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

AMERHEALTH HMO, INC. HMO PLAN

INDIVIDUAL HEALTH MAINTENANCE ORGANIZATION (HMO) CONTRACT

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

EFFECTIVE DATE OF CONTRACT: January 1, 2021

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

In consideration of the application for this Contract and the payment of premiums as stated herein, We agree to arrange or provide services and supplies in accordance with and subject to the terms of this Contract. This Contract is delivered in New Jersey and is governed by the laws thereof.

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

Michael A. Munoz
Senior Vice President
Marketing & Sales

AMERIHEALTH HMO, INC.

Telephone: 1-844-937-2448 (TTY: 711)

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SCHEDULE OF PREMIUM RATES

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

Age	Non-Tobacco	Tobacco
0-14	$258.25	$258.25
15	$281.20	$281.20
16	$289.98	$289.98
17	$298.76	$298.76
18	$308.21	$308.21
19	$317.66	$317.66
20	$327.45	$327.45
21	$337.58	$337.58
22	$337.58	$337.58
23	$337.58	$337.58
24	$337.58	$337.58
25	$338.93	$338.93
26	$345.68	$345.68
27	$353.78	$353.78
28	$366.95	$366.95
29	$377.75	$377.75
30	$383.15	$383.15
31	$391.26	$391.26
32	$399.36	$399.36
33	$404.42	$404.42
34	$409.82	$409.82
35	$412.52	$412.52
36	$415.22	$415.22
37	$417.92	$417.92
38	$420.62	$420.62
39	$426.03	$426.03
40	$431.43	$431.43
41	$439.53	$439.53
42	$447.29	$447.29
43	$458.10	$458.10
44	$471.60	$471.60
45	$487.47	$487.47
46	$506.37	$506.37
47	$527.64	$527.64
48	$551.94	$551.94
49	$575.91	$575.91
50	$602.92	$602.92
51	$629.59	$629.59
52	$658.96	$658.96

53	$688.66	$688.66
54	$720.73	$720.73
55	$752.80	$752.80
56	$787.57	$787.57
57	$822.68	$822.68
58	$860.15	$860.15
59	$878.72	$878.72
60	$916.19	$916.19
61	$948.60	$948.60
62	$969.87	$969.87
63	$996.54	$996.54
64+	$1,012.74	$1,012.74

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

SCHEDULE OF SERVICES AND SUPPLIES

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

SERVICES	**COPAYMENT**
For Preventive Care	NONE
Maternity (pre-natal care)	NONE
For Primary Care Provider but not for Preventive Care Visits	$5 Copayment/visit
Specialist Services	$20 Copayment/visit
Outpatient Treatment for Mental Illness or Substance Use Disorder	$20 Copayment/visit/Member
Telemedicine and Telehealth Services	
- Provided by a contracted vendor	$0 Copayment/visit
- Provided by a Network PCP	$2.50 Copayment/visit
- Provided by a Network Mental Illness or Substance Use Disorder Provider	$10 Copayment/visit
- Provided by a Network Specialist	$10 Copayment/visit
Complex Imaging Services	$50 Copayment/visit
All Other Diagnostic Services Outpatient	$25 Copayment/visit
Laboratory Services	$0 Copayment/visit/Member
Emergency Room	$100 Copayment/visit/Member (waived if admitted within 24 hours)
Note: The Emergency Room Copayment is payable in addition to the applicable Copayment, Deductible and Coinsurance, if any.	
Urgent Care	$85 Copayment/visit/Member
Therapeutic Manipulations	$20 Copayment/visit/Member; Maximum 30 visits/Calendar Year
Cardiac/Pulmonary/Respiration Therapy	$20 Copayment/visit/Member

Therapy Services: Physical, Occupational, Speech,	$20 Copayment/visit/Member
Cognitive Therapy	
Infusion Therapy	$20 Copayment/visit/Member
All other services and supplies	Copayment Not Applicable; Refer to the Deductible and Coinsurance sections

DEDUCTIBLE PER CALENDAR YEAR

For Preventive Care and immunizations and lead screening for children	NONE
Maternity (pre-natal care)	NONE
All other Covered Services and Supplies	
Per Member	$100
Per Covered Family	$200

COINSURANCE

For Preventive Care:	NONE
Ambulance Services	50%, after deductible
Dialysis	50%, after deductible
Durable Medical Equipment and Prosthetics	50%, after deductible
Home Health Care, including Private Duty Nursing	50%, after deductible
Hospice Services	50%, after deductible

Prescription Drugs

Retail Pharmacy and Mail Order Pharmacy (per 30 day supply)	
Generic Drugs	$7, no deductible
Preferred Drugs	50%, up to $150, after deductible
Non-Preferred Drugs	50%, up to $150, after deductible
Retail Pharmacy and Mail Order Pharmacy (per 31 to 90 day supply)	
Generic Drugs	$14, no deductible
Preferred Drugs	50%, up to $300, after deductible
Non-Preferred Drugs	50%, up to $300, after deductible

Vision Benefits (for Members through the end of the month in which the Member turns age 19)

Eye exam (once every 12 months)	0%, no deductible
Eyeglass lenses (once every 12 months)	0%, no deductible
Standard frames (once every 12 months)	0%, no deductible
All services and supplies to which a Copayment does not apply	10%, after deductible
All services and supplies to which a Copayment applies	NONE

