health plan so that the plan sponsor can administer the group health plan; and
- If you are enrolled in a group health plan, your plan sponsor may have met certain requirements of the HIPAA Privacy Rule that will permit us to disclose PHI to the plan sponsor. Sometimes the plan sponsor of a group health plan is the employer. In those circumstances, we may disclose PHI to your employer. You should talk to your employer to find out how this information will be used.

Research: We may use or disclose your PHI for research purposes if certain conditions are met. Before we disclose your PHI for research purposes without your written permission, an Institutional Review Board (a board responsible under federal law for reviewing and approving research involving human subjects) or Privacy Board reviews the research proposal to ensure that the privacy of your PHI is protected, and to approve the research.

Required by Law: We may disclose your PHI when required to do so by applicable law. For example, the law requires us to disclose your PHI:

- When required by the Secretary of the U.S. Department of Health and Human Services to investigate our compliance efforts; and
- To health oversight agencies, to allow them to conduct audits certain Health Oversight Activities described below.

Public Health Activities: We may disclose your PHI to public health agencies for public health activities that are permitted or required by law, such as to:

- prevent or control disease, injury or disability;
- maintain vital records, such as births and deaths;
- report child abuse and neglect;
- notify a person about potential exposure to a communicable disease;
- notify a person about a potential risk for spreading or contracting a disease or condition;
- report reactions to drugs or problems with products or devices;
- notify individuals if a product or device they may be using has been recalled; and
- notify appropriate government agency(ies) and authority(ies) about the potential abuse or neglect of an adult patient, including domestic violence.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Health oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Lawsuits and Other Legal Disputes: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process once we have met all administrative requirements of the HIPAA Privacy Rule.

Law Enforcement: We may disclose your PHI to law enforcement officials under certain conditions. For example, we may disclose PHI:

- to permit identification and location of witnesses, victims, and fugitives;
- in response to a search warrant or court order;
- as necessary to report a crime on our premises;
- to report a death that we believe may be the result of criminal conduct; or
- in an emergency, to report a crime.

Coroners, Medical Examiners, or Funeral Directors: We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties.

Organ and Tissue Donation: We may use or disclose your PHI to organizations that handle organ and tissue donation and distribution, banking, or transplantation.

To Prevent a Serious Threat to Health or Safety: As permitted by law, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Military and National Security: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counter-intelligence, and other national security activities.

Inmates: If you are a prison inmate, we may disclose your PHI to the prison or to a law enforcement official for: (1) the prison to provide health care to you; (2) your health and safety, and the health and safety of others; or (3) the safety and security of the prison.

Underwriting: We will not use genetic information about you for underwriting purposes.

Workers' Compensation: As part of your workers' compensation claim, we may have to disclose your PHI to a worker's compensation carrier.

To You: When you ask us to, we will disclose to you your PHI that is in a "designated record set." Generally, a designated record set contains medical, enrollment, claims and billing records we may have about you, as well as other records that we use to make decisions about your health care benefits. You can request the PHI from your designated record set as described in the section below called "Your Privacy Rights Concerning Your Protected Health Information."

To Your Personal Representative: If you tell us to, we will disclose your PHI to someone who is qualified to act as your personal representative according to any relevant state laws. In order for us to disclose your PHI to your personal representative, you must send us a completed AmeriHealth Personal Representative Designation Form and documentation that supports the person's qualification according to state law (such as a power of attorney or guardianship). To request the AmeriHealth Personal Representative Designation Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.amerihealth.com, or write us at the address at the end of this Notice. However, the HIPAA Privacy Rule permits us to choose not to treat that person as your personal representative when we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse or neglect by the person; (ii) treating the person as your personal representative could endanger you; or (iii) in our professional judgment, it is not in your best interest to treat the person as your personal representative.

To Family and Friends: Unless you object, we may disclose your PHI to a friend or family member who has been identified as being involved in your health care. We also may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your PHI, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

Parents as Personal Representatives of Minors: In most cases, we may disclose your minor child's PHI to you. However, we may be required to deny a parent's access to a minor's PHI according to applicable state law.

Health Information Exchanges

We share your health information electronically through certain Health Information Exchanges ("HIEs"). A HIE is a secure electronic data sharing network. In accordance with applicable federal and state privacy and security requirements, regional health care providers participate in HIEs to exchange patient information in real-time to help facilitate delivery of health care, avoid duplication of services, and more efficiently coordinate care. As a participant in HIEs, Independence shares your health information we may have received when a claim has been submitted for services you have received among authorized participating providers, such as physicians, hospitals, and health systems for the purpose of treatment, payment and health care operations as permitted by law.
During an emergency, patients and their families may forget critical portions of their medical history which may be very important to the treating physician who is trying to make a quick, accurate diagnosis in order to treat the sick patient. Independence, through its participation in an HIE, makes pertinent medical history, including diagnoses, studies, lab results, medications and the treating physicians we may receive on a claim available to participating emergency room physicians while the patient is receiving care. This is invaluable to the physician, expediting the diagnosis and proper treatment of the patient.

Your treating providers who participate with an HIE, and also submit health information with the HIE, will have the ability to access your health information through the HIE and send records to your treating physicians. Through direct requests to the HIE, we will receive various types of protected health information such as pharmacy or laboratory services, or information when you have been discharged from a hospital which may be used to coordinate your care, provide case management services, or otherwise reduce duplicative services and improve the overall quality of care to our members. All providers that participate in HIEs agree to comply with certain privacy and security standards relating to their use and disclosure of the health information available through the HIE.

