

**AETNA HEALTH INC.
(NEW JERSEY)**

GROUP AGREEMENT COVER SHEET

Contract Holder: The Government of the District of Columbia

Contract Holder Number: 172614
041

HMO Referred Benefit Level: CHARTER OPEN ACCESS PLAN Benefits Package

Effective Date: 12:01 a.m. on January 1, 2013

Term of Group Agreement: The **Initial Term** shall be: From January 1, 2013 through December 31, 2013
Thereafter, **Subsequent Terms** shall be: From January 1st through December 31st


Premium Due Dates: The **Group Agreement Effective Date** and the 1st day of each succeeding calendar month.

Governing Law: Federal law and the laws of New Jersey.

Notice Address for HMO: 1425 Union Meeting Road
Post Office Box 1445
Blue Bell, PA 19422

The signature below is evidence of Aetna Health Inc.'s acceptance of the **Contract Holder's** Group Application on the terms hereof and constitutes execution of the **Group Agreement(s)** attached hereto on behalf of Aetna Health Inc.

AETNA HEALTH INC.

By: 
Gregory S. Martino
Vice President

Contract Holder Name: The Government of the District of Columbia
Contract Holder Number: 172614
Contract Holder Locations: 041
Contract Holder Group Agreement Effective Date: January 1, 2013

**AETNA HEALTH INC.
(NEW JERSEY)**

GROUP AGREEMENT

This **Group Agreement** is entered into by and between **Aetna Health Inc. (HMO)** and the **Contract Holder** specified in the attached Cover Sheet. This **Group Agreement** shall be effective on the **Effective Date** specified in the Cover Sheet, and shall continue in force until terminated as provided herein.

In consideration of the mutual promises hereunder and the payment of **Premiums** and fees when due, **We** will provide coverage for benefits in accordance with the terms, conditions, limitations and exclusions set forth in this **Group Agreement**.

Upon acceptance by **Us** of **Contract Holder's** Group Application, and upon receipt of the required initial **Premium**, this **Group Agreement** shall be considered to be agreed to by **Contract Holder** and **Us**, and is fully enforceable in all respects against **Contract Holder** and **Us**.

SECTION 1. DEFINITIONS

- 1.1 The terms "**Contract Holder**", "**Effective Date**", "**Initial Term**", "**Premium Due Date**" and "**Subsequent Terms**" will have the meaning set forth in the attached Cover Sheet. If any of such terms are undefined in the Cover Sheet, such undefined terms shall have the following meaning:
- "**Effective Date**" would mean the date health coverage commences for the **Contract Holder**.
 - "**Initial Term**" would be the period following the **Effective Date** as indicated on the Cover Sheet.
 - "**Premium Due Date(s)**" would be the **Effective Date** and each monthly anniversary of the **Effective Date**.
 - "**Subsequent Term(s)**" would mean the periods following the **Initial Term** as indicated on the Cover Sheet.
- 1.2 The terms "**HMO**", "**Us**", "**We**" or "**Our**" mean Aetna Health Inc.
- 1.3 "**Certificate**" means the Certificate of Coverage issued pursuant to this **Group Agreement**.
- 1.4 "**Grace Period**" is defined in Section 3.3.
- 1.5 "**Group Agreement**" means the **Contract Holder's** Group Application, this document, the attached Cover Sheet; the **Certificate** and Schedule of Benefits issued hereunder; the initial rate sheet and any subsequent notice of rates issued by **Us** in connection with this **Group Agreement**; and any riders, amendments, and endorsements issued pursuant hereto, all of which are incorporated into and made a part of this **Group Agreement**.
- 1.6 "**Party, Parties**" means **HMO** and **Contract Holder**.
- 1.7 "**Premium(s)**" is defined in Section 3.1.
- 1.8 "**Renewal Date**" means the first day following the end of the **Initial Term** or any **Subsequent Term**.
- 1.9 "**Term**" means the **Initial Term** or any **Subsequent Term**.
- 1.10 Capitalized and bolded terms not defined in this **Group Agreement** shall have the meaning set forth in the **Certificate**. In the event of a conflict between the terms of this **Group Agreement** and the terms of the **Certificate**, the terms of this **Group Agreement** shall prevail.

SECTION 2. COVERAGE

- 2.1 **Covered Benefits.** We will provide coverage for **Covered Benefits** to **Members** subject to the terms and conditions of this **Group Agreement**. Coverage will be provided in accordance with the reasonable exercise of **Our** business judgment, consistent with applicable law. **Members** covered under this **Group Agreement** are subject to all of the conditions and provisions contained herein and in the incorporated documents.
- 2.2 **Policies and Procedures.** We have the right to adopt reasonable policies, procedures, rules, and interpretations of this **Group Agreement** and the **Certificate** in order to promote orderly and efficient administration.

SECTION 3. PREMIUMS AND FEES

- 3.1 **Premiums.** **Contract Holder** shall pay **Us** on or before each **Premium Due Date** a monthly advance premium (the "**Premium**") determined in accordance with the **Premium** rates and the manner of calculating **Premiums** specified by **HMO**. **Premium** rates and the manner of calculating **Premiums** may be adjusted in accordance with Section 3.5 below. **Premiums** are subject to adjustment, if any, for partial month participation as specified in Section 3.4 below. Membership as of each **Premium Due Date** will be determined by **Us** in accordance with **Our Member** records. A check does not constitute payment until it is honored by a bank. We may return a check issued against insufficient funds without making a second deposit attempt. We may accept a partial payment of **Premium** without waiving our right to collect the entire amount due.
- 3.2 **Fees.** In addition to the **Premium**, We may charge the following fees:
- An installation fee may be charged upon initial installation of coverage or any significant change in installation (e.g., a significant change in the number of **Members** or a change in the method of reporting **Member** eligibility to **Us**). A fee may also be charged upon initial installation for any custom plan set-ups.
 - A billing fee may be added to each monthly **Premium** bill. The billing fee may include a reasonable fee for the recovery of any surcharges for amounts paid through credit card, debit card or other similar means.
 - A reinstatement fee as set forth in Section 6.4.
- 3.3 **Past Due Premiums and Fees.** If a **Premium** payment or any fees are not paid in full by **Contract Holder** on or before the **Premium Due Date**, a late payment charge of 1½% of the total amount due per month (or partial month) will be added to the amount due. If all **Premiums** and fees are not received before the end of a 30 day grace period (the "**Grace Period**"), this **Group Agreement** will be automatically terminated pursuant to Section 6.3 hereof.

If the **Group Agreement** terminates for any reason, **Contract Holder** will continue to be held liable for all **Premiums** and fees due and unpaid before the termination, including, but not limited to, **Premium** payments for any period of time the **Group Agreement** is in force during the **Grace Period**.

- 3.4 **Prorations.** **Premiums** shall be paid in full for **Members** whose coverage is in effect on the **Premium Due Date** or whose coverage terminates on the last day of the **Premium** period.

Premiums for **Members** whose coverage is effective on a day other than the first day of the billing month or whose coverage terminates on a day other than the last day of the billing month shall be adjusted as indicated below:

- If membership becomes effective between the 1st through the 15th of the month, the **Premium** for the whole month is due. If membership is effective between the 16th through the 31st of the month, no **Premium** is due for the first month of membership.
- If membership terminates between the 1st through the 15th of the month, no **Premium** is due for that month. If membership terminates between the 16th through the 31st of the month, the **Premium** for the whole month is due.

3.5 **Changes in Premium.** We may also adjust the **Premium** rates and/or the manner of calculating **Premiums** effective as of any **Premium Due Date** upon 60 days prior written notice to **Contract Holder**, provided that no such adjustment will be made during the **Initial Term** except to reflect changes in applicable law or regulation or a judicial decision having a material impact on the cost of providing **Covered Benefits** to **Members**.

3.6 **Membership Adjustments.** We may, at **Our** discretion, make retroactive adjustments to the **Contract Holder's** billings for the termination of **Members** not posted to previous billings. However, **Contract Holder** may only receive a maximum of 2 calendar months' credit for **Member** terminations that occurred more than 30 days before the date **Contract Holder** notified **Us** of the termination. We may reduce any such credits by the amount of any payments **We** may have made on behalf of such **Members** (including capitation payments and other claim payments) before **We** were informed their coverage had been terminated. Retroactive additions will be made at **Our** discretion based upon eligibility guidelines, as set forth in the **Certificate**, and are subject to the payment of all applicable **Premiums**.

SECTION 4. ENROLLMENT

4.1 **Open Enrollment.** As described in the **Certificate**, **Contract Holder** will offer enrollment in **HMO**:

- at least once during every twelve month period during the **Open Enrollment Period**; and
- within 31 days from the date the individual and any dependent becomes eligible for coverage.

Eligible individuals and dependents who are not enrolled within the **Open Enrollment Period** or 31 days of becoming eligible, may be enrolled during any subsequent **Open Enrollment Period**. Coverage will not become effective until confirmed by **Us**. **Contract Holder** agrees to hold the **Open Enrollment Period** consistent with the **Open Enrollment Period** applicable to any other group health benefit plan being offered by the **Contract Holder** and in compliance with applicable law. The **Contract Holder** shall permit **Our** representatives to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure. As described in the **Certificate**, other enrollment periods may apply.

4.2 **Waiting Period.** There may be a waiting period before individuals are eligible for coverage under this **Group Agreement**. The waiting period, if any, is specified on the **Schedule of Benefits**.

4.3 **Eligibility.** The number of eligible individuals and dependents and composition of the group, the identity and status of the **Contract Holder**, the eligibility requirements used to determine membership in the group, and the participation and contribution standards applicable to the group which exist at the **Effective Date** of this **Group Agreement** are material to the execution and continuation of this **Group Agreement** by **Us**. The **Contract Holder** shall not, during the term of this **Group Agreement**, modify the **Open Enrollment Period**, the waiting period as described on the **Schedule of Benefits**, or any other eligibility requirements as described in the **Certificate** and on the **Schedule of Benefits**, for the purposes of enrolling **Contract Holder's** eligible individuals and dependents under this **Group Agreement**, unless **We** agree to the modification in writing. The eligibility requirements can be found in the Eligibility and Enrollment section of the **HMO Certificate** of Coverage and on the **Schedule of Benefits**.

4.4 **Special Enrollment Period.** When a new eligible dependent is acquired through marriage, birth, adoption or placement for adoption, the new eligible dependent (and, if not otherwise enrolled, the eligible individual and other eligible dependents) may be enrolled during a special enrollment period.

The special enrollment period is a period of 31 days, beginning on the date of the marriage, birth, adoption or placement for adoption (as the case may be). If a completed request for enrollment is made during that period, the **Effective Date of Coverage** will be:

- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

The eligible individual or the eligible dependents enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in the **Certificate**.

Please refer to the Special Enrollment Period in the **Certificate** for more details regarding the Special Enrollment Period.

SECTION 5. RESPONSIBILITIES OF THE CONTRACT HOLDER

In addition to other obligations set forth in this **Group Agreement**, **Contract Holder** agrees to:

5.1 **Records.** Furnish to **Us**, on a monthly basis (or as otherwise required), on our form (or such other form as **We** may reasonably approve) by facsimile (or such other means as **We** may reasonably approve), such information as **We** may reasonably require to administer this **Group Agreement**. This includes, but is not limited to, information needed to enroll members of the **Contract Holder**, process terminations, and effect changes in family status and transfer of employment of **Members**. **We** will not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **Us**. **Contract Holder** must notify **Us** of the date in which a **Subscriber's** employment ceases for the purpose of termination of coverage under this **Group Agreement**. Subject to applicable law, unless otherwise specifically agreed to in writing, **We** will consider **Subscriber's** employment to continue until the earlier of:

- until stopped by the **Contract Holder**;
- if **Subscriber** has stopped working due to temporary lay off or leave of absence, not beyond the end of the policy month after the policy month in which the absence started; and
- if **Subscriber** stopped working due to disability, not beyond the end of the 30th policy month after the month in which the absence started.

Contract Holder represents that all enrollment and eligibility information that has been or will be supplied to **Us** is accurate. **Contract Holder** acknowledges that **We** can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for **Covered Benefits** under the **Group Agreement**. To the extent such information is supplied to **Us** electronically, **Contract Holder** agrees to:

- Maintain a reasonably complete record of such information (in electronic or hard copy format, including evidence of coverage, elections, evidence of eligibility, changes to such elections and terminations) for at least seven years, and to make such information available to **Us** upon request.
- Obtain from all Subscribers a "Disclosure of Healthcare Information" authorization in the form currently being used by **Us** in the enrollment process (or such other form as **We** may reasonably approve).

- 5.2 **Access.** Make payroll and other records directly related to **Member's** coverage under this **Group Agreement** available to **Us** for inspection, at **Our** expense, at **Contract Holder's** office, during regular business hours, upon reasonable advance request. This provision shall survive termination of this **Group Agreement**.
- 5.3 **Forms.** Distribute materials to **HMO Members** regarding enrollment, health plan features, including **Covered Benefits** and exclusions and limitations of coverage. **Contract Holder** shall, within 31 days of receipt from an eligible individual, forward all completed enrollment information and other required information to **Us**.
- 5.4 **Policies and Procedures; Compliance Verification.** Comply with all policies and procedures established by **Us** in administering and interpreting this **Group Agreement**. **Contract Holder** shall, upon request, provide a certification of its compliance with **Our** participation and contribution requirements and the requirements for a group as defined under applicable law or regulation.
- 5.5 **Continuation Rights and Conversion.** Notify all eligible **Members** of their right to continue or convert coverage pursuant to applicable law.
- 5.6 **ERISA Requirements.** Maintain responsibility for making reports and disclosures required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), including the creation, distribution and final content of summary plan descriptions, summary of material modifications and summary annual reports.

SECTION 6. TERMINATION

- 6.1 **Termination by Contract Holder.** This **Group Agreement** may be terminated by **Contract Holder** as of any **Premium Due Date** by providing **Us** with 30 days' prior written notice. However, **We** may in **Our** discretion accept an oral indication by **Contract Holder** or its agent or broker of intent to terminate.
- 6.2 **Non-Renewal by Contract Holder.** **We** may request from **Contract Holder** a written indication of their intention to renew or non-renew this **Group Agreement** at any time during the final three months of any **Term**. If **Contract Holder** fails to reply to such request within the timeframe specified the **Contract Holder** shall be deemed to have provided notice of non-renewal to **Us** and this **Group Agreement** shall be deemed to terminate automatically as of the end of the **Term**. Similarly, upon **Our** written confirmation to **Contract Holder**, **We** may accept an oral indication by **Contract Holder** or its agent or broker of intent to non-renew as **Contract Holder's** notice of termination effective as of the end of the **Term**.
- 6.3 **Termination by Us.** This **Group Agreement** will terminate immediately upon notice to **Contract Holder** if the **Premium** remains unpaid at the end of the **Grace Period**.

This **Group Agreement** may also be terminated by **Us** as follows:

- Immediately upon notice to **Contract Holder** if **Contract Holder** has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this **Group Agreement**;
- Immediately upon notice to **Contract Holder** if **Contract Holder** no longer has any enrollee under the Plan who resides or works in the **Service Area**;

This **Group Agreement** may be non-renewed by **Us** as follows:

- Upon 30 days' written notice to **Contract Holder** if **Contract Holder** (i) breaches a provision of this **Group Agreement** and such breach remains uncured at the end of the 30 day notice period; (ii) ceases to meet **Our** requirements for an employer group; (iii) fails to meet **Our** contribution or participation requirements applicable to this **Group Agreement** (which contribution and participation requirements are available upon request); (iv) fails to provide the certification

required by Section 5.4 within a reasonable period of time specified by Us; or (v) changes its eligibility or participation requirements without **Our** consent;

- If **We** cease to offer the product to which this **Group Agreement** relates, **We** will provide at least 90 days' written notice to the **Contract Holder**, to all participants, and beneficiaries of the plan of our intent to non-renew this plan prior to the plan's upcoming renewal. **We** will offer to the **Contract Holder** the option to select all or any other health insurance coverage that **We** offer without regard to the claims experience of the certificate or policyholder or any health status-related factor relating to any participant or beneficiaries covered or new participant or beneficiaries who may become eligible for coverage.
- If **We** cease to offer and not renew all health insurance coverage, we will provide at least 180 days' written notice to the **Contract Holder**, to all participants and beneficiaries and the **Department of Banking and Insurance** of the nonrenewal prior to the date of the plan's upcoming renewal. If we cease to offer all health insurance coverage for groups in the State under the provisions of sections 14 through 27 of P.L. 1997, c.146 (C.17B:27-54 through C.17B:27-67), we will not be permitted to offer health insurance during a five-year period beginning on the termination date of the last health insurance coverage that was not renewed.

6.4 **Effect of Termination.** No termination of this **Group Agreement** will relieve either party from any obligation incurred before the date of termination. When terminated, this **Group Agreement** and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. **We** may charge the **Contract Holder** a reinstatement fee if coverage is terminated and subsequently reinstated under this **Group Agreement**. Upon termination, **We** will provide **Members** with Certificates of Creditable Coverage which will show evidence of a **Member's** prior health coverage with **Us** for a period of up to 18 months prior to the loss of coverage.

6.5 **Notice to Subscribers and Members.** It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**. When **Subscribers** and **Members** terminate coverage under the plan in accordance with the **Certificate**, the **Contract Holder** shall provide written notice to **Members** of their continuation rights upon termination of coverage.

SECTION 7. **PRIVACY OF INFORMATION**

7.1 **Compliance with Privacy Laws.** **We** and **Contract Holder** will abide by all applicable laws and regulations regarding confidentiality of individually identifiable health and other personal information, including the privacy requirements of HIPAA.

7.2 **Disclosure of Protected Health Information.** **We** will not provide protected health information ("PHI"), as defined in HIPAA, to **Contract Holder**, and **Contract Holder** will not request PHI from **Us**, unless **Contract Holder** has either:

- provided the certification required by 45 C.F.R. § 164.504(f) and amended **Contract Holder's** plan documents to incorporate the necessary changes required by such rule; or
- provided confirmation that the PHI will not be disclosed to the "plan sponsor", as such term is defined in 45 C.F.R. § 164.501.

7.3 **Brokers and Consultants.** To the extent any broker or consultant receives PHI in the underwriting process or while advocating on behalf of a **Member**, **Contract Holder** understands and agrees that such broker or consultant is acting on behalf of **Contract Holder** and not **Us**. **We** are entitled to rely on **Contract Holder's** representations that any such broker or consultant is authorized to act on **Contract Holder's** behalf and entitled to have access to the PHI under the relevant circumstances.

SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS

- 8.1 **Relationship Between Us and Participating Providers.** The relationship between Us and **Participating Providers** is a contractual relationship among independent contractors. **Participating Providers** are not agents or employees of Us nor are We an agent or employee of any **Participating Provider**.

Participating Providers are responsible for any health services rendered to their **Member** patients. We make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician, Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**, subject to applicable law. **Participating Providers** provide health care diagnosis, treatment and services for **Members**. We administer and determine plan benefits.

- 8.2 **Relationship Between the Parties.** The relationship between the **Parties** is a contractual relationship between independent contractors. Neither **Party** is an agent or employee of the other in performing its obligations pursuant to this **Group Agreement**.

SECTION 9. MISCELLANEOUS

- 9.1 **Delegation and Subcontracting.** **Contract Holder** acknowledges and agrees that We may enter into arrangements with third parties to delegate functions hereunder such as utilization management, quality assurance and provider credentialing, as We deem appropriate in **Our** sole discretion and as consistent with applicable laws and regulations. **Contract Holder** also acknowledges that **Our** arrangements with third party vendors (i.e. pharmacy, behavioral health) are subject to change in accordance with applicable laws and regulations.

- 9.2 **Accreditation and Qualification Status.** We may from time to time obtain voluntary accreditation or qualification status from a private accreditation organization or government agency. We make no express or implied warranty about **Our** continued qualification or accreditation status.

- 9.3 **Prior Agreements; Severability.** As of the **Effective Date**, this **Group Agreement** replaces and supersedes all other prior agreements between the **Parties** as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the **Parties** related to matters covered by this **Group Agreement** or the documents incorporated herein. If any provision of this **Group Agreement** is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this **Group Agreement** shall continue in full force and effect.

- 9.4 **Amendments.** This **Group Agreement** may be amended as follows:

- This **Group Agreement** shall be deemed to be automatically amended to conform with all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over Us;
- By written agreement between both **Parties**; or
- By written agreement between both **Parties** upon 60 days' written notice to **Contract Holder** at the time of renewal.

The **Parties** agree that an amendment does not require the consent of any employee, **Member** or other person. Except for automatic amendments to comply with law, all amendments to this **Group Agreement** must be approved and executed by Us. No other individual has the authority to modify this **Group Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind Us by making any other commitment or representation or by giving or receiving any information.

- 9.5 **Clerical Errors.** Clerical errors or delays by Us in keeping or reporting data relative to coverage will not reduce or invalidate a **Member's** coverage. Upon discovery of an error or delay, an adjustment of

Premiums shall be made. **We** may also modify or replace a **Group Agreement, Certificate** or other document issued in error.

9.6 **Claim Determinations.** **We** have complete authority to review all claims for **Covered Benefits** under this **Group Agreement**. In exercising such responsibility, **We** shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and to construe any disputed or doubtful terms under this **Group Agreement**, the **Certificate** or any other document incorporated herein. **Our** review of claims may include the use of commercial software (including Claim Check) and other tools to take into account factors such as an individual's claims history, a **Provider's** billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing. The **Member** may be eligible to appeal **HMO's** decision through an Independent Utilization Review Organization (IURO). Please refer to the Appeal Procedure section of the **Certificate** for more information on this process.

9.7 **Misstatements.** If any fact as to the **Contract Holder** or a **Member** is found to have been misstated, an equitable adjustment of **Premiums** may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

9.8 **Incontestability.** Except as to a fraudulent misstatement, or issues concerning **Premiums** due:

- No statement made by **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for two years from its effective date.

9.9 **Assignability.** No rights or benefits under this **Group Agreement** are assignable by **Contract Holder** to any other party unless approved by **HMO**.

9.10 **Waiver.** **Our** failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **Certificate** incorporated hereunder, at any given time or times, shall not constitute a waiver of **Our** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.

If by **Our** actions after the end of the **grace period**, **We** consider the policy or contract as continuing in force beyond the end of the **grace period** (such as continuing to recognize claims subsequently incurred or continuing to provide services or supplies), **We** shall be liable for valid claims for losses beginning, and services or supplies provided, prior to the effective date of the written notice of discontinuance to the **Contract Holder** or other entity responsible for making premium payments or submitting subscriptions charges to **Us**. The effective date of the discontinuance shall be no earlier than midnight at the end of the third scheduled business day after the date the notice is received.

9.11 **Notices.** Any notice required or permitted under this **Group Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application or Cover Sheet, or to any more recent address of which the sending party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.

9.12 **Third Parties.** This **Group Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.

9.13 **Non-Discrimination.** **Contract Holder** agrees to make no attempt, whether through differential contributions or otherwise, to encourage or discourage enrollment in **HMO** of eligible individuals and eligible **Dependents** based on health status or health risk.

- 9.14 **Applicable Law.** This **Group Agreement** shall be governed and construed in accordance with applicable federal law and the law of the state specified in the Cover Sheet or, if no state law is specified, **Our** domicile state.
- 9.15 **Inability to Arrange Services.** If 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 Participating Providers** or entities with whom **We** have contracted for services under this **Group Agreement**, or similar causes, the provision of medical or **Hospital** benefits or other services provided under this **Group Agreement** is delayed or rendered impractical, **We** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **Us** on the date such event occurs. **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.
- 9.16 **Use of the HMO Name and all Symbols, Trademarks, and Service Marks.** **We** reserve the right to control the use of **Our** name and all symbols, trademarks, and service marks presently existing or subsequently established. **Contract Holder** agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without **Our** prior written consent and will cease any and all usage immediately upon **Our** request or upon termination of this **Group Agreement**.
- 9.17 **Workers' Compensation.** **Contract Holder** is responsible for protecting **Our** interests in any Workers' Compensation claims or settlements with any eligible individual. **We** shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

On or before the **Effective Date** of this **Group Agreement** and upon renewal, **Contract Holder** shall submit proof of their Workers' Compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Workers' Compensation. Upon **Our** request, **Contract Holder** shall also submit a monthly report to **Us** listing all Workers' Compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individuals.

HEALTH CARE REFORM CONTRIBUTION CHANGE NOTICE

If you maintain a grandfathered health plan as defined under The Patient Protection and Affordable Care Act and you intend to make a change in the contribution rate at any point during the year, you must provide written notice to Aetna 60 days in advance of the effective date of the contribution rate change.

**AETNA HEALTH INC.
(NEW JERSEY)**

CERTIFICATE OF COVERAGE

This Certificate of Coverage ("**Certificate**") is part of the Group Agreement ("**Group Agreement**") between Aetna Health Inc., hereinafter referred to as **HMO**, and the **Contract Holder**. The **Group Agreement** determines the terms and conditions of coverage. Provisions of this **Certificate** include the Schedule of Benefits, and any amendments, riders or endorsements. Amendments, riders or endorsements may be delivered with the **Certificate** or added thereafter.

HMO agrees with the **Contract Holder** to provide coverage for benefits from **Providers** participating in the **HMO** network, in accordance with the conditions, rights, and privileges as set forth in this **Certificate**. **Members** covered under this **Certificate** are subject to all the conditions and provisions of the **Group Agreement**.

This **Certificate** describes covered health care benefits from **Providers** participating in the **HMO** network. Coverage for services or supplies is provided only if it is furnished while an individual is a **Member**. This means that coverage is provided only for health care services furnished while this coverage is in force. Except as shown in the Continuation section of this **Certificate**, coverage is not provided for any services received before coverage starts or after coverage ends.

Certain words have specific meanings when used in this **Certificate**. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this **Certificate**.

This Certificate is not in lieu of insurance for Workers' Compensation. This Certificate is governed by applicable federal law and the laws of New Jersey.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND HMO. IT IS THE CONTRACT HOLDER'S AND THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PREAUTHORIZATION BY HMO.

NO SERVICES ARE COVERED UNDER THIS CERTIFICATE IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE 30 DAY GRACE PERIOD AND THE PREMIUMS SECTION OF THE GROUP AGREEMENT.

THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE.

NO PARTICIPATING PROVIDER OR OTHER PROVIDER, INSTITUTION, FACILITY OR AGENCY IS AN AGENT OR EMPLOYEE OF HMO.

<p>Contract Holder: The Government of the District of Columbia Contract Holder Number: 172614 Contract Holder Group Agreement Effective Date: January 1, 2013</p>
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TABLE OF CONTENTS

<u>Section</u>	<u>Page</u>
HMO Procedure	1
Eligibility and Enrollment	2
Covered Benefits	6
Exclusions and Limitations	21
Termination of Coverage	27
Continuation	29
Claim Determination Procedures/Complaints and Appeals	37
Coordination of Benefits (COB)	43
Responsibility of Members	49
General Provisions	49
Definitions	52

HMO PROCEDURE

A. **Selecting a Participating Primary Care Physician.**

At the time of enrollment, each **Member** must select a **Participating Primary Care Physician (PCP)** from **HMO's** Directory of Participating Providers to access **Covered Benefits** as described in this **Certificate**. The choice of a **PCP** is made solely by the **Member**. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf. Until a **PCP** is selected, benefits will be limited to coverage for **Medical Emergency** care.

B. **The Primary Care Physician.**

The **PCP** coordinates a **Member's** medical care, as appropriate, either by providing treatment or by issuing **Referrals** to direct the **Member** to a **Participating Provider**. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Except in a **Medical Emergency** or for certain direct access **Specialist** benefits as described in this **Certificate**, only those services which are provided by or referred by a **Member's PCP** will be covered. **Covered Benefits** are described in the Covered Benefits section of this **Certificate**. It is a **Member's** responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

If the **Member's PCP** performs, suggests, or recommends a **Member** for a course of treatment that includes services that are not **Covered Benefits**, the entire cost of any such non-covered services will be the **Member's** responsibility.

C. **Availability of Providers.**

HMO cannot guarantee the availability or continued participation of a particular **Provider**. Either **HMO** or any **Participating Provider** may terminate the **Provider** contract or limit the number of **Members** that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients, the **Member** will be notified and given an opportunity to make another **PCP** selection. The **Member** must then cooperate with **HMO** to select another **PCP**. Until a **PCP** is selected, benefits are limited to coverage for **Medical Emergency** care.

D. **Changing a PCP.**

A **Member** may change the **PCP** at any time by calling the Member Services 800 telephone number listed on the **Member's** identification card or by written or electronic submission of the **HMO's** change form. A **Member** may contact **HMO** to request a change form or for assistance in completing that form. The change will become effective upon **HMO's** receipt and approval of the request, but no later than 14 days after the receipt of the request. The change shall become effective immediately if the change of the **PCP** is necessitated by the termination of the **PCP** from the network.

E. **Ongoing Reviews.**

HMO conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are **Covered Benefits** under this **Certificate**. If **HMO** determines that the recommended services and supplies are not **Covered Benefits**, the **Member** will be notified. If a **Member** wishes to appeal such determination, the **Member** may then contact **HMO** to seek a review of the determination. To seek a review, please see the **Complaints and Appeal** section of the **Certificate**.

F. **Authorization.**

Certain services and supplies under this **Certificate** may require authorization by **HMO** to determine if they are **Covered Benefits** under this **Certificate**. Those services and supplies requiring **HMO** authorization are indicated in this **Certificate**.