MAXIMUM OUT OF POCKET

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

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

Per Member per Calendar Year	$1,250
Per Family per Calendar Year	$2,500

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

LIMITATIONS ON SERVICES AND SUPPLIES

Home Health Care	Unlimited days, subject to Pre-Approval.
Hospice Services	Unlimited days, subject to Pre-Approval.
Speech Therapy See below for the separate benefits available under the Diagnosis and Treatment of Autism or other Developmental Disabilities provision	30 visits per Calendar Year
Cognitive Rehabilitation Therapy	30 visits per Calendar Year
Physical Therapy See below for the separate benefits available under the Diagnosis and Treatment of Autism or other Developmental Disabilities provision	30 visits per Calendar Year
Occupational Therapy See below for the separate benefits available under the Diagnosis and Treatment of Autism or other Developmental Disabilities provision	30 visits per Calendar Year

Charges for physical, occupational and speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision
Note: These services are habilitative services in that they are provided to help develop rather than restore a function. The 30-visit limit does not apply to the treatment of autism.

(limit applies separately to each therapy and is in addition to the therapy visits listed above)	30 visits
Charges for hearing aids for a Member age 15 or younger	one hearing aid per hearing impaired ear per 24-month period
Therapeutic Manipulation	30 visits per Calendar Year
Skilled Nursing Facility/ Extended Care Center	Unlimited days, subject to Pre-Approval

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

ANNUAL OPEN ENROLLMENT PERIOD. The designated period of time each year during which:
a) individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and
b) individuals who already have coverage may replace current coverage with a different standard health benefits plans or standard health benefits plan with rider.

BIRTHING CENTER. A Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

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

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

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

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

CASH DEDUCTIBLE. A fixed dollar amount that a Member must pay before AmeriHealth provides the Member with coverage for Covered Services or Supplies.

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

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

COMPLEX IMAGING SERVICES. Any of the following services:
a) Computed Tomography (CT),
b) Computed Tomography Angiography (CTA),
c) Magnetic Resonance Imaging (MRI),
d) Magnetic Resonance Angiogram (MRA),
e) Magnetic Resonance Spectroscopy (MRS)
f) Positron Emission Tomography (PET),
g) Nuclear Medicine including Nuclear Cardiology.

CONTRACT. This contract, including the application and any riders, amendments or endorsements, between the Contractholder and AmeriHealth.

CONTRACTHOLDER. The person who purchased this Contract.

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

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

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of this Contract.

Read the entire Contract to find out what We limit or exclude.

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

CUSTODIAL CARE. Any service or supply, including room and board, which:
a) is furnished mainly to help a Member meet a Member's routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

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

DEPENDENT.
Your:
a) Spouse;
b) Dependent child who is under age 26.

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

Your "Dependent child" includes:
a) Your biological child,
b) Your legally adopted child,
c) Your foster child from the time the child is placed in the home'
d) Your step-child,
e) the child of Your civil union partner,
f) the child of Your Domestic Partner and
g) children under a court appointed guardianship.

We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

Also, any other child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent child under this Contract provided the child depends on You for most of the child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)

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

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

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

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

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

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

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

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

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

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

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

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Member's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

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

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

ELIGIBLE PERSON. A person who is a Resident of New Jersey who is not covered under Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. § 1395 et. seq.) (Medicare). An eligible person must be a U.S. Citizen, national or lawfully present in the United States.

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

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

EXPERIMENTAL or INVESTIGATIONAL.
Services or supplies which We Determine are:

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

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

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

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

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

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

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

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

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

2. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

EXTENDED CARE CENTER. See Skilled Nursing Facility.

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

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

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

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

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

medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

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

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

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

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

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

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

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

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

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

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

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

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

MAIL ORDER PROGRAM. A program under which a Member can obtain Prescription Drugs from:
a) a Participating Mail Order Pharmacy by ordering the drugs through the mail or
b) a Participating Pharmacy that has agreed to accept the same terms, conditions, price and services as a Participating Mail Order Pharmacy.

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

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for a Member's convenience;
e) the most appropriate level of medical care that a Member needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

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

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

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

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

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

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

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

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

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

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

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

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

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
b) provides medical services which are within the scope of the nurse's license or certificate.

ORTHOTIC APPLIANCE. A brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

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

PARTICIPATING MAIL ORDER PHARMACY. A licensed and registered pharmacy with whom AmeriHealth has signed a pharmacy service agreement, that is:
a) equipped to provide Prescription Drugs through the mail; or
b) is a Participating Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement

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

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

PRACTITIONER. A medical practitioner who:

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

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

PRE-APPROVAL or PRE-APPROVED. Specific direction or instruction from a Network Practitioner or from Us in conformance with Our policies and procedures that authorizes a Member to use a Provider for health care services or supplies. For information regarding the services for which We require Pre-Approval, consult our website at www.amerihealthnj.com.

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

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

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

   Coverage for the above drugs also includes Medically Necessary and Appropriate services associated with the administration of the drugs.

   In no event will We pay for:
   a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
   b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PREVENTIVE CARE. Preventive care means:
a) Evidence based items or services that are rated “A” or “B” in the current recommendations of the United States Preventive Services task Force with respect to the Member;
b) Immunizations for routine use for Members of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Member;
c) Evidence–informed preventive care and screenings for Members who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
d) Evidence–informed preventive care and screenings for female Members as included in the comprehensive guidelines supported by the Health Resources and Services Administration; and

e) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

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

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

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

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

PROVIDER. A recognized Facility or Practitioner of health care. 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.

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

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

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

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

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

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

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

SERVICE AREA. A geographic area We define by county.

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

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

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

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

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

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

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

SPECIALTY PHARMACETICALS. 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'sDisease; 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 Phamaceuticals. The list is also available on AmeriHealth's website.

