APPENDIX

EXHIBIT A

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan [A/50] [B] [C] [D].

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN [A/50] [B] [C] [D]
(New Jersey Individual Health Benefits [A/50] [B] [C] [D] Plan)

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

EFFECTIVE DATE OF POLICY: [September 23, 2010]

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

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

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

[Secretary President]

[Include legal name, trade name, phone, fax and e-mail numbers by which consumers may contact the carrier, including at least one toll-free number for Covered Persons]]

POLICY INDEX

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN A/50]

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$1,000, $2,500, $5,000, $10,000]
Per Covered Family	[$2,000, $5,000, $10,000, $20,000]
Emergency Room Copayment (waived if admitted within 24 hours)	$100

Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows:

For Preventive Care	0%
For all other Covered Charges	50%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	[$6,000, $7,500, $10,000, $15,000]
[Per Covered Family per Calendar Year	[$12,000, $15,000, $20,000, $30,000]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN A/50

[Note to carriers: This schedule illustrates the deductible and maximum out of pocket that must be offered with Plan A/50]

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	$1,000
Per Covered Family	$2,000

Emergency Room Copayment

(waived if admitted within 24 hours)	$100

Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows:

For Preventive Care:	0%
For all other Covered Charges	50%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	$6,000
[Per Covered Family per Calendar Year	$12,000

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN B]

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$1,000, $2,500, $5,000, $10,000]
Per Covered Family	[$2,000, $5,000, $10,000, $20,000]

Emergency Room Copayment
(waived if admitted within 24 hours) $100
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows:

For Preventive Care:	0%
For all other Covered Charges	40%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	[$4,000, $5,500, $8,000, $13,000]
Per Covered Family per Calendar Year	[$8,000, $11,000, $16,000, $26,000]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN B

[Note to carriers: This schedule illustrates the deductible and maximum out of pocket that must be offered with Plan B by Carriers that elect to offer Plan B as an indemnity plan.]

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	$1,000
Per Covered Family	$2,000

Emergency Room Copayment
(waived if admitted within 24 hours) $100
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows:

For Preventive Care:	0%
For all other Covered Charges	40%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	$4,000
Per Covered Family per Calendar Year	$8,000

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN C]

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	[$1,000, $2,500, $5,000, $10,000]
Per Covered Family	[$2,000, $5,000, $10,000, $20,000]
Emergency Room Copayment (waived if admitted within 24 hours)	$100

Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows:

For Preventive Care:	0%
For all other Covered Charges	30%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	[$3,500, $5,000, $7,500, $12,500]
Per Covered Family per Calendar Year	[$7,000, $10,000, $15,000, $25,000]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN C

[Note to carriers: This schedule illustrates the deductible and maximum out of pocket that must be offered with Plan C by carriers that elect to offer Plan C as an indemnity plan]

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	$1,000
Per Covered Family	$2,000

Emergency Room Copayment
(waived if admitted within 24 hours) $100
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows:
For Preventive Care: 0%
For all other Covered Charges 30%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Maximum Out of Pocket** for this Policy is as follows:
Per Covered Person per Calendar Year $3,500
Per Covered Family per Calendar Year $7,000
Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN D]

Calendar Year Cash Deductible
for Preventive Care NONE
for immunizations and
lead screening for children NONE
For all other Covered Charges
Per Covered Person [$1,000, $2,500, $5,000, $10,000]
Per Covered Family [$2,000, $5,000, $10,000, $20,000]

Emergency Room Copayment
(waived if admitted within 24 hours) $100
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows:
For Preventive Care 0%
For all other Covered Charges 20%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	[$3,000, $4,500, $7,000, $12,000]
Per Covered Family per Calendar Year	[$6,000, $9,000, $14,000, $24,000]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES **PLAN D**

[Note to carriers: This schedule illustrates the deductible and maximum out of pocket that must be offered with Plan D by carriers that elect to offer Plan D as an indemnity plan]

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
For all other Covered Charges	
Per Covered Person	$1,000
Per Covered Family	$2,000
Emergency Room Copayment (waived if admitted within 24 hours)	$100

Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows:

For Preventive Care:	0%
For all other Covered Charges	20%

Maximum Out of Pocket
Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	$3,000
Per Covered Family per Calendar Year	$6,000

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES **Example High Deductible health plan text that could be used in conjunction with an MSA or and HSA**