As an Independence member, you have the right to opt-out which means your health information will not be accessible through the HIE. Through the regional HIE (www.hsxsepa.org/patient-options-opt-out-back) website or the State HIE (www.dhs.pa.gov/citizens/healthinformationexchange/) website consumers or providers can access an online, fax, or mail form permitting patients to remove themselves (opt-out) or reinstate themselves (opt back in) to the HIE. It will take approximately one business day to process an opt-out request. If you choose to opt-out of the HIE, your health care providers will not be able to access your information through the HIE. Even if you opt-out, this will not prevent your health information from being made available and released through other means (i.e. fax, secure email) to authorized individuals, such as network providers for paying claims, coordinating care, or administering your health benefits in accordance with the law and in the normal course of conducting our business as permitted under applicable law. For more information on HIEs, please go to www.hsxsepa.org/consumers-0 or to https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Information%20Technology/Health-Information-Exchange-Citizens.aspx.

Right to Provide an Authorization for Other Uses and Disclosures

- Other uses and disclosures of your PHI that are not described above will be made only with your written authorization.
- You may give us written authorization permitting us to use your PHI or disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your PHI that are not identified by this Notice, or are not otherwise permitted by applicable law.

Any authorization that you provide to us regarding the use and disclosure of your PHI may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Of course, we are unable to take back any disclosures that we have already made with your authorization. We may also be required to disclose PHI as necessary for purposes of payment for services received by you prior to the date when you revoked your authorization.

Your authorization must be in writing and contain certain elements to be considered a valid authorization. For your convenience, you may use our approved AmeriHealth Authorization Form. To request the AmeriHealth Authorization Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.amerihealth.com, or write us at the address at the end of this Notice.

Your Privacy Rights Concerning Your Protected Health Information (PHI)
You have the following rights regarding the PHI that we maintain about you. Requests to exercise your rights as listed below must be in writing. For your convenience, you may use our approved AmeriHealth form(s). To request a form, please contact Member Services at the telephone number listed on the back of your Member Identification card or write to us at the address listed at the end of this Notice.

Right to Access Your PHI: You have the right to inspect or get copies of your PHI contained in a designated record set. Generally, a “designated record set” contains medical, enrollment, claims and billing records we may have about you, as well as other records that we may use to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies of your PHI in a format other than photocopies such as by electronic means in certain situations. We will use the format you request unless we cannot practicably do so. We may charge a reasonable fee for copies of PHI (based on our costs), for postage, and for a custom summary or explanation of PHI. You will receive notification of any fee(s) to be charged before we release your PHI, and you will have the opportunity to modify your request in order to avoid and/or reduce the fee. In certain situations we may deny your request for access to your PHI. If we do, we will tell you our reasons in writing, and explain your right to have the denial reviewed.

Right to Amend Your PHI: You have the right to request that we amend your PHI if you believe there is a mistake in your PHI, or that important information is missing. Approved amendments made to your PHI will also be sent to those who need to know, including (where appropriate) AmeriHealth’s vendors (known as "Business Associates"). We may also deny your request if, for instance, we did not create the information you want amended. If we deny your request to amend your PHI, we will tell you our reasons in writing, and explain your right to file a written statement of disagreement.

Right to an Accounting of Certain Disclosures: You may request, in writing, that we tell you when we or our Business Associates have disclosed your PHI (an "Accounting"). Any accounting of disclosures will **not** include those we made:

- for payment, or health care operations;
- to you or individuals involved in your care;
- with your authorization;
- for national security purposes;
- to correctional institution personnel; or
- before April 14, 2003.

The first accounting in any 12-month period is without charge. We may charge you a reasonable fee (based on our cost) for each subsequent accounting request within a 12-month period. If a subsequent request is received, we will notify you of any fee to be charged, and we will give you an opportunity to withdraw or modify your request in order to avoid or reduce the fee.

Right to Request Restrictions: You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to your request. However, if we do agree, we will be bound by our agreement except when required by law, in emergencies, or when information is necessary to treat you. An approved restriction continues until you revoke it in writing, or until we tell you that we are terminating our agreement to a restriction.

Right to Request Confidential Communications: You have the right to request that we use alternate means or an alternative location to communicate with you in confidence about your PHI. For instance, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. Your written request must clearly state that the disclosure of all or part of your PHI at your current address or method of contact we have on record could be an endangerment to you. We will require that you provide a reasonable alternate address or other method of contact for the confidential communications. In assessing reasonableness, we will consider our ability to continue to receive payment and conduct health care operations effectively, and the subscriber's right to payment information. We may exclude certain communications that are commonly provided to all members from confidential communications. Examples of such communications include benefit booklets and newsletters.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of our Notice of Privacy Practices. You can request a copy at any time, even if you have agreed to receive this Notice electronically. To request a paper copy of this Notice, please contact Member Services at the telephone number on the back of your Member Identification Card.

Right to Notification of a Breach of Your PHI: You have the right to and will be notified following a breach of your unsecured PHI or if a security breach occurs involving your PHI.

Your Right to File a Privacy Complaint

If you believe your privacy rights have been violated, or if you are dissatisfied with AmeriHealth's privacy practices or procedures, you may file a complaint with the AmeriHealth Privacy Office and with the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

To file a privacy complaint with us, you may contact Member Services at the telephone number on the back of your member ID card, or you may contact the Privacy Office as follows:

AmeriHealth
Privacy Office
P.O. Box 41762
Philadelphia, PA 19101 – 1762
Fax: 215-241-4023 or 1-888-678-7006 (toll-free)
E-mail: Privacy@amerihealth.com
Phone: 215-241-4735 or 1-888-678-7005 (toll-free)


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