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

SUBSTANCE USE DISORDER. The term 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. A Facility that mainly provides treatment for people with Substance Use Disorder. 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; or
b) approved for its stated purpose by Medicare.
c) accreditied by the Commission on Accreditation of Rehabilitation Facilities (CARF); or;
d) credentialed by Us.

SURGERY.

a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures;
b) the correction of fractures and dislocations;
c) pre-operative and post-operative care;
d) any of the procedures designated by the Current Procedural Terminology Codes as surgery.

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

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

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

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

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

a) The date an Eligible Person loses eligibility for minimum essential coverage, or the Eligible Person's Dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace.
b) The date a Dependent child's coverage ends as a result of attaining age 26 whether or not the Dependent is eligible for continuing coverage in accordance with federal or state laws.
c) The date a Dependent child's coverage under a parent's group plan ends as a result of attaining age 31.
d) The effective date of a marketplace redetermination 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 and his or her Dependent child(ren) who are victims of domestic abuse or spousal abandonment need to enroll for coverage apart from the perpetrator of the abuse or abandonment.

i) The date an Eligible Person gains access to plans in New Jersey as a result of a permanent move provided the Eligible Person demonstrates having minimum essential coverage for one or more days during the 60 days preceding the permanent move.

j) The date of a marketplace or Carrier finding that it erroneously permitted or denied an Eligible Person enrollment in a qualified health plan.

k) The date of a court order that requires coverage for a Dependent.

l) The date the Eligible Person demonstrates to the marketplace or a State regulatory agency that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

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

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

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

WE, US, OUR. AmeriHealth HMO, Inc. or AmeriHealth.

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

ELIGIBILITY

Types of Coverage

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

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

Who is Eligible

The Contractholder -You, if You are an Eligible Person, who lives in the designated Service Area in the State of New Jersey.
Spouse - Your Spouse who lives, resides or works in the designated Service Area in the State of New Jersey, 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 lives, resides or works in the designated Service Area in the State of New Jersey, who is an Eligible Person and who qualifies as a Dependent, as defined in this Contract, **except**: a child need not be a Resident; 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 Contract, such a child may stay eligible for Dependent health benefits past this Contract's age limit for eligible Dependents.

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

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

The child's coverage ends when Your coverage ends.
In order to obtain and continue health care coverage with Us, the Member, who is not covered as either a Dependent Spouse or as a Dependent child, must be a Resident and a U.S. Citizen, National, or lawfully present in the United States. We reserve the right to require proof that such Member is a Resident and a U.S. Citizen, National, or lawfully present in the United States.

Adding dependents to this contract

Spouse - You may apply to add Your Spouse by notifying Us in writing. If Your application is made and submitted to Us within 60 days of Your marriage or documentation of domestic partnership or civil union, the Spouse will be covered as of the first 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 Contract unless the child is eligible to be covered as Your Dependent, as defined.

MEMBER PROVISIONS

THE ROLE OF A MEMBER'S PRIMARY CARE PROVIDER

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

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

SELECTING OR CHANGING A PRIMARY CARE PROVIDER When You first obtain this coverage You and each of Your covered Dependents must select a Primary Care Provider.

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

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

NETWORK

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

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such Identification Card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the Contractholder, coverage may be terminated for the Contractholder as well as any of his or her Dependents who are Members. To be eligible for services or benefits under this Contract, the holder of the card must be a Member on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

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

CONFIDENTIALITY

Information contained in the medical records of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us, may not be

disclosed without the Member's written consent, except as required or authorized by law.

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

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

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

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT
A Member has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A Member has the right to participate in decision-making regarding the Member's care. Further, a Member may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a Network Practitioner. A Member who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another Network Practitioner. If such Network Practitioner(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the Network Practitioner shall inform the Member of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the Member and or the Member's family or other person acting on the Member's behalf. If the Member refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the Member in writing that We will not provide further benefits or services for the particular condition or its consequences The Member's decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Appeals Procedure and We will continue to provide all benefits covered by the Contract during the pendency of the Appeals Procedure. We reserve the right to expedite the Appeals Procedure. If the Appeals Procedure results in a decision upholding the position of the Network Practitioner(s) and the dispute is unresolved, We will have no further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences unless the Member asks, in writing and within 7 days of being informed of the result of the Appeals Procedure, to terminate his or her coverage under this Contract. In such event, We will continue to provide all benefits covered by this Contract for 30 days or until the date of termination, whichever comes first, and We and the Network Practitioner will cooperate with the Member in facilitating a transfer of care.

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

TERMINATION FOR CAUSE

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

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

If We give the Member such written notice:

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

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

REPORTS AND RECORDS

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

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

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

PROVIDER PAYMENT
Different providers in Our Network have agreed to be paid in different ways by Us. A Member's Provider may be paid each time he or she treats the Member ("fee for service", or may be paid a set fee for each month for each Member whether or not the Member actually receives services ("capitation"), or may receive a salary. These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Member satisfaction, quality of care, and control of costs and use of services among them. If a Member desires additional information about how Our Primary Care Providers or any other Provider in Our Network are compensated, please call Us at 1-888-968-7241 (TTY: 711), 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 Member wants more information about this the Member, the Member should contact his or her physician, chiropractor or podiatrist. If a Member believes he or she is not receiving the information to which the Member is entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 (TTY: 711) OR (800) 242-5846 (TTY: 711).