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children as detailed in the Immunizations and Lead Screening provision	NONE
For all other Covered Charges	
Note to carriers: Use the following text for MSA plans	
•for all other Covered Charges	
[per Covered Person	[$XXXX][$XXXX]][Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [XXXX], the amount is $[XXXX, $XXXX]]
per Covered Family	[$XXXX][$XXXX[Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [XXXX], the amount is [$XXXX, $XXXX]

Note to carriers: Use the following text for HSA plans

•for all other Covered Charges

[per Covered Person	[the greater of: $XXXX or the lowest amount to qualify as a high deductible health plan under Internal Revenue Code section 223] [$XXXX] [$XXXX or the highest amount for which deductions are permitted under Internal Revenue Code 223] [$XXXX]]
[per Covered Family	[the greater of: $XXXX or the lowest amount to qualify as a high deductible health plan under Internal Revenue Code section 223] [$XXXX] [$XXXX or the highest amount for which deductions are permitted under Internal Revenue Code 223] [$XXXX]]

Coinsurance

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

The **Coinsurance** for this Policy is as follows:

For Preventive Care:	0%
For all other Covered Charges	[30%, 20%]

Maximum Out of Pocket

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

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

Note to carriers: Use the following text for MSA plans

per Covered Person	[$XXXX][Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [[XXXX]], the amount is $[XXXX].]
per Covered Family	[$XXXX][Internal Revenue Service Inflation-Adjusted Amount; for Calendar Year [[XXXX]], the amount is $[XXXX].]

Note to carriers: Use the following text for HSA plans

[per Covered Person	[the greater of $XXXX or the maximum amount permitted under Internal Revenue Code 223]]
[per Covered Family	[the greater of $XXXX or the maximum amount permitted under Internal Revenue Code 223]]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE PPO (using Plan C, without Copayment, separate Network and Non-Network Deductibles and Maximum Out of Pockets)**

Calendar Year Cash Deductibles

For treatment, services and supplies given by a **Network** Provider, except for Prescription Drugs

for Preventive Care for immunizations and lead screening for children	NONE
for all other Covered Charges	NONE
Per Covered Person	[$1,000, $2,500]
Per Covered Family	[$2,000, $5,000]

For treatment, services and supplies given by a **Non-Network** Provider, and for Prescription Drugs

for Preventive Care for immunizations and lead screening for children	NONE
for all other Covered Charges	NONE
Per Covered Person	[$2,000, $5,000]
Per Covered Family	[$4,000, $10,000]

Emergency Room Copayment (waived if admitted within 24 hours)	100

Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and We will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows:

For Preventive Care:	0%
• if treatment, services or supplies are given by a Network Provider	10%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider	30%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is:	30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Except as stated below, once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	$5,000
Per Covered Family per Calendar Year	$10,000

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Except as stated below, once the Non-Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Non-Network covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The Non-**Network Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	$10,000
Per Covered Family per Calendar Year	[$20,000

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE PPO (using Plan C, with Copayment on specified services, separate Network and Non-Network Deductibles and Maximum Out of Pockets)

Copayment

For treatment, services and supplies given by a **Network** Provider	
For Preventive Care	NONE
For Physician Visits for all other Covered Charges	[$15, $30, $40 or $50]

Calendar Year Cash Deductibles

For treatment, services and supplies given by a **Network** Provider, except for Physician Visits and Prescription Drugs	
Per Covered Person	[$1,000, $2,500]
Per Covered Family	[$2,000, $5,000]]
For Treatment, services and supplies given by a **Non-Network** Provider, and for Prescription Drugs	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE

for all other Covered Charges

Per Covered Person	[Dollar amount equal to two times the Network Deductible]
Per Covered Family	[Dollar amount equal to two times the Non-Network Deductible]

Emergency Room Copayment
(waived if admitted within 24 hours) $100
Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and We will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows:

For Preventive Care:	0%
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider	30%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is:	30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Except as stated below, once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	$5,000
Per Covered Family per Calendar Year	$10,000

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Except as stated below, once the Non-Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Non-Network covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Non-Network Maximum Out of Pocket** for this Policy is as follows:

Per Covered Person per Calendar Year	$10,000
Per Covered Family per Calendar Year	$20,000

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE PPO (using Plan C, with Copayment on specified services, common Deductible and Maximum Out of Pocket)