Maximum Out-of-Pocket Limit.

If a **Member's Copayments** reach the Maximum Out-of-Pocket Limit set forth on the **HMO** Schedule of Benefits, **HMO** will pay 100% of the contracted charges for **Covered Benefits** for the remainder of that calendar year, up to the Maximum Benefit, if any, listed on the Schedule of Benefits. **Covered Benefits** must be rendered to the **Member** during that calendar year.

Calculations; Determination of Benefits.

A **Member's** financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one calendar year. It is within the discretion of **HMO** to determine when benefits are covered under this **Certificate**; subject to any reviews as specified under the External Review section of your **Certificate**. If coverage is terminated or discontinued and you are hospitalized prior to the termination date, all charges with respect to hospitalization will be considered on the date of admission for all services and supplies provided through the date of discharge.

ELIGIBILITY AND ENROLLMENT

A. Eligibility.

1. To be eligible to enroll as a **Subscriber**, an individual must:
 - a. meet all applicable eligibility requirements agreed upon by the **Contract Holder** and **HMO**; and
 - b. live or work in the **Service Area**.
2. To be eligible to enroll as a **Covered Dependent**, the **Contract Holder** must provide dependent coverage for **Subscribers**, and the dependent must be:
 - a. the legal spouse of a **Subscriber** under this **Certificate**; or
 - b. a dependent unmarried child (including natural, foster, step, legally adopted children, proposed adoptive children, a child under court order) who meets the eligibility requirements described on the Schedule of Benefits.

The term "spouse" shall include a Civil Union partner as defined by New Jersey State Law. In addition, if applicable, any references under this Certificate made to "marriage", "husband", "wife", "family", "immediate family", "dependent", "next of kin", "widow", "widower", "widowed" or another word which in a specific context denotes a marital or spousal relationship, the same shall include a Civil Union. In addition, a same sex relationship entered into outside of New Jersey which is valid under the law of another state or foreign nation that provides substantially all of the rights and benefits of marriage, shall be valid in New Jersey.

3. A **Member's** eligibility for Medicaid shall not prohibit eligibility for, or the provision of, benefits under this **Certificate**.
4. A **Member** who resides outside the **Service Area** is required to choose a **PCP** and return to the **Service Area** for **Covered Benefits**. The only services covered outside the **Service Area** are **Emergency Services** and **Urgent Care**.

B. Enrollment.

Unless otherwise noted, an eligible individual and any eligible dependents may enroll in **HMO** regardless of health status, age, or requirements for health services within 31 days from the eligibility date.

1. Newly Eligible Individuals and Eligible Dependents.

An eligible individual and any eligible dependents may enroll within 31 days of the eligibility date.

2. Open Enrollment Period.

Eligible individuals or dependents who are eligible for enrollment but do not enroll as stated above, may be enrolled during any subsequent **Open Enrollment Period** upon submission of complete enrollment information and **Premium** payment to **HMO**.

3. Enrollment of Newly Eligible Dependents.

a. Newborn Children.

A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, the child must be enrolled in **HMO** within the initial 31 day period. If coverage does not require the payment of an additional **Premium** for a **Covered Dependent**, the **Subscriber** must still enroll the child within 31 days after the date of birth.

The coverage for newly born, adopted children, and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of congenital defects and birth abnormalities, and within the limits of this **Certificate**. Coverage includes necessary transportation costs from place of birth to the nearest specialized **Participating** treatment center.

b. Adopted Children.

A legally adopted child or a child for whom a **Subscriber** is a court appointed legal guardian, and who meets the definition of a **Covered Dependent**, will be treated as a dependent from the date of adoption or upon the date the child was placed for adoption with the **Subscriber**. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The placement must take effect on or after the date a **Subscriber's** coverage becomes effective, and the **Subscriber** must make a written request for coverage within 31 days of the date the child is adopted or placed with the **Subscriber** for adoption.

The initial coverage will not be affected by any provision in this **Certificate** which:

- i. delays coverage due to a confinement; or
- ii. limits coverage as to a preexisting condition.

4. Special Rules Which Apply to Children.

a. Qualified Medical Support Order.

Coverage is available for a dependent child not residing with a **Subscriber** and who resides outside the **Service Area**, if there is a qualified medical child support order requiring the **Subscriber** to provide dependent health coverage for a non-resident child, and is issued on or after the date the **Subscriber's** coverage becomes effective. The child must meet the definition of a **Covered Dependent**, and the **Subscriber** must make a written request for coverage within 31 days of the court order.

The initial coverage will not be affected by any provision in this **Certificate** which:

- i. delays coverage due to a confinement; or
 - ii. limits coverage as to a preexisting condition.
- b. Handicapped Children.

Coverage is available for a child who is chiefly dependent upon the **Subscriber** for support and maintenance, and who is 19 years of age or older but incapable of self-support due to mental or physical incapacity. The incapacity must have commenced prior to the age the dependent lost eligibility. In order to continue coverage for a handicapped child, the **Subscriber** must provide evidence of the child's incapacity and dependency to **HMO** within 31 days of the date the child's coverage would otherwise terminate. Proof of continued incapacity, including a medical examination, must be submitted to **HMO** as requested, but not more frequently than annually beginning after the two year period following the child's attainment of the age specified on the Schedule of Benefits. This eligibility provision will no longer apply on the date the dependent's incapacity ends.

5. Notification of Change in Status.

It shall be a **Member's** responsibility to notify **HMO** of any changes which affect the **Member's** coverage under this **Certificate**. Such status changes include, but are not limited to, change of address, change of **Covered Dependent** status, and enrollment in Medicare or any other group health plan of any **Member**. Additionally, if requested, a **Subscriber** must provide to **HMO**, within 31 days of the date of the request, evidence satisfactory to **HMO** that a dependent meets the eligibility requirements described in the **Eligibility and Enrollment Section A.2** of this **Certificate**.

An eligible individual and any eligible dependents may be enrolled if the eligible individual's spouse was covered under another health benefit plan and lost coverage because of termination of coverage, for reasons other than gross misconduct, within 31 days of the loss of coverage even though it is not during the **Open Enrollment Period**. The eligible individual or the eligible dependent will not be subject to the later enrollment provision, if any, described below. **HMO's** completed change form must be submitted to the **Contract Holder** within 31 days of the event causing the change in status.

6. **Special Enrollment Period.**

An eligible individual and eligible dependents may be enrolled during a Special Enrollment Period. A Special Enrollment Period may apply when an eligible individual or eligible dependent

- a. loses other health coverage or when an eligible individual acquires a new eligible dependent through marriage, birth, adoption or placement for adoption; or

- b. **the eligible individual or eligible dependent becomes eligible for State premium assistance in connection with coverage under the HMO.**

Special Enrollment Period for Certain Individuals Who Lose Other Health Coverage:

An eligible individual or an eligible dependent may be enrolled during a Special Enrollment Period, if the following requirements, as applicable, are met:

- a. the eligible individual or the eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under **HMO**;
- b. the eligible individual or eligible dependent previously declined coverage in writing under **HMO**;
- c. the eligible individual or eligible dependent loses coverage under the other group health plan or other health insurance coverage for one of the following reasons:
- i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted;
- ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated; or
- iii. the other health insurance coverage is Medicaid or an S-Chip plan and the eligible individual or eligible dependent no longer qualifies for such coverage.

Loss of eligibility includes the following:

- a loss of coverage as a result of, divorce or death;
- termination of employment;
- reduction in the number of hours of employment;
- any loss of eligibility after a period that is measured by reference to any of the foregoing;
- termination of **HMO** coverage due to **Member** action- movement outside of the **HMO**'s service area; and also the termination of health coverage including Non-**HMO**, due to plan termination.
- plan ceases to offer coverage to a group of similarly situated individuals;
- cessation of a dependent's status as an eligible dependent
- termination of benefit package

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay **Premiums** on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of this **Certificate**.

To be enrolled in **HMO** during a Special Enrollment Period, the eligible individual or eligible dependent must enroll within:

- a. 31 days, beginning on the date of the eligible individual's or eligible dependent's loss of other group health plan or other health insurance coverage; or
- b. 60 days, beginning on the date the eligible individual or eligible dependent
- (i) becomes eligible for premium assistance in connection with coverage under **HMO**, or

- (ii) is no longer qualified for coverage under Medicaid or S-Chip.

The **Effective Date of Coverage** will be the first day of the first calendar month following the date the completed request for enrollment is received.

Special Enrollment Period When a New Eligible Dependent is Acquired:

When a new eligible dependent is acquired through marriage, birth, adoption or placement for adoption, the new eligible dependent (and, if not otherwise enrolled, the eligible individual and other eligible dependents) may be enrolled during a special enrollment period.

The special enrollment period is a period of 31 days, beginning on the date of the marriage, birth, adoption or placement for adoption (as the case may be). If a completed request for enrollment is made during that period, the **Effective Date of Coverage** will be:

- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

The eligible individual or the eligible dependent enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this **Certificate**.

C. **Effective Date of Coverage.**

Coverage shall take effect at 12:01 a.m. on the **Member's** effective date. Coverage shall continue in effect from month to month subject to payment of **Premiums** made by the **Contract Holder** and subject to the Contract Holder Termination section of the **Group Agreement**.

1. Hospital Confinement on Effective Date of Coverage.

If a **Member** is an inpatient in a **Hospital** on the **Effective Date of Coverage**, the **Member** will be covered as of that date. Please see Section G. Discontinuance and Replacement Provisions in the Continuation Section of the Certificate for more information on how your hospitalization will be covered. **HMO** will not cover any service that is not a **Covered Benefit** under this **Certificate**. To be covered, the **Member** must utilize **Participating Providers** and is subject to all the terms and conditions of this **Certificate**. If a **Member** wishes to appeal a determination, the **Member** may contact **HMO** to seek a review. Please refer to the Claims Determination Procedures/Complaints and Appeals section of this **Certificate**.

COVERED BENEFITS

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **Certificate**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **HMO** may determine whether any benefit provided under the **Certificate** is **Medically Necessary**, and **HMO** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. For **Specialist** services, the **Member** is afforded the choice of a **Participating Specialist** subject to their availability and acceptance of new patients. Preventive care, as described below, will be considered **Medically Necessary**.

To be **Medically Necessary**, the service or supply must be: Health care or dental services, and supplies (including contraceptive devices) or prescription drugs that a **physician**, other health care provider or dental **provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing contraception; preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

- (a) in accordance with generally accepted standards of medical or dental practice;
- (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and
- (c) not primarily for the convenience of the patient, **physician**, other health care or dental **provider**; and
- (d) and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or dentists practicing in relevant clinical areas and any other relevant factors.

All **Covered Benefits** will be covered in accordance with the guidelines determined by **HMO**.

If a **Member** has questions regarding coverage under this **Certificate**, the **Member** may call the Member Services 800 telephone number listed on the **Member's** identification card.

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE DEDUCTIBLES AND/OR COPAYMENTS LISTED ON THE SCHEDULE OF BENEFITS.

EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY OR URGENT CARE SITUATION AS DESCRIBED IN THIS CERTIFICATE, THE FOLLOWING BENEFITS MUST BE ACCESSED THROUGH THE PCP'S OFFICE THAT IS SHOWN ON THE MEMBER'S IDENTIFICATION CARD, OR ELSEWHERE UPON PRIOR REFERRAL ISSUED BY THE MEMBER'S PCP.

A. Primary Care Physician Benefits.

1. Office visits during office hours.
2. Home visits.
3. After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a **Member** becomes sick or is injured after the **PCP's** regular office hours, the **Member** should:
 - a. call the **PCP's** office; and
 - b. identify himself or herself as a **Member**; and
 - c. follow the **PCP's** or covering **Physician's** instructions.

If the **Member's** injury or illness is a **Medical Emergency**, the **Member** should follow the procedures outlined under the Emergency Care/Urgent Care Benefits section of this **Certificate**.

4. Hospital visits.

5. Periodic health evaluations to include:
 - a. well child care from birth including immunizations and booster doses of all immunizing agents used in child immunizations which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services, and the New Jersey Department of Health and Senior Services.

Screenings by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing, as specified by the New Jersey Department of Health, and medical evaluation and any necessary medical follow-up treatment for lead poisoned children.

Newborn hearing loss screenings by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss. This benefit is provided to the same extent as for any other medical condition in this **Certificate** of Coverage. Applicable deductibles, if any, do not apply.
 - b. routine physical examinations.
 - c. routine gynecological examinations, including pap smears, for routine care, administered by the **PCP**. Or the **Member** may also go directly to a **Participating** gynecologist without a **Referral** for routine GYN examinations and pap smears. See the Direct Access Specialist Benefits section of this **Certificate** for a description of these benefits.
 - d. routine hearing screenings.
 - e. immunizations (but not if solely for the purpose of travel or employment).
 - f. routine vision screenings.
 - g. an annual test, including but not limited to, blood hemoglobin, blood glucose, blood pressure and blood cholesterol for **Members** age 20 or older.
 - h. an annual stool examination for the presence of blood for **Members** age 40 and older.
 - i. a left-sided colon examination of 35 to 60 centimeters once every 5 years for **Members** age 45 and older.
 - j. a routine diagnostic examination, including but not limited to, a digital rectal examination and a prostate-specific antigen test per year for **Members** age 50 and over, and for **Members** age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.
 - k. a glaucoma eye test every 5 years for **Members** age 35 and older.
6. Injections, including allergy desensitization injections.
7. Casts and dressings.
8. Health Education Counseling and Information.

9. Diabetic Supplies and Equipment. The following equipment, supplies and education services for the treatment of diabetic conditions are covered when ordered or prescribed by a **Participating Physician** (or **Participating** nurse practitioner or clinical nurse specialist) and obtained through a **Participating Provider**: blood glucose monitors and blood glucose monitors for the legally blind, test strips for glucose monitors and visual reading and urine test strips, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, and oral agents for controlling blood sugar.

Coverage also includes diabetes self-management education to ensure that **Members** with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet. Such coverage for self-management education and education relating to diet shall be limited to visits **Medically Necessary** upon the diagnosis of diabetes, where a **Participating Physician** (or **Participating** nurse practitioner or clinical nurse specialist) diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a **Member's** self-management, or where re-education or refresher education is necessary. Such education must be provided by a **Participating** dietitian registered by a nationally recognized professional association of dietitians or a health professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators.

B. **Diagnostic Services.**

Services include, but are not limited to, the following:

1. diagnostic, laboratory, and x-ray services.
2. mammograms, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from her **PCP** or gynecologist, or obtain prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

Screening mammogram benefits for female **Members** are provided as follows:

- age 35 through 39, one baseline mammogram;
- age 40 and older, one routine mammogram every year;
- under age 40, annual and interval mammograms for women with a family history of breast cancer risk factors, beginning at that age deemed **Medically Necessary** by the Participating Provider; or
- when **Medically Necessary**.

3. Colorectal Cancer Screening. For **Members** 50 years of age or older and **Members** of any age who are considered to be a high risk for Colorectal Cancer, the screening at regular intervals includes the following:

- Annual guaiac-based fecal occult blood test (gFOBT) with high test sensitivity for cancer
- Annual immunochemical-based fecal occult blood test (FIT) with high test sensitivity for cancer
- Stool DNA (sDNA) test with high test sensitivity for cancer
- Flexible sigmoidoscopy every five years
- Colonoscopy every ten years
- Double contrast barium enema every five years
- Computed tomography colonography (virtual colonoscopy) every five years.

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

These colorectal cancer-screening benefits will be provided to the same extent as for any other medical condition under the **Certificate of Coverage**.

High Risk for Colorectal Cancer means a Member who has:

- Family history of familial adenomatous polyposis;
- Family history of hereditary non-polyposis colon cancer;
- Chronic inflammatory bowel disease;
- Family history of breast, ovarian, endometrial, colon cancer or polyps; or
- A background, ethnicity, or lifestyle, such that the **Physician** treating the **Member** believes the **Member** is at elevated risk for colorectal cancer.

C. Specialist Physician Benefits.

Covered Benefits include outpatient and inpatient services. Benefits include the expenses incurred in the treatment of Wilm's tumor, including autologous bone marrow transplants when standard chemotherapy is unsuccessful, notwithstanding that any such treatment may be deemed **Experimental or Investigational Procedures**. Benefits also include the treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants when performed by institutions approved by the National Cancer Institute or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.

D. Direct Access Specialist Benefits.

The following services are covered without a **Referral** when rendered by a **Participating Provider**.

- Routine Gynecological Examination(s). Routine gynecological visit(s) and pap smear(s). The maximum number of visits, if any, is listed on the Schedule of Benefits.
- Open Access to Gynecologists. Benefits are provided to female **Members** for services performed by a **Participating** gynecologist for diagnosis and treatment of gynecological problems other than Infertility Services which require a **Referral**. See the Infertility Services section of this **Certificate** for a description of **Infertility** benefits.
- Routine Eye Examinations, including refraction, as follows:
 1. if the **Member** is age 1 through 18 and wears eyeglasses or contact lenses, one exam every 12-month period.
 2. if the **Member** is age 19 and over and wears eyeglasses or contact lenses, one exam every 24-month period.
 3. if the **Member** is age 1 through 45 and does not wear eyeglasses or contact lenses, one exam every 36-month period.
 4. if the **Member** is age 46 and over and does not wear eyeglasses or contact lenses, one exam every 24-month period.

E. Maternity Care and Related Newborn Care.

Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by **Participating Providers** are a **Covered Benefit**. To be covered for these benefits, the **Member** must choose a **Participating** obstetrician from **HMO's** list of **Participating Providers** and inform **HMO** by calling the Member Services 800 telephone number listed on the **Member's**

identification card, prior to receiving services. The **Participating Provider** is responsible for obtaining prior authorization for all obstetrical care from **HMO** after the first prenatal visit.

Coverage does not include routine maternity care (including delivery) received while outside the **Service Area** unless the **Member** receives prior authorization from **HMO**. As with any other medical condition, **Emergency Services** are covered when **Medically Necessary**.

F. **Inpatient Hospital & Skilled Nursing Facility Benefits.**

A **Member** is covered for services, including reconstructive breast surgery (and the costs of breast prostheses after reconstructive breast surgery) only at **Participating Hospitals** and **Participating Skilled Nursing Facilities**. All services are subject to preauthorization by **HMO**. In the event that the **Member** elects to remain in the **Hospital** or **Skilled Nursing Facility** after the date that the **Participating Provider** and/or the **HMO** Medical Director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Hospital** or **Skilled Nursing Facility** for such additional **Hospital, Skilled Nursing Facility, Physician** and other **Provider** services, and **HMO** shall not be financially responsible for such additional services. If a **Member** wishes to appeal a determination, the **Member** may contact **HMO** to seek a review. Please refer to the Claims Determination Procedures/Complaints and Appeals section of this **Certificate**.

As an exception to the **Medically Necessary** requirements of this **Certificate**, the following coverage is provided for a mother and newly born child:

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a vaginal delivery;
2. a minimum of 96 hours of inpatient care in a **Participating Hospital** following a cesarean section; or

We provide such coverage subject to the following:

1. the attending **Participating Provider** must determine that inpatient care is **Medically Necessary**; or
2. the mother must request the inpatient care.

The **Member** will be covered for one home health care visit scheduled to occur within 24 hours of discharge. An additional visit will be covered when prescribed by the **Participating Provider**. This benefit is in addition to the home health maximum number of visits, if any, shown on the Schedule of Benefits. A **Copayment** will not apply for home health care visits.

Coverage for **Skilled Nursing Facility** benefits is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

As an exception to the **Medically Necessary** requirements of this **Certificate**, the following coverage is provided to a **Member** who is severely disabled and requires dental services, or to a Covered Dependent child age 5 or under who requires dental services:

1. general anesthesia and hospitalization; or
2. a medical condition requiring hospitalization or general anesthesia, regardless of where dental services are provided.

G. **Transplants.**

Once it has been determined that a **Member** may require a **Transplant**, the **Member** or the **Member's Physician** must call the **HMO** precertification department to discuss coordination of the **Transplant** process. Non-experimental or non-investigational **Transplants** coordinated by **HMO** are **Covered Benefits**. The facility must be specifically approved and designated by **HMO** to perform the **Transplant** required by the **Member**.

Covered Benefits include the following:

- Inpatient and outpatient expenses directly related to a **Transplant Occurrence**.
- Charges made by a **Physician** or **Transplant** team.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your: biological parent, sibling or child.
- Charges for activating the donor search process with national registries.
- Charges made by a **Hospital** or outpatient facility and/or **Physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the **Transplant** Occurrence process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; **Home Health Services** and home infusion services.

Any **Copayments** or **Coinsurance** associated with **Transplants** are set forth in the **Schedule of Benefits**. **Copayments** or **Coinsurance** apply per **Transplant Occurrence**.

One **Transplant Occurrence** includes the following four phases of **Transplant** care:

1. **Pre-Transplant Evaluation/Screening:** Includes all **Transplant**-related professional and technical components required for assessment, evaluation and acceptance into a **Transplant** facility's **Transplant** program.
2. **Pre-Transplant/Candidacy Screening:** Includes HLA typing of immediate family members.
3. **Transplant Event:** Includes:
 - inpatient and outpatient services for all **Transplant**-related health services and supplies provided to a **Member** and donor during the one or more surgical procedures or medical therapies for a **Transplant**;
 - prescription drugs provided during the **Member's** inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs;
 - physical, speech or occupational therapy provided during the **Member's** inpatient stay or outpatient visit(s); and
 - cadaveric and live donor organ procurement.
4. **Follow-up Care:** Includes **Home Health Services**, home infusion services and **Transplant**-related outpatient services rendered within 365 days from the date of the **Transplant**.

For the purposes of this section, the following will be considered to be one **Transplant Occurrence**:

- Heart
- Lung
- Heart/Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine

- Bone Marrow/Stem Cell Transplant
- Multiple organs replaced during one Transplant surgery
- Tandem **Transplants** (Stem Cell)
- Sequential **Transplants**
- Re-transplant of same organ type within 365 days of the first **Transplant**
- Any other single organ **Transplant**, unless otherwise excluded under the coverage.

The following will be considered to be more than one **Transplant Occurrence**:

- Autologous Blood/Bone Marrow **Transplant** followed by Allogenic Blood/Bone Marrow **Transplant** (when not part of a tandem Transplant)
- Allogenic Blood/Bone Marrow **Transplant** followed by an Autologous Blood/Bone Marrow **Transplant** (when not part of a tandem Transplant)
- Re-transplant after 365 days of the first **Transplant**
- Pancreas **Transplant** following a kidney **Transplant**
- A **Transplant** necessitated by an additional organ failure during the original **Transplant** surgery/process.
- More than one **Transplant** when not performed as part of a planned tandem or sequential **Transplant**, (e.g. a liver **Transplant** with subsequent heart **Transplant**).

H. **Outpatient Surgery Benefits.**

Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure when furnished by a **Participating** outpatient surgery center. All services and supplies are subject to preauthorization by **HMO**.

I. **Substance Abuse Benefits.**

A **Member** is covered for the following services as authorized and provided by **Participating Behavioral Health Providers**.

1. Outpatient care benefits are covered for **Detoxification**. Benefits include diagnosis, medical treatment and medical referral services (including referral services for appropriate ancillary services) by the **Member's PCP** for the abuse of or addiction to alcohol or drugs.

The **Member** is entitled to outpatient visits to a **Participating Behavioral Health Provider** upon **Referral** by the **PCP** for diagnostic, medical, or therapeutic **Substance Abuse Rehabilitation** services for **Substance Abuse**. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

2. Inpatient care benefits are covered for **Detoxification**. Benefits include medical treatment and referral services for **Substance Abuse** or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; **Physicians**, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.

The **Member** is entitled to medical, nursing, counseling, or therapeutic **Substance Abuse Rehabilitation** services in an inpatient, **Hospital or non-hospital Residential Treatment Facility**, appropriately licensed by the Department of Health, upon referral by the **Member's Participating Behavioral Health Provider** for alcohol or drug abuse or dependency. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

J. **Mental Disorders Benefits.**

A **Member** is covered for services for the treatment of **Mental Disorders through Participating Behavioral Health Providers.**

1. Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and is subject to the maximums, if any, shown on the Schedule of Benefits.
2. Inpatient benefits may be covered for medical, nursing, counseling or therapeutic services in an inpatient, **Hospital**, or non-hospital **Residential Treatment Facility**, appropriately licensed by the Department of Health or its equivalent. Coverage, if applicable, is subject to the maximum number of days, if any, shown on the Schedule of Benefits.
3. This benefit will be provided under the same terms and conditions as provided for any other sickness under this Certificate of Coverage.

K. **Emergency Care/Urgent Care Benefits.**

1. A **Member** is covered for **Emergency Services**, provided the service is a **Covered Benefit**, and **HMO's** medical review determines that the **Member's** symptoms meet the definition of **Medical Emergency** as defined in this **Certificate**.

The **Copayment** for an emergency room visit as described on the Schedule of Benefits will not apply either in the event that the **Member** was referred for such visit by the **Member's PCP** for services that should have been rendered in the **PCP's** office or if the **Member** is admitted into the **Hospital**.

The **Member** will be reimbursed for the cost for **Emergency Services** rendered by a non-participating **Provider** located either within or outside the **HMO Service Area**, for those expenses, less **Copayments**, which are incurred up to the time the **Member** is determined by **HMO** and the attending **Physician** to be medically able to travel or to be transported to a **Participating Provider**. In the event that transportation is **Medically Necessary**, the **Member** will be reimbursed for the cost as determined by **HMO**, minus any applicable **Copayments**. For **Emergency Services** rendered other than in an emergency room, reimbursement may be subject to payment by the **Member** of all **Copayments** which would have been required had similar benefits been provided during office hours and upon prior **Referral** to a **Participating Provider**.

Medical transportation is covered during a **Medical Emergency** subject to any applicable copayments or coinsurance shown on the Schedule of Benefits.

2. **Urgent Care:** An **urgent care** condition means a non-life threatening condition that requires care by a provider within 24 hours.
 - **Urgent Care Within the HMO Service Area.** If the **Member** needs **Urgent Care** while within the **HMO Service Area**, but the **Member's** illness, injury or condition is not serious enough to be a **Medical Emergency**, the **Member** should first seek care through the **Member's Primary Care Physician**. If the **Member's Primary Care Physician** is not reasonably available to provide services for the **Member**, the **Member** may access **Urgent Care** from a **Participating Urgent Care** facility within the **HMO Service Area**.
 - **Urgent Care Outside the HMO Service Area.** The **Member** will be covered for **Urgent Care** obtained from a **Physician** or licensed facility outside of the **HMO**

Service Area if the **Member** is temporarily absent from the **HMO Service Area** and receipt of the health care service cannot be delayed until the **Member** returns to the **HMO Service Area**.

3. A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for emergency or **Urgent Care** which is provided to a **Member** after the **Medical Emergency** care or **Urgent Care** situation has terminated. All follow-up and continuing care must be provided or arranged by a **Member's PCP**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all follow-up services received.

L. **Rehabilitation Benefits.**

The following benefits are covered when rendered by **Participating Providers** upon **Referral** issued by the **Member's PCP** and pre-authorized by **HMO**:

1. Cardiac and Pulmonary Rehabilitation Benefits.
 - a. Cardiac rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A limited course of outpatient cardiac rehabilitation is covered when **Medically Necessary** following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
 - b. Pulmonary rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A limited course of outpatient pulmonary rehabilitation is covered when **Medically Necessary** for the treatment of reversible pulmonary disease states.
2. Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Coverage is subject to the limits, if any, shown on the Schedule of Benefits. For inpatient rehabilitation benefits for the services listed below, refer to the Inpatient Hospital and Skilled Nursing Facility benefits provision under the **Covered Benefits** section of this **Certificate**.

- a. Cognitive therapy related to physical rehabilitation is covered when the cognitive deficits have been acquired as a result of a neurologic impairment due to: trauma; stroke or encephalopathy; and when the therapy is coordinated with **HMO** as part of a treatment plan intended to restore previous cognitive function.
- b. Physical therapy is covered for non-chronic conditions and acute illnesses and injuries.
- c. Occupational therapy is covered for non-chronic conditions and acute illness or injury. This does not mean vocational rehabilitation or counseling for work.
- d. Speech therapy is covered for non-chronic conditions and acute illness or injury.

For the treatment of **Mental Disorders**, the rule that any of therapies listed above be for non-chronic conditions does not apply.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are covered subject to a maximum of 40 visits per condition. This maximum will not apply to **Mental Disorders** which will be paid subject to the same terms and conditions as any other illness.

Refer to the Outpatient Patient Rehabilitation Benefits section of the Schedule of Benefits for applicable **Member** cost-sharing.

M. **Home Health Benefits.**

The following services are covered for a **Member** when provided by a **Participating** home health care agency. Services are only covered when rendered to a person in his place of residence, under the following conditions:

1. On a part-time and intermittent basis, except when full-time or 24 hour services are needed on a short term basis;
2. If continuing hospitalization would otherwise have been required if home health care were not provided;
3. Pursuant to a **Physician's** order and under a plan of care established by the responsible **Physician** in collaboration with a home health care provider, which plan shall be periodically reviewed and approved by said **Physician**. All care plans shall be established within 14 days following the commencement of home health care.