APPEAL PROCEDURE

Member Complaints

A Complaint is an expression of dissatisfaction regarding any aspect of the coverage, operations, or management of the HMO Plan, including but not limited to the HMO Plan's health care services, quality of care and service, choice and accessibility of Providers, and network adequacy. Complaints fall into one of two categories: Administrative Complaints and Quality Complaints. Administrative Complaints typically revolve around dissatisfaction with some aspect of the HMO Plan's coverage, operations or management, including but not limited to choice of network providers, network adequacy, HMO 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 (Member Designee). To submit a Complaint, you or your Member 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. Members 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 HMO Plan and you or your Member Designee is dissatisfied with the resolution reached through the Complaint process, Plan staff will ensure that you or your Member 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 Member Designee is dissatisfied with the outcome reached through the HMO 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 (TTY: 711)
Fax: (609) 633-0807

Utilization Management Appeals

The HMO maintains a Utilization Management Appeals process for any Member who is dissatisfied with any HMO Utilization Management coverage decision. The Utilization Management Appeals process provides the Member 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.

Member Representatives

A Provider or another individual may Appeal on your behalf as your authorized representative if a valid consent/authorization form from the Member ("Member Designee") is provided to the HMO. However, in Expedited or Urgent Care Appeals, a valid Member 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 Member Designee. Also, the HMO 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 Precertified 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 Member Designee has two opportunities to appeal a Utilization Management coverage decision. There is one internal Appeals Stage conducted by the HMO. 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 Member Designee may pursue a civil action against the HMO for losses resulting from the HMO'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 consists of information obtained from the HMO's investigation, as well as any additional information submitted by you or your Member Designee. You or your designee are entitled to a full and fair review. Upon request at any time during the Appeal process, the HMO will provide you or your Member Designee a copy of the correspondence, documents, medical records, and other information provided to the decision makers for internal Appeal review. The HMO may redact or delete from the copy provided to you or your Member Designee certain information that the HMO 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 advanced review.

Stage I Appeal (Internal)

You, a Provider, or your Member Designee may initiate a Stage I Appeal with a Plan Medical Director/peer reviewer by calling or writing the HMO's New Jersey Appeals Unit as outlined in the initial HMO 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 HMO'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 Member is confined in an Inpatient facility. Expedited Appeal review will be completed within seventy-two (72) hours after the HMO's receipt of the Appeal.

You, your Member 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 HMO 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 Member 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 I Appeal, you or your Member 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 Member Designee may initiate the External Appeal/Review within one hundred and twenty (120) days of receipt of the Stage I determination to an IURO. If the IURO accepts the Appeal/Review, it will issue a decision within thirty (30) business 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 Member Designee prior to the end of the original 30 business-day review period setting forth the reasons for the delay. A decision reached by an IURO that is adverse to the HMO is binding on the HMO. You or your Member 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 the Stage I internal Appeals process.

To request an external review, follow the instructions in the decision letter for the HMO Stage I 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 Member Appeals process. For additional information, contact Customer Service at the telephone number listed on the back of your ID Card.

Member Administrative Appeals

The HMO maintains an Administrative Appeals process for any Member 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.

Member 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 (“Member Designee”) if a valid consent/authorization form from the Member is provided to the HMO. The HMO also has staff available to assist and/or represent Members 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 Precertified or Pre-approved before medical care is obtained; all other Appeals are Post-service Appeals.

Appeal Stages

As described below, you or your Member 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 Member 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 Member 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 HMO 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 member or member 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 Member'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 electronic requests to **dobi.ihcap@dobi.nj.gov**;
- Mail requests to

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

- Claimant may call toll free at 888-393-1062 (TTY: 711), x 50998 or 609-292-5316 (TTY: 711), x 50998 with any questions/concerns;
- Final external review decisions are made within forty-five (45) days and forwarded in writing to the claimant and the Plan;
- External review decision is binding on the Plan and Member.

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 (TTY: 711);
- External examiner provides the decision within seventy-two (72) hours of request for external review.
- External review decision is binding on the Plan and Member.

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

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

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

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

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

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

Services shall be provided to the same extent as provided while the health care professional was employed by or under 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 Member is admitted to a health care Facility on the date this Contract is terminated, We shall continue to provide benefits for the Member until the date the Member is discharged from the Facility.

We shall not continue services in those instances in which the health care professional has been terminated based upon the opinion of Our medical director that the health care professional is an imminent danger to a patient or to the public health, safety and welfare, a determination of fraud or a

breach of contract by a health care professional. The Determination of the Medical Necessity and Appropriateness of a Member's continued treatment with a health care professional shall be subject to the appeal procedures set forth in this Contract. We shall not be liable for any inappropriate treatment provided to a Member by a health care professional who is no longer employed by or under contract with Us.

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

COVERAGE PROVISION

The Schedule lists Copayments, Deductible Amounts, and/or Coinsurance as well as Maximum Out of Pocket Amounts. These terms are explained below.

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

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

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

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

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

COVERED SERVICES & SUPPLIES

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

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

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

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

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

8. **Durable Medical Equipment** when ordered by a Member's Primary Care Provider and arranged through Us. Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.
9. Subject to Our Pre-Approval, as applicable, **Prescription Drugs which require a Practitioner's prescription**, and insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Network Provider. Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.
    A prescription or refill will not include a prescription or refill that is more than:
    a) the greater of a 90 day supply or 100 unit doses for each prescription or refill; or
    b) the amount usually prescribed by the Member's Network Provider.
    A supply will be considered to be furnished at the time the Prescription Drug is received.