Copayment
For treatment, services and supplies given by a **Network** Provider

For Preventive Care	NONE
For Physician Visits for all other Covered Charges	[$15, $30, $40 or $50]

Calendar Year Cash Deductible
For treatment, services and supplies given by a **Network** or **Non-Network** Providers, except for Network Physician Visits

Per Covered Person	[$1,000, $2,500]
Per Covered Family	[$2,000, $5,000]

Emergency Room Copayment

(waived if admitted within 24 hours)	$100

Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to any combination of Network and Non-Network services and supplies. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for this Policy is as follows:

For Preventive Care:	0%
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider	30%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is:	30%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network **and** Non-Network covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Except as stated below, once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network or Non-Network covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

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

Per Covered Person per Calendar Year	$7,500
Per Covered Family per Calendar Year	$$15,000

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE EXAMPLE POS (using Plan D, with Copayment on specified services, separate Network and Non-Network Deductibles and Maximum Out of Pockets)

Copayment
For treatment, services and supplies given by a **Network** Provider

For Preventive Care	NONE
For Physician Visits for all other Covered Charges	[$15, $30, $40 or $50]
Hospital Confinement	[$300 per day, up to $1500 per confinement, $3,000 per Calendar Year]

Exception: If the Hospital is a Network facility, the Hospital will be paid as a Network Facility regardless of whether the admitting Practitioner is a Network Practitioner.

Calendar Year Cash Deductibles
For treatment, services and supplies given by a **Network** Provider, except for Physician Visits, Hospital Confinement and Prescription Drugs

Per Covered Person	[$1000 or $2,500]
[Per Covered Family	[$2,000 or $5,000]

For Treatment, services and supplies given by a **Non-Network** Provider, and for Prescription Drugs

for Preventive Care	NONE
for immunizations and lead screening for children	NONE

for all other Covered Charges

Per Covered Person	[Dollar amount equal to two times the Network Deductible]
[Per Covered Family	[Dollar amount equal to two times the Non-Network Deductible]

Emergency Room Copayment
(waived if admitted within 24 hours) $100
Note: The Emergency Room Copayment is payable in addition to the applicable Copayment, Deductible and Coinsurance.

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Except as stated below, We will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and We will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. This Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.
Exception: Coinsurance paid for covered Prescription Drugs does not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Coinsurance** for the Policy is as follows:

For Preventive Care:	0%
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	0%, **except as stated below**
• if treatment, services or supplies are given by a Non-Network Provider	20%, **except as stated below**
Exception: The Coinsurance for Prescription Drugs does not vary according to use of a Network Provider or a Non-Network Provider. The Coinsurance for Prescription Drugs is:	20%

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Except as stated below, once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The **Network Maximum Out of Pocket** for the Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed $7,500]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person maximum.]

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Except as stated below, once the Non-Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Non-Network covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

The Non-**Network Maximum Out of Pocket** for the Policy is as follows:

Per Covered Person per Calendar Year	[An amount not to exceed two times the Network Maximum]
[Per Covered Family per Calendar Year	[Dollar amount equal to two times the per Covered Person Maximum.]

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

SCHEDULE OF INSURANCE AND PREMIUM RATES (Continued) **[PLANS A/50, B, C, D]**
Daily Room and Board Limits

During a Period of Hospital Confinement

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

[Plans A/50, B, C, D (Continued)]

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

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

During a Confinement In An Extended Care Center Or Rehabilitation Center

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

Pre-Approval is required for charges incurred in connection with:
- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- [Speech, Cognitive Rehabilitation, Occupational and Physical Therapies]
- [Therapeutic Manipulation]
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- Nutritional Counseling
- [Certain Prescription Drugs]
- [Exchange of unused Inpatient days for additional Outpatient visits to treat a Non-Biologically Based Mental Illness]

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

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

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech therapy per Calendar Year See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for cognitive therapy per Calendar Year See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical therapy per Calendar Year See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for occupational therapy per Calendar Year See below for the separate benefits available under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision	30 visits
Charges for physical, occupational and speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (limit applies separately to each therapy and is in addition to the therapy visits listed above)	30 visits

Charges for Applied Behavior Analysis per Calendar Year (the maximum benefit is subject to annual adjustment beginning in 2012)	[$36,000]

Charges for Preventive Care per Calendar Year as follows:
(Not subject to any Copayment, Cash Deductible or Coinsurance)

• for a Covered Person who is a Dependent child for the first year of life	$750[*]
• for all other Covered Persons	$500[*]

[* The $750 and $500 limits do not apply if a Covered Person uses a Network Provider.]
Note to carriers: Include the above asterisks and asterisk text if the plan provides both network and non-network benefits.