Preauthorization must be obtained from the **HMO** by the **Member's** attending **Participating Physician**. **HMO** shall not be required to provide home health benefits when **HMO** determines the treatment setting is not appropriate. Coverage for **Home Health Services** is not determined by the availability of caregivers to perform the services; the absence of a person to perform a non-skilled or **Custodial Care** service does not cause the service to become covered. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

Skilled Nursing services that require the medical training of and are provided by a licensed nursing professional are a covered benefit. Services must be provided on a part-time and intermittent basis, except when full-time or 24 hour services are needed on a short-term basis. Each visit by a member of a home health care team shall be considered as one home health care visit. Services are subject to the limits, if any, listed in the Outpatient Home Health Visits section of the Schedule of Benefits.

Outpatient home health short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Coverage is subject to the conditions and limits listed in the Outpatient Rehabilitation Benefit section of the Certificate and the Outpatient Rehabilitation section of the Schedule of Benefits.

N. **Hospice Benefits.**

Hospice Care services for a terminally ill or injured **Member** are covered when preauthorized by **HMO**. Services may include home and **Hospital** visits by nurses and social workers; pain management and symptom control; instruction and supervision of a family **Member**; inpatient care; counseling and emotional support; and other home health benefits listed above.

Coverage is not provided for bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling. Homemaker or caretaker services, and any service not solely related to the care of the **Member**, including but not limited to, sitter or companion services for the **Member** or other **Members** of the family, transportation, house cleaning, and maintenance of the house are not covered. Coverage is not provided for **Respite Care**.

O. **Orthotic or Prosthetic Appliances Benefit.**

Covered Benefits include charges incurred in obtaining orthotic or prosthetic appliances from a licensed orthotist or prosthetist or any certified pedorthist, if the appliance is determined **Medically Necessary** by the **Member's Participating Provider**.

Covered Benefits for an orthotic appliance include a brace or support. Coverage 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.

For the purposes of this section:

“Orthotic appliance” means, a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, corset shops or surgical supply facilities.

Covered Benefits for a prosthetic appliance include any artificial device that is not surgically implanted and that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, finger, feet and toes but does not include:

- Dental appliances; and
- Largely cosmetic devices such as artificial breasts, eyelashes, wigs or other devices;

which could, not by their use, have a significantly detrimental impact upon the musculoskeletal functions of the body.

For the purposes of this section:

“Prosthetic appliance” means any artificial device that is not surgically implanted and 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, or other devices which could not by their use have a significantly detrimental impact upon the muscular skeletal functions of the body.

P. Injectable Medications.

Injectable medications, except **Self-Injectable Drugs** eligible under the Prescription Drug Rider, are a **Covered Benefit**, unless specifically excluded as described in the Exclusions and Limitations section. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines, and approved in advance of treatment by **HMO**. If the drug therapy treatment is approved for self-administration, the **Member** is required to obtain covered medications at an **HMO Participating** pharmacy designated to fill injectable prescriptions.

Injectable drugs or medication used for a treatment for which it has not been approved by the FDA for that indication are covered, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or is recommended by a clinical study or review article in a major-peer reviewed professional journal. Any coverage of an injectable drug as described in this paragraph shall also include **Medically Necessary Services** associated with the administration of the injectable drug.

Q. Infertility Services.

Covered Benefits include **Infertility** services and supplies for the diagnosis and treatment of **Infertility**. Covered **Infertility** services include, and are not limited to:

- Diagnosis and diagnostic tests;
- **Prescription Drugs**;
- Surgery;
- Artificial insemination;
- In-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT)
- Ovulation induction;
- Intracytoplasmic sperm injection (ICSI);
- Fresh and cryopreserved embryo transfer;
- Assisted hatching;
- Microsurgical Sperm aspiration;
- Care of: a) a female **Member** who is participating in a donor IVF program, including fertilization and culture, the transfer of the embryo, and synchronization of the **Member's** cycle with the donor's cycle; and b) the donor until the donor is released from care by the reproductive endocrinologist; and
- Obtaining the sperm of a female **Member's** partner.

Covered Benefits will be covered on the same basis as for disease. **Infertility** services must be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

Infertility procedures involving IVF, GIFT and ZIFT are subject to the following limitations:

- These procedures are covered only if a successful pregnancy cannot be attained through all reasonable, less expensive and medically appropriate treatments available under this Certificate.
- Not more than a total of four complete egg retrievals will be covered during a female **Member's** lifetime. Egg retrievals where the cost is not covered by any plan or program will not count in determining this limitation. "Egg retrieval" is a procedure to collect eggs contained in the ovarian follicles.
- Is 45 years of age or younger.

R. **Mastectomy and Reconstructive Breast Surgery Services.**

Covered services for reconstructive breast surgery resulting from a mastectomy, on one breast or both breasts, include:

- Reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant;
- Surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed; and
- **Medically Necessary** physical therapy to treat the complications of the mastectomy, including lymphedema.

The following coverage is provided following a mastectomy:

- A minimum of 72 hours of inpatient care following a modified radical mastectomy;
- A minimum of 48 hours of inpatient care following a simple mastectomy; or
- A shorter length of stay, if the patient in consultation with the patient's **physician** determines that a shorter length of stay is medically appropriate.

S. **Additional Benefits.**

- **Subluxation Benefits.** Services by a **Participating Provider** when **Medically Necessary** and upon prior **Referral** issued by the **PCP** are covered. Services must be consistent with **HMO** guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation which could be documented by diagnostic x-rays performed by an **HMO Participating** radiologist. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

A **Copayment**, a maximum annual out-of-pocket payment, and a maximum annual benefit may apply to this service. Refer to the Schedule of Benefits attached to this **Certificate**.

- **Durable Medical Equipment Benefits.** **Durable Medical Equipment** will be provided when preauthorized by **HMO**. The wide variety of **Durable Medical Equipment** and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the **HMO** Medical Director has the authority to approve requests on a case-by-case basis. Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Certificate**. **HMO** reserves the right to provide the most cost effective item that meets the needs of the patient. The decision to rent or purchase is at the discretion of **HMO**.

Instruction and appropriate services required for the **Member** to properly use the item, such as attachment or insertion, are also covered upon preauthorization by **HMO**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **HMO** that:

1. it is needed due to a change in the **Member's** physical condition; or
2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

All maintenance and repairs that result from a misuse or abuse are a **Member's** responsibility.

A **Copayment**, a maximum annual out-of-pocket payment, and a maximum annual benefit may apply to this service. Refer to the Schedule of Benefits attached to this **Certificate**.

- **Hearing Aid Benefits.** For **Covered Dependents** age 15 years and younger, **Covered Benefits** include the cost of a **Medically Necessary** hearing aid for each ear as prescribed or recommended by a **Member's Participating Physician** or **Participating** audiologist, up to the Hearing Aid Benefit Maximum, subject to any applicable **Copayment**. **Covered Benefits** also include **Medically Necessary** services and supplies related to the hearing aid. Coverage is provided under the same terms and conditions as for any other condition.
- **Inherited Metabolic Diseases Benefit.** Coverage is provided for expenses incurred in the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products, when diagnosed and determined to be **Medically Necessary** by the **Member's Physician**. The benefits shall be provided to the same extent as for any medical condition under the **Certificate**.
- **Non-standard formulas.** Certain infant formulas are covered when:

1. the **Covered Dependent** infant (birth through 12 months) has been diagnosed as having multiple food protein intolerance and a Physician has determined that specialized, non-standard, formulas are **Medically Necessary**; and
2. the **Covered Dependent** infant (birth through 12 months) has not been responsive to trials of standard non-cow milk-based formulas including soybean and goat milk.

Specialized, non-standard, infant formulas will be provided under the same terms and conditions as provided for any other **Prescription Drug** under the Prescription Plan Rider.

- **Home Hemophilia Treatment.** Home treatment of bleeding disorders associated with hemophilia must be provided by a “designated” health care provider. A “designated” health care provider means a provider that has been approved by the New Jersey Department of Banking and Insurance to contract with carriers for the purpose of rendering services for the home treatment of bleeding episodes associated with hemophilia.

Loss of Designated Status

When a designated health care provider with which the **HMO** has arranged for the provision of services and supplies for the home treatment of bleeding episodes associated with hemophilia loses designation, the **HMO** shall not continue to refer covered persons to the services and supplies of that health care provider for home treatment of bleeding episodes associated with hemophilia.

With respect to covered persons that have been receiving services and supplies from a health care provider that has lost its designation, the **HMO** shall continue to provide services or benefits to or on behalf of the covered person at an in-network level for home treatment services and supplies, until such time as arrangements are made for the covered person to receive home treatment services and supplies from another in-network designated health care provider, or for four months following the date of the loss of designation, whichever occurs first.

The **HMO** shall not be required to continue to provide services or benefits to a covered person at an in-network level when the health provider’s loss of designation is the result of revocation or surrender of a license, permit or registration, or is the result of a suspension of a license, permit or registration that cannot be corrected by reinstatement within 45 days following the date of the suspension, except as may be necessary for the carrier and health care provider to transition the covered person’s care to another designated health care provider.

Termination of the Agreement for services and supplies for home treatment of bleeding episodes associated with Hemophilia

In the event that the **HMO** or a designated health care provider terminates their agreement for, or which includes among its terms, the provisions of services and supplies to the **HMO Member** for home treatment of bleeding episodes associated with hemophilia, **HMO** shall continue to provide services or benefits to or on behalf of a **Member** at an in-network level until the end of four months following the date of termination, or until arrangements are made for the **Member** to obtain home treatment services and supplies from another in-network designated health care provider, whichever occurs first. The requirements above shall not apply when the agreement terminates on the basis of breach, fraud, or a determination by the **HMO’s** medical director that the health care provider is an imminent danger to one or more covered persons, whether such breach, fraud or imminent harm is related to the provision of services or supplies for

home treatment of bleeding episodes associated with hemophilia, or other services and supplies for which the **HMO** and health care provider have an agreement.

EXCLUSIONS AND LIMITATIONS

A. Exclusions.

The following are not **Covered Benefits** except as described in the Covered Benefits section of this **Certificate** or by a rider attached to this **Certificate**:

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Beam neurologic testing.
- Behavioral Health Services:
 - Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field;
 - Treatment in wilderness programs or other similar programs.
- Biofeedback, except as specifically approved by **HMO**.
- Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local law requires to be treated in a public facility, including but not limited to, mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Certain Transplant Occurrence related services or supplies including: Treatment furnished to a donor when the **Transplant** recipient is not a **Member**; services and supplies, including the harvesting or storage of organs without the expectation of immediate transplantation for an existing illness; harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness; outpatient prescription drugs not expressly related to an outpatient **Transplant Occurrence**; and home infusion therapy.
- **Cosmetic** services and plastic surgery (except coverage will be provided for covered newborns from the moment of birth for the **Medically Necessary** care and treatment of medically diagnosed congenital defects and birth abnormalities): any treatment, surgery (**cosmetic** or plastic), service or supply to alter the shape or appearance of the body except as specifically described under the **Covered Benefits** section including:
 - Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
 - Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
 - Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the

- skin unless it is due to an accidental injury that occurred within the last two years or part of a staged reconstructive surgery schedule;
 - Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **Medically Necessary**;
 - Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy);
 - Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices.
- Costs for services resulting from the commission or attempt to commit a felony or to which a contributing cause was the covered person's engagement in an illegal occupation. This exclusion will not operate to deny benefits otherwise provided for treatment of an injury if the injury results from an act of domestic violence or medical condition (including both physical and mental health conditions.).
- Court-ordered services, or those required by court order as a condition of parole or probation.
- **Custodial Care.**
- Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors or orthodontogenic cysts.
- **Durable Medical Equipment**, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a **Member's** house or place of business, and adjustments made to vehicles.
- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered. The item above does not apply to the treatment of **Mental Disorders**, including pervasive developmental disorders and autism.
- **Experimental or Investigational Procedures**, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by **HMO**, unless approved by **HMO** prior to the treatment being rendered.

This exclusion will not apply with respect to drugs:

1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;

2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
 3. **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
- False teeth.
 - Family planning services.
 - Hair analysis.
 - Health services, including those related to pregnancy, rendered before the effective date or after the termination of the **Member's** coverage, unless coverage is continued under the Continuation section of this **Certificate**.
 - Hearing aids, except as provided under the **Covered Benefits** section of this **Certificate**.
 - Household equipment, including but not limited to, the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds.
 - Household fixtures, including but not limited to, the purchase or rental of escalators, elevators, and swimming pools.
 - Hypnotherapy, except when specifically approved by **HMO**.
 - Implantable drugs.
 - **Infertility** services and supplies except as described in the **Covered Benefits** section of this **Certificate**, and
 - Reversal of prior voluntary sterilization procedures;
 - Services rendered to a surrogate for the purposes of childbearing, if the surrogate is not a **Member**;
 - Charges associated with cryopreservation, storage of cryopreserved sperm, eggs, or embryos;
 - Non-medical costs of an egg or sperm donor;
 - **Infertility treatments** that are **Experimental or Investigational** in nature;
 - Home ovulation predictor kits, sperm testing kits and supplies;
 - In-vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), and zygote intrafallopian tube transfer (ZIFT) for **Members** who have not used all reasonable less expensive and medically appropriate treatments for **Infertility**, who have exceeded the limit of four covered completed egg retrievals, or who are 46 years of age, or older;
 - **Prescription Drugs** related to treatment of non-covered benefits or related to treatment of **Infertility** that are not **Medically Necessary**;
 - **Infertility Prescription Drugs** to the extent covered elsewhere under the **Group Agreement**, or under another Group Agreement or Group Policy sponsored by the **Contract Holder**;
 - Any charges associated with obtaining sperm for non-covered **Members**;
 - Gestational carrier programs, except for embryo transfers; and
 - Any service provided by a non-participating **Provider**, or any service provided without a prior **Referral**.

- Military service related diseases, disabilities or injuries for which the **Member** is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the **Member**.
- Missed appointment charges, including any charge incurred for a missed appointment with a **Participating Provider**.
- Non-medically necessary services, including but not limited to, those services and supplies:
 1. which are not **Medically Necessary**, as determined by **HMO**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
 2. that do not require the technical skills of a medical, mental health or a dental professional;
 3. furnished mainly for the personal comfort or convenience of the **Member**, or any person who cares for the **Member**, or any person who is part of the **Member's** family, or any **Provider**;
 4. furnished solely because the **Member** is an inpatient on any day in which the **Member's** disease or injury could safely and adequately be diagnosed or treated while not confined;
 5. furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Physician's** or a dentist's office or other less costly setting.
- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Outpatient prescription or non-prescription drugs and medicines; except diabetic and infertility drugs as noted in the **Covered Benefits** section.
- Outpatient supplies, including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips; except those supplies otherwise covered for diabetes.
- When a person is or could have been covered with respect to Part B of Medicare and did not enroll in Part B of Medicare, Aetna may reduce your claim. Please refer to the Coordination of Benefits Section in your **Certificate**.
- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.
- Private Duty Nursing (See the Home Health Benefits section regarding coverage of nursing services).

- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational, and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.
- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.
- Routine foot/hand care, including routine reduction of nails, calluses and corns.
- Services for which a **Member** is not legally obligated to pay in the absence of this coverage.
- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Services performed by a relative of a **Member** for which, in the absence of any health benefits coverage, no charge would be made.
- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.
- Services which are not a **Covered Benefit** under this **Certificate**, even when a prior **Referral** has been issued by a **PCP**.
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Specific injectable drugs, including:
 1. experimental drugs or medications;
 2. needles, syringes and other injectable aids except those for diabetes;
 3. drugs related to the treatment of non-covered services.
- Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- Therapy or rehabilitation, including but not limited to, primal therapy, chelation therapy (except for the treatment of lead-poisoned children), rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide unless specifically listed in the Covered Benefits Section of the **Certificate**.
- Thermograms and thermography.

- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member's** physical characteristics from the **Member's** biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment of mental retardation. This exclusion does not apply to mental health services or to medical treatment of mentally retarded **Members** in accordance with the benefits provided in the Covered Benefits section of this **Certificate**.
- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. However, if proof is furnished to **HMO** that the **Member** is covered under a workers' compensation law or similar law, but is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause.
- Treatment of spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or dislocation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column.
- Unauthorized services, including any service obtained by or on behalf of a **Member** without prior **Referral** issued by the **Member's PCP** or certified by **HMO**. This exclusion does not apply in a **Medical Emergency**, in an **Urgent Care** situation, or when it is a direct access benefit.
- Vision care services and supplies, except as specified in the **Covered Benefits** section.
- Weight Reduction Programs: Any treatment, drug, service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of co-morbid conditions; except as provided by this **Certificate**, including but not limited to:
 - Drugs, stimulants, preparations, food or diet supplements, dietary regimens and supplements, food or food supplements (will not apply to the dietary treatment of a disease or condition based on Inherited Metabolic disease), appetite suppressants and other medications;
 - Counseling, coaching, training, hypnosis or other forms of therapy except as provided in an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including nutrition and diet recommendations, exercise plans and weight control; and
 - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.
- Acupuncture and acupuncture therapy, except when performed by a **Participating Physician** as a form of anesthesia in connection with covered surgery.
- Temporomandibular joint disorder treatment (TMJ), including treatment performed by prosthesis placed directly on the teeth.

B. Limitations.

- In the event there are two or more alternative **Medical Services** which in the judgment of **HMO** are equivalent in quality of care (subject to the Level One and Two Appeals Procedure and the External Appeal Process sections of this Certificate), **HMO** reserves the right to provide coverage only for the least costly **Medical Service**, as determined by **HMO**, provided that **HMO** approves coverage for the **Medical Service** or treatment in advance.
- Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **Certificate** are at the discretion of **HMO**, subject to the terms and the Appeals Procedure section of this **Certificate**.
- Infertility procedures involving IVF, GIFT and ZIFT are subject to the following limitations:
 - These procedures are covered only if a successful pregnancy cannot be attained through all reasonable, less expensive and medically appropriate treatments available under this Certificate.
 - Not more than a total of four complete egg retrievals will be covered during a female Member's lifetime. Egg retrievals where the cost is not covered by any plan or program will not count in determining this limitation. "Egg retrieval" is a procedure to collect eggs contained in the ovarian follicles.
 - Is 45 years of age or younger.

DETERMINATIONS REGARDING DENIAL OF BENEFITS DUE TO INAPPROPRIATE USE OF THE HMO NETWORK ARE AT THE DISCRETION OF THE HMO, SUBJECT TO THE APPEALS PROCEDURE SECTION OF THIS CERTIFICATE.

TERMINATION OF COVERAGE

A **Member's** coverage under this **Certificate** will terminate upon the earliest of any of the conditions listed below, and termination will be effective on the date indicated on the Schedule of Benefits.

A. Termination of Subscriber Coverage.

A **Subscriber's** coverage will terminate for any of the following reasons:

1. employment terminates;
2. the **Group Agreement** terminates;
3. non-payment of applicable premium;
4. the **Subscriber** is no longer eligible as outlined on the Schedule of Benefits; or
5. the **Subscriber** becomes covered under an alternative health benefit plan or under any other plan which is offered by, through, or in connection with, the **Contract Holder** in lieu of coverage under this **Certificate**.

B. Termination of Dependent Coverage.

A **Covered Dependent's** coverage will terminate for any of the following reasons:

1. a **Covered Dependent** is no longer eligible, as outlined on the Schedule of Benefits;
2. the **Group Agreement** terminates; or
3. the **Subscriber's** coverage terminates.

C. Termination For Cause.

HMO may terminate coverage for cause:

1. Subject to the Complaint and Appeals procedures described in this **Certificate**, upon 31 days' advance written notice, if the **Member** has failed to make any required **Copayment** or any other payment which the **Member** is obligated to pay. Upon the effective date of such termination, pre-payments received by **HMO** on account of such terminated **Member** or **Members** for periods after the effective date of termination shall be refunded to **Contract Holder**.
2. immediately, upon discovering a material misrepresentation by the **Member** in applying for or obtaining coverage or benefits under this **Certificate** or discovering that the **Member** has committed fraud against **HMO**. This may include, but is not limited to, furnishing incorrect or misleading information to **HMO**, or allowing or assisting a person other than the **Member** named on the identification card to obtain **HMO** benefits. **HMO** may, at its discretion, rescind a **Member's** coverage on and after the date that such misrepresentation or fraud occurred. It may also recover from the **Member** the reasonable and recognized charges for **Covered Benefits**, plus **HMO's** cost of recovering those charges, including reasonable attorneys' fees. In the absence of fraud or material misrepresentation, all statements made by any **Member** or any person applying for coverage under this **Certificate** will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will result in the termination of coverage or reduction of benefits unless the statement is contained in writing and signed by the **Member**, and a copy of same has been furnished to the **Member** prior to termination;
3. Subject to the Complaint and Appeals procedures in this **Certificate**, upon 31 days' advance written notice for failure to abide by the rules and/or policies and procedures of the **HMO**.

HMO shall have no further liability or responsibility under this **Certificate** except for coverage for **Covered Benefits** provided prior to the date of termination of coverage.

The fact that **Members** are not notified by the **Contract Holder** of the termination of their coverage due to the termination of the **Group Agreement** shall not deem the continuation of a **Members'** coverage beyond the date coverage terminates.

A **Member** may register a **Complaint** with **HMO**, as described in the Claim Determination Procedures/Complaints and Appeals section of this **Certificate**, after receiving notice that **HMO** has or will terminate the **Member's** coverage as described in the Termination For Cause subsection of the **Certificate**. **HMO** will continue the **Member's** coverage in force until a final decision on the **Complaint** is rendered, provided the **Premium** is paid throughout the period prior to the issuance of that final decision. **HMO** may rescind coverage, to the date coverage would have terminated had the **Member** not registered a **Complaint** with **HMO**, if the final decision is in favor of **HMO**. If coverage is rescinded, **HMO** will refund any

Premiums paid for that period after the termination date, minus the cost of **Covered Benefits** provided to a **Member** during this period.

Coverage will not be terminated on the basis of a **Member's** health status or health care needs, nor if a **Member** has exercised the **Member's** rights under the **Certificate's** Claim Determination Procedures/Complaints and Appeals section to register a **Complaint** with **HMO**. The **Complaint** process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination for Cause subsection of this **Certificate**.

CONTINUATION

A. COBRA Continuation Coverage.

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986. This Act permits **Members** or **Covered Dependents** to elect to continue group coverage as follows:

Employees and their Covered Dependents will not be eligible for the continuation of coverage provided by this section if the Contract Holder is exempt from the provisions of COBRA.

1. Minimum Size of Group:

The **Contract Holder** must have normally employed more than 20 employees on a typical business day during the preceding calendar year. This refers to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

2. Loss of coverage due to termination (other than for gross misconduct) or reduction of hours of employment:

Member may elect to continue coverage for 18 months after eligibility for coverage under this **Certificate** would otherwise cease.

3. Loss of coverage due to:

- a. divorce or legal separation, or
- b. **Subscriber's** death, or
- c. **Subscriber's** entitlement to Medicare benefits, or,
- d. cessation of **Covered Dependent** child status under the Eligibility and Enrollment section of this **Certificate**:

The **Member** may elect to continue coverage for 36 months after eligibility for coverage under this **Certificate** would otherwise cease.

4. Continuation coverage ends at the earliest of the following events:
 - a. the last day of the 18-month period.
 - b. the last day of the 36-month period.
 - c. the first day on which timely payment of **Premium** is not made subject to a Grace Period of 30 days.
 - d. the first day on which the **Contract Holder** ceases to maintain any group health plan.
 - e. the first day on which a **Member** is actually covered by any other group health plan. In the event the **Member** has a pre-existing condition, and the **Member** would be denied coverage under the new plan for a pre-existing condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the **Member's** pre-existing condition becomes covered under the new plan, whichever occurs first.
 - f. the day after the qualifying event that a **Member** is first entitled to Medicare.

5. Extensions of Coverage Periods:
 - a. The 18-month coverage period may be extended if an event which would otherwise qualify the **Member** for the 36-month coverage period occurs during the 18-month period, but in no event may coverage be longer than 36 months from the event which qualified the **Member** for continuation coverage initially.
 - b. In the event that a **Member** is determined, within the meaning of the Social Security Act, to be disabled and notifies the **Contract Holder** before the end of the initial 18-month period, continuation coverage may be extended up to an additional 11 months for a total of 29 months. This provision is limited to **Members** who are disabled at any time during the first 60 days of continuation coverage under this subsection (A) and only when the qualifying event is the **Members** reduction in hours or termination. The **Member** may be charged a higher rate for the extended period.

6. Responsibility to provide **Member** with notice of Continuation Rights:

The **Contract Holder** is responsible for providing the necessary notification to **Members**, within the defined time period (forty-four (44) days), as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

7. Responsibility to pay **Premiums** to **HMO**:

Coverage for the sixty (60) day period as described above to initially enroll, will be extended only where the **Subscriber** or **Member** pays the applicable **Premium** charges due within forty-five (45) days measured from the date of the election and the submitting of the application to the **Contract Holder** and **Contract Holder** in turn remitting same to **HMO**.

8. **Premiums** due **HMO** for the continuation of coverage under this section shall be due in accordance with the procedures of the Premiums section of the **Group Agreement** and shall be calculated in accordance with applicable federal law and regulations.

A **Subscriber**, who is a Civil Union partner, who is eligible for COBRA continuation of coverage may elect COBRA continuation of coverage for the **Subscriber** and the **Subscriber's Covered Dependent**, including a Civil Union partner. However, a **Covered Dependent** who is a Civil Union partner, may not make a COBRA continuation of coverage election for themselves and their eligible dependents after any event that would otherwise give rise to COBRA rights, as they do not meet the federal definition of a "qualified beneficiary" under COBRA rules.

B. Continuation Coverage for Dependents.

If a **Subscriber** dies while covered under this plan, any coverage then in force for the **Covered Dependents** will be continued, provided the **Contract Holder** continues to make **Premium** payments. A **Subscriber's** spouse's coverage will cease when the spouse remarries. Any **Covered Dependent's** coverage, including a spouse's, will cease upon the earliest of:

1. the end of the 12 month period right after the **Subscriber's** death;
2. a **Covered Dependent** no longer meets the eligibility requirements as outlined on the Schedule of Benefits;
3. a **Covered Dependent** becomes eligible for like coverage under this Plan or any other plan providing group health benefits.
4. when the **Contract Holder** no longer provides coverage for the class of eligible enrollees of which the **Subscriber** was part of right before the **Subscriber's** death; or
5. any required contributions cease.
6. If coverage is being continued for a **Covered Dependent**, a child born after the **Subscriber's** death will also be covered.

Continuation Coverage for Dependent Students on Medical Leave of Absence

If a **Member**, who is eligible for coverage and enrolled in **HMO** by reason of his or her status as a full-time student at a postsecondary educational institution, ceases to be eligible due to:

1. a medically necessary leave of absence from school; or
2. a change in his or her status as a full-time student,

resulting from a serious illness or injury, such **Member's** coverage under this **Certificate** may continue.

Any **Covered Dependent's** coverage provided under this continuation provision will cease upon the first to occur of the following events:

1. the end of the 12 month period following the first day of the dependent child's leave of absence from school, or change in his or her status as a full-time student;
2. the dependent child's coverage would otherwise end under the terms of this plan; or
3. the **Subscriber** fails to make any required premium payments toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence or the change in his or her status as a full-time student.

In order to continue coverage for a dependent child under this provision, the **Subscriber** must notify the **Contract Holder** as soon as possible after the child's leave of absence begins or a change in full time student status occurs. **HMO** may require a written certification from the treating **physician** which states that the child is suffering from a serious illness or injury and that the resulting leave of absence (or other change in full-time student status) is medically necessary.

If:

1. a dependent child's eligibility under a prior plan is a result of his or her status as a full-time student at a postsecondary educational institution; and
2. such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and
3. this plan provides coverage for eligible dependents;

coverage under **HMO** will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided above.

C. **New Jersey Continuation Rights for Over-Age Dependents**

As used in this provision, "Over-Age Dependent" means a **Subscriber's** child by blood or law who:

- has reached the limiting age as described in the Dependent Eligibility section of the Schedule of Benefits, but is less than 31 years of age;
- is not married or in a domestic partnership or civil union partnership;
- has no Dependents of his or her own;
- is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and
- is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

If A Dependent Is Over the Limiting Age for Dependent Coverage

If a Dependent Child is over the limiting age for dependent coverage and:

- the Dependent child's group health benefits are ending or have ended due to his or her attainment of the limiting age; or
- the Dependent child has proof of prior creditable coverage or receipt of benefits, he or she may elect to be covered under the **Contract Holder's** plan until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends section below.

Conditions for Election

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

- The Over-Age Dependent must provide evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare. Such prior coverage must have been effect at some time prior to making an election for this Over-Age Dependent coverage,
- A parent of an Over-Age Dependent must be enrolled as having elected dependent coverage at the time the Over-Age Dependent elects continued coverage. Except, if the Subscriber has no other Dependents, or has a Spouse who is covered elsewhere, the Over-Age Dependent may nonetheless select continued coverage.

Election of Continuation

- To continue group health benefits, the Over-Age Dependent, whose coverage under the plan terminated due to reaching the limiting age before the dependent's 31st birthday, may make a written election for coverage.

The effective date of the continued coverage will be the later of:

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

For a dependent whose coverage has not yet terminated due to the attainment of the limiting age, the written election must be made within 30 days prior to termination of coverage due to attainment of the limiting age if the Dependent child seeks to maintain continuous coverage. The written election may be made later, and if made later would result in a lapse of coverage. See the Application of a Pre-Existing Conditions Exclusion section below.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made at any time. See the Application of a Pre-Existing Conditions Exclusion section below.