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

If a Member brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, the 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 Contract. If We do not give Pre-Approval, the Member may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Member paying for the Prescription Drug. The Member may submit a claim for the Prescription Drug, subject to the terms of this Contract. The Member may appeal the decision by following the Appeals Procedure process set forth in this Contract.

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

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

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

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

a) It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia-Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed journal; and

b) The Practitioner states that all Preferred Drugs used to treat the Illness or Injury have been ineffective in the treatment of the Member's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the Member.

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

The Contract only pays benefits for Prescription Drugs which are:

a) prescribed by a Practitioner (except for insulin)

b) dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy; and

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

Such charges will not include charges made for more than:

a) a 90-day supply for each prescription or refill which is not obtained through the Mail Order Program where the copayment is calculated based on the multiple of 30-day supplies received;

b) a 90-day supply of a Maintenance Drug obtained through the Mail Order Program where the copayment is the copayment specified for a 90-day supply; and

c) the amount usually prescribed by the Member's Practitioner.

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

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

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

As explained in the **Orally Administered Anti-Cancer Prescription Drugs** provision below additional benefits for such prescription drugs may be payable.

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

For the purpose of this benefit:
"inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;
"low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and
"medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Practitioner.

14. **Specialized non-standard infant formulas** are covered to the same extent and subject to the same terms and conditions as coverage is provided under this Contract for Prescription Drugs. We cover specialized non-standard infant formulas provided:

a) The child's Practitioner has diagnosed the child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
b) The child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

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

15. **Donated Human Breast Milk** is covered for Members under the age of six months subject to the following conditions:
    a) The Member is medically or physically unable to receive maternal breast milk or participate in breast feeding, or the Member'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 member's Practitioner issued an order for the donated human breast milk

We also cover pasteurized donated human breast milk as ordered by the Member's Practitioner for Members under the age of six months if the Member meets any of the following conditions:
    a) A body weight below healthy levels determined by the Member's Practitioner;
    b) A congenital or acquired condition that places the Member 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 Member's Practitioner.

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

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

We will pay the Hospital's clinical laboratory for the laboratory services at the same rate We would pay a Network clinical laboratory for comparable services.
18. **Colorectal Cancer Screening** We provide coverage for colorectal cancer screening provided to a Member age 50 or over and to younger Members who are considered to be high risk for colorectal cancer. Coverage will be provided, subject to all the terms of this Contract, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the Member's Practitioner in consultation with the Member regarding methods to use, We will cover:
a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;

f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

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

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

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

20**. Hearing Aids** We cover charges for medically necessary services incurred in the purchase of a hearing aid for a Member age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, 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 the medically necessary services incurred in the purchase of a hearing aid.

Hearing aids are habilitative devices.

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

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision.
See also the following benefit for Digital Tomosynthesis.

22. **Digital Tomosynthesis Charges** are covered when used 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 Member age 40 years and older, We cover charges for digital tomosysthesis as Preventive Care which means they are covered without application of any copayment, deductible or coinsurance.
b) When used for diagnostic purposes for a Member of any age, We cover charges for digital tomosynthesis as a diagnostic service subject to the applicable copayment, deductible and coinsurance.

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

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

24. **Contraceptives** We cover 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.

25. **Procedures and Prescription Drugs to Enhance Fertility** Subject to Pre-Approval, We cover charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs used to stimulate ovulation for artificial insemination or for unassisted conception. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Contract.

26. **Vision Benefit** We cover the vision benefits described in this provision for Members through the end of the month in which the Member turns age 19.. We cover one comprehensive eye examination by a Network ophthalmologist or optometrist in a 12 month period. When purchased from a Network provider, We cover one pair of standard lenses, for glasses or contact lenses, in a 12 month period. We cover one pair of standard frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

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

27. **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.

(b) **SPECIALIST DOCTOR BENEFITS.** Services are covered when rendered by a Network specialist doctor at the doctor's office or any other Network Facility or a Network Hospital outpatient department during office or business hours upon prior written Referral by a Member's Primary Care Provider.

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS**. The following services are covered when hospitalized by a Network Provider upon prior written referral from a Member's Primary Care Provider, only at Network Hospitals and Network Providers (or at Non-Network facilities subject to Our Pre-Approval); however, Network Skilled Nursing Facility services and supplies are limited to those which constitute Skilled Nursing Care and Hospice services are subject to Our Pre-Approval:

1. Semi-private room and board accommodations

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

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

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

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

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

We provide childbirth and newborn coverage subject to the following:

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

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

2. Private accommodations will be provided only when Pre-Approved by Us. If a Member occupies a private room without such certification, a Member shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Network Hospice, Network Hospital, Network Rehabilitation Center or Network Skilled Nursing Facility and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services; We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts. We also cover treatment of the physical complications of mastectomy, including lymphedemas.

20. The following transplants: Cornea, Kidney, Lung, Liver, Heart, heart-lung, heart valve, Pancreas and Intestines.
21. Allogeneic bone marrow transplants.
22. Autologous Bone Marrow 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;
23. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.
24. Donor's costs associated with transplants if the donor does not have health coverage that would cover the medical costs associated with his or her role as a donor. We do not cover costs for travel, accommodations, or comfort items.

(d) **BENEFITS FOR MENTAL ILLNESS OR SUBSTANCE DISORDER.** Except as stated below for the treatment of Substance Use Disorder, We cover services and supplies for the treatment of Mental Illness or Substance Use Disorder the same way We would for any other illness, if such treatment is prescribed by a Practitioner.