Charges for hearing aids for a Covered Person age 15 or younger	$1,000 per hearing impaired ear per 24-month period

Charges for all treatment of Non-Biologically-based Mental Illnesses and Substance Abuse, per Calendar Year

Inpatient Confinement	30 days *
Outpatient Care	20 visits

* [Subject to Our Pre-Approval,] Unused Inpatient days may be exchanged for additional Outpatient visits, where each Inpatient day may be exchanged for two Outpatient visits.

Maximum Benefit (for all Illnesses and Injuries)	Unlimited

PREMIUM RATES

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Policy are:
Single Coverage Only.....$

Two Adults..... $

Adult and Child(ren) Coverage.....$

Family Coverage.....$]

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

DEFINITIONS

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

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

Alcohol Abuse means abuse of or addiction to alcohol. Alcohol Abuse does not include abuse of or addiction to drugs. Please see the definition of Substance Abuse.

Allowed Charge means an amount that is not more than the [lesser of:
• the] allowance for the service or supply as determined by Us based on a standard approved by the Board[; or
[• the negotiated fee schedule.]

The Board will decide a standard for what is considered an Allowed Charge under this Policy. For charges that are not determined by a negotiated fee schedule, the Covered Person may be billed for the difference between the Allowed Charge and the charge billed by the Provider.

Please note: The Coordination of Benefits and Services provision includes a distinct definition of Allowed Charge.

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

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have permanent operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written back-up arrangements with a local Hospital for emergency care.

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

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

Anniversary Date means the date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

[**Approved Cancer Clinical Trial** means a scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer in human beings that meets the following requirements:
a) The treatment or intervention is provided pursuant to an approved cancer clinical trial that has been authorized or approved by one of the following: 1) The National Institutes of Health (Phase I, II and III); (2) the United States Food and Drug Administration, in the form of an investigational new drug (IND) exemption (Phase I, II and III); 3) The United States Department of Defense; or 4) The United States Department of Veteran Affairs.
b) The proposed therapy has been reviewed and approved by the applicable qualified Institutional Review Board.
c) The available clinical or pre-clinical data to indicate that the treatment or intervention provided pursuant to the Approved Cancer Clinical Trial will be at least as effective as standard therapy, if such therapy exists, and is expected to constitute an improvement in effectiveness for treatment, prevention and palliation of cancer.
d) The Facility and personnel providing the treatment are capable of doing so by virtue of their experience and training.
e) The trial consists of a scientific plan of treatment that includes specified goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of quantitative measures for determining treatment response and methods for documenting and treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval by one of the federal entities identified in item a. A cost-benefit analysis of clinical trials will be performed when such an evaluation can be included with a reasonable expectation of sound assessment.]

Biologically-based Mental Illness means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

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

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

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

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

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

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

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

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

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

Cosmetic Surgery or Procedure means any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

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

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

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

Creditable Coverage means, coverage under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a Public Health Plan as defined by federal regulation (Please refer to the definition of Public Health Plan in this Policy and note the different meaning of the term with respect to a Federally Defined Eligible Individual and a person who is not a Federally Defined Eligible Individual); a health benefits plan under section 5(e) of the "Peace Corps Act"; Title XXI of the federal Social Security Act (State Children's Health Insurance Program), or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

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

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

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

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

Your "Dependent child" includes:
a) Your biological child,
b) Your legally adopted child,
c) Your step-child,
d) The child of your civil union partner,
e) the child of Your Domestic Partner, and
f) children under a court appointed guardianship.
We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

In addition to the Dependent Children described above, any other child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship may be covered to the same extent as a Dependent Child under this Policy provided the child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)

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

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

Developmental Disability or Developmentally Disabled 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 purposes 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.

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

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

Discretion / Determination / Determine means Our right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

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

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

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

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

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

Eligible Person means a person who is a Resident of New Jersey who is not eligible to be covered under a Group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. § 1395 et. seq.) (Medicare).

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

Enrollment Date means with respect to a Federally Defined Eligible Individual means the date the person submits a substantially complete application for coverage. With respect to all other persons, Enrollment Date means the Effective Date of coverage under this Contract for the person.