For a person who did not qualify as an Over-Age Dependent because he or she failed to meet all requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election may be made at any time after the person meets all of the requirements of an Over-Age Dependent. See the Application of a Pre-Existing Conditions Exclusion section below.

Application of a Pre-Existing Conditions Exclusion

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

Payment of Premium

The first month's premium will be determined by the effective date the Over-Age Dependent elects to continue coverage.

The Over-Age Dependent must pay subsequent premiums monthly, in advance, at the times and in the manner specified by **HMO**. The monthly premium will be set by the **HMO**, and must be consistent with the requirements of P.L. 2005, c. 375.

Payment of Premiums Grace Period

An Over-Age Dependent's premium payment is timely if, with respect to the first payment after the Over-Age Dependent elects to continue, such payment is made no later than 31 days after such billing due date. In all other cases, such premium payment is timely if it is made within 31 days of the date it is due.

The Continued Coverage

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

When Continuation Ends

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

- the date the Over-Age Dependent:
 1. attains age 31;
 2. marries or enters into a civil union partnership;
 3. acquires a Dependent;
 4. is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
 5. becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare
- the end of the period for which premium has been paid for the Over-Age Dependent, subject to the Grace Period for such payment;
- the date the plan ceases to provide coverage to the Over-Age Dependent's parent who is the **Subscriber** under the plan.
- The date the plan under which the Over-Age Dependent elected to continue coverage is amended to eliminate coverage for Dependents.
- The date the Over-Age Dependent's parent who is covered as a **Subscriber** under the plan waives Dependent coverage. Except, if the **Subscriber** has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the **Subscriber** waiving Dependent coverage.

Important Note:

- Once the **Contract Holder** has validated the parent of an Over-Age Dependent is covered under the plan, the *Temporary HINT Supplemental Enrollment Information Form* must be completed by the enrollee and submitted to **HMO** according to the timeframes identified in the "Election of Continuation" section shown above.
- An Over-Age Dependent while being issued continued coverage as an Over-Age Dependent is not considered to be a **Subscriber**.
- **HMO** will bill the covered Over-Age Dependent, directly and enrollees will remit the premium directly to **HMO**. Enrollees will be required to enter an address on the *Temporary HINT Supplemental Enrollment Information Form* even when it is the same as the **Subscribers** address.
- Although the **Subscriber** must continue eligibility under the Group plan for continued coverage of the dependent, the dependent must also meet the applicable eligibility criteria. All cost sharing requirements and limitations will apply, and will not be aggregated with the **Subscriber's** plan. Consequently, **Covered Benefits** incurred by the dependent will not contribute towards the family deductible and Out-of-Pocket Maximums, nor will family incurred expenses contribute towards the Over-Age Dependent's deductibles or Out-of-Pocket Maximums.
- Any deductible or Out-of-Pocket Maximums that the Over-Age Dependent satisfied as a Dependent under the group plan will not be used to satisfy the applicable deductible or Out-of-Pocket Maximum cost sharing for the continued coverage for the Over-Age Dependent. The Over-Age Dependent will need to satisfy any applicable deductible and Out-of-Pocket Maximum under the Over-Age Dependent Continuation Coverage.
- The Termination of Coverage section of the **Certificate** does not apply to an Over-Age Dependent. The Over-Age Dependent should refer to the New Jersey Continuation Rights for Over-Age Dependents and the section titled "When Continuation Ends."
- Over-Age Dependents who have made an Election for Continuation and whose coverage is later terminated under the New Jersey Continuation Rights for Over-Age Dependents

are not eligible for the continuation provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or New Jersey Continuation under the group plan.

- The Dependent Eligibility section in the group Schedule of Benefits does not apply to the Over-Age Dependent. The first provision in the New Jersey Continuation Rights for Over-Age Dependents above, defines an Over-Age Dependent eligibility.
- A dependent of an Over-Age Dependent will not be covered for any **Covered Benefits** in the **Certificate**. This would also include any newborn children.

D. Continuation of Coverage During Temporary Lay-off or Approved Leave of Absence.

If a **Subscriber's** coverage would terminate due to a temporary lay-off or an approved leave of absence, coverage may be continued for up to 60 days, or as otherwise agreed upon by the **Contract Holder** and **HMO**, if the **Contract Holder**: (1) pays the **Premium** for such continued coverage; and (2) provides continued coverage from **HMO** or its other sponsored health benefit plans to all eligible enrollees in the same class as the **Subscriber** whose coverage would otherwise terminate because of a temporary lay-off or approved leave of absence.

E. Extension of Benefits While Member is Receiving Inpatient Care.

Any **Member** who is receiving inpatient care in a **Hospital** or **Skilled Nursing Facility** on the date coverage under this **Certificate** terminates is covered in accordance with the **Certificate** until the earlier of:

1. the date of discharge from such inpatient stay; or
2. determination by the **HMO** Medical Director in consultation with the attending **Physician**, that care in the **Hospital** or **Skilled Nursing Facility** is no longer **Medically Necessary**; or
3. the date the contractual benefit limit has been reached.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation of coverage under any New Jersey Continuation law or COBRA, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for any continuation plan selected by the **Member**.

F. Extension of Benefits Upon Total Disability.

Any **Member** who is **Totally Disabled** on the date coverage under this **Certificate** terminates is covered in accordance with the **Certificate**.

This extension of benefits shall only:

1. provide **Covered Benefits** that are necessary to treat medical conditions as determined by **HMO**; and
2. remain in effect until the earlier of the date that:
 - a. the **Member** is no longer **Totally Disabled**; or
 - b. the **Member** has exhausted the **Covered Benefits** available for treatment ; or
 - c. the **Member** has become eligible for coverage from another health benefit plan which does not exclude coverage for the disabling condition; or
 - d. after a period of twelve (12) months in which benefits under such coverage are provided to the **Member**.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation of coverage under any New Jersey Continuation law or COBRA, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for any continuation plan selected by the **Member**.

G. Discontinuance and Replacement Provisions.

- (a) This section shall determine a carrier's liability where one carrier's policy or contract replaces another carrier's plan providing similar types of coverage.
- (b) The prior carrier remains liable only to the extent of its accrued liabilities and extension of benefits. The position of the prior carrier shall be the same whether the group policyholder, contractholder, or other entity secures replacement coverage from a new carrier, self-funds, or foregoes the provision of coverage.
- (c) The liability of the succeeding carriers are governed by the following:
 - 1. Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits (in respect of classes eligible and actively at work to the extent permitted by State and Federal law) shall be covered by that carrier's plan of benefits.
 - 2. Each person not covered under the succeeding carrier's plan of benefits in accordance with (c) 1 above shall be covered by the succeeding carrier in accordance with the following rules if such individual was validly covered (including benefit extension) under the prior plan on the date of discontinuance and if such individual is a member of the class or classes of individuals eligible for coverage under the succeeding carrier's plan. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding carrier's coverage becomes effective:
 - i. The minimum level of benefits or services or supplies to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits payable or services or supplies provided by the prior plan;
 - ii. Coverage shall be provided by the succeeding carrier until at least the earliest of the following:
 - (1) The date the individual becomes eligible under the succeeding carrier's plan as described in paragraph 1 above;
 - (2) For each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding carrier's plan provision applicable to individual termination of coverage (for example, at termination of employment or ceasing to be an eligible dependent, as the case may be);
 - (3) In the case of an individual who was totally disabled, and in the case of a type of coverage for which New Jersey law requires an extension of accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by New Jersey law,
 - 3. With respect to group medical insurance, any preexisting condition, limitation or exclusion in the succeeding carrier's plan applicable to person's becoming covered by the succeeding carrier's plan shall be reduced or eliminated for each person separately on the basis of each person's creditable coverage pursuant to New Jersey law.
 - 4. The succeeding carrier, in applying any deductible or waiting period in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. If applicable, the definition of waiting periods includes, but is not limited to, the period of time required to be satisfied before maternity benefits or coverage becomes available. The aggregate period of time may be the greater of that required by either the

prior plan or the succeeding plan. But in any event, the aggregate period of time will be satisfied by taking into consideration the full portion of the waiting period satisfied under the prior plan. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provision's of the prior carrier's plan during the 90 days preceding the effective date of the succeeding carrier's plan, but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to the a similar deductible provision.

5. In any situation where determination of the prior carrier's benefit or coverage is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits or coverage available or pertinent information sufficient to permit verification of the benefit or coverage or the determination itself by the succeeding carrier.

CLAIM DETERMINATION PROCEDURES/COMPLAINTS AND APPEALS

CLAIM DETERMINATION PROCEDURES

A claim occurs whenever a **Member** or the **Member's** authorized representative, such as a **Participating Provider**, requests pre-authorization as required by the plan from **HMO**, a **Referral** as required by the plan from a **Participating Provider** or requests payment for services or treatment received. As an **HMO Member**, most claims do not require forms to be submitted. However, if a **Member** receives a bill for **Covered Benefits**, the bill must be submitted promptly to the **HMO** for claim determination and payment. Send the itemized bill for payment with the **Member's** identification number clearly marked to the address shown on the **Member's** ID card. Claim payment will be made in accordance with the Claim Payment Procedure section of the **Certificate**.

The **HMO** will make a decision on the **Member's** claim. For urgent care claims and pre-service claims, the **HMO** will send the **Member** written notification of the determination, whether adverse or not adverse. For other types of claims, the **Member** may only receive notice if the **HMO** makes an adverse benefit determination.

Adverse benefit determinations are decisions made by the **HMO** that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- **Utilization Review.** **HMO** determines that the service or supply is not **Medically Necessary** or are **Experimental or Investigational Procedures**;
- **No Coverage.** **HMO** determines that a service or supply is not covered by the plan. A service or supply is not covered if it is not included in the list of **Covered Benefits**;
- it is excluded from coverage;
- an **HMO** limitation has been reached; or
- **Eligibility.** **HMO** determines that the **Subscriber** or **Subscriber's Covered Dependents** are not eligible to be covered by the **HMO**.

All adverse benefit determinations related to Utilization Review (to deny or limit an admission; deny services as not medically necessary) will be rendered by a **Physician**.

Written notice of an adverse benefit determination will be provided to the **Member** within the following time frames. Under certain circumstances, these time frames may be extended. The notice will provide important information that will assist the **Member** in making an **Appeal** of the adverse benefit determination, if the **Member** wishes to do so. Please see the Complaints and Appeals section of this **Certificate** for more information about **Appeals**.

<u>HMO Timeframe for Notification of an Adverse Benefit Determination</u>	
Type of Claim	HMO Response Time from Receipt of Claim
Urgent Care Claim. A claim for medical care or treatment of a non-life threatening condition that requires care by a Provider within 24 hours.	As soon as possible but not later than 72 hours
Pre-Service Claim. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.	Within 5 business days
Concurrent Care Claim Extension. A request to extend a course of treatment previously pre-authorized by HMO .	If an urgent care claim or an inpatient hospital confinement, as soon as possible but not later than 24 hours. Otherwise, within 15 calendar days
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously pre-authorized by HMO due to fraud by the covered person or participating provider.	Treated like a Level 1 Appeal for Urgent Care Claim
Post-Service Claim. A claim for a benefit that is not a pre-service claim.	As soon as possible but not later than 30 calendar days

COMPLAINTS AND APPEALS

HMO has procedures for **Members** to use if they are dissatisfied with a decision that the **HMO** has made or with the operation of the **HMO**. The procedure the **Member** needs to follow will depend on the type of issue or problem the **Member** has.

- **Appeal.** An **Appeal** is a request to the **HMO** to reconsider an adverse benefit determination. The **Appeal** procedure for an adverse benefit determination has two levels.
- **Complaint.** A **Complaint** is an expression of dissatisfaction about quality of care or the operation of the **HMO**.

A. **Complaints.**

If the **Member** is dissatisfied with the administrative services the **Member** receives from the **HMO** or wants to complain about a **Participating Provider**, call or write Member Services within 30 calendar days of the incident. The **Member** will need to include a detailed description of the matter and include copies of any records or documents that the **Member** thinks are relevant to the matter. The **HMO** will review the information and provide the **Member** with a written response within 30 calendar days of the receipt of the **Complaint**, unless additional information is needed and it cannot be obtained within this time frame. The response will tell the **Member** what the **Member** needs to do to seek an additional review.

B. **Appeals of Adverse Benefit Determinations.**

The **Member** will receive written notice of an adverse benefit determination from the **HMO**. The notice will include the reason for the decision and it will explain what steps must be taken if the

Member wishes to **Appeal**. The notice will also identify the **Member's** rights to receive additional information that may be relevant to an **Appeal**. Requests for an **Appeal** must be made in writing within 180 calendar days from the date of the notice. However, Level One Appeals may also be requested orally.

A **Member**, or a **Provider** acting on behalf of a **Member** and with the **Member's** consent, dissatisfied with a utilization management adverse benefit determination will have the opportunity to **Appeal**.

The **HMO** provides for two levels of **Appeal** of the adverse benefit determination. The **Member** must complete the two levels of **HMO** review before pursuing an **Appeal** to an independent utilization review organization (IURO) or bringing a lawsuit against the **HMO**, unless serious or significant harm to the **Member** has occurred or will imminently occur. If the **Member** decides to **Appeal** to the second level, the request must be made in writing within 60 calendar days from the date of the **HMO's** notice at the conclusion of the Level One **Appeal** explaining the **Member's** right to make a Level Two **Appeal**. Within 10 business days of receipt of a Level Two **Appeal**, the **HMO** will acknowledge the **Appeal** in writing.

The Level One **Appeal** review will be conducted by a **Physician** who was not the original reviewer nor a subordinate of the original reviewer who rendered the initial adverse benefit determination.

For a Level Two **Appeal**, the **HMO** will conduct a same or similar specialty review for Appeals involving clinical issues before a panel of **Physicians** and/or other health care professionals selected by **HMO** who have not been involved in any of the previous utilization management decisions.

The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

<u>HMO Timeframe for Responding to an Adverse Benefit Determination Appeal</u>		
Type of Claim	Level One Appeal HMO Response Time from Receipt of Appeal	Level Two Appeal HMO Response Time from Receipt of Appeal
Urgent Care Claim. A claim for medical care or treatment of a non-life threatening condition that requires care by a Provider within 24 hours.	Within 36 hours Review provided by HMO personnel not involved in making the adverse benefit determination.	Within 24 hours Review provided by HMO Appeals Committee.
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 5 business days Review provided by HMO personnel not involved in making the adverse benefit determination.	Within 5 business days Review provided by HMO Appeals Committee.
Concurrent Care Claim Extension. A request to extend or a decision to reduce a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim depending on the circumstances	Treated like an urgent care claim or a pre-service claim depending on the circumstances
Post-Service Claim. Any claim for a benefit that is not a pre-service claim.	Within 5 business days Review provided by HMO personnel not involved in making the adverse benefit determination.	Within 15 business days Review provided by HMO Appeals Committee.

HMO maintains a formal Internal Utilization Management **Appeal** process (Level Two) whereby any **Member** or **Provider** acting on behalf of a **Member** with the **Member's** consent, who is dissatisfied with the results of a Level One **Appeal**, shall have the opportunity to pursue his or her **Appeal** before a panel of **Physicians** and/or other health care professionals selected by **HMO** who have not been involved in any of the previous utilization management decisions. The **Member** and/or an authorized representative may attend the Level Two **Appeal** hearing and question the representatives of **HMO** and present his/her case.

C. **Exhaustion of Process.**

You may contact the New Jersey Department of Banking and Insurance to file a complaint/appeal or, request an investigation of a complaint/appeal at any time. You are not required to exhaust the Level One and Level Two appeals process before contacting the New Jersey Department of Banking and Insurance.

Unless serious or significant harm has occurred or will imminently occur to you, you must exhaust an appeal through the Independent Health Care Appeals Program before you establish any litigation; arbitration; or administrative proceeding; regarding an alleged breach of the policy terms by **HMO**; or any matter within the scope of the appeals procedure.

In the event that **HMO** fails to comply with any of the deadlines for completion of the Level One **Appeal** or Level Two **Appeal**, or in the event that **HMO**, for any reason, expressly waives its rights to an internal review of any **Appeal**, then the **Member** and/or **Provider** shall be relieved of their obligation to complete the **HMO** internal review process and may, at their option, proceed directly to the external appeals process set forth in section D below.

D. External Appeal Process.

Any **Member**, or any **Provider** acting on behalf of a **Member**, with the **Member's** consent, who is dissatisfied with the result of the Level One **Appeal** and Level Two **Appeal** process above, shall have the right to pursue their appeal to an independent utilization review organization (IURO) in accordance with the procedures set forth below. Except as set forth in section C above, the right to an external appeal under this section shall be contingent upon the **Member's** full compliance with both stages of the **HMO** Level One and Level Two **Appeal** processes, except that you and any **Provider** acting on your behalf with your consent shall be relieved of the carrier's internal **appeal** process and may pursue an **appeal** through the Independent Health Care Appeals program if:

- A determination on any **appeal** regarding urgent or **emergency care** is not forthcoming from **HMO** within 72 hours or receipt by **HMO** of notice (in the manner required under the plan) of the **appeal**;
 - A determination on an initial **appeal**, other than one regarding urgent or **emergency care**, is not forthcoming from **HMO** within 5 business days of the date that **HMO** received notice (in the manner required under the plan) of the **appeal**; or
 - A determination of a subsequent level of **appeal**, other than one regarding urgent or **emergency care**, is not forthcoming from **HMO** within 20 business days of the date that **HMO** received notice (in the manner required under the plan) of the **appeal**.
1. Within 60 calendar days from receipt of the written determination of the Level Two **Appeal** panel, the **Member**, or a **Provider** acting on behalf of the **Member** with the **Member's** consent, shall file a written request with the New Jersey Department of Banking and Insurance. The request shall be filed on forms, if applicable, provided to the **Member** by **HMO** and include both a filing fee and a general release executed by the **Member** for all medical records pertinent to the appeal. The request shall be mailed to:

Consumer Protection Services
Department of Banking and Insurance
20 West State Street, 9th Floor
Trenton, New Jersey 08625-0360
Main Telephone Number: (609) 292-5316
Fax: (609) 292-5865

2. The fee for filing an appeal shall be \$25.00, payable by check or money order to the New Jersey Department of Banking and Insurance. Upon a determination of financial hardship, the fee may be reduced to \$2.00. Financial hardship may be demonstrated by

the **Member** through evidence of eligibility for either the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ FamilyCare, General Assistance, SSI, or New Jersey Unemployment Assistance.

3. Upon receipt of the appeal, together with the executed release and the appropriate fee, the New Jersey Department of Banking and Insurance shall immediately assign the appeal to an IURO.
4. Upon receipt of the request for appeal from the New Jersey Department of Banking and Insurance, the IURO shall conduct a preliminary review of the appeal and accept it for processing if it determines that:
 - i. the individual was or is a **Member** of the **HMO**;
 - ii. the service which is the subject of the complaint or appeal reasonably appears to be a **Covered Benefit** under the Certificate of Coverage;
 - iii. the **Member** has fully complied with both the Level One and Level Two **Appeal** processes;
 - iv. the **Member** has provided all information required by the IURO and the New Jersey Department of Banking and Insurance to make the preliminary determination including the appeal form and a copy of any information provided by the **HMO** regarding its decision to deny, reduce, or terminate the **Covered Benefit**, and a fully executed release to obtain any necessary medical records from the **HMO** and any other relevant health care **Provider**; and
 - v. you have remitted the required fee to the New Jersey Department of Banking and Insurance.
5. Upon completion of the preliminary review, the IURO shall immediately notify the **Member** and/or **Provider** in writing as to whether the appeal has been accepted for processing and if not so accepted, the reasons therefore.
6. Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of the **HMO**'s utilization management determination, the **Member** was deprived of **Medically Necessary Covered Benefits**. In reaching this determination, the IURO shall take into consideration all pertinent medical records, consulting **Physician** reports, and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by the **HMO**.
7. The full review referenced above shall initially be conducted by a registered, professional nurse or **Physician** licensed to practice in New Jersey. When necessary, the IURO shall refer all cases for review to a consultant **Physician** in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the IURO shall be approved by the medical director of the IURO.
8. The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 30 business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event, the IURO shall, prior to the conclusion of the preliminary review, provide written notice to the **Member**, to the New Jersey Department of Banking

and Insurance, and to the **HMO** setting forth the status of its review and the specific reasons for the delay.

9. If the IURO determines that the **Member** was deprived of **Medically Necessary Covered Benefits**, the IURO shall recommend to the **Member**, the **HMO**, and the New Jersey Department of Banking and Insurance, the appropriate covered health care services the **Member** should receive.
10. Once the review is complete, **HMO** will abide by the decision of the IURO.
11. The cost of the review by IURO will be borne by **HMO**.

E. **Record Retention.**

HMO shall retain the records of all **Complaints** and **Appeals** for a period of at least 7 years.

F. **Fees and Costs.**

Except as set forth in section D. 11 above for an external appeal, nothing herein shall be construed to require **HMO** to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a **Complaint** or **Appeal**.

COORDINATION OF BENEFITS (COB)

The words shown below have special meanings when used in this section. Please read these definitions carefully.

"Allowable Expense" means 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.

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

HMO 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**.

When **This Plan** is coordinating benefits with a **Plan** that restricts **COB** to a specific coverage, **This Plan** will only consider corresponding services, supplies or items of expense to which **COB** applies as an **Allowable Expense**.

"Claim Determination Period" means a calendar year or portion of a calendar year, during which a **Member** is covered by **This Plan** and at least one other **Plan** and incurs one or more **Allowable Expense(s)** under such **Plans**.

"Coordination of Benefits (COB)" means a provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more **Plans**. It avoids claims payment delays by establishing an order in which **Plans** pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a **Plan** when, by the rules established by this provision, it does not have to pay its benefits first.

"Plan(s)" means coverage with which COB is allowed. Plan includes:

- i. Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- ii. Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- iii. 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;
- iv. Group hospital indemnity benefit amounts that exceed \$150 per day;
- v. Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

“**Plan(s)**” shall not include:

- i. Individual or family insurance contracts or subscriber contracts;
- ii. Individual or family coverage through an **HMO** or under any other prepayment, group practice and individual practice plans;
- iii. Group or group-type coverage where the cost of the coverage is paid solely by the **Member** except when coverage is being continued pursuant to Federal or State continuation law;
- iv. Group hospital indemnity benefit amounts of \$150.00 per day or less;
- v. School accident-type coverage;
- vi. A State plan under Medicaid.

“**This Plan**” is the part of this **Certificate** that provides benefits for health care expenses.

“**Primary Plan(s)**” means a **Plan** whose benefits for a **Member’s** health care coverage must be determined without taking into consideration the existence of any other **Plan**. There may be more than one **Primary Plan**. A **Plan** will be the **Primary Plan** if:

- i. the **Plan** has no order of benefit determination rules, or it has rules that differ from those contained in this **Certificate**; or
- ii. all **Plans** which cover the **Member** use order of benefit determination rules consistent with those contained in this **Certificate** and under those rules, the **Plan** determines its benefit first.

“**Reasonable Charge**” means an amount this is not more than the usual or customary charge for the service or supply as determined by **This Plan**, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

“**Secondary Plan(s)**” means a **Plan** which is not a **Primary Plan**. If a **Member** is covered by more than one **Secondary Plan**, the order of benefit determination rules of this **COB** section shall be used to determine the order in which the benefits payable under the multiple **Secondary Plans** are paid in relation to each other. The benefits of each **Secondary Plan** may take into consideration the benefits of the **Primary Plan** or **Plans** and the benefits of any other **Plan** which, under this **Certificate**, has its benefits determined before those of that **Secondary Plan**.

Primary and Secondary Plan:

This Plan considers each **Plan** separately when coordinating payments.

The **Primary Plan** pays or provides services or supplies first, without taking into consideration the existence of a **Secondary Plan**. If a **Plan** has no **COB** provision, or if the order of benefit determination rules differ from those set forth in this **Certificate**, it is the **Primary Plan**.

A **Secondary Plan** takes into consideration the benefits provided by a **Primary Plan** when, according to the rules set forth below, the **Plan** is the **Secondary Plan**. If there is more than one **Secondary Plan**, the order of benefit determination rules determine the order among the **Secondary Plans**. The **Secondary Plans** will pay up to the remaining unpaid **Allowable Expenses**, but no **Secondary Plan** will pay more

than it would have paid if it had been the **Primary Plan**. The method the **Secondary Plan** uses to determine the amount to pay is set forth below in the Procedures to be followed by the Secondary Plan to Calculate Benefits section below.

Rules for the Order of Benefit Determination:

The benefits of the **Plan** that covers the **Member** as an employee, member, subscriber or retiree shall be determined before those of the **Plan** that covers the **Member** as a dependent. The coverage as an employee, member, subscriber or retiree is the **Primary Plan**.

The benefits of the **Plan** that covers the **Member** as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the **Plan** that covers the **Member** as a laid off or retired employee, or as such a person's dependent. If the other **Plan** does not contain this rule, and as a result the **Plans** do not agree on the order of benefit determination, this provision shall be ignored.

The benefits of the **Plan** that covers the **Member** as an employee, member, subscriber or retiree, or dependent of such person, shall be determined before those of the **Plan** that covers the **Member** under a right of continuation pursuant to Federal or State law. If the other **Plan** does not contain this rule, and as a result the **Plans** do not agree on the order of benefit determination, this provision shall be ignored.

If a child is covered as a dependent under **Plans** through both parents, and the parents are neither separated nor divorced, the following rules apply:

- i. The benefits of the **Plan** of the parent whose birthday falls earlier in the calendar year shall be determined before those of the parent whose birthday falls later in the calendar year.
- ii. If both parents have the same birthday, the benefits of the **Plan** which covered the parent for a longer period of time shall be determined before those of the parent for a shorter period of time.
- iii. Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
- iv. If the other **Plan** contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a dependent under **Plans** through both parents, and the parents are separated or divorced, the following rules apply:

- i. The benefits of the **Plan** of the parent with custody of the child shall be determined first.
- ii. The benefits of the **Plan** of the spouse of the parent with custody shall be determined second.
- iii. The benefits of the **Plan** of the parent without custody shall be determined last.
- iv. If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that **Plan** has knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the **Plan** of the other parent shall be considered as secondary. Until the entity providing coverage under the **Plan** has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which **Plan** is the **Primary Plan**, the benefits of the **Plan** that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the **Plans** that covered the person for a shorter period of time.

Procedures to be followed by the Secondary Plan to Calculate Benefits.

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

- i. the basis on which the **Primary Plan** and the **Secondary Plan** pay benefits; and
- ii. whether the provider who provides or arranges the services and supplies is in the network of either the **Primary Plan** or the **Secondary Plan**.

Benefits may be based on the **Reasonable Charge**, 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 bill charge. In this section, “Reasonable Charge Plan” means a plan that bases benefits on a **Reasonable Charge**.

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, “Fee Schedule Plan(s)” means a **Plan** that bases benefits on a negotiated fee schedule. If the **Member** uses the services of a non-network provider, the **Plan** will be treated as a Reasonable Charge Plan even though the **Plan** under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means that the **HMO** pays the Network 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 will only pay benefits in the event of emergency care or urgent care. In this section, “Capitation Plan” means a **Plan** that pays Network Providers based upon capitation.

Primary and Secondary Plans are Fee Schedule Plans

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:

- i. the amount of any deductible, coinsurance or copayment required by the **Primary Plan**; or
- ii. 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 deductible, coinsurance or copayment of the **Secondary Plan**.

Primary Plan is Reasonable Charge 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:

- i. the difference between the amount of the billed charges for the **Allowable Charges** and the amount paid by the **Primary Plan**; or
- ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

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

Primary Plan is Fee Schedule Plan and Secondary Plan is Reasonable Charge 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:

- i. the amount of any deductible, coinsurance or copayment required by the **Primary Plan**; or
- ii. 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 Reasonable Charge Plan or Fee Schedule Plan

If the **Primary Plan** is an **HMO** plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply 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 Reasonable Charge Plan

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

- i. the amount of any deductible, coinsurance or copayment required by the **Primary Plan**; or
- ii. 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 Reasonable Charge Plan and Secondary Plan is Capitation Plan

If the **Member** receives services or supplies from a Network Provider of the **Secondary Plan**, the **Secondary Plan** shall be liable to pay the capitation to the Network 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 copayment of either the **Primary Plan** or the **Secondary Plan**.

Primary Plan is an HMO and Secondary Plan is an HMO

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

Primary and Secondary Plans are Reasonable Charge Plans

The **Secondary Plan** shall pay the lesser of:

- i. the difference between the amount of the billed charges and the amount paid by the **Primary Plan**; or
- ii. 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**.

COB-BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under this Plan when expenses are incurred 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 by:

- a) the Policy;

- b) PIP; or
- c) OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an injury which is covered under this Plan 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.

The Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the **Member** under this Plan. 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. The Policy may be primary for one **Members**, but not for another if the person has separate automobile policies and has made different selections regarding primacy of health coverage.

The Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Plan will be primary.

If there is a dispute as to which policy is primary, this Plan will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC.

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

The rules of the **COORDINATION OF BENEFITS** section of this Plan will apply if:

- a) the Covered Person is insured under more than one insurance plan; and
- b) such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if it is secondary to PIP or OSAIC.

If this Plan 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 benefits that would have been paid if this Plan had been primary.