We provide coverage 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 Member'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 Plan 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 licensed, certified or State approved facility, including but not limited to:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of The Joint Commission;
d) a Mental Health Center; or
e) a Substance Abuse Center; or
f) a combination Mental Health Facility and Substance Use Disorder Facility.

(e) **EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following services are covered without prior written Referral by a Member's Primary Care Provider in the event of an Emergency as Determined by Us.

1. A Member's Primary Care Provider is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a Member's health, Member shall call a Member's Primary Care Provider prior to seeking Emergency treatment.
2. We will cover the cost of Emergency medical and hospital services performed within or outside our service area without a prior written Referral only if:
a. Our review Determines that a Member's symptoms were severe and delay of treatment would have been detrimental to a Member's health, the symptoms occurred suddenly, and Member sought immediate medical attention.
b. The service rendered is provided as a Covered Service or Supply under this Contract and is not a service or supply which is normally treated on a non-Emergency basis; and
c. We and the Member's Primary Care Provider are notified within 48 hours of the Emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the Emergency services within 30 days. A Member shall be responsible for payment for services received unless We Determine that a Member's failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event a Member is Hospitalized in a Non-Network Facility, coverage will only be provided until the Member is medically able to travel or to be transported to a Network Facility. If the Member elects to continue treatment with Non-Network Providers, We shall have no responsibility for payment beyond the date the Member is Determined to be medically able to be transported.

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

4. Coverage for Emergency services includes only such treatment necessary to treat the Emergency. Any elective procedures performed after a Member has been admitted to a Facility as the result of an Emergency shall require prior written Referral or the Member shall be responsible for payment.

5. The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if a Member is admitted as an Inpatient to the Hospital as a result of the Emergency.

6. Coverage for Emergency and Urgent Care include coverage of trauma services at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgement of the attending physician, the Member is medically stable, no longer requires critical care, and can be safely transferred to another Facility. We also provides coverage for a medical screening examination provided upon a Member's arrival in a Hospital, as required to be performed by the Hospital in accordance with Federal law, but only as necessary to determine whether an Emergency medical condition exists.

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a Network Provider upon prior written Referral by a Member's Primary Care Provider. Subject to the stated limits, We cover the Therapy Services listed below. We cover other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.

a. *Chelation Therapy* - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

b. *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.

c. *Dialysis Treatment* - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

d. *Radiation Therapy* - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.

e. *Respiration Therapy* - the introduction of dry or moist gases into the lungs.

f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.

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

g. *Speech Therapy* -except as stated below, treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes. Exception: For a Member 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 Member who has been diagnosed with a biologically-based Mental Illness, occupational therapy means treatment to develop a Member's ability to perform the ordinary tasks of daily living.

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

i. *Physical Therapy* - except as stated below, the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb. Exception: For a Member who has been diagnosed with a biologically-based Mental Illness, physical therapy means treatment to develop a Member's physical function.

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

j. Infusion Therapy - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion**.**

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

(g) **DIAGNOSIS AND TREATMENT OF AUTISM AND OTHER DEVELOPMENTAL DISABILITIES**
We provide coverage for charges for the screening and diagnosis of autism and other Developmental Disabilities.

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

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

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

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

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

If a Member:

a) is eligible for early intervention services through the New Jersey Early Intervention System; and
b) has been diagnosed with autism or other Developmental Disability; and
c) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services

the portion of the family cost share attributable to such services is a covered service under this Contract. The deductible, coinsurance or copayment as applicable to a physician visit to a non-Specialist Doctor for treatment of an Illness or Injury will apply to the family cost share.

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

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

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

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

a. The Member's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. Home health care is covered **only** in situations where continuing hospitalization or confinement in a Skilled Nursing Facility or Rehabilitation Center would otherwise have been required if home health care were not provided.

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

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

c. The home health care plan must be set up in writing by the Member's Practitioner within 14 days after home health care starts. And it must be reviewed by the Member's Practitioner at least once every 60 days.

e. We do not pay for:
   1. services furnished to family members, other than the patient; or
   2. services and supplies not included in the home health care plan.

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

We **only** cover services by a Nurse for Medically Necessary and Appropriate private duty nursing care if such care is authorized as part of a written home health care plan, coordinated by a Home Health

Agency, and covered under this **Home Health Care** section. Any other services for private duty nursing care are Non-Covered Services.

(i)**HOSPICE CARE** if Members are terminally Ill or terminally Injured with life expectancy of six months or less, as certified by the Member's Primary Care Provider. Services may include home and Hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other home health care benefits listed above.

(j)**DENTAL CARE AND TREATMENT**. This Dental Care and Treatment provision applies to all Members. The following services are covered when rendered by a Network Practitioner upon prior Referral by a Member's Primary Care Provider. We cover:

1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

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

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

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

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

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

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

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

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

(n)**SURGICAL TREATMENT OF MORBID OBESITY** Coverage is provided for surgical treatment of morbid obesity for one surgical procedure within a two-year period, measured from the date of the first surgical procedure to treat morbid obesity, unless a multi-stage procedure is planned and We authorize

coverage for such multi-stage procedure. In addition, We will cover surgery required as a result of complications that may arise from surgical treatment of morbid obesity.

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

NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS CONTRACT.

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 Member is being transferred to another Inpatient health care Facility.

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

Broken appointments.

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

Completion of claim forms.

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

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

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

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

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

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

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

Services or supplies for or in connection with:

a) except as otherwise stated in this Contract for Members through the end of the month in which he or she turns age 19, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;

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

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

Services or supplies furnished in connection with any procedures to enhance **fertility** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: invitro fertilization; embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); donor sperm, surrogate motherhood; b) Prescription Drugs not eligible under the Prescription Drugs section of the Policy; and c) ovulation predictor kits. See also the separate Exclusion addressing sterilization reversal.