Experimental or Investigational means We determine a service or supply is:
a) not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or

c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

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

We will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

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

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

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

1. The American Hospital Formulary Service Drug Information; or
2. The United States Pharmacopeia Drug Information

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

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

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
e. Proof as reflected in the published peer reviewed medical literature must exist that improvements in health outcomes; as defined in item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare.
In some places, an "Extended Care Center" may be called a "Skilled Nursing Facility."

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

Federally Defined Eligible Individual means an Eligible Person, as defined:
a) for whom, as of the date on which he or she seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months during which time the Eligible Person has not had any significant break in coverage (significant break in coverage means a break in coverage of 63 days or more during which time the Eligible Person has no Creditable Coverage);
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and

f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

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

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

Group Health Benefits Plan. means a policy, program or plan that provides medical benefits to a group of two or more individuals.

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

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

Health Status-Related Factor means any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally Ill or terminally Injured people under a hospice care program. We will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) approved for its stated purpose by Medicare; or
b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

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

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

Illness or Ill means a sickness or disease suffered by a Covered Person or a description of a Covered Person suffering from a sickness or disease.

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

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

Joint Commission means the Joint Commission on the Accreditation of Health Care Organizations.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and We determine at Our Discretion, that it is:
a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b) provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c) in accordance with generally accepted medical practice;
d) not for the convenience of a Covered Person;
e) the most appropriate level of medical care the Covered Person needs; and
f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

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

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

Mental Health Center means a Facility which mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) accredited or licensed by the state of New Jersey to provide mental health services.

[Network] Provider means a Provider which has an agreement [directly or indirectly] with Us [or Our Associated Medical Groups] to provide Covered Services or Supplies. You will periodically be given up-to-date lists of [Network] Providers. The up-to date lists will be furnished automatically, without charge.

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

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

Non-Biologically-based Mental Illness means an Illness which manifests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the Illness is not biologically-based.

In determining whether or not a particular condition is a Non-Biologically-based Mental Illness, We may refer to the current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association.

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

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

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

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

Outpatient means a Covered Person who is **not** confined as a registered bed patient in a Hospital or recognized health care Facility and is not an Inpatient; or services and supplies provided in such Outpatient settings.

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

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

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

Policyholder means the person who purchased this Policy.

Practitioner means a person We are required by law to recognize who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.

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

Pre-Approval or Pre-Approved means Our approval using paper or electronic means for specified services and supplies prior to the date charges are incurred. We will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.

Pre-Existing Condition means, for a Covered Person age 19 or older, an Illness or Injury which manifests itself in the six months before Your Enrollment Date, and for which:
a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your Enrollment Date; or
b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her Enrollment Date.

A pregnancy which exists on Your Enrollment Date is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.

Pre-Existing Condition Limitation. With respect to coverage of a Covered Person who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information.

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

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, and Nicotine Dependence Treatment.

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

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

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy

Public Health Plan means, with respect to a person who is a Federally Defined Eligible Individual, any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

With respect to all other persons, Public Health Plan means any plan established or maintained by a State, the U.S. government, or any political subdivision of a State, or the U.S. government that provides health coverage to individuals who are enrolled in the plan.

[**Referral** means specific direction or instructions from a Covered Person's Primary Care Physician [or care manager] in conformance with Our policies and procedures that directs a Covered Person to a Facility or Practitioner for health care.]

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) approved for its stated purpose by Medicare.

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

Resident means a person:
a) whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year, except as stated below; or

Emergency room visits to PO Facilities are subject to a Copayment in addition to whatever copayment, deductible or coinsurance apply to the services an supplies received, and such visits must be retrospectively reviewed [by the PCP]. We will waive the emergency room Copayment if the Covered Person is hospitalized within 24 hours of the visit.

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

Utilization Review
The Policy has utilization features. See the **Utilization Review Features** section of the Policy.

Benefits
The Schedule shows Network Benefits, Non-Network Benefits, and Copayments applicable to the Point of Service arrangement. What We pay is subject to all the terms of the Policy.