Medicare

If this Plan supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

RECOVERY RIGHTS RELATED TO WORKERS' COMPENSATION

If medical benefits are provided by **HMO** for illness or injuries to a **Member** and the **Member** receives Workers' Compensation benefits for the same incident that resulted in the illness or injuries, **HMO** has the right to recover those benefits as described below. "Workers' Compensation benefits" includes benefits paid in connection with a Workers' Compensation claim, whether paid by an employer directly, a Workers' Compensation insurance carrier, or any fund designed to provide compensation for Workers' Compensation claims. **HMO** may exercise its Recovery Rights if the Deputy Directors or Referees of the Workers' Compensation Board incorporate into any award, order or approval of settlement, an order requiring the employer or the insurance carrier to reimburse **HMO** the amount of medical benefits paid by **HMO**.

The Recovery Rights will be applied even though **HMO** does not intervene in the action.

By accepting benefits under this Plan, the **Member** or the **Member's** representatives agree to notify **HMO** of any Workers' Compensation claim made, and to cooperate with the process as described above.

RESPONSIBILITY OF MEMBERS

- A. **Members** or applicants shall complete and submit to **HMO** such application or other forms or statements as **HMO** may reasonably request. **Members** represent that all information contained in such applications, forms and statements submitted to **HMO** incident to enrollment under this **Certificate** or the administration herein shall be true, correct, and complete to the best of the **Member's** knowledge and belief.
- B. The **Member** shall notify **HMO** immediately of any change of address for the **Member** or any of the **Member's Covered Dependents**.
- C. The **Member** understands that **HMO** is acting in reliance upon all information provided to it by the **Member** at time of enrollment and afterwards and represents that information so provided is true and accurate.
- D. By electing coverage pursuant to this **Certificate**, or accepting benefits hereunder, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.
- E. **Members** are subject to and shall abide by the rules and regulations of each **Provider** from which benefits are provided.

GENERAL PROVISIONS

- A. **Identification Card.** The identification card issued by **HMO** to **Members** pursuant to this **Certificate** is for identification purposes only. Possession of an **HMO** identification card confers no right to services or benefits under this **Certificate**, and misuse of such identification card may be grounds for termination of **Member's** coverage pursuant to the Termination of Coverage section of this **Certificate**. If the **Member** who misuses the card is the **Subscriber**, coverage may be terminated for the **Subscriber** as well as any of the **Covered Dependents**. To be eligible for services or benefits under this **Certificate**, the holder of the card must be a **Member** on whose behalf all applicable **Premium** charges under this **Certificate** have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this **Certificate** shall be charged for such services or benefits at billed charges.

If any **Member** permits the use of the **Member's HMO** identification card by any other person, such card may be retained by **HMO**, and all rights of such **Member**, if any, pursuant to this **Certificate** shall be terminated immediately, subject to the Complaint Procedure set forth in the Claim Determination Procedures/Complaints and Appeals section of this **Certificate**.

- B. **Reports and Records.** **HMO** is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **Certificate** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **Certificate**. By accepting coverage under this **Certificate**, the **Subscriber**, for himself or herself, and for all **Covered Dependents** covered hereunder, authorizes each and every **Provider** who renders services to a **Member** hereunder to:
 - 1. disclose all facts pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim;

2. render reports pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim; and
 3. permit copying of the **Member's** records by **HMO**.
- C. **Refusal of Treatment.** A **Member** may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a **Participating Provider**. **Participating Providers** will use their best efforts to work with the **Member** to provide an acceptable course of treatment.
- D. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member** and may not be assigned.
- E. **Legal Action.** No legal action can be brought to recover payment under any benefit after 3 years following the date the claims were incurred.
- F. **Independent Contractor Relationship.**
1. No **Participating Provider** or other **Provider**, institution, facility or agency is an agent or employee of **HMO**. Neither **HMO** nor any **Member** of **HMO** is an agent or employee of any **Participating Provider** or other **Provider**, institution, facility or agency.
 2. Neither the **Contract Holder** nor a **Member** is the agent or representative of **HMO**, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which **HMO** has made or hereafter shall make arrangements for services under this **Certificate**.
 3. **Participating Physicians** maintain the physician-patient relationship with **Members** and are responsible to **Member** for all **Medical Services** which are rendered by **Participating Physicians**.
 4. **HMO** cannot guarantee the continued participation of any **Provider** or facility with **HMO**. In the event a **PCP** terminates its contract or is terminated by **HMO**, **HMO** shall provide notification to **Members** in the following manner:
 - a. within thirty business days of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and
 - b. If your health care provider stops participation with **HMO** for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, **HMO** will continue coverage for an ongoing health care provider during a transitional period. Coverage shall continue for up to four months from the provider termination date with **HMO**, in cases where it is **Medically Necessary** for you to continue treatment with the termed provider, except as set forth below:
 - In the case of pregnancy, **Medical Necessity** shall be deemed to have been demonstrated and coverage of services by the terminated provider shall continue to the postpartum evaluation of the insured up to six weeks after delivery; or
 - In the case of post-operative care, coverage of services by the terminated provider shall continue for a period of up to six months; or

- In the case of oncological treatment, coverage of services by the terminated provider shall continue for a period of up to one year; or
- In the case of psychiatric treatment, coverage of services by the terminated provider shall continue for a period of up to one year.

This provision shall not be construed to require **HMO** to provide coverage for benefits not otherwise covered under this **Certificate**.

5. **Restriction on Choice of Providers:** Unless otherwise approved by **HMO**, **Members** must utilize **Participating Providers** and facilities who have contracted with **HMO** to provide services.
- G. **Inability to Provide Service.** In the event that due to circumstances not within the reasonable control of **HMO**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Participating Provider Network, the rendition of medical or **Hospital** benefits or other services provided under this **Certificate** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is 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.
- H. **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 in accordance with applicable law. Information may not be disclosed without the consent of the **Member** except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by **HMO** in connection with the administration of this **Certificate**, or in the compiling of aggregate statistical data.
- I. **Limitation on Services.** Except as provided under N.J.S.A. 30:7E, or in cases of a **Medical Emergency** and **Urgent Care**, as provided under the **Covered Benefits** section of this **Certificate**, services are available only from **Participating Providers**. **HMO** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from any **Physician**, **Hospital**, **Skilled Nursing Facility**, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by **HMO**.
- J. **Incontestability.** In the absence of fraud, all statements made by a **Member** shall be considered representations and not warranties, and no statement shall be the basis for voiding coverage or denying a claim after the **Group Agreement** has been in force for 2 years from its effective date, unless the statement was material to the risk and was contained in a written application.
- K. This **Certificate** applies to coverage only, and does not restrict a **Member's** ability to receive health care **benefits** that are not, or might not be, **Covered Benefits**.
- L. **Contract Holder** hereby makes **HMO** coverage available to persons who are eligible under the Eligibility and Enrollment section of this **Certificate**. However, this **Certificate** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Department of Banking and Insurance. This can also be done by mutual written agreement between **HMO** and **Contract Holder** without the consent of **Members**.
- M. **HMO** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Certificate**.

- N. No agent or other person, except an authorized representative of **HMO**, has authority to waive any condition or restriction of this **Certificate**, to extend the time for making a payment, or to bind **HMO** by making any promise or representation or by giving or receiving any information. No change in this **Certificate** shall be valid unless evidenced by an endorsement to it signed by an authorized representative.
- O. This **Certificate**, including the Schedule of Benefits, any Riders, and any amendments or endorsements, constitutes the entire **Certificate** between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this **Certificate** shall be binding unless executed in writing by authorized representatives of the parties.
- P. This **Certificate** has been entered into and shall be construed according to applicable state and federal law.
- Q. **Claim Payment Procedure.** The **Provider** is required to seek compensation for **Covered Benefits** rendered directly from **HMO** except for any applicable **Copayment** or **Deductible** listed in the Schedule of Benefits. Should a **Member** receive a bill for **Covered Benefits** or at the **Member** option submit a claim on their own behalf, the claim (bill) must be submitted promptly to **HMO** for payment which will be processed less any applicable **Copayment** or **Deductible**. Send the itemized bill for payment with the **Member's** identification number clearly marked to the address shown in the **Member's** ID card.

Claims for compensation by **Providers** or payment by **Members** will be made by **HMO** no later than 30 calendar days following receipt of claim if the claim is submitted by electronic means and no later than 40 calendar days following receipt if the claim is submitted in writing. **HMO** will acknowledge receipt of a claim within 2 working days following receipt by electronic means, or within 15 working days following receipt by written notice.

Claims that are not disputed and are not paid by **HMO** within the required timeframe will be deemed to be overdue. An overdue payment shall bear simple interest at the rate of 12% per annum and **HMO** shall add the interest amount to the claim amount when paying the claim.

HMO may deny or dispute a claim, in full or in part. If only a portion of a claim is disputed or denied, **HMO** shall remit payment for the uncontested portion according to the above timeframes. **HMO** shall notify the **Member** when the **Member** has increased responsibility for payment and the **Provider** of the basis for **HMO's** decision to deny or dispute the claim within 30 or 40 calendar days of receipt.

If **HMO** has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan, or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to New Jersey Law.

DEFINITIONS

The following words and phrases when used in this **Certificate** shall have, unless the context clearly indicates otherwise, the meaning given to them below:

- **Behavioral Health Provider.** A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

- **Certificate.** This Certificate of Coverage, including the Schedule of Benefits, and any riders, amendments, or endorsements, which outlines coverage for a **Subscriber** and **Covered Dependents** according to the **Group Agreement**.
- **Contract Holder.** An employer or organization who agrees to remit the **Premiums** for coverage under the **Group Agreement** payable to **HMO**. The **Contract Holder** shall act only as an agent of **HMO Members** in the **Contract Holder's** group, and shall not be the agent of **HMO** for any purpose.
- **Contract Year.** A period of one year commencing on the **Contract Holder's Effective Date of Coverage** and ends at 12:00 midnight on the last day of the one-year period.
- **Copayment.** A specified dollar amount required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the Schedule of Benefits.
- **Copayment Maximum.** The maximum annual out-of-pocket amount for payment of **Copayments**, if any, to be paid by a **Subscriber** and any **Covered Dependents**, if any.
- **Cosmetic Surgery.** Any non-medically necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.
- **Covered Dependent or Dependent.** Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **Certificate** and the Dependent Eligibility section of the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements set forth in the Premiums section of the **Group Agreement**.
- **Covered Benefits.** Those **Medically Necessary Services** and supplies set forth in this **Certificate**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **Certificate**.
- **Creditable Coverage.** Coverage of the **Member** under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, including coverage received under a plan established or maintained by a foreign country or political subdivision as well as one established and maintained by the government of the United States, any health benefit plan under section 5(e) of the Peace Corps Acts and the State Children's Health Insurance Program (S-CHIP). **Creditable Coverage** does not include coverage only for accident; Workers' Compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that are provided in a separate policy.
- **Custodial Care.** Services and supplies that are primarily intended to help a **Member** meet their personal needs. Care can be **Custodial Care** even if it is prescribed by a **Physician**, delivered by trained medical personnel, or even if it involves artificial methods (or equipment) such as feeding tubes, monitors, or catheters. Examples of **Custodial Care** include, but are not limited to:
 1. Changing dressings and bandages, periodic turning and positioning in bed, administering oral medication, watching or protecting a **Member**.
 2. Care of a stable tracheostomy, including intermittent suctioning.

3. Care of a stable colostomy/ileostomy.
 4. Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
 5. Care of a stable indwelling bladder catheter, including emptying/changing containers and clamping tube.
 6. Respite care, adult (or child) day care, or convalescent care.
 7. Helping a **Member** perform an activity of daily living, such as: walking, grooming, bathing, dressing, getting in and out of bed, toileting, eating, or preparing food.
 8. Any services that an individual without medical or paramedical training can perform or be trained to perform.
- **Detoxification.** The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.
 - **Durable Medical Equipment.** Equipment, as determined by **HMO**, which is a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; c) suited for use while not confined as an inpatient in the **Hospital**; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.
 - **Effective Date of Coverage.** The commencement date of coverage under this **Certificate** as shown on the records of **HMO** and on the **Member** identification card.
 - **Emergency Service.** Professional health services that are provided to treat a **Medical Emergency**.
 - **Experimental or Investigational Procedures.** Services or supplies that are, as determined by **HMO**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:
 1. there is not sufficient outcome data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
 2. required FDA approval has not been granted for marketing; or
 3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
 4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
 5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or
 6. it is not generally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or
 7. it is provided or performed in special settings for research purposes.
 - **Group Agreement.** The **Group Agreement** between **HMO** and the **Contract Holder**, including the Group Application, Cover Sheet, this **Certificate**, the Schedule of Benefits, any Riders, any amendments, any endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the New Jersey Department of Banking and Insurance.

- **Health Professional.** A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.
- **HMO.** Aetna Health Inc., a New Jersey corporation licensed by the New Jersey Department of Banking and Insurance as a Health Maintenance Organization.
- **Homebound Member.** A **Member** who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or which restricts the **Member's** ability to leave the **Member's** place of residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person.
- **Home Health Services.** Those items and services provided by **Participating Providers** as an alternative to hospitalization, and approved and coordinated in advance by **HMO**.
- **Hospice Care.** A program of care that is provided by a **Hospital, Skilled Nursing Facility, hospice, or a duly licensed Hospice Care agency, and is approved by HMO, and is focused on a palliative rather than curative treatment for Members who have a medical condition and a prognosis of less than 6 months to live.**
- **Hospital.** An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.
- **Infertility.** A disease or condition that results in the abnormal function of the reproductive system such that:
 - a person is not able to impregnate another person;
 - a person is not able to conceive after 1 year(s) of unprotected intercourse, if the female partner is under 35 years of age; or conceive after 1 year of unprotected intercourse if the female partner is 35 years of age or older;
 - one of the partners is determined to be medically sterile; or
 - a person is not able to carry a pregnancy to live birth.

Infertility shall not mean a person who has been voluntarily sterilized regardless of whether the person has attempted to reverse the sterilization.
- **Medical Community.** A majority of **Physicians** who are Board Certified in the appropriate specialty.
- **Medical Emergency.** A medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
 - Placing your health in serious jeopardy; or
 - Serious impairment to bodily function; or
 - Serious dysfunction of a body part or organ; or
 - In the case of a pregnant woman, serious jeopardy to the health of the woman or unborn child. 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 the unborn child.

- **Medical Services.** The professional services of **Health Professionals**, including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.
- **Medically Necessary, Medically Necessary Services, or Medical Necessity.** Health care or dental services, and supplies (including contraceptive devices) or **prescription drugs** that a **Physician, other health care provider or dental provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing contraception, preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms, and that provision of the service, supply or **prescription drug** is:
 - (a) in accordance with generally accepted standards of medical or dental practice;
 - (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s **illness, injury** or disease; and
 - (c) not primarily for the convenience of the patient, **Physician, other health care or dental provider**; and
 - (d) and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s **illness, injury**, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with **Physician** or dental specialty society recommendations and the views of **Physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

- **Member.** A **Subscriber** or **Covered Dependent** as defined in this **Certificate**.
- **Mental Disorder.** An **illness** commonly understood to be a **Mental Disorder**, whether or not it has a physiological or organic basis, and for which treatment is generally provided by or under the direction of a **Behavioral Health Provider** such as a **Psychiatric Physician**, a psychologist or a psychiatric social worker.

The following conditions are considered a **Mental Disorder** under this plan:

- Anorexia/Bulimia Nervosa
 - Schizophrenia;
 - Schizoaffective Disorder;
 - Major Depressive Disorder;
 - Bipolar Disorder;
 - Psychotic Disorders/Delusional Disorder;
 - Obsessive-Compulsive Disorder;
 - Panic Disorder;
 - Pervasive Mental Developmental Disorder (including Autism).
- **Non-Emergency Care.** Medical care for a medical condition treated in the emergency room that is not considered to be a **Medical Emergency**.
 - **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.
 - **Open Enrollment Period.** A period of not less than ten (10) consecutive working days, each calendar year, when eligible enrollees of the **Contract Holder** may enroll in **HMO** without a waiting period or exclusion or limitation based on health status or, if already enrolled in **HMO**, may transfer to an alternative health plan offered by the **Contract Holder**.

- **Partial Hospitalization.** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as an **Alcoholism or Drug Abuse** or **Mental Disorders** treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.
- **Participating.** A description of a **Provider** that has entered into a contractual agreement with **HMO** for the provision of services to **Members**.
- **Physician.** A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.
- **Premium.** The amount the **Contract Holder** or **Member** is required to pay to **HMO** to continue coverage.
- **Primary Care Physician.** A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an internist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.
- **Provider.** A **Physician, Health Professional, Hospital, Skilled Nursing Facility**, home health agency or other recognized entity or person licensed to provide **Hospital** or **Medical Services** to **Members**.
- **Psychiatric Physician.** This is a **Physician** who:
 - Specializes in psychiatry; or
 - Has the training or experience to do the required evaluation and treatment of **substance abuse** or **Mental Disorders**.
- **Reasonable Charge.** The charge for a **Covered Benefit** which is determined by the **HMO** to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. **HMO** may take into account factors such as the complexity, degree of skill needed, type or specialty of the **Provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the **Reasonable Charge** for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.
- **Referral.** Specific directions or instructions from a **Member's PCP**, in conformance with **HMO's** policies and procedures, that direct a **Member** to a **Participating Provider** for **Medically Necessary** care.
- **Residential Treatment Facility - (Mental Disorders).** This is an institution that meets all of the following requirements:
 - On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
 - Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
 - Is admitted by a **Physician**.
 - Has access to necessary medical services 24 hours per day/7 days a week.
 - Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
 - Offers group therapy sessions with at least an RN or Masters-Level Health Professional.

- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
 - Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
 - Has peer-oriented activities.
 - Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **HMO** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
 - Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
 - Provides a level of skilled intervention consistent with patient risk.
 - Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
 - Is not a Wilderness Treatment Program or any such related or similar program, school and /or education service.
- **Residential Treatment Facility - (Alcoholism and Drug Abuse).** This is an institution that meets all of the following requirements:
 - On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
 - Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
 - Is admitted by a **Physician**.
 - Has access to necessary medical services 24 hours per day/7 days a week.
 - Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
 - Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
 - Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
 - Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
 - Has peer-oriented activities.
 - Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **HMO** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
 - Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
 - Provides a level of skilled intervention consistent with patient risk.
 - Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
 - Is not a Wilderness Treatment Program or any such related or similar program, school and /or education service.
 - Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
 - 24-hours per day/7 days a week supervision by a **Physician** with evidence of close and frequent observation.
 - On-site, licensed **Behavioral Health Provider**, medical or **Alcoholism or Drug Abuse** professionals 24 hours per day/7 days a week.
 - If the **Member** requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7 days a week, which must be actively supervised by an attending **Physician**.
 - **Respite Care.** Care furnished during a period of time when the **Member's** family or usual caretaker cannot, or will not, attend to the **Member's** needs.

- **Self-injectable Drug(s).** Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.
- **Service Area.** The geographic area, established by **HMO** and approved by the New Jersey Department of Banking and Insurance.
- **Skilled Nursing.** Services that require the medical training of and are provided by a licensed nursing professional and are not **Custodial Care**.
- **Skilled Nursing Facility.** An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing **Skilled Nursing** care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. **Skilled Nursing Facility** does not include institutions which provide only minimal care, **Custodial Care** services, ambulatory or part-time care services, or institutions which primarily provide for the care and treatment of **Alcoholism and Drug Abuse** or **Mental Disorders** care. The facility must qualify as a **Skilled Nursing Facility** under Medicare or as an institution accredited by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, the Commission on the Accreditation of Rehabilitative Facilities, or as otherwise determined by the health insurer to meet the reasonable standards applied by any of the aforesaid authorities. Examples of **Skilled Nursing Facilities** include Rehabilitation Hospitals (all levels of care, e.g. acute) and portions of a **Hospital** designated for Skilled or Rehabilitation services.
- **Specialist.** A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.
- **Subscriber.** A person who meets all applicable eligibility requirements as described in this **Certificate** and on the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements as set forth in the Premiums section of the **Group Agreement**.
- **Alcoholism and Drug Abuse.** Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.
- **Alcoholism and Drug Abuse Rehabilitation.** Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individualized treatment plans.
- **Surgery or Surgical Procedure.** The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g. heart or bladder catheterization) or scope (e.g. colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.
- **Totally Disabled or Total Disability.** A **Member** shall be considered **Totally Disabled** if:
 1. the **Member** is a **Subscriber** and is prevented, because of injury or disease, from performing any occupation for which the **Member** is reasonably fitted by training, experience, and accomplishments; or
 2. the **Member** is a **Covered Dependent** and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

- **Transplant.** Replacement of solid organs, stem cells, bone marrow or intestinal tissue, tissue that has sustained a significant burn or tissue that is taken from the liver.
- **Transplant Occurrence.** Considered to begin at the point of authorization for evaluation for a **Transplant**, and end: (1) 365 days from the date of the **Transplant**; or (2) upon the date the **Member** is discharged from the **Hospital** or outpatient facility for the admission or visit(s) related to the **Transplant**, whichever is later.
- **Urgent Care.** A non-life threatening condition that requires care by a **Provider** within 24 hours.

**AETNA HEALTH INC.
(NEW JERSEY)**

**ALLOWED AMOUNT
AMENDMENT**

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc., **Certificate** is hereby amended as follows:

1. The first paragraph of the “Covered Benefits” section is hereby deleted and replaced it in its entirety with the following:

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **Certificate**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary** and provided by a **Network Provider** except in a **Medical Emergency** or **Urgent Care** situation. For the purpose of coverage, **HMO** may determine the **Allowed Amount** and whether any benefit provided under the **Certificate** is **Medically Necessary**. The **HMO** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. For **Specialist** services, the **Member** is afforded the choice of a **Network Specialist** subject to their availability and acceptance of new patients. Preventive care, as described below, will be considered **Medically Necessary**.

2. The Definitions Section of the **Certificate** is hereby amended to add the following definitions:

Allowed Amount: An amount determined by the **HMO** as the least of the following amounts:

- (a) the actual charge made by the **Provider** for the service or supply; or
- (b) in the case of **Network Providers**, the amount that the provider has agreed to accept for the service or supply; or
- (c) in the case of **Out-of-Network Providers**, the amount determined for the service or supply is:
 - for professional services and other services or supplies not mentioned below:
125% of the Medicare Allowable Rate;
for the Geographic Area where the service is furnished.
 - for inpatient charges of hospitals and other facilities:
125% of the Medicare Allowable Rate;
for the Geographic Area where the service is furnished.
 - for outpatient charges of hospitals and other facilities:
125% of the Medicare Allowable Rate;
for the Geographic Area where the service is furnished.

As used above, Geographic Area is defined as follows:

Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.

As used above, Medicare Allowable Rates are defined as follows:

Medicare Allowable Rates: Except as specified below, these are the rates established and periodically updated by The Centers for Medicare and Medicaid Services (CMS) for payment for services and supplies provided to Medicare enrollees. Aetna updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate for a particular service, the rate will be based on the same method that CMS uses to set Medicare rates.

Important Note:

To ensure coverage under the **HMO**, services must be provided by **Network Providers** except for **Medical Emergency** or **Urgent Care** situations. **Network Providers** will always be reimbursed at the **Contracted Rate**.

Exceptions:

1. The above method for determining an **Allowed Amount** does not apply with respect to the Plan's coverage of Orthotic and Prosthetic Devices. The **Allowed Amount** for such devices shall be the greater of (i) the reimbursement rate for the device in the federal Medicare reimbursement schedule; and (ii) in the case of **[Network] Providers**, the amount that the **Provider** has agreed to accept for the device or the **Contracted Rate**. If there is no such rate for the device, the amount determined for (i) shall be the Medicare reimbursement rate for the most similar device.
2. With respect to (i) **Medical Emergency and Urgent Care Services**; or (ii) **Covered Benefits** provided in a **Network Hospital**, the **Allowed Amount** is determined in accordance with (c), above, for any **Covered Benefits** provided by **Out-of-Network Providers**. Aetna shall take appropriate action to ensure that the **Member** has no greater liability than they would have if they are treated by **Network Providers**.
3. In a case where a **Member's Primary Care Physician** refers him/her to an **Out-of-Network Provider**, the **Allowed Amount** for the **Out-of-Network Provider's** services will be an amount determined in accordance with (c), above.
4. If **HMO** has an agreement with a provider (directly or through a third party) which sets the rate that **HMO** will pay for a service or supply, then the **Allowed Amount** is the rate established in such agreement.

HMO may also reduce the **Allowed Amount** by applying **HMO** Reimbursement Policies. **HMO** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- The duration and complexity of a service;
- Whether multiple procedures are billed at the same time, but no additional overhead is required;
- Whether an assistant surgeon is involved and necessary for the service;
- If follow up care is included;
- Whether there are any other characteristics that may modify or make a particular service unique; and
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

HMO Reimbursement Policies are based on **HMO's** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental

specialty society recommendations; and the views of physicians and dentists practicing in the relevant clinical areas. HMO uses a commercial software package to administer some of these policies.

Contracted Rate(s). The **Contracted Rate** is the amount that a **Network Provider** has agreed to accept as payment in full for any service or supply for the purpose of the **Covered Benefits** under this plan. As used within the **HMO** agreement, including the **HMO Quality Point of Service Certificate**, Schedule of Benefits, riders and amendments, any references to "contracted charge(s)", "negotiated fee(s)" or "negotiated rate(s)" mean "**Contracted Rates**".

3. The **Exclusions and Limitations** Section of the Certificate is amended to add the following:

Cost for services above the **Allowed Amount**.

4. The **Emergency/Urgent Care Benefits** provision is hereby deleted and replaced with the following:

K. **Emergency Care/Urgent Care Benefits.**

1. A **Member** is covered for **Emergency Services**, provided the service is a **Covered Benefit**, and HMO's medical review determines that the **Member's** symptoms meet the definition of **Medical Emergency** as defined in this **Certificate**.

The **Copayment** for an emergency room visit as described on the Schedule of Benefits will not apply either in the event that the **Member** was referred for such visit by the **Member's PCP** for services that should have been rendered in the **PCP's** office or if the **Member** is admitted into the **Hospital**.

The **Member** will be reimbursed for the cost for **Emergency Services** rendered by a non-participating **Provider**, up to the **Amount Allowed**, located either within or outside the **HMO Service Area**, for those expenses, less **Copayments**, which are incurred up to the time the **Member** is determined by HMO and the attending **Physician** to be medically able to travel or to be transported to a **Participating Provider**. In the event that transportation is **Medically Necessary**, the **Member** will be reimbursed for the cost as determined by HMO, minus any applicable **Copayments**. For **Emergency Services** rendered other than in an emergency room, reimbursement may be subject to payment by the **Member** of all **Copayments** which would have been required had similar benefits been provided during office hours and upon prior **Referral** to a **Participating Provider**.

Medical transportation is covered during a **Medical Emergency** subject to any applicable copayments or coinsurance shown on the Schedule of Benefits.

2. **Urgent Care:** An **urgent care** condition means a non-life threatening condition that requires care by a provider within 24 hours.

- **Urgent Care Within the HMO Service Area.** If the **Member** needs **Urgent Care** while within the **HMO Service Area**, but the **Member's** illness, injury or condition is not serious enough to be a **Medical Emergency**, the **Member** should first seek care through the **Member's Primary Care Physician**. If the **Member's Primary Care Physician** is not reasonably available to provide services for the **Member**, the **Member** may access **Urgent Care** from a **Participating Urgent Care** facility within the **HMO Service Area**.
- **Urgent Care Outside the HMO Service Area.** The **Member** will be covered for **Urgent Care** obtained from a **Physician** or licensed facility outside of the **HMO Service Area**, up to the **Allowed Amount**, if the **Member** is temporarily absent

from the **HMO Service Area** and receipt of the health care service cannot be delayed until the **Member** returns to the **HMO Service Area**.

3. A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for emergency or **Urgent Care** which is provided to a **Member** after the **Medical Emergency** care or **Urgent Care** situation has terminated. All follow-up and continuing care must be provided or arranged by a **Member's PCP**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all follow-up services received.

All other terms and conditions of the **Certificate** shall remain in full force and effect except as amended herein.

**AETNA HEALTH INC.
(NEW JERSEY)**

ENROLLMENT ENDORSEMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended as follows:

ELIGIBILITY AND ENROLLMENT

Subsection B.5 of the Eligibility and Enrollment section of the **Certificate** is amended to include the following:

- Employees will be permitted to enroll in **HMO** at any time during the year provided the circumstances surrounding the enrollment involve a "Life Event" occurrence and the enrollment form is received by **HMO** within 31 days of when the event occurs.

"Life Events" are limited to:

- a marriage or divorce of the employee;
- the death of the employee's spouse or a dependent;
- the birth, proposed adoption or adoption of a child of the employee;
- the termination or commencement of employment of the employee's spouse;
- the switching from part-time to full-time employment status or from full-time to part-time status by the employee or employee's spouse;
- the taking of an unpaid leave of absence of the employee or employee's spouse;
- a significant change in health coverage of employee or spouse attributable to spouse's employment.

AETNA HEALTH INC.
(NEW JERSEY)

TERMINATION OF COVERAGE
&
CLAIMS DETERMINATION PROCEDURES/COMPLAINTS AND APPEALS,
EXTERNAL REVIEW
CERTIFICATE OF COVERAGE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended as follows:

1. The last 2 paragraphs of the Termination of Coverage section of the **Certificate**, and any amendments to those sections of the **Certificate**, are replaced by the following:

A **Member** may register a **Complaint** with **HMO**, as described in the Claim Determination Procedures/Complaints and Appeals, External Review sections of the **Certificate**, after receiving notice that **HMO** has or will terminate the **Member's** coverage as described in the Termination For Cause subsection of the **Certificate**. **HMO** will continue the **Member's** coverage in force until a final decision on the **Complaint** is rendered, provided the **Premium** is paid throughout the period prior to the issuance of that final decision. **HMO** may rescind coverage, to the date coverage would have terminated had the **Member** not registered a **Complaint** with **HMO**, if the final decision is in favor of **HMO**. If coverage is rescinded, **HMO** will provide the **Member** with a 30-day advance written notice prior to the date of the rescission, and refund any **Premiums** paid for any period after the termination date, minus the cost of **Covered Benefits** provided to a **Member** during this period.

Coverage will not be terminated on the basis of a **Member's** health status or health care needs, nor if a **Member** has exercised the **Member's** rights under the **Certificate's** Complaints and Appeals, External Review sections to register a **Complaint** with **HMO**. The **Complaint** process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination for Cause subsection of the **Certificate**.

2. The Claim Determination Procedures/Complaints and Appeals, External Review sections of the **Certificate** and any amendments to these sections of the **Certificate** are replaced with the following:

CLAIM DETERMINATION PROCEDURES/COMPLAINTS AND APPEALS, EXTERNAL REVIEW

CLAIM DETERMINATION PROCEDURES

A claim occurs whenever a **Member** or the **Member's** authorized representative, such as a **Participating Provider**, requests pre-authorization as required by the plan from **HMO**, a **Referral** as required by the plan from a **Participating Provider** or requests payment for services or treatment received. As an **HMO Member**, most claims do not require forms to be submitted. However, if a **Member** receives a bill for **Covered Benefits**, the bill must be submitted promptly to the **HMO** for claim determination and payment. Send the itemized bill for payment with the **Member's** identification number clearly marked to the address shown on the **Member's** ID card. Claim payment will be made in accordance with the Claim Payment Procedure section of the **Certificate**.

The **HMO** will make a decision on the **Member's** claim. For **Urgent Care Claims** and **Pre-Service Claims**, the **HMO** will send the **Member** written notification of the determination, whether adverse or not adverse. For other types of claims, the **Member** may only receive notice if the **HMO** makes an **Adverse Benefit Determination** or in the case of a concurrent care claim to your provider.

Adverse Benefit Determinations are decisions made by the **HMO** that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or

service or termination of a Member's coverage back to the original effective date (rescission). Such **Adverse Benefit Determinations** can be made for one or more of the following reasons:

- **Utilization Review (UR).** HMO determines that the service or supply is not **Medically Necessary** or are **Experimental or Investigational Procedures**. **Utilization Review (UR)** includes decisions regarding medical necessity, appropriateness, health care setting, level of care, and effectiveness of a **Covered Benefit**.
- **No Coverage.** HMO determines that a service or supply is not covered by the plan. A service or supply is not covered if it is not included in the list of **Covered Benefits**.
- **Exclusion.** A service or supply is excluded from coverage.
- **Limitation.** A HMO limitation has been reached.
- **Eligibility.** HMO determines that the **Subscriber** or **Subscriber's Covered Dependents** are not eligible to be covered by the **HMO**.
- **Experimental or Investigational.** A decision that the service or supply is an **Experimental or Investigational Procedure**.
- **Medically Necessary.** A decision that the service or supply is not **Medically Necessary**.

All **Adverse Benefit Determinations** related to Utilization Review (to deny or limit an admission, service, deny services as not **Medically Necessary**) procedure or extension of stay will be rendered by a **Physician**.

Written notice of an **Adverse Benefit Determination** will be provided to the **Member** within the following time frames. Under certain circumstances, these time frames may be extended. The notice will provide important information that will assist the **Member** in making an **Appeal** of the **Adverse Benefit Determination**, if the **Member** wishes to do so. Please see the Complaints and Appeals, External Review section of this **Certificate** for more information about **Appeals**. A **Member**, an authorized representative for the **Member**, or **Provider** acting on a **Member's** behalf must be given written notice of any **Adverse Benefit Determination** within two business days of the **Adverse Benefit Determination**. The written notice must include an explanation of the Appeals Process.

A "**Final Internal Adverse Benefit Determination**" is an **Adverse Benefit Determination** that has been upheld by a plan or issuer at the completion of the internal appeals process or an **Adverse Benefit Determination** with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules.

HMO Timeframe for Notification of a Benefit Determination for UR Claims

Type of Claim	HMO Response Time from Receipt of Claim
Urgent Care Claim. A claim for medical care or treatment of a non-life threatening condition that requires care by a Provider within 24 hours.	A Member will be notified of all Urgent Care Claim benefit determinations whether adverse or not as soon as possible but not later than 72 hours unless the Member fails to provide sufficient information to make a benefit determination. HMO shall notify the Member as soon as reasonably possible, but not later than 72 hours after receipt of the claim by the HMO of the specific information necessary to complete the claim. The Member shall be afforded a reasonable amount of time but not less than 48 hours to provide the specific information.
Pre-Service Claim. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.	Within 5 business days
Concurrent Care Claim Extension. A request to extend a course of treatment previously pre-authorized by HMO .	If an Urgent Care Claim or an inpatient Hospital confinement, as soon as possible but not later than 24 hours. Otherwise, within 15 calendar days
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously pre-authorized by HMO due to fraud by the covered person or Participating Provider.	With enough advance written notice to allow the Member to Appeal If the Member files an Appeal , Covered Benefits under the Certificate will continue for the previously approved course of treatment until a final internal Appeal decision is rendered. During this continuation period, the Member is responsible for any cost sharing that applies to the services; supplies; and treatment; that are rendered in connection with the claim that is under Appeal . If HMO's initial claim decision is upheld in the final internal Appeal decision, the Member will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.
Post-Service Claim. A claim for a benefit that is not a Pre-Service Claim .	As soon as possible but not later than 30 calendar days

HMO Timeframe for Notification of Benefit determination for Non-UR Claims

Type of Benefit Determination	HMO Response Time from Receipt of Issue
Rescission of Coverage	30-day advance written notification to allow the Member to Appeal.
Post-Service Claim. A claim for a benefit that is not a Pre-Service Claim.	As soon as possible but not later than 30 calendar days

COMPLAINTS AND APPEALS, EXTERNAL REVIEW

HMO has procedures for **Members** to use if they are dissatisfied with a decision that the **HMO** has made or with the operation of the **HMO**. The procedure the **Member** needs to follow will depend on the type of issue or problem the **Member** has.

- **Appeal.** An **Appeal** is a request to the **HMO** to reconsider an **Adverse Benefit Determination**. The **Appeal** procedure for an **Adverse Benefit Determination** has two levels.
- **Complaint.** A **Complaint** is an expression of dissatisfaction about quality of care or the operation of the **HMO**.
- **External Review.** A review of an **Adverse Benefit Determination** or a **Final Internal Adverse Benefit Determination** by an Independent Utilization Review Organization (IURO) assigned by the State Insurance Commissioner made up of **Physicians** or other appropriate **Providers**. The IURO must have expertise in the problem or question involved.

A. **Complaints.**

If the **Member** is dissatisfied with the administrative services the **Member** receives from the **HMO** or wants to complain about a **Participating Provider**, call or write Member Services within 30 calendar days of the incident. The **Member** will need to include a detailed description of the matter and include copies of any records or documents that the **Member** thinks are relevant to the matter. The **HMO** will review the information and provide the **Member** with a written response within 30 calendar days of the receipt of the **Complaint**, unless additional information is needed and it cannot be obtained within this time frame. The response will tell the **Member** what the **Member** needs to do to seek an additional review.

B. **Full and Fair Review of Claim Determinations and Appeals**

Prior to issuing a **Final Internal Adverse Benefit Determination**, **HMO** will provide the **Member** with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue free of charge. This will be provided to the **Member** as soon as possible and sufficiently in advance of the date on which the notice of the **Final Internal Adverse Benefit Determination** is required to be provided so that the **Member**, the **Member's** authorized representative, or a **Provider** acting on behalf of the **Member** has a reasonable opportunity to respond prior to that date.

HMO will make sure that all claims and appeals are adjudicated in a manner designed to avoid conflict of interest by ensuring the independence and impartiality of the persons involved in making the decision.

C. **Appeals of Adverse Benefit Determinations.**

The **Member** will receive written notice of an **Adverse Benefit Determination** from the **HMO**. The notice will include the reason for the decision and it will explain what steps must be taken if the **Member**

wishes to **Appeal**. The notice will also identify the **Member's** rights to receive additional information that may be relevant to an **Appeal**. Requests for an **Appeal** must be made in writing within 180 calendar days from the date of the notice. However, Level One **Appeals** may also be requested orally.

A **Member**, an authorized representative for the **Member**, or a **Provider** acting on behalf of a **Member** and with the **Member's** consent, dissatisfied with a utilization management **Adverse Benefit Determination** will have the opportunity to **Appeal**.

The **HMO** provides for two levels of **Appeal of the Adverse Benefit Determination**. The **Member** must complete the two levels of **HMO** review before pursuing an **Appeal** to an Independent Utilization Review Organization (IURO) or bringing a lawsuit against the HMO, unless serious or significant harm to the **Member** has occurred or will imminently occur. A **Final Internal Adverse Benefit Determination** notice will provide an option to request an External Review. If the **Member** decides to **Appeal** to the second level, the request must be made in writing within 60 calendar days from the date of the **HMO's** notice at the conclusion of the Level One **Appeal** explaining the **Member's** right to make a Level Two **Appeal**. Within 10 business days of receipt of an Utilization Review Level Two **Appeal**, the **HMO** will acknowledge the Appeal in writing.

The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

HMO Timeframe for Responding to an Adverse Benefit Determination Appeal For UR Claims

Type of Claim	Level One Appeal HMO Response Time from Receipt of Appeal	Level Two Appeal HMO Response Time from Receipt of Appeal
Urgent Care Claim. A claim for medical care or treatment of a non-life threatening condition that requires care by a Provider within 24 hours. An Urgent Care Claim appeal may be submitted orally or in writing.	Within 36 hours Review provided by HMO personnel not involved in making the Adverse Benefit Determination .	Within 36 hours Review provided by HMO Appeals Committee. Review provided by HMO personnel not involved in making the Adverse Benefit Determination .
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 10 calendar days Review provided by HMO personnel not involved in making the Adverse Benefit Determination .	Within 15 calendar days Review provided by HMO Appeals Committee. Review provided by HMO personnel not involved in making the Adverse Benefit Determination .
Concurrent Care Claim Extension. A request to extend or a decision to reduce a previously approved course of treatment.	Treated like an Urgent Care Claim or a Pre-Service Claim depending on the circumstances	Treated like an Urgent Care Claim or a Pre-Service Claim depending on the circumstances

Post-Service Claim. Any claim for a benefit that is not a Pre-Service Claim.	Within 10 calendar days	Within 15 business days
	Review provided by HMO personnel not involved in making the Adverse Benefit Determination.	Review provided by HMO Appeals Committee. Review provided by HMO personnel not involved in making the Adverse Benefit Determination.

HMO Timeframe for Responding to an Adverse Benefit Determination for Non-UR Claims

Type of Benefit Determination	Level One Appeal HMO Response Time from Receipt of Appeal	Level Two Appeal HMO Response Time from Receipt of Appeal
Rescission of Coverage	Within 30 calendar days	Within 30 calendar days
Post-Service Claim. Any claim for a benefit that is not a Pre-Service Claim	Within 30 calendar days	Within 30 calendar days

When the Level One **Appeal** is for an **Adverse Benefit Determination**, based in whole or in part on a medical professional’s judgment and input, the review will be conducted by a **Physician** who was not the original reviewer nor a subordinate of the original reviewer who rendered the initial **Adverse Benefit Determination**.

When the Level Two **Appeal** is for an **Adverse Benefit Determination**, based in whole or in part on a medical professionals judgment and input, the **HMO** will conduct a same or similar specialty review for **Appeals** involving clinical issues before a panel of **Physicians** and/or other health care professionals selected by **HMO** who have not been involved in any of the previous utilization management decisions. In no event, however, will the consulting practitioner or professional have been involved in the utilization management determination at issue.

The hearing will be informal. A **Member’s Physician** or other experts may testify. The **Member** and/or an authorized representative may attend the Level Two **Appeal** and question the representatives of **HMO** and present his/her case. **HMO** also has the right to present witnesses.

D. Exhaustion of Process.

You may contact the New Jersey Department of Banking and Insurance to file a **Complaint/Appeal** or, request an investigation of a **Complaint/Appeal** at any time. You are not required to exhaust the Level One and Level Two **Appeals** process before contacting the New Jersey Department of Banking and Insurance.

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

Before filing a Level One or Two **Appeal** with **Aetna**, you or your authorized representative, may also contact the New Jersey Office of Insurance Claims Ombudsman if you are dissatisfied with the decision reached by **Aetna**.

Office of Insurance Claims Ombudsman
Department of Banking and Insurance
P.O. Box 472
Trenton, NJ 08625-0472
Phone: 800-446-7467 (outside of NJ call 609-292-5316 and ask for the Ombudsman's Office)
Fax: 609-292-2431
Email: ombudsman@dobi.state.nj.us

Unless serious or significant harm has occurred or will imminently occur to you, you must exhaust an **Appeal** through the Independent Health Care **Appeals** Program before you establish any litigation; arbitration; or administrative proceeding; regarding an alleged breach of the policy terms by **HMO**; or any matter within the scope of the **Appeals** procedure.

Under certain circumstances a **Member** may seek simultaneous review through the Internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where the **Member** is receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

If **HMO** does not adhere to all claim determination and **Appeal** requirements of the Federal Department of Health and Human Services, the **Member** is considered to have exhausted the **Appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits though, on what sends a claim or an **Appeal** straight to **External Review**. A **Member's** claim or internal **Appeals** *will not go* straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm the **Member**;
- it was for a good cause or was beyond **HMO's** control; and
- it was part of an ongoing, good faith exchange between the **Member** and **HMO**.

In the event that **HMO** fails to comply with any of the deadlines for completion of the Level One **Appeal** or Level Two **Appeal**, or in the event that **HMO**, for any reason, expressly waives its rights to an internal review of any **Appeal**, then the **Member** and/or **Provider** shall be relieved of their obligation to complete the **HMO** internal review process and may, at their option, proceed directly to the External Review Process set forth in section E below. There are limits though, on what sends a claim or an **Appeal** straight to **External Review**. A **Member's** claim or internal **Appeals** *will not go* straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm the **Member**;
- it was for a good cause or was beyond **HMO's** control; and
- it was part of an ongoing, good faith exchange between the **Member** and **HMO**.

The **Member**, authorized representative of the **Member**, or a **Provider** acting on behalf of a **Member** may request a written explanation of the violation from the **HMO** and the **HMO** must provide such explanation of the violation within ten days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal Claim and Appeals Process to be deemed exhausted.

If an external reviewer or a court rejects the **Member's**, authorized representative, or **Provider's** request for immediate review on the basis that the **HMO** met the standards for the exception set forth in this paragraph, the **Member**, authorized representative, or **Provider** has the right to resubmit and pursue the internal **Appeal** of the claim. An **Appeal** should be made within a reasonable time after the external reviewer or court rejects the claim for immediate review, not to exceed ten (10) days. The **HMO** must provide the **Member** with notice of the opportunity to resubmit and pursue the internal **Appeal**. The time period for submitting the **Appeal** begins to run when the **Member**, authorized representative, or **Provider** receives notice.

E. **External Review Process.**

Any **Member**, or any **Provider** acting on behalf of a **Member**, with the **Member's** consent, who is dissatisfied with the result of the Level One **Appeal** and Level Two **Appeal** process above, shall have the right to pursue their appeal to an Independent Utilization Review Organization (IURO) in accordance with the procedures set forth below for **Final Internal Adverse Benefit Determinations** based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a **Covered Benefit**. Except as set forth in section C above, the right to an **External Review** under this section shall be contingent upon the **Member's** full compliance with both stages of the **HMO** Level One and Level Two **Appeal** processes, except that you and any **Provider** acting on your behalf with your consent shall be relieved of the carrier's internal **Appeal** process and may pursue an **Appeal** through the Independent Health Care **Appeals** program if:

- A determination on any **Appeal** regarding **Urgent** or **Emergency Care** is not forthcoming from **HMO** within 72 hours of receipt by **HMO** or notice (in the manner required under the plan) of the **Appeal**;
 - A determination on an initial **Appeal**, other than one regarding **Urgent** or **Emergency Care**, is not forthcoming from **HMO** within 10 calendar days of the date that **HMO** received notice (in the manner required under the plan) of the **Appeal**; or
 - A determination of a subsequent level of **Appeal**, other than one regarding **Urgent** or **Emergency Care**, is not forthcoming from **HMO** within 20 business days of the date that **HMO** received notice (in the manner required under the plan) of the **Appeal**.
1. Within four-months from receipt of the written determination of the Level Two **Appeal** panel, the **Member**, or a **Provider** acting on behalf of the **Member** with the **Member's** consent, shall file a written request with the New Jersey Department of Banking and Insurance. The request shall be filed on forms, if applicable, provided to the **Member** by **HMO** and include both a filing fee and a general release executed by the **Member** for all medical records pertinent to the **Appeal**. The request shall be mailed to:

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

2. The fee for filing an **Appeal** shall be \$25.00, payable by check or money order to the New Jersey Department of Banking and Insurance. The filing fee shall be refunded if the **Final Internal Adverse Benefit Determination** is reversed by the IURO. Upon a determination of financial hardship, the fee may be reduced to \$2.00. Financial hardship may be demonstrated by the **Member** through evidence of eligibility for either the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ FamilyCare, General Assistance, SSI, or New Jersey Unemployment Assistance. Annual filing fees for any one **Member** shall not exceed \$75.00.
3. Upon receipt of the **Appeal**, together with the executed release and the appropriate fee, the New Jersey Department of Banking and Insurance shall immediately assign the **Appeal** to an IURO.
4. Upon receipt of the request for **Appeal** from the New Jersey Department of Banking and Insurance, the IURO shall conduct a preliminary review of the **Appeal** and accept it for processing if it determines that:
- i. the individual was or is a **Member** of the **HMO**;

- ii. the service which is the subject of the **Complaint** or **Appeal** reasonably appears to be a **Covered Benefit** under the Certificate of Coverage;
 - iii. the **Member** has fully complied with both the Level One and Level Two **Appeal** processes unless the **HMO** fails to comply with any of the deadlines for completion of the internal Appeals Process. This will not apply if the **HMO's** violation does not cause and is not likely to cause, prejudice, or harm to the **Member** and/or **Provider**. The **HMO** must demonstrate that the violation was for good cause or due to matters beyond the control of the **HMO** and that the violation occurred in the context of an ongoing good faith exchange of information between the **HMO**, the **Member**, the **Member's** authorized representative; and/or a **Provider** acting on behalf of the **Member** and is not reflective of a pattern of non-compliance by the **HMO**;
 - iv. the **Member** has provided all information required by the IURO and the New Jersey Department of Banking and Insurance to make the preliminary determination including the **Appeal** form and a copy of any information provided by the **HMO** regarding its decision to deny, reduce, or terminate the **Covered Benefit**, and a fully executed release to obtain any necessary medical records from the **HMO** and any other relevant health care **Provider**; and
 - v. you have remitted the required fee to the New Jersey Department of Banking and Insurance.
5. Upon completion of the preliminary review, the IURO shall immediately notify the **Member** and/or **Provider** in writing as to whether the **Appeal** has been accepted for processing and if not so accepted, the reasons therefore. Additionally, the IURO shall notify the **Member** and/or **Provider** of his or her right to submit in writing, within five business days of the **Member's** or **Provider's** receipt of the notice of acceptance of his or her **Appeal**, any additional information to be considered in the IURO's review. The IURO shall provide the **HMO** with any such additional information within one business day of receipt of the information.
6. Upon acceptance of the **Appeal** for processing, the IURO shall conduct a full review to determine whether, as a result of the **HMO's** utilization management determination, the **Member** was deprived of **Medically Necessary Covered Benefits**. In reaching this determination, the IURO shall take into consideration all pertinent medical records, consulting **Physician** reports, and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by the **HMO**.
7. The full review referenced above shall refer all cases for review to an expert **Physician** in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the **Appeal**. All final decisions of the IURO shall be approved by the medical director of the IURO who shall be a **Physician** licensed to practice in New Jersey.
8. The IURO shall complete its review and issue its decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 45 calendar days from receipt of the request for the IURO review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event, the IURO shall, prior to the conclusion of the preliminary review, provide written notice to the **Member**, to the New Jersey Department of Banking and Insurance, and to the **HMO** setting forth the status of its review and the specific reasons for the delay. If the **Appeal** involves care for an urgent or emergency case, an admission, availability of care, continued stay, health care services for which the **Member** received

emergency services but has not been discharged from a facility or involves a medical condition for which standard external review time frame would seriously jeopardize the life or health of the **Member** or jeopardize the **Member's** ability to regain maximum function, the IURO must complete its review within no more than 48 hours following its receipt of the **Appeal**.

9. If the IURO determines that the **Member** was deprived of **Medically Necessary Covered Benefits**, the IURO shall recommend to the **Member**, the **HMO**, and the New Jersey Department of Banking and Insurance, the appropriate covered health care services the **Member** should receive.
10. Once the review is complete, **HMO** will abide by the decision of the IURO except to the extent that other remedies are available to either party under State or Federal law. The **HMO** shall provide benefits (including payment on the claim) pursuant to the ⁴ IURO's determination without delay even if the **HMO** plans to seek judicial review of the external review decision (unless there is a judicial decision stating otherwise). Within 10 business days of the receipt of the decision of the ⁴ IURO, the **HMO** must submit a written report to the ⁴ IURO, the **Member**, the **Member's** authorized representative, or the **Provider** who made the **Appeal** acting on behalf of the **Member** with the **Member's** consent and the Department of Banking and Insurance indicating how the **HMO** will implement the IURO's determination.
11. The cost of the review by IURO will be borne by **HMO**.

F. **Record Retention.**

HMO shall retain the records of all **Complaints** and **Appeals** for a period of at least 7 years.

G. **Fees and Costs.**

Except as set forth in section E. 11 above for an **External Review**, nothing herein shall be construed to require **HMO** to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a **Complaint** or **Appeal**.

**AETNA HEALTH INC.
(NEW JERSEY)**

AETNA OPEN ACCESS RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

HMO and **Contract Holder** agree to provide **Covered Benefits** under this plan as described below and subject to the provisions of this Rider. The **Member** may obtain **Covered Benefits** from **Participating Providers** without a **Referral** from their selected **PCP**.

Item A under the **HMO** Procedure section of the **Certificate** is amended to delete the following sentence:

Until a **PCP** is selected, benefits will be limited to coverage for **Medical Emergency** care.

Item B under the **HMO** Procedure section of the **Certificate** is deleted and replaced with the following:

B. The Primary Care Physician (PCP).

The **PCP** provides services for the treatment of routine illnesses, injuries, well baby and preventive care services which do not require the services of a **Specialist**, and for non-office hour **Urgent Care** services under this plan. The **Member's** selected **PCP** or that **PCP's** covering **Physician** is required to be available 7 days a week, 24 hours a day for **Urgent Care** services.

A **Member** is encouraged to select a **PCP** for themselves and for each of their **Covered Dependents** at the time of enrollment, however this is not a plan requirement. If a **Member** selects a **PCP**, the **Member** may change their **PCP** at any time by contacting **HMO**.

A **Member** will be subject to the **PCP Copayment** listed on the Schedule of Benefits when a **Member** obtains **Covered Benefits** from any **Participating PCP**.

Certain **PCP** offices are affiliated with integrated delivery systems or other provider groups (i.e., Independent Practice Associations and Physician-Hospital Organizations), and **Members** who select these **PCPs** will generally be referred to **Specialists** and **Hospitals** within that system or group. However, if the group does not include a **Provider** qualified to meet the **Member's** medical needs, the **Member** may request to have services provided by nonaffiliated **Providers**.

If the **Member's PCP** performs, suggests, or recommends a **Member** for a course of treatment that includes services that are not **Covered Benefits**, the entire cost of any such non-covered services will be the **Member's** responsibility.

The **Covered Benefits** section of the **Certificate** is amended to include the following provisions:

- **Self-Referral Services.**

Except as described in the Exclusions and Limitations section of this Rider, the **Certificate**, any amendments and/or riders are hereby revised to remove the requirement that a **Member** must obtain a **Referral** from their **PCP** prior to accessing **Covered Benefits** from **Participating Providers**.

Under this provision, a **Member** may directly access **Participating Specialists**, ancillary **Providers** and facilities for **Covered Benefits** without a **PCP Referral**, subject to the terms and conditions of the **Certificate** and any cost-sharing requirements set forth in the Schedule of Benefits. **Participating Providers** will be responsible for obtaining pre-authorization of services from **HMO**.

Except as described in this Rider, the Covered Benefits section and the Exclusions and Limitations section of the **Certificate** remain unchanged and the ability of a **Member** to directly access **Participating Providers** does not alter any other provisions of the **Certificate**. Except for **Emergency Services** and out-of-area **Urgent Care** services, a **Member** must access **Covered Benefits** from **Participating Providers**. Services rendered by non-**Participating Providers** will not be covered in non-emergent and non-urgent situations unless **HMO** has pre-authorized the use of such non-**Participating Provider**.

The Infertility Services Benefit provision of the **Covered Benefits** section of the **Certificate** is amended to include the following provision:

- **Infertility Program** – A **Member** or their **Participating Physician** may contact the **Infertility** case management unit to apply for eligibility. A **Member** who is eligible for the program may be subject to case management, have access to a select network of **Participating Providers** and will be required to utilize **Participating Providers** from this select network to receive **Covered Benefits**.

The Exclusions and Limitations section of the Certificate is amended to delete the following exclusion:

- Unauthorized services, including any service obtained by or on behalf of a **Member** without a prior written **Referral** issued by the **Member's PCP** or certified by **HMO**. This exclusion does not apply in a **Medical Emergency** or in an **Urgent Care** situation or when it is a direct access benefit.

The Exclusions and Limitations section of the Certificate is amended to include the following limitations:

- Upon pre-authorization, other treatment plans may be subject to case management and a **Member** may be directed to specific **Participating Providers** for **Covered Benefits** including, but not limited to transplants and other treatment plans.
- Supplemental plans provided under a separate contract or policy in addition to an **HMO** health benefit plan, including but not limited to dental plans and behavioral health plans, are not subject to the provisions of this Rider and a **Member** is required to abide by the terms and conditions of the separate contract or policy.

The Continuation and Conversion section of the **Certificate** is amended to include the following provision:

- The conversion privilege does not apply to the Aetna Open Access Rider.

**AETNA HEALTH INC.
(NEW JERSEY)**

**INHERITED METABOLIC DISEASE
AMENDMENT**

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate is hereby amended:**

The **Covered Benefits, Additional Benefits, Inherited Metabolic Diseases** section is hereby deleted and replaced with the following:

- **Inherited Metabolic Diseases Benefit.** Coverage is provided for expenses incurred in the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products, when diagnosed and determined to be **Medically Necessary** by the **Member's Physician**. The benefits shall be provided to the same extent as for any medical condition under the **Certificate**.

All other terms and conditions of the **Certificate** shall remain in full force and effect except as amended herein.

**AETNA HEALTH INC.
(NEW JERSEY)**

**AUTISM AND OTHER DEVELOPMENTAL DISABILITIES
AMENDMENT**

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **(HMO) Certificate** is hereby amended as follows:

1. The Definitions section of the **Certificate** is hereby amended to add the following definition(s):

Autism/Autism Spectrum Disorder: This means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- a) Autistic Disorder;
- b) Rett's Disorder;
- c) Childhood Disintegrative Disorder;
- d) Asperger's Syndrome; and
- e) Pervasive Developmental Disorder - Not Otherwise Specified.

Developmental Disability or Developmentally Disabled: This means a severe, chronic disability that:

- a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
- b) is manifested before the Covered Person:
 - 1. attains age 22 for purpose of the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision; or
 - 2. attains age 26 for all other provisions;
- c) is likely to continue indefinitely;
- d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
- e) reflects the Covered Person's need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

2. The Definitions section of the **Certificate** is hereby amended as follows:

The **Physician** definition is hereby deleted and replaced with the following:

Physician. A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.

For the purpose of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, **Physician** 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.

3. The General Exclusions Section of the **Certificate** has been amended as follows:

The Educational Exclusion is hereby deleted and replaced with the following:

Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered. This item does not apply to the treatment of **Biologically-Based Mental Illnesses**, including pervasive developmental disorders, developmental disabilities and autism as provided in the **Covered Benefits** section.

4. The **Covered Benefits** section of the **Certificate** is hereby amended to add the following benefit(s) under the **Additional Benefits** Section:

Diagnosis and Treatment of Autism /Autism Spectrum Disorder and Other Developmental Disabilities

Coverage is provided for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Covered Person's primary diagnosis is autism or another developmental disability, the following medically necessary therapies as prescribed through a treatment plan and subject to any benefit limits reflected on the Schedule of Benefits are covered:

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

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 under the Rehabilitation Benefits Section of this **Certificate**.

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

The treatment plan(s) 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.

The **HMO** may request additional information if necessary to determine the coverage under the plan. The **HMO** may require the submission of an updated treatment plan once every six (6) months unless the **HMO** and the treating **Physician** agree to more frequent updates.

If a Covered Person:

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

the portion of the family cost-share attributable to such services is a Covered Benefit. The deductible, coinsurance or copayments applicable to a **Primary Care Physician** visit for treatment of an illness or injury will apply to the family cost-share.

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

- 5. The Schedule of Benefits is hereby amended to add the following:

<u>Benefit</u>	<u>Network</u>
Autism/Autism Spectrum Disorder and Other Developmental Disabilities	Cost-sharing is based upon the type of service or supply provided and the place where the service or supply is rendered. For therapy services received through the New Jersey Early Intervention program, the cost-sharing is based upon the cost-sharing applicable to the Primary Care Physician .

- 6. The **Covered Benefits** section of the **Certificate** is hereby amended. Item 2 under Rehabilitation Benefits is hereby added as follows:

- 2. Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Coverage is subject to the limits, if any, shown on the Schedule of Benefits. For inpatient rehabilitation benefits for the services listed below, refer to the Inpatient Hospital and Skilled Nursing Facility benefits provision under the **Covered Benefits** section of this **Certificate**.

- a. Cognitive therapy related to physical rehabilitation is covered when the cognitive deficits have been acquired as a result of a neurologic impairment due to trauma; stroke or encephalopathy; and when the therapy is coordinated with **HMO** as part of a treatment plan intended to restore previous cognitive function.
- b. Physical therapy is covered for non-chronic conditions and acute illnesses and injuries.
- c. Occupational therapy is covered for non-chronic conditions and acute illness or injury. This does not mean vocational rehabilitation or counseling for work.
- d. Speech therapy is covered for non-chronic conditions and acute illness or injury.

For the treatment of **Biologically-Based Mental Illness**, the rule that any of therapies listed above be for non-chronic conditions does not apply.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are covered subject to a maximum of 40 visits per condition. This maximum will not apply to **Biologically-Based Mental Illness** which will be paid subject to the same terms and

conditions as any other illness. The limitations on therapy services do not apply to the Diagnosis and Treatment of Autism or Other Developmental Disabilities.

Refer to the Outpatient Rehabilitation Benefits section of the Schedule of Benefits for applicable **Member** cost-sharing.

**AETNA HEALTH INC.
(NEW JERSEY)**

**ASSIGNMENT OF BENEFITS
AMENDMENT**

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended to add the following paragraphs to the General Provisions, Section D. Assignment of Benefits:

Assignment of Benefits

When a covered person submits a claim for **Emergency** or **Urgent Care** and they assign their right to receive reimbursement for **covered medically necessary** services to an out of network provider, **HMO** is required to pay benefits in line with the assignment of benefits by remitting payment directly to the health care provider in the form of a check payable to the health care provider, or in the alternative, to the health care provider and the covered person as a joint payee, with signature lines for each of the payees.

Any payment made solely to the covered person rather than the health care provider under these circumstances shall be considered unpaid, and unless remitted to the health care provider within the time frames established by New Jersey Law, shall be considered overdue and subject to an interest charge as provided in that act.

All other terms and conditions of the **Certificate** shall remain in full force and effect except as amended herein.

**AETNA HEALTH INC.
(NEW JERSEY)**

COMPASSIONATE CARE AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended as follows:

1. The **Hospice Care** definition in the Definitions section of the **Certificate** is deleted and replaced with the following:
 - **Hospice Care.** A program of care that is provided by a **Hospital, Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 12 months to live.

**AETNA HEALTH INC.
(NEW JERSEY)**

**HMO PROCEDURES
AMENDMENT**

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended to delete and replace the Important Note at the end of **Section C. New Jersey Continuation Rights for Over-Age Dependents** with the following:

Important Note:

- Once the **Contract Holder** has validated the parent of an Over-Age Dependent is covered under the plan, the *Temporary HINT Supplemental Enrollment Information Form* must be completed by the enrollee and submitted to **HMO** according to the timeframes identified in the “Election of Continuation” section shown above.
- An Over-Age Dependent while being issued continued coverage as an Over-Age Dependent is not considered to be a **Subscriber**.
- **HMO** will bill the covered Over-Age Dependent directly and enrollees will remit the premium directly to **HMO**. Enrollees will be required to enter an address on the *Temporary HINT Supplemental Enrollment Information Form* even when it is the same as the **Subscriber's** address.
- Although the **Subscriber** must continue eligibility under the Group plan for continued coverage of the dependent, the dependent must also meet the applicable eligibility criteria. All cost-sharing requirements and limitations will apply, and will not be aggregated with the **Subscriber's** plan. Consequently, **Covered Benefits** incurred by the dependent will not contribute towards the family deductible and Out-of-Pocket Maximums, nor will family incurred expenses contribute towards the Over-Age Dependent's deductibles or Out-of-Pocket Maximums.
- Any deductible or Out-of-Pocket Maximums that the Over-Age Dependent satisfied as a Dependent under the group plan will be used to satisfy the applicable deductible or Out-of-Pocket Maximum cost-sharing for the continued coverage for the Over-Age Dependent.
- The Termination of Coverage section of the **Certificate** does not apply to an Over-Age Dependent. The Over-Age Dependent should refer to the New Jersey Continuation Rights for Over-Age Dependents and the section titled “When Continuation Ends.”
- Over-Age Dependents who have made an Election for Continuation and whose coverage is later terminated under the New Jersey Continuation Rights for Over-Age Dependents are not eligible for the continuation provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or New Jersey Continuation under the group plan.
- The Dependent Eligibility section in the group Schedule of Benefits does not apply to the Over-Age Dependent. The first provision in the New Jersey Continuation Rights for Over-Age Dependents defines an Over-Age Dependent eligibility.
- A dependent of an Over-Age Dependent will not be covered for any **Covered Benefits** in the **Certificate**. This would also include any newborn children.

**AETNA HEALTH INC.
(NEW JERSEY)**

**INFERTILITY
AMENDMENT**

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended:

1. The **Covered Benefits, Infertility Benefits** section is hereby deleted and replaced with the following:

- **Infertility Services.**

Covered Benefits include **Infertility Services** and supplies for the diagnosis and treatment of **Infertility** provided on the same basis as for disease. **Infertility Services** must be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists. Covered **Infertility Services** include, but are not limited to, payment of benefits for the following services and procedures recognized by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists:

- Diagnosis and diagnostic tests;
- **Prescription Drugs** and injectable **prescriptions drugs**;
- Surgery, including microsurgical sperm aspiration;
- Artificial insemination with no limits as to the number of cycles;
- In-vitro fertilization (IVF), including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate;
- gamete intra fallopian transfer (GIFT) and zygote intra fallopian transfer (ZIFT);
- Ovulation induction;
- Intracytoplasmic sperm injection (ICSI) ;
- Fresh and frozen embryo transfer;
- Assisted hatching;
- Obtaining the sperm of a female **Member's** partner; and
- Four completed egg retrievals per lifetime per **Member**:
 - i. Where a live donor is used in the egg retrieval, the medical costs of the donor shall be covered until the donor is released from treatment by the reproductive endocrinologist;

- ii. Only egg retrievals that are a **Covered Benefit** under this **Certificate**, or another **Certificate** or insurance plan with the same **Contract Holder** through **HMO** or any affiliated company of **HMO** will count in determining this limitation.

Fertility Preservation for Members with Cancer

Even though the **Member's** condition does not meet the definition of **Infertility**, **We** will consider **Members** with a diagnosis of cancer, who are planning cancer treatment that is demonstrated to result in **Infertility**, covered for **Infertility** treatment.

Planned cancer treatments include but are not limited to:

- Bilateral orchiectomy (removal of testicles);
- Bilateral oophorectomy (removal of ovaries)
- Hysterectomy (removal of uterus); or
- Chemotherapy or radiation therapy that is established in the medical literature to result in **Infertility**.

In order to qualify for the “**Fertility Preservation for Members with Cancer**” coverage, the **Member** must meet the following criteria:

- Obtain preauthorization from **HMO**.
- **Members** or their partners must not have undergone a previous elective sterilization procedure (e.g. hysterectomy, tubal ligation, vasectomy), with or without surgical reversal, regardless of post reversal results.
- If less than age 35, **Member** must have had a day 3 FSH test in the prior 12 months.
- if age 35 or more, **Member** must have had a day 3 FSH test in the prior 6 months.
- Day 3 FSH level of the female **Member** must not be 19 mIU/mL or greater, in any (past or current) menstrual cycle regardless of the type of **Infertility Service** planned (including donor egg, donor embryo or frozen embryo cycle).
- Only those **Infertility Services** that are **Medically Necessary** are covered.

Infertility procedures involving IVF, GIFT and ZIFT are subject to the following limitations:

- These procedures are covered only if a successful pregnancy cannot be attained through all reasonable, less expensive and medically appropriate treatments available under this **Certificate**.
- Not more than a total of four complete egg retrievals will be covered during a female **Member's** lifetime. Only egg retrievals that are a **Covered Benefit** under this **Certificate**, or another **Certificate** or insurance plan with the same **Contract Holder** through **HMO** or any affiliated company of **HMO** will count

in determining this limitation. “Egg retrieval” is a procedure to collect eggs contained in the woman’s ovarian follicles.

- The number of covered embryo transfers are limited by the number of eggs retrieved in the lifetime maximum of four completed egg retrievals; and
- The **Member** is 45 years of age or younger.

2. The exclusion for **Infertility Services** in the **Exclusions and Limitations** section of the **Certificate** is hereby deleted and replaced with the following:

- **Infertility Services** and supplies (except as described in the **Covered Benefits** section of this **Certificate**),and
 - Reversal of prior voluntary sterilization procedures, except coverage for **Infertility Services** provided to partners of persons who have successfully reversed sterilization may not be excluded provided that the partner is infertile as defined by P. L. 2001, c. 236 and New Jersey Administrative Code 11:4-54.1-54.7;
 - Services rendered to a surrogate for the purposes of childbearing, if the surrogate is not a **Member**;
 - Charges associated with cryopreservation, storage of cryopreserved sperm, eggs, or embryos;
 - **Infertility** treatment that results from voluntary sterilization (even if the person has attempted to reverse sterilization) or gender reassignment surgery (male to female or female to male);
 - Non-medical costs of an egg or sperm donor, except as listed in the **Covered Benefits** section for **Infertility Services.**;
 - **Infertility** treatments that are **Experimental or Investigational** in nature;
 - Home ovulation predictor kits, sperm testing kits and supplies;
 - In vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), and zygote intrafallopian tube transfer (ZIFT) for **Members** who are 46 years of age, or older;
 - **Prescription Drugs** related to treatment of non-covered benefits or related to treatment of **Infertility** that are not **Medically Necessary**;
 - **Infertility Prescription Drugs** to the extent covered elsewhere under the **Group Agreement**, or under another **Group Agreement** or **Group Policy** sponsored by the **Contract Holder**.
 - Any charges associated with obtaining sperm for non-covered **Members**; and
 - Any service provided by a non-participating **Provider**, or any service provided without a prior **Referral**.

3. The Limitation for **Infertility Services** in the **Exclusion and Limitations** section of the **Certificate** is hereby deleted and replaced with the following:

B. **Infertility** procedures involving IVF, GIFT and ZIFT are subject to the following limitations:

- These procedures are covered only if a successful pregnancy cannot be attained through all reasonable, less expensive and medically appropriate treatments available under this **Certificate**.
- Not more than a total of four complete egg retrievals will be covered during a female **Member's** lifetime. Only egg retrievals that are a **Covered Benefit** under this **Certificate**, or another **Certificate** or insurance plan with the same **Contract Holder** through **HMO** or any affiliated company of **HMO** will count in determining this limitation. "Egg retrieval" is a procedure to collect eggs contained in the woman's ovarian follicles.
- The number of covered embryo transfers are limited by the number of eggs retrieved in the lifetime maximum of four completed egg retrievals; and
- The **Member** is 45 years of age or younger.

4. The definition of **Infertility** in the **Definitions Section** of the **Certificate** is hereby deleted and replaced with the following:

Infertility is a disease or condition that results in the abnormal function of the reproductive system such that:

- A male is not able to impregnate a female;
- A female under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
- A female 35 years of age and over is unable to conceive after 12 months of unprotected sexual intercourse;
- The male or female is determined to be medically sterile; or
- The female is not able to carry a pregnancy to live birth.

Additionally, a female without a male partner may be considered infertile if:

- For females under age 35, she is unable to conceive after at least 12 cycles of donor insemination.
- For females age 35 or older, unable to conceive after at least 12 cycles of donor insemination.

All other terms and conditions of the **Certificate** shall remain in full force and effect except as amended herein.

**AETNA HEALTH INC.
(NEW JERSEY)**

**HMO PROCEDURES
AMENDMENT**

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended to delete and replace Item A. **Selecting a Participating Primary Care Physician** under **HMO Procedure** with the following:

A. **Selecting a Participating Primary Care Physician.**

At the time of enrollment, each **Member** must select a **Participating Primary Care Physician (PCP)** from **HMO's** Directory of **Participating Providers** to access **Covered Benefits** as described in this **Certificate**. The choice of a **PCP** is made solely by the **Member**. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf. If the **Member** does not select a **PCP**, **HMO** will designate a **PCP** for the **Member** and notify the **Member** of such selection. The **Member** can change the selection of the **PCP** thereafter. The **PCP** is not an agent or employee of **HMO** and the selection of a **PCP** by **HMO** is merely a convenience for **Members** to assure access to **Covered Benefits**.

All other terms and conditions of the **Certificate** shall remain in full force and effect except as amended herein.

**AETNA HEALTH INC.
(NEW JERSEY)**

**EMERGENCY CARE AND URGENT CARE
AMENDMENT**

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended.

The **HMO Procedure, B. The Primary Care Physician Section** is hereby deleted and replaced with the following:

B. The Primary Care Physician.

The **PCP** coordinates a **Member's** medical care, as appropriate, either by providing treatment or by issuing **Referrals** to direct the **Member** to a **Participating Provider**. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Except in a **Medical Emergency/Urgent Care** situation or for certain direct access **Specialist** benefits as described in this **Certificate**, only those services which are provided by or referred by a **Member's PCP** will be covered. **Covered Benefits** are described in the Covered Benefits section of this **Certificate**. It is a **Member's** responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

If the **Member's PCP** performs, suggests, or recommends a **Member** for a course of treatment that includes services that are not **Covered Benefits**, the entire cost of any such non-covered services will be the **Member's** responsibility.

The **HMO Procedure, F. Authorization Section** is hereby deleted and replaced with the following:

F. Authorization.

Certain services and supplies under this **Certificate** may require authorization by **HMO** to determine if they are **Covered Benefits** under this **Certificate**. Those services and supplies requiring **HMO** authorization are indicated in this **Certificate**. Preauthorization is not required for **Medical Emergency** and **Urgent Care** services.

The **Covered Benefits, K. Emergency Care/Urgent Care Section** is modified to add the following:

3. Preauthorization is not required for **Emergency Care/Urgent Care** services.

All other terms and conditions of the **Certificate** and the Schedule of Benefits shall remain in full force and effect except as amended herein.

**AETNA HEALTH INC.
(NEW JERSEY)**

**CERTIFICATE OF COVERAGE AND
SCHEDULE OF BENEFITS
AMENDMENT**

Contract Holder Group Agreement Effective Date: January 1, 2013

The Aetna Health Inc. **Certificate** is hereby amended as follows:

- The eligibility rules for **Covered Dependents** in the Eligibility and Enrollment section of the **Certificate** and the Dependent Eligibility section of the Schedule of Benefits have been changed. A child will now be eligible to enroll if he or she is under 26 years of age. Any rule that they be a full-time student, unmarried or not in a Domestic or Civil Union Partnership or chiefly dependent upon the **Subscriber** for support will not apply. All other dependent eligibility rules still apply.

If the **Subscriber** has a child that can now be enrolled, the **Subscriber** may contact Member Services for details.

Coverage is available for a child who has reached the age at which coverage would otherwise end who is chiefly dependent upon the **Subscriber** for support and maintenance, and is incapable of self-support due to mental or physical incapacity, either of which commenced prior to the age the dependent lost eligibility who is not married, or who is not in a civil union partnership or a domestic partner relationship.

- The first paragraph of the New Jersey Continuation Rights for Overage Dependents has been modified to read as follows:

As used in this provision, "Over-Age Dependent" means your child by blood or law who:

- a) has reached the limiting age as described in the Dependent Eligibility section of the **Certificate** and Schedule of Benefits but is less than 31 years of age;
 - b) is not married or in a domestic partnership or civil union partnership;
 - c) has no Dependents of his or her own;
 - d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and
 - e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.
- Any overall plan Calendar Year; **Contract Year**; or Lifetime Maximum Benefits that are dollar maximums in the Schedule of Benefits no longer apply. All references to these overall plan dollar maximums that may appear in the Schedule of Benefits and **Certificate**, including any amendments or Riders, which have been issued to the **Member** are removed.
 - The following Preventive Care services are **Covered Benefits**, and will be paid at 100% with no cost-sharing such as **Copayment**, **Coinsurance**, or **Deductibles** and dollar maximum benefits:
 - Routine Adult Physical Examinations (including immunizations, routine vision and hearing screenings);
 - Routine Well Child Care (including immunizations);
 - Routine Cancer Screenings (which include Screening Mammograms; Prostate Specific Antigen (PSA) Tests; Digital-Rectal Exams (DRE); Fecal Occult Blood Tests (FOBT); Sigmoidoscopies; Double Contrast Barium Enemas (DCBE) and Colonoscopies); and
 - Routine Gynecological Exams, including routine Pap smears.

These benefits will be subject to age; family history; and frequency guidelines. The guidelines will be determined by applying the more generous rules, as they apply to the **Member**, as set forth in:

- the most recently published preventive health care guidelines as required by the Federal Department of Health and Human Services; or
 - the state laws and regulations that govern the **Group Agreement**.
- Any calendar year; **Contract Year**; or lifetime dollar maximum benefit that applies to an "Essential Service" (as defined by the Federal Department of Health and Human Services) listed below, no longer applies.

If the following Essential Services are **Covered Benefits** under the **Member's Certificate**, and such **Covered Benefits** include these dollar maximums, then the maximums are removed from the Schedule of Benefits and **Certificate**, including any amendments or riders, which have been issued to the **Member**:

- Diagnostic X-Ray and Laboratory Testing;
- **Emergency Services** (including medical transportation during a **Medical Emergency**);
- **Home Health Care**;
- Infusion Therapy;
- Injectable Medications;
- Inpatient **Hospital**;
- Maternity Care and Related Newborn Care;
- **Mental Disorders** (inpatient and outpatient);
- **Substance Abuse** (inpatient and outpatient);
- Outpatient Prescription Drug Rider benefits;
- Outpatient **Surgery** (when performed at a **Hospital** Outpatient Facility or at a facility other than a **Hospital** Outpatient Facility, including **Physician's** office visit surgery when performed by a **PCP** or **Specialist**);
- **Primary Care Physician (PCP)** and **Specialist Physician** Office Visits (including **E-visits**);
- Prosthetic Devices;
- **Skilled Nursing Facility**;
- Short Term Outpatient Rehabilitation Therapies (cognitive, occupational, physical and speech);
- **Transplants** (facility and non-facility);
- **Urgent Care**; and
- **Walk-in Clinic** visits.

THE ABOVE ESSENTIAL SERVICES MAY NOT BE **COVERED BENEFITS** UNDER THE **MEMBER'S CERTIFICATE**. **MEMBERS** SHOULD REFER TO THEIR **CERTIFICATE** FOR A COMPLETE LIST OF **COVERED BENEFITS** AND EXCLUSIONS AND LIMITATIONS.

Essential Services will continue to be subject to any **Copayments**, **Coinsurance**, **Deductibles**, other types of maximums (e.g., day and visit), **Referral** and pre-authorization rules, and exclusions and limitations that apply to these **Covered Benefits** as indicated in the Schedule of Benefits and **Certificate**, including any amendments or riders.

- Office visits for obstetrical care, including preventive, routine and diagnostic, are now Direct Access Specialist Benefits and are covered without a **Referral** or pre-authorization when rendered by a **Participating Provider**.
- If a **Member's** coverage under the **Certificate** is rescinded, **HMO** will provide the **Member** with a 30-day advance written notice prior to the date of the rescission.

**AETNA HEALTH INC.
(NEW JERSEY)**

DOMESTIC PARTNER RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

Subsection A.2.a of the Eligibility and Enrollment section of the **Certificate** is hereby deleted and replaced with the following:

- a. the legal spouse or domestic partner of a **Subscriber** under this **Certificate**, and who, as of the date of enrollment (with respect to a domestic partner):
 - i. provides proof of cohabitation (e.g. driver's license or tax return);
 - ii. are both of the age of consent in their state of residence;
 - iii. are not related by blood in any manner that would bar marriage in their state of residence;
 - iv. have a close, committed and monogamous personal relationship;
 - v. have been sharing the same household on a continuous basis for at least 6 months;
 - vi. have registered as domestic partners where such registration is available;
 - vii. is not married to, or separated from, another individual;
 - viii. have not been registered as a member of another domestic partnership within the last 6 months; and
 - ix. demonstrates financial interdependence by submission of proof of three or more of the following:
 - a) common ownership of real property or a common leasehold interest in such property;
 - b) common ownership of a motor vehicle;
 - c) joint bank accounts or credit accounts;
 - d) designation as a beneficiary for life insurance or retirement benefits, or under the partner's will;
 - e) assignment of a durable power of attorney or health care power of attorney; or
 - f) such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case
 - x. and is of the same sex as the **Subscriber**.

HMO may request documentation of any of the foregoing prior to commencing coverage for a domestic partner; or

**AETNA HEALTH INC.
(NEW JERSEY)**

PRESCRIPTION LENS RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

Aetna Health Inc. ("HMO") and **Contract Holder** agree to offer to **Members** the **HMO** Prescription Lens plan, subject to the following provisions:

The Covered Benefits section of the **Certificate** is amended to add the following provision:

- **Prescription Lens Benefits.**

Member is eligible for an allowance up to \$100 for the purchase of prescription lenses and frames (including prescription contact lenses). This allowance is payable once in each 24 month period commencing with the date of **Member's** initial use of this benefit.

Member will be reimbursed for the amount of this allowance. However, if the prescription lenses or frames are purchased from select **Providers** who have an agreement with **HMO** to bill **HMO** directly, the allowance will be directly deducted from the cost of the prescription lenses or frames.

The Continuation and Conversion section of the **Certificate** is hereby amended to add the following provision:

The conversion privilege does not apply to the Prescription Lens Rider.

**AETNA HEALTH INC.
(NEW JERSEY)**

MORBID OBESITY SURGICAL TREATMENT RIDER

Contract Holder Group Agreement Effective Date: January 1, 2013

Aetna Health Inc., ("HMO") and **Contract Holder**, agree to provide to **Members** the Morbid Obesity Surgical Treatment Rider subject to the following provisions:

The Definitions section of the **Certificate** is hereby amended to add the following definition(s):

- **Body Mass Index.** A practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.
- **Morbid Obesity.** 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 medical condition, including significant cardiovascular disease, sleep apnea, or uncontrolled type-2 diabetes.

The Covered Benefits section of the **Certificate** is hereby amended to add the following benefit(s):

- **Morbid Obesity Surgical Benefits**

Surgical treatment of **Morbid Obesity** is a **Covered Benefit**, when provided by a **Participating Provider** and when authorized in advance by **HMO**. Coverage includes one surgical procedure within a two-year period, beginning with the date of the first **Morbid Obesity** surgical procedure, unless a multi-stage procedure is planned and approved by **HMO**.

Coverage for Morbid Obesity Surgical benefits are only provided for referred care.

Refer to the Schedule of Benefits attached to this **Certificate** for applicable cost sharing provisions.

The following exclusions are hereby deleted from the Exclusions and Limitations section of the **Certificate**:

- Surgical operations, procedures or treatment of obesity, except when pre-authorized by **HMO**.
- Weight reduction programs, or dietary supplements.

The Exclusions and Limitations section of the **Certificate** is hereby amended to add the following exclusion(s):

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and 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 provided by this rider.

The Continuation and Conversion section of the **Certificate** is hereby amended to add the following provision:

The conversion privilege, if any, does not apply to the Morbid Obesity Surgical Treatment Rider.

The Schedule of Benefits is hereby amended to add the following:

MORBID OBESITY SURGICAL TREATMENT BENEFITS

Benefit

Deductible/Copayment/Maximums

Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services).

Refer to the Schedule of Benefits for applicable cost sharing provisions.

Copayment(s) for **Morbid Obesity** services do not apply to the Maximum Out-of-Pocket Copayment Limit, if any, listed in the Schedule of Benefits.

**AETNA HEALTH INC.
(NEW JERSEY)**

PRESCRIPTION PLAN RIDER

Group Agreement Effective Date: January 1, 2013

HMO and **Contract Holder** agree to provide to **Members** the **HMO** Prescription Plan Rider, subject to the following provisions:

DEFINITIONS

The Definitions section of the **Certificate** is amended to include the following definitions:

- **Brand Name Prescription Drug(s).** A prescription drug as determined by the Food and Drug Administration (FDA) and is protected by the trademark registration of the pharmaceutical company which produces them.
- **Drug Formulary.** A list of prescription drugs and insulin established by **HMO** or an affiliate, which includes both **Brand Name Prescription Drugs**, and **Generic Prescription Drugs**. This list is subject to periodic review and modification by **HMO** or an affiliate. A copy of the **Drug Formulary** will be available upon request by the **Member** or may be accessed at the pharmacy website, at www.aetna.com.

For purposes of **Copayment** determination under a formulary/non-formulary **Copayment** plan design, a **Member** will pay the formulary drug **Copayment** for a covered **Non-Formulary Prescription Drug** when the **Provider** certifies to **HMO** the **Medical Necessity** of the drug by following the **Medical Exceptions Process** defined below.

To obtain a **Copayment** reduction the **Member** or **Provider** must follow the Medical Exception Process as specified in this rider.

- **Generic Prescription Drug(s).** A prescription drug as determined by the Food and Drug Administration (FDA) and which is identical to the **Brand Name Prescription Drug** in strength or concentration, dosage, form and route of administration.
- **Medical Exception Process.** A **Member** and their **Provider** may request that a covered **Non-Formulary Prescription Drug** be covered subject to the applicable **Copayment** for a **Formulary Prescription Drug**. **HMO** will consider a **Non-Formulary Prescription Drug** to be **Medically Necessary** and appropriate if:
 - a. it is approved under the Federal Food, Drug and Cosmetic Act (21 U.S.C. §§ 301 et seq.); or
 - b. 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 professional journal; and
 - c. the prescribing **Provider** states that all prescription drugs on the **Drug Formulary** have been ineffective in the treatment of the **Member's** disease or condition or all prescription drugs on the **Drug Formulary** cause, or are reasonably expected to cause, adverse or harmful reactions in the **Member**.

HMO will respond to the **Provider** by telephone or other telecommunication device within 24 hours of a request for **Medical Exception**. Failure of **HMO** to respond within 24 hours may be deemed an approval of the request.

Clinical denials shall be issued to the **Provider** and the **Member** in writing within 5 business days of receipt of the request for approval of coverage of a **Non-Formulary Prescription Drug**. The denial shall include the clinical reason for the denial and that the denial is appealable to the Independent Health Care Appeals Program in the Department of Banking and Insurance. Refer to the Claim Determination Procedures/Complaints and Appeal section in the **Certificate** for details of the appeal process.

- **Negotiated Charge.** The compensation amount negotiated between **HMO** or an affiliate and a **Participating Retail Pharmacy, Mail Order Pharmacy or Specialty Pharmacy Network** pharmacy for **Medically Necessary** outpatient prescription drugs and insulin dispensed to a **Member** and covered under the **Member's** benefit plan. This negotiated compensation amount does not reflect or include any amount **HMO** or an affiliate may receive under a rebate arrangement between **HMO** or an affiliate and a drug manufacturer for any drug, including drugs on the **Drug Formulary**.
- **Non-Formulary Prescription Drug(s).** A product or drug not listed on the **Drug Formulary**.
- **Participating Mail Order Pharmacy.** A pharmacy, which has contracted with **HMO** or an affiliate to provide covered outpatient prescription drugs or medicines, and insulin to **Members** by mail or other carrier.
- **Participating Retail Pharmacy.** A community pharmacy which has contracted with **HMO** or an affiliate to provide covered outpatient prescription drugs to **Members**.
- **Precertification Program.** For certain outpatient prescription drugs, a prescribing **Physician** must contact **HMO** or an affiliate to request and obtain coverage for such drugs. **HMO** will respond to the **Physician** by telephone or other telecommunication device within 24 hours of a request for precertification. Failure of **HMO** to respond within 24 hours may be deemed an approval of the request. The list of prescription drugs requiring precertification is subject to change by **HMO** or an affiliate. An updated copy of the list of prescription drugs requiring precertification shall be available upon request by the **Member** or may be accessed at the pharmacy website, at www.aetna.com. If precertification is not obtained, the **Member** must directly pay the **Participating Retail, Specialty Pharmacy Network or Participating Mail Order Pharmacy** in full for the cost of the prescription drug. To be eligible for reimbursement, the **Member** is responsible for submitting a request for reimbursement in writing to **HMO**. The request must include a copy of the receipt for the cost of the prescription drug and documentation from the prescribing **Physician** that the prescription drug is **Medically Necessary** for the **Member's** medical condition. Upon approval of the claim, **HMO** will directly reimburse the **Member** 100% of the cost of the prescription drug, less the applicable **Copayment** specified in this rider.
- **Self-Injectable Drug(s).** Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions. An updated copy of the list of covered **Self-Injectable Drugs**, designated by **HMO** as eligible for coverage under this rider, shall be available upon request by the **Member** or may be accessed at the **HMO** website, at www.aetna.com. The list is subject to change by **HMO** or an affiliate.
- **Specialty Pharmacy Network.** A network of **Participating** pharmacies designated to fill **Self-Injectable Drug** prescriptions.

COVERED BENEFITS

The Covered Benefits section of the **Certificate** is amended to add the following provision:

A. **Outpatient Prescription Drugs Benefit.**

Medically Necessary outpatient prescription drugs and insulin are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines subject to the terms, **HMO** policies and Exclusions and Limitations section described in this rider and the **Certificate**. Coverage is based on **HMO's** or an affiliate's determination if a prescription drug is covered, subject to the Claim Determination

Procedures/Complaints and Appeal section of the **Certificate**. Some items are covered only with precertification from **HMO**. Items covered by this rider are subject to drug utilization review by **HMO** and/or **Member's Participating Provider** and/or **Member's Participating Retail, Specialty Pharmacy Network** or **Mail Order Pharmacy**.

- B. Each prescription is limited to a maximum 90 day supply when filled by the **Participating Retail, Specialty Pharmacy Network** or **Mail Order Pharmacy** designated by **HMO**. Except in an emergency or **Urgent Care** situation, or when the **Member** is traveling outside the **HMO Service Area**, prescriptions must be filled at a **Participating Retail, Specialty Pharmacy Network** or **Mail Order Pharmacy**. Coverage of prescription drugs may be subject to the **Precertification Program** or other **HMO** requirements or limitations, in **HMO's** discretion.
- C. FDA approved prescription drugs are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer-reviewed journal. Coverage of off-label use of these drugs may, in **HMO's** discretion, be subject to the **Precertification Program** or other plan requirements or limitations.
- D. **Emergency Prescriptions** - Emergency prescriptions are covered subject to the following terms:

When a **Member** needs a prescription filled in an emergency or **Urgent Care** situation, or when the **Member** is traveling outside of the **HMO Service Area**, **HMO** will reimburse the **Member** as described below.

When a **Member** obtains an emergency or out-of-area **Urgent Care** prescription at a non-**Participating Retail Pharmacy**, **Member** must directly pay the pharmacy in full for the cost of the prescription. **Member** is responsible for submitting a request for reimbursement in writing to **HMO** with a receipt for the cost of the prescription. Reimbursement requests are subject to professional review by **HMO** to determine if the event meets **HMO's** requirements. Upon approval of the claim, **HMO** will directly reimburse the **Member** 100% of the cost of the prescription, less the applicable **Copayment** specified below. Coverage for items obtained from a non-**Participating** pharmacy is limited to items obtained in connection with covered emergency and out-of-area **Urgent Care** services. **Members** must access a **Participating Retail Pharmacy** or a **Specialty Pharmacy Network** pharmacy for **Urgent Care** prescriptions inside the **HMO Service Area**.

When a **Member** obtains an emergency or **Urgent Care** prescription at any **Participating Retail Pharmacy** or a **Specialty Pharmacy Network** pharmacy, including an out-of-area **Participating Retail Pharmacy** or a **Specialty Pharmacy Network** pharmacy, the **Member** will pay to the **Participating Retail Pharmacy** or **Specialty Pharmacy Network** pharmacy the **Copayment(s)** as described below. **Members** are required to present their ID card at the time the prescription is filled. In the event a **Member** does not have their ID card at the time the prescription is filled, the **Member** needs to inform the pharmacist who can then call **HMO** to confirm eligibility. **HMO** will not cover claims submitted as a direct reimbursement request from a **Member** for a prescription purchased at a **Participating Retail Pharmacy** or **Specialty Pharmacy Network** pharmacy except in circumstances where the **HMO's** on-line system was currently unavailable and the **Participating Retail Pharmacy** or a **Specialty Pharmacy Network** pharmacy was unable to submit through the on-line system. In that case, the **Member** may be required to purchase the prescription, the **Participating Retail Pharmacy** would then submit the prescription through **HMO's** on-line system when it becomes available and **HMO** would then reimburse the **Member**. **Members** must access a **Participating Retail Pharmacy** or **Specialty Pharmacy Network** pharmacy for **Urgent Care** prescriptions inside the **HMO Service Area**.

- E. **Mail Order Prescription Drugs**. Subject to the terms and limitations set forth in this rider, **Medically Necessary** outpatient prescription drugs and insulin are covered when dispensed by the **Participating Mail**

Order Pharmacy or Specialty Pharmacy Network designated by **HMO** and when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs. Outpatient prescription drugs and insulin will not be covered if dispensed by a **Participating Mail Order Pharmacy or Specialty Pharmacy Network** in quantities that are more than a 90 day supply (if the **Provider** prescribes such amounts).

F. **Diabetic Supplies.**

The following diabetic supplies are covered if **Medically Necessary** upon prescription or upon a **Physician's** order only at a **Participating Retail, Specialty Pharmacy Network or Mail Order Pharmacy**. The **Member** must pay applicable **Copayments** as described in the **Copayments** section below.

1. Diabetic needles/syringes.
2. Test strips for glucose monitoring and/or visual reading.
3. Diabetic test agents.
4. Lancets/lancing devices.
5. Alcohol swabs.
6. Oral agents for controlling blood sugar.

Diabetic Supplies will be provided under the same terms and conditions as provided for any other prescriptions under this Prescription Plan Rider. Any applicable **Copayment** will apply as shown below in the **Copayments** section.

G. **Infertility Drugs.** **Infertility** prescription drugs used for the purpose of treating **Infertility** are covered, if **Medically Necessary**. Infertility Drugs will be provided under the same terms and conditions as provided for any other prescriptions under this Prescription Plan Rider. Any applicable **Copayment** will apply as shown below in the **Copayments** section.

H. **Specialized, Non-Standard, Infant Formulas.** Specialized, non-standard, infant formulas are covered by **HMO**:

1. when the infant **Member's Physician** has diagnosed the infant **Member** as having multiple food protein intolerance and has determined this formula to be **Medically Necessary**; and
2. when the infant **Member** has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

Specialized, non-standard, infant formulas will be provided under the same terms and conditions as provided for any other prescription under this Prescription Plan Rider. Any applicable **Copayment** will apply as shown below in the **Copayments** section.

I. **Additional Benefits.**

The following prescription drugs, medicines, and supplies are also covered subject to the terms described in this rider:

- **Contraceptives.**

The following contraceptives and contraceptive devices are covered upon prescription or upon the **Physician's** order only at a **Participating Retail, Specialty Pharmacy Network or Mail Order Pharmacy**:

1. Oral Contraceptives.
2. Diaphragms, 1 per 365 consecutive day period.
3. Injectable contraceptives, the prescription plan **Copayment** applies for each vial up to a maximum of 5 vials per calendar year.

4. Contraceptive patches.
5. Contraceptive rings.
6. Norplant and IUDs are covered when obtained from a **Physician**. The **Physician** will provide insertion and removal of the device. An office visit **Copayment** will apply, if any. A **Copayment** for the contraceptive device may also apply.
7. Any other drug or device used for contraception by a female, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in a state with a prescription written by a health care professional licensed or authorized to write prescriptions.

- **Self-Injectable Drugs.**

Self-Injectable Drugs are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines. The prescription may be filled at either a **Participating Retail Pharmacy, Participating Mail Order Pharmacy or Specialty Pharmacy Network** pharmacy. Coverage of **Self-Injectable Drugs** may, in **HMO's** discretion, be subject to the **Precertification Program** or other **HMO** plan requirements or limitations.

Food and Drug Administration (FDA) approved **Self-Injectable Drugs** are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer-reviewed journal. Coverage of off-label use of these drugs may, in **HMO's** discretion, be subject to the **Precertification Program** or other **HMO** plan requirements or limitations.

Member is responsible for the payment of the applicable **Copayment** for each prescription or refill. The **Copayment** is specified in the copayment section below.

J. Copayments:

Member is responsible for the **Copayments** specified in this rider. The **Copayment**, if any, is payable directly to the **Participating Retail, Specialty Pharmacy Network or Mail Order Pharmacy** for each prescription or refill at the time the prescription or refill is dispensed. If the **Member** obtains more than a 30 day supply of prescription drugs or medicines at the **Participating Retail, Specialty Pharmacy Network or Mail Order Pharmacy**, not to exceed a 60 day supply, 2 **Copayments** are payable for each supply dispensed; 1 **Copayment** is payable for each 30 day supply; 2 **Copayments** are payable for more than a 60 day supply but less than a 91 day supply. The **Copayment** does not apply to the Maximum Out-of-Pocket Limit shown in the Schedule of Benefits for the medical plan, if any.

Prescription Drug/Medicine Quantity	Generic Formulary Prescription Drugs	Brand Name Formulary Prescription Drugs	Non-Formulary Prescription Drugs
For each 30 day supply	\$20	\$40	\$70

EXCLUSIONS AND LIMITATIONS

The Exclusions and Limitations section of the **Certificate** is amended to include the following exclusions and limitations:

A. Exclusions.

Unless specifically covered under this rider, the following are not covered:

1. Any drug which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug) or for which an equivalent over-the-counter product in strength, is available even when a prescription is written, unless otherwise covered by **HMO**.
2. Any drug determined not to be **Medically Necessary** for the treatment of disease or injury unless otherwise covered under this rider.
3. Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by **HMO**.
4. Cosmetic or any drugs used for cosmetic purposes, except those used to treat newborn congenital defects, or to promote hair growth, including but not limited to health and beauty aids.
5. Needles and syringes, excluding diabetic needles and syringes.
6. Any medication which is consumed or administered at the place where it is dispensed, or while a **Member** is in a **Hospital**, or similar facility; or take home prescriptions dispensed from a **Hospital** pharmacy upon discharge, unless the pharmacy is a **Participating Retail Pharmacy**.
7. Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
8. Drugs used for the purpose of weight reduction (e.g., appetite suppressants), including the treatment of obesity.
9. Any refill in excess of the amount specified by the prescription order. Before recognizing charges, **HMO** may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
10. Any refill dispensed more than 1 year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.
11. Drugs prescribed for uses other than uses approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations, or any drug labeled "Caution: Limited by Federal Law to Investigational Use" or experimental drugs. This exclusion does not apply to prescription drugs when the off-label use has not been approved by the FDA for that indication provided that such drug is recognized for treatment of such indication in one of the standard reference compendia described in the Covered Benefits section of the rider, or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one clinical study or review article published in a nationally recognized major peer-reviewed professional journal.
12. Medical supplies, devices (not including contraceptive devices) and equipment and non-medical supplies or substances regardless of their intended use. This exclusion does not apply to certain infant formulas as described under the Covered Benefits section of this Rider.
13. Test agents and devices, excluding diabetic test agents.
14. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this rider.
15. Replacement for lost or stolen prescriptions.
16. Performance, athletic performance or lifestyle enhancement drugs and supplies.
17. Drugs and supplies when not indicated or prescribed for a medical condition as determined by **HMO** or otherwise specifically covered under this rider or the medical plan.
18. Drugs dispensed by other than a **Participating Retail, Specialty Pharmacy Network** pharmacy or **Mail Order Pharmacy**, except as **Medically Necessary** for treatment of an emergency or **Urgent Care** condition.
19. Medication packaged in unit dose form. (Except those products approved for payment by **HMO**).
20. Prophylactic drugs for travel.
21. Drugs for the convenience of **Members** or for preventive purposes.
22. Sildenafil citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Any prescription drug in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes unless otherwise covered under this rider.
23. Nutritional supplements.

24. Smoking cessation aids or drugs.
25. Growth hormones.
26. Injectable drugs, except for insulin.

B. Limitations:

1. A **Participating Retail, Specialty Pharmacy Network** or **Mail Order Pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.
2. Non-emergency and non-**Urgent Care** prescriptions will be covered only when filled at a **Participating Retail Pharmacy, Specialty Pharmacy Network** pharmacy or the **Participating Mail Order Pharmacy**. **Members** are required to present their ID card at the time the prescription is filled. A **Member** who fails to verify coverage by presenting the ID card will not be entitled to direct reimbursement from **HMO**, and **Member** will be responsible for the entire cost of the prescription. Refer to the **Certificate** for a description of emergency and **Urgent Care** coverage. **HMO** will not reimburse **Members** for out-of-pocket expenses for prescriptions purchased from a **Participating Retail Pharmacy, Specialty Pharmacy Network** pharmacy, **Participating Mail Order Pharmacy** or a non-**Participating Retail** or **Mail Order Pharmacy** in non-emergency, non-**Urgent Care** situations. **HMO** retains the right to review all requests for reimbursement and make reimbursement determinations subject to the Claim Determination Procedures/Complaint and Appeals section of the **Certificate**.
3. **HMO** is not responsible for the cost of any prescription drug for which the actual charge to the **Member** is less than the required **Copayment** or for any drug for which no charge is made to the recipient.
4. The Continuation and Conversion section of the **Certificate** is hereby amended to include the following provision: The conversion privilege does not apply to the **HMO** Prescription Plan.

AUDIT PROCEDURES

HMO, or **HMO's** agent, will audit reimbursements to **Participating Retail, Specialty Pharmacy Network** and **Mail Order Pharmacies** to ensure compliance with program guidelines. Audits may take the form of a phone call, letter or an on-site visit. Any audit shall take place at a time mutually agreeable to the **Participating Retail, Specialty Pharmacy Network** and/or **Mail Order Pharmacy** and the auditor. No audit shall include a review of any document relating to any person or prescription plan other than those reimbursable by **HMO**. Any potential discrepancies are identified and forwarded to the **Participating Retail, Specialty Pharmacy Network** and/or **Mail Order Pharmacy** for review and response within 14 calendar days. Substantive discrepancies (involving dollar discrepancies) that are not resolved in a reasonable period of time will result in full or partial charge-backs to the **Participating Retail, Specialty Pharmacy Network** and/or **Mail Order Pharmacy**. Non-substantive discrepancies will not be used to calculate charge-backs to the **Participating Retail, Specialty Pharmacy Network** and/or **Mail Order Pharmacy**. **HMO**, or **HMO's** agent, employs auditing procedures that apply statistically valid sampling methods. Factors considered during the audit process include:

- Review of prescription drug records associated with claims paid to the **Participating Retail, Specialty Pharmacy Network** and/or **Mail Order Pharmacy** during the previous 12 to 18 months;
- Access to examine, audit and copy all original records deemed necessary to determine compliance with the terms of the **Participating Retail, Specialty Pharmacy Network** and/or **Mail Order Pharmacy's** agreement to provide prescription drugs to **Members** under the **Certificate**;
- Timely submission (within 14 calendar days) of requests for any information necessary to verify and/or substantiate compliance with the terms of the **Participating Retail, Specialty Pharmacy Network** and/or **Mail Order Pharmacy's** agreement to provide prescription drugs to **Members** under the **Certificate**;

- Records of prescription drugs, including oral, telephone and/or computer generated prescription, which document information that includes, but is not limited to, the: patient's name; prescriber's name and address; name and strength of medication prescribed; prescriber's generic substitution instructions; early refill documentation; signature of individual securing prescription.

Records of documentation necessary to determine compliance with the terms of the **Participating Retail, Specialty Pharmacy Network** and/or **Mail Order Pharmacy's** agreement to provide prescription drugs to **Members** under the **Certificate** will be maintained, in a retrievable manner, in accordance with industry standards and applicable laws, rules and regulations (and for at least six (6) years, or in the case of minors until six (6) years after majority). Such records will include:

- Paper prescription drug records
- Signature Logs
- Quality assurance plans or dispensing procedures
- Daily prescription drug logs
- Wholesaler, manufacturer and distributor invoices
- Refill data
- Prescriber information
- Patient information

HMO does not prohibit a **Participating Retail, Specialty Pharmacy Network** and/or **Mail Order Pharmacy** from charging **Member** for services that are in addition to charges for the prescription drug, for dispensing the prescription drug, or for prescription drug counseling. Services for which a **Participating Retail, Specialty Pharmacy Network** and/or **Mail Order Pharmacy** may impose additional charges are subject to the approval of the Board of Pharmacy. Prior to dispensing a prescription drug, the **Participating Retail, Specialty Pharmacy Network** and/or **Mail Order Pharmacy** must disclose to the **Member** all charges for additional services in connection with dispensing that prescription drug, and the **Member's** out-of-pocket cost for those services. A **Participating Retail, Specialty Pharmacy Network** and/or **Mail Order Pharmacy** shall not impose any additional charges for patient counseling or for other services required by the Board of Pharmacy or state or federal law.

RECOVERY OF OVERPAYMENT

If a benefit payment is made by **HMO**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **HMO** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in their family; within the following guidelines:

With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, **HMO** will not seek reimbursement for overpayment of a claim previously paid later than 18 months after the date the first payment on the claim was made. **HMO** will not seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to the health care provider, **HMO** will provide written documentation that identifies the error made in the processing or payment of the claim that justifies the reimbursement request. **HMO** will not base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

- (a) in judicial or quasi-judicial proceedings, including arbitration;
- (b) in administrative proceedings;
- (c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or

- (d) in which there is clear evidence of fraud by the health care provider and **HMO** has investigated the claim in accordance with its fraud prevention plan and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

In seeking reimbursement for the overpayment from the health care provider, except in cases where the overpayment to the health care provider is a result of fraud, **HMO** shall not collect or attempt to collect:

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

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

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

Notice

Please be aware that administration of the definition of “negotiated charge” for Prescription Drug Expense Coverage for most plans has been changed to support the following:

As to the Prescription Drug Expense Coverage:

The amount **HMO** has established for each **prescription drug** obtained from a **Participating Retail, Mail Order, or Specialty Pharmacy Network Pharmacy**. The **Negotiated Charge** may reflect amounts **HMO** has agreed to pay directly to the **Participating Retail, Mail Order, or Specialty Pharmacy Network Pharmacy**, or to a third party vendor for the prescription drug, and may include an additional service or risk charge set by **HMO**.

The **Negotiated Charge** does not include or reflect any amount **HMO**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **HMO**, an affiliate or a third party vendor and a drug manufacturer for any prescription drug, including prescription drugs on the **Drug Formulary**.

Where permitted by law, this change has been, or will be made to all Member Plan Documents effective as of the first renewal date for the plan occurring after January 1, 2010.

**AETNA HEALTH INC.
(NEW JERSEY)**

SCHEDULE OF BENEFITS

Plan Name: CHARTER OPEN ACCESS PLAN
Contract Holder Name: The Government of the District of Columbia
Contract Holder Group Agreement Effective Date: January 1, 2013
Contract Holder Number: 172614
Contract Holder Locations: 041
Contract Holder Service Areas: GN02

<u>Benefit</u>	<u>Maximums</u>
Maximum Out-of-Pocket Limit (Includes Copayments/Coinsurance) It does not apply to Prescription Drug Benefits.	
Individual Limit	\$3,500 per Member per calendar year
Family Limit	\$7,000 per family per calendar year

The family Maximum Out-of-Pocket Limit is a cumulative Maximum Out-of-Pocket Limit for all family members. The family Maximum Out-of-Pocket Limit can be met by a combination of family members with no single individual within the family contributing more than the individual limit.

Copayments, Coinsurance and Deductibles paid by the Member are tracked by HMO.

OUTPATIENT BENEFITS	
<u>Benefit</u>	<u>Network</u>
Primary Care Physician Services	
Adult Physical Examination including Immunizations	Copayment: \$0 per visit
Visits are subject to the following visit maximum:	Covered at 100%, not subject to a deductible, copayment or coinsurance.
Adults 18-65 years old: 1 visit per 12-month period	
Adults over 65 years old: 1 visit per 12-month period	
Well Child Physical Examination including Immunizations	Copayment: \$0 per visit
	Covered at 100%, not subject to a deductible, copayment or coinsurance.
	Deductibles and Coinsurance do not apply to preventive care services.
Office Hours Visits (Non-Preventive Care)	Copayment: \$10 per visit
After-Office Hours and Home Visits	Copayment: \$15 per visit

Specialist Physician Services

Office Visits (Preventive Care)	Copayment: \$0 per visit Covered at 100%, not subject to a deductible, copayment or coinsurance.
	Deductibles and Coinsurance do not apply to preventive care services.
Office Visits	Copayment: \$20 per visit
Other than Office Visits	Copayment: \$20 per visit
Routine Gynecological Exam(s) 1 visit(s) per 365 day period	
Performed at a Primary Care Physician Office	Copayment: \$0 per visit Covered at 100%, not subject to a deductible, copayment or coinsurance.
Performed at a Specialist Office	Copayment: \$0 per visit Covered at 100%, not subject to a deductible, copayment or coinsurance.
Prenatal Visit(s) by the attending Obstetrician	Copayment: \$0 per visit
Outpatient Physical, Occupational and Speech Therapy Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment	Copayment: \$20 per visit
The Outpatient Physical, Occupational and Speech Therapy limit does not apply to treatment of Biologically-Based Mental Illness, Autism/Autism Spectrum Disorder and Other Developmental Disabilities.	
Outpatient Facility Visits	Copayment: \$20 per visit
Diagnostic X-Ray Testing	Copayment: \$0 per visit
Complex Imaging Services, including, but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET)	Copayment: \$0 per visit
Diagnostic Mammography	Copayment: \$0 per visit
Routine Mammography	Copayment: \$0 per visit Covered at 100%, not subject to a deductible, copayment or coinsurance
Diagnostic Laboratory Testing	Copayment: \$0 per visit
Outpatient Emergency Services Hospital Emergency Room or Outpatient Department	Copayment: \$50 per visit
Urgent Care Facility	Copayment: \$50 per visit

Ambulance (Applicable to emergency and non-emergency transportation)	Copayment: \$0 per trip
Outpatient Mental Disorders Coverage is provided under the same terms, conditions and Member cost-sharing as any other illness under the Certificate.	Copayment: \$10 per visit
Outpatient Substance Abuse (Alcohol and Drug Detoxification and Rehabilitation) Coverage is provided under the same terms, conditions and Member cost-sharing as any other illness under the Certificate.	Copayment: \$10 per visit/day
Outpatient Surgery	Copayment: \$50 per visit
Outpatient Home Health Visits Unlimited visits per calendar year	Copayment: \$0 per visit
Outpatient Hospice Care Visits	Copayment: \$0 per visit
Prosthetic and Orthotic Appliances	Copayment: \$10 per visit A Participating Provider's reimbursement for orthotic and prosthetic appliances shall be either the Federal Medicare reimbursement schedule or the HMO contracted rate, whichever is greater.
Hearing Aids and Medically Necessary Services and Supplies Related to the Hearing Aid (dependents age 15 years of age or younger) Hearing Aid Benefit Maximum	Copayment: \$0 per visit \$1,000 per hearing aid for each hearing-impaired ear every 24 months. This maximum does not apply to the Medically Necessary services and supplies related to the hearing aid.

INPATIENT BENEFITS

<u>Benefit</u>	<u>Network</u>
Inpatient Hospital (Includes all inpatient hospital services not specifically listed separately)	Copayment: \$100 per admission
Mental Disorders and Substance Abuse (Detoxification and Rehabilitation) During confinement in a <ul style="list-style-type: none"> • Hospital; or • Residential Treatment Facility 	Copayment: \$100 per admission
Maternity	Copayment: \$100 per admission

Skilled Nursing Facility
Maximum of 60 days per calendar year

Copayment: \$100 per admission (waived if a Member is transferred from a Hospital to a Skilled Nursing Facility)

Hospice Care

Copayment: \$0 per admission (waived if a Member is transferred from a Hospital to a Hospice Care facility)

Transplant

Autologous bone marrow transplants for Wilm's tumor when standard chemotherapy is unsuccessful

Benefits are provided to the same extent as for any other sickness under the Certificate.

All Other Transplants

Transplant Facility Expense Services

Inpatient Care

Copayment: \$100 per admission

ADDITIONAL BENEFITS

Benefit

Network

Routine Eye Examination by a Specialist (including refraction) as per the schedule in the Certificate

Copayment: \$20 per visit

Deductibles and Coinsurance do not apply to preventive care services.

Subluxation

20 visits per calendar year

Copayment: \$20 per visit

Durable Medical Equipment (DME)

Coinsurance: 50% (of the cost) per item

DME Maximum Benefit

Unlimited per Member per calendar year

Diabetic Supplies and Equipment

Copayment: \$10 per visit or per item

Autism/Autism Spectrum Disorder and Other Developmental Disabilities

Cost-sharing is based upon the type of service or supply provided and the place where the service or supply is rendered. For therapy services received through the New Jersey Early Intervention program, the cost-sharing is based upon the cost-sharing applicable to a non-specialist physician visit.

Subscriber Eligibility:

All full-time employees of the Contract Holder who regularly work at least the minimum number of hours per week as defined by the Contract Holder and agreed to by HMO.

Eligible for benefits on the date of hire.

Dependent Eligibility: The legal spouse / civil union partner of a Subscriber under this Certificate who satisfies the eligibility requirements defined by the Contract Holder and agreed to by HMO.

The term “spouse” shall include a Civil Union partner as defined by New Jersey State Law. In addition, if applicable, any references under this Certificate made to “marriage”, “husband”, “wife”, “family”, “immediate family”, “dependent”, “next of kin”, “widow”, “widower”, “widowed” or another word which in a specific context denotes a marital or spousal relationship, the same shall include a Civil Union. In addition, a same-sex relationship entered into outside of New Jersey which is valid under the law of another state or foreign nation that provides substantially all of the rights and benefits of marriage shall be valid in New Jersey.

A dependent child of the Subscriber (including natural, foster, step, legally adopted children, children placed for adoption, a child under court order) who meets the eligibility requirements described below:

- under 26 years of age;
If the Subscriber has a child that can now be enrolled, the Subscriber may contact Member Services for details.
- Coverage is available for a child who has reached the age at which coverage would otherwise end, who is chiefly dependent upon the Subscriber for support and maintenance, and is incapable of self-support due to mental or physical incapacity, either of which commenced prior to the age the dependent lost eligibility, who is not married or not in a Domestic or Civil Union Partnership.

Termination of Coverage: Coverage of the Subscriber and the Subscriber’s dependents, including civil union partners and domestic partners, who are Members, if any, will terminate on the earlier of the date the Group Agreement terminates or immediately following the date on which the Subscriber ceased to meet the eligibility requirements.

Coverage of Covered Dependents, including civil union partners and domestic partners, will cease immediately following the date on which the dependent ceased to meet the eligibility requirements.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to recent changes to preventive services coverage and women's preventive health coverage under the Federal Affordable Care Act (ACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that Aetna is administering medical and outpatient prescription drug coverage in compliance with the applicable components of the ACA.

The following is a summary of the recent changes to preventive services coverage and women's preventive health coverage under the ACA that applies to non-grandfathered plans that are not otherwise exempt from the requirements. Preventive services, as required by ACA, will be paid without cost-sharing such as payment percentages, copayments and deductibles.

For details on any benefit maximums and the cost-sharing under your plan, call the Member Services number on the back of your ID card.

1. An annual routine physical exam for covered persons through age 21.
2. For covered females:
 - Screening and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
 - Screening and counseling services, such as:
 - Interpersonal and domestic violence;
 - Sexually transmitted diseases; and
 - Human Immune Deficiency Virus (HIV) infections.
 - Screening for gestational diabetes.
 - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once every three years.
 - A routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration.
3. Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
 - Preventive counseling visits and/or risk factor reduction intervention;
 - Medical nutrition therapy;
 - Nutritional counseling; and
 - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Benefits under your plan may be subject to visit maximums.

4. Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Benefits under your plan may be subject to visit maximums.

5. Screening and counseling services to aid you to stop the use of tobacco products. Coverage includes:

- Preventive counseling visits;
- Treatment visits; and
- Class visits.

Benefits under your plan may be subject to visit maximums.

6. Prenatal care received by a pregnant female. Coverage is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

7. Comprehensive lactation support, (assistance and training in breast-feeding), and counseling services provided by a certified lactation support provider, in a group or individual setting, to females during pregnancy and in the post partum period.

The rental or purchase of breast-feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk), and the purchase of the accessories and supplies needed to operate the item. Aetna reserves the right to limit the payment of charges up to the most cost-efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

Benefits under your plan may be subject to maximums.

8. For females with reproductive capacity, coverage includes:

- FDA-approved contraceptive methods including certain FDA-approved generic drugs, implantable devices, sterilization procedures and patient education and counseling for women with reproductive capacity.
- Counseling services provided by a physician in either a group or individual setting on contraceptive methods. Benefits may be subject to visit maximums.
- Female voluntary sterilization procedures and related services and supplies including tubal ligation and sterilization implants. Coverage does not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.
- FDA-approved female generic emergency contraceptive methods that are prescribed by your physician. The prescription must be submitted to the pharmacist for processing.

Additional exemptions may apply to plans that are sponsored by religious employers or religious organizations and meet certain criteria which exempt the health plan from the federal requirement to provide coverage for contraceptive services.

The drug list is subject to change. Visit “Medication Search” on your secure member website at www.aetna.com for the most up-to-date information on drug coverage for your plan.