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

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

Services or supplies related to **hypnotism**.

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

Except as stated below, Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;
Exception: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

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

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

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

Charges for **missed appointments**.

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

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

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

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

c) Charges for a Prescription Drug which is: labeled "Caution — limited by Federal Law to Investigational use"; or experimental.

d) Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.

e) Charges for refills dispensed after one year from the original date of the prescription.

f) Charges for Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, misused, stolen, broken or destroyed.

g) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.

h) Charges for a Prescription Drug which is to be taken by or given to the Member, in whole or in part, while confined in:

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

o) Member taking part in the commission of a felony.

p) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

q) Charges for drugs dispensed to a Member while on active duty in any armed force.

r) Charges for drugs for which there is no charge. This usually means drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and We are legally required to pay it, We will.

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

t) Except as stated below, charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws. **Exception**: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

u) Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.

v) Prescription Drugs or new dosage forms that are used in conjunction with a treatment or procedure that is determined to not be a Covered Service.

w) Drugs when used for cosmetic purposes. This exclusion is not applicable to Members with a medically diagnosed congenital defect or birth abnormality who have been covered under the policy from the moment of birth.

x) Drugs used solely for the purpose for weight loss.

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

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

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

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

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

Services or supplies related to **Routine Foot Care, except:**
a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

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

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

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

Stand-by services required by a Provider.

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

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

Transplants, except as otherwise listed in the Contract.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

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

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

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

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A Member may be covered under this Contract and subsequently become covered by or eligible for coverage under Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan**.** This provision allows Us to coordinate the services and supplies We provide with what Medicare pays or what Medicare would pay. This provision also allows us to coordinate benefits with what a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan pays. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Member is covered.

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

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

Allowable Expense: The charge for any health care service, supply or other item of expense for which the Member is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

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

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 Member is covered by this Contract and covered by or eligible to be covered by Medicare and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:
a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;
e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

For purposes of determining plans with which this plan can coordinate, Plan does not include:
a) Individual or family insurance contracts or subscriber contracts;

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

PRIMARY AND SECONDARY PLAN

We consider each plan separately when coordinating payments.

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

This Contract takes into consideration the benefits provided by Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan. During each Claim Determination Period, this Contract will pay up to the remaining unpaid allowable expenses, but this Contract will not pay more than it would have paid if it had been the Primary Plan. The method this Contract uses to determine the amount to pay is set forth below in the "**Procedures to be Followed by the Secondary Plan to Calculate Benefits"** section of this provision.

This Contract shall not reduce Allowable Expenses for Medically Necessary and Appropriate services or supplies on the basis that precertification, 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 Member may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on an allowed charge is called an "ACPlan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the Member may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." An HMO and Exclusive Provider Organization (EPO) are examples of network only plans that could use a fee schedule. If the Member uses the services of a non-network provider, the plan will be treated as an AC Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation". This means that then HMO or other plans pays the provider a fixed amount per Member. The Member is liable only for the applicable deductible, coinsurance or copayment. If the Member uses the services of a non-network provider, the HMO, EPO or other plans will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, “provider” refers to the provider who provides or arranges the services or supplies and “HMO” refers to a health maintenance organization plan, and “EPO” refers to Exclusive Provider Organization.

Primary Plan is AC Plan and Secondary Plan is AC Plan

The Secondary Plan shall pay the lesser of:

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

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a) the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary plan, the Secondary plan and the Member shall not exceed the fee schedule of the Primary Plan. In no event shall the Member be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

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

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

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

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

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

If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

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

If the Primary Plan is an HMO or EPO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Member receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or AC Plan

If Member receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

a) the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan

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

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

If the Primary Plan is an HMO or EPO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Member receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

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

Definitions
"Automobile Related Injury" means bodily Injury sustained by a Member as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;
caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:
a) this Contract;
b) PIP; or
c) OSAIC.

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

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

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

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

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

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

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

Benefits this Contract will pay if it is secondary to PIP or OSAIC.
If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:
a) the Allowable Expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or
b) the equivalent value of services if this Contract had been primary.

GENERAL PROVISIONS

AMENDMENT

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

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

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

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

ASSIGNMENT

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

CLERICAL ERROR - MISSTATEMENTS

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

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

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

CONFORMITY WITH LAW

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

CONTINUING RIGHTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PAYMENT OF PREMIUMS - GRACE PERIOD

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

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

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

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

REINSTATEMENT

If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Contract. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Contract will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the forty-fifth day following the date for the conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. The reinstated Contract shall cover only loss resulting from Injury or Illness that begins more than 10 days after the date of reinstatement. In all other respects, We and the Member shall have the same rights under the Contract as before the end of the grace period.

PREMIUM RATE CHANGES

The premium rates in effect on the Effective Date are shown in the Contract's Schedule of Premium Rates. We have the right to prospectively change premium rates as of any of these dates:
any premium due date;
any date that the extent or nature of the risk under the Contract is changed:

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

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

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

STATEMENTS
No statement will void the coverage, or be used in defense of a claim under this Contract, unless it is contained in a writing signed by a Member, and We furnish a copy to the Member. All statements will be deemed representations and not warranties.

RENEWAL PRIVILEGE – TERMINATION

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

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

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

a) subject to 180 days advance written notice, We cease to do business in the individual health benefits market;

b) subject to 90 days advance written notice, We cease offering and non-renew a particular type of Health Benefits Plan in the individual market provided We act uniformly without regard to any Health Status-Related Factor of Members or persons who may become eligible for coverage;

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.