Service Area
[Carrier must include a description of the Service Area, as required by N.J.A.C. 8:38-17.3(a)11]

[[Different] providers in Our Network have agreed to be paid [in different ways by Us. A Provider may be paid] [each time he or she treats a Covered Person ("fee for service"] [, or may be paid] [a set fee for each month for each Covered Person whether or not the Covered Person actually receives services ("capitation")] [, or may receive] [a salary]. [These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Covered Person satisfaction, quality of care, and control of costs and use of services among them.] If a Covered Person desires additional information about how Our primary care physicians or any other Provider in Our Network are compensated, please call Us at [telephone number] or write [address].

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

POINT OF SERVICE PROVISIONS
[Use if referral is not required.]

Definitions
a) ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person [may] [must] select who is available to supervise and coordinate his or her health care in the [XYZ] Provider Organization. We will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization.
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner or any other Practitioner in the network provides care, treatment, services, and supplies to the Covered Person.
d) ***Non-Network Benefits*** mean the benefits shown in the Schedule which are provided for care, treatment, services, and supplies given by a non-network provider.
e) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)
The Provider Organization for the Policy is the [XYZ] Provider Organization. The Policy does *not* require that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits. A Covered Person may elect to seek guidance from his or her PCP regarding care, treatment, services or supplies. To the extent a Covered Person seeks care, treatment, services or supplies from a network provider, network benefits will be provided. The Covered Person will periodically be given up-to date lists of [XYZ] PO Providers. The up-to date lists will be furnished automatically, without charge.

The Primary Care Practitioner (PCP)
The PCP is available to supervise and coordinate the Covered Person's health care in the [XYZ] PO.

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

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing]. For a discretionary change, the new PCP selection will take effect no more than

14 days following the date of the request. For a change necessitated by termination of the prior PCP from the Network, the new PCP selection will take effect immediately.

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

Non-Network Services
If a Covered Person uses the services of a non-network Provider, he or she will be eligible for Non-Network Benefits. However, if a [Covered Person] is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

Emergency Services
If a Covered Person requires services for Urgent care or an Emergency which occurs inside the PO Service Area, he or she must notify his or her PCP or Us within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Copayment in addition to whatever copayment, deductible or coinsurance apply to the services an supplies received. We will waive the emergency room Copayment if the Covered Person is hospitalized within 24 hours of the visit.

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

Utilization Review
The Policy has utilization features. See the **Utilization Review Features** section of the Policy.

Benefits
The Schedule shows Network Benefits, Non-Network Benefits, and Copayments applicable to the Point of Service arrangement. What We pay is subject to all the terms of the Policy.

Service Area
[Carrier must include a description of the Service Area, as required by N.J.A.C. 8:38-17.3(a)11]

[[Different] providers in Our Network have agreed to be paid [in different ways by Us. A Provider may be paid] [each time he or she treats a Covered Person ("fee for service"] [, or may be paid] [a set fee for each month for each Covered Person whether or not the Covered Person actually receives services ("capitation")] [, or may receive] [a salary]. [These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Covered Person satisfaction, quality of care, and control of costs and use of services among them.] If a Covered Person desires additional information about how Our primary care physicians or any other Provider in Our Network are compensated, please call Us at [telephone number] or write [address].

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

[APPEALS PROCEDURE

The Appeal Procedure text must satisfy the requirements of N.J.A.C. 11;24-8.5 et seq. or N.J.A.C. 11:24A-3.4 et seq., as appropriate. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

[CONTINUATION OF CARE

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

We shall assure continued coverage of covered services at the contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the Covered Person to continue treatment with the terminated health care

NOTE: There is no Coinsurance credit from previous coverage. In addition, there is no Deductible or Coinsurance carryover into the next Calendar Year.

[Maximum Out of Pocket
Maximum out of pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.
Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.]

[Note to Carriers: Use this Maximum Out of Pocket text for a pure indemnity plan that is not high deductible health plans that could be used in conjunction with an MSA or an HSA]

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

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

Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Network Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Network Maximum Out of Pocket has been reached.]

[Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Except as stated below, once the Non-Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Non-Network covered services and supplies for the remainder of the Calendar Year.

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

Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Non-Network Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Non-Network Maximum Out of Pocket has been reached.]

[Note to Carriers: Use these paragraphs if the Maximum Out of Pocket is separate for Network and Non-Network]

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

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

Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.]

[Note to Carriers: Use this text if the Maximum Out of Pocket is common to both Network and Non-Network services and supplies.]

[Maximum Out of Pocket:
The Per Covered Person and Per Covered Family Maximum Out of Pocket amounts are shown in the Schedule.

In the case of single coverage, for a Covered Person, the Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as per Covered Person Cash Deductible *plus* Coinsurance for all covered services and supplies in a Calendar Year. Once the Per Covered Person Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance will be required for such Covered Person for the rest of the Calendar Year.

In the case of coverage which is other than single coverage, for a Covered Family, the Maximum Out of Pocket is the annual maximum dollar amount that members of a covered family must pay as per Covered Family Cash Deductible *plus* Coinsurance for all covered services and supplies in a Calendar Year. Once the Per Covered Family Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance will be required for members of the covered family for the rest of the Calendar Year.]
[Note to carriers: Use the above text if the plan is issued as a high deductible health plan that could be used in conjunction with an MSA or an HSA.]

Payment Limits
We limit what We will pay for certain types of charges.

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

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

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

Except as stated below, We cover charges for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the Covered Person, in consultation with the Practitioner, determines that a shorter length of stay is medically necessary and appropriate.

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

We provide such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the in-patient care.
[As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

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

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, [subject to this Policy's **Emergency Room Copayment Requirement** section] *[note to carriers: delete this emergency room copayment phrase if the plan is issued in conjunction with an MSA or HSA].*

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

We limit what We pay for the treatment of Non-Biologically-based Mental Illnesses and Substance Abuse. See the **Charges Covered with Special Limitations** section of this Policy.

Emergency Room Copayment Requirement
Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a $100.00 Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

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

Alcohol Abuse
We pay benefits for the Covered Charges a Covered Person incurs for the treatment of Alcohol Abuse the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305; or
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Treatment for Biologically-based Mental Illness
We pay benefits for the Covered Charges a Covered Person incurs for the treatment of Biologically-based Mental Illness the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. We do not pay for Custodial Care, education, or training.

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

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

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

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

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

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

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

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

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

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

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

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

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

Orthotic or Prosthetic Appliances
We pay benefits for Covered Charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Covered Person's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a [physician visit to a non Specialist Doctor] [PCP visit] for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

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

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

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

Nutritional Counseling
Subject to Our Pre-Approval, We cover charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

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

Food and Food Products for Inherited Metabolic Diseases
We covers charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by the Covered Person's Practitioner.

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

Specialized Infant Formulas

We cover specialized non-standard infant formulas to the same extent and subject to the same terms and conditions as coverage is provided under this [Policy] for Prescription Drugs. We cover specialized non-standard infant formulas provided:
a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.
We may review continued Medical Necessity and Appropriateness of the specialized infant formula.

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

Prescription Drugs
[Subject to Our Pre-Approval, for certain Prescription Drugs] We cover drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. But We only covers drugs which are:
a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Hospital Formulary Service Drug Information;
2. The United States Pharmacopeia Drug Information; or

c. recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will We pay for:

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

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

[We have identified certain Prescription Drugs for which Pre-Approval is required. We will provide the list of Prescription Drugs for which Pre-Approval is required to You prior to enforcing the Pre-Approval requirement. We will give at least 30 days advance written notice to You before adding a Prescription Drug to the list.

[If a Covered Person brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the Covered Person must contact Us to request Pre-Approval.] [the Pharmacy will contact the Practitioner to request that the Practitioner contact Us to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. We will review the Pre-Approval request within the time period allowed by law. If We give Pre-Approval, We will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of this Policy. If We do not give Pre-Approval, the Covered Person may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Covered Person paying for the Prescription Drug. The Covered Person may submit a claim for the Prescription Drug, subject to the terms of this Policy. The Covered Person may appeal the decision by following the Appeals Procedure process set forth in this Policy.] (Note to Carriers: For use if the plan is a PPO)

[If a Covered Person brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, the Covered Person must contact Us to request Pre-Approval. The Covered Person may choose to delay purchasing the Prescription Drug until after We make a decision regarding Pre-Approval or may choose to purchase the Prescription Drug prior to the decision being made. In either case, the Covered Person must pay for the Prescription Drug when it is dispensed. The Covered Person may submit a claim for the Prescription Drug, subject to the terms of this Policy. If We do not give Pre-Approval, the Covered Person may appeal the decision by following the Appeals Procedure process set forth in this Policy.] (Note to Carriers: For use if the plan is an indemnity plan)

Supplies to Administer Prescription Drugs

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

COVERED CHARGES WITH SPECIAL LIMITATIONS

[Cancer Clinical Trial