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

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

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

a) You have failed to pay premiums in accordance with the terms of the Contract, or We have not received timely premium payments; (Coverage will end as described In the Grace Period provision.)

b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract; (Coverage will end immediately.)

c) with respect to a Member other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)

d) You become covered under another individual Health Benefits Plan; (Coverage will end at midnight on the day before the date the individual Health Benefits Plan takes effect, provided We receive notice of the replacement within 30 days after the effective date of the new plan.)

e) You no longer reside, live or work in the Service Area, or in an area for which We are authorized to do business, provided that coverage is terminated uniformly without regard to any Health Status-Related Factor of Members.

f) with respect to a catastrophic plan, the date of a marketplace redetermination of exemption eligibility that finds the Member is no longer eligible for an exemption, or until the end of the plan year in which the Member attains age 30, whichever occurs first.

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

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

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

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

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

CONVERSION RIGHTS FOR DIVORCED SPOUSES

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

Exceptions
No former Spouse may use this conversion right:
a) if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered; This may happen if the Spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage. or
c) if he or she permanently relocates outside the Service Area.

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

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

AMERIHEALTH HMO, INC.

AMENDMENT TO THE INDIVIDUAL HMO CONTRACT

This Amendment modifies the Individual Health Maintenance Organization (HMO) Contract.

This Amendment modifies:

(a) The **SCHEDULE OF SERVICES AND SUPPLIES** section;
(b) The **DEFINITIONS** section;
(c) The **COVERED SERVICES AND SUPPLIES** section.

1. The **SCHEDULE OF SERVICES AND SUPPLIES** section is modified to include the following:

ORTHOTIC DEVICES	50%
PROSTHETIC DEVICES	50%

2. The following new terms are added to the **DEFINITIONS** section:

ORTHOTIC DEVICES – means the following orthotics. An Orthotic Device is not an Orthotic Appliance.

A. Elastic Knee Braces;
B. Prefabricated orthotics;
C. Cervical collars;
D. Arch supports where required for the prevention or treatment of complications associated with diabetes;
E. Over the counter corsets;
F. Elastic hose;
G. Thoracic Rib Belts;
H. Fabric and elastic supports such as socks;
I. Dental orthotics; and
J. Other similar devices

PROSTHETIC DEVICES – devices (except dental prosthetics and Prosthetic Appliances) which replace all or part of: (1) an absent body organ including contiguous tissue; or (2) the function of a permanently inoperative or malfunctioning body organ. A Prosthetic Device is not a Prosthetic Appliance.

3. The **COVERED SERVICES AND SUPPLIES** section is modified to include the following:

1. **Diabetic Education**. 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 Primary Care Provider, Participating Specialist or nurse practitioner/clinical nurse specialist determines that such a program is Medically Necessary and Appropriate for the proper self-management and treatment of the Member's diabetic condition at first diagnosis. Benefits are payable for a program prescribed:

A. At first diagnosis of diabetes;
B. If upon diagnosis by a Physician, or nurse practitioner/clinical nurse specialist of a significant change in the Member's symptoms or conditions which necessitates changes in the Member's self-management; and

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

2. **Orthotic Devices** benefits will be provided for:

A. The initial purchase and fitting (per medical episode) of orthotic devices except, foot orthotics; and
B. The replacement of orthotics except foot orthotics, for Dependent children when required due to natural growth.

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

3. **Prosthetic Devices**

Benefits will be provided for Prosthetic Devices required as a result of illness or injury. This benefit does not apply to Prosthetic Appliances or Orthotic Appliances as mandated by New Jersey law.

Benefits include but are not limited to:

1. The purchase and fitting, and the necessary adjustments and repairs, of Prosthetic Devices and supplies (except dental prostheses) are covered. The devices or supplies must replace all or part of an absent body organ and its adjoining tissues or replace all or part of the function of a permanently useless or malfunctioning body organ.

2. Supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device;

3. With respect to visual Prosthetics when Medically Necessary and Prescribed for one of the following conditions:

    a. Initial contact lenses Prescribed for the treatment of infantile glaucoma;

    b. Initial pinhole glasses Prescribed for use after surgery for detached retina;

    c. Initial corneal or scleral lenses Prescribed in connection with the treatment of keratoconus or 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. An initial pair of basic eyeglasses when Prescribed to perform the function of a human lens lost (aphakia) as a result of Accidental Injury; trauma; or ocular surgery.

The "Repair and Replacement" paragraphs set forth below do not apply to this item 3.

Benefits are provided for the replacement of a previously approved Prosthetic Device with an equivalent Prosthetic Device when:

a. There is a significant change in the Member's condition that requires a replacement;
b. The Prosthetic Device breaks because it is defective;
c. The Prosthetic Device breaks because it has exceeded its life duration as determined by the manufacturer; or
d. The Prosthetic Device needs to be replaced for a Dependent child due to the normal growth process when Medically Necessary.

Benefits will be provided for the repair of a Prosthetic Device when the cost to repair is less than the cost to replace it. Repair means the restoration of the Prosthetic Device or one of its components to correct problems due to wear or damage. Replacement means the removal and substitution of the Prosthetic Device or one of its components necessary for proper functioning. The HMO will neither replace nor repair the Prosthetic Device due to abuse or loss of the item.

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

AMERIHEALTH HMO, INC.

Michael A. Munoz
Senior Vice President, Market President - AmeriHealth New Jersey

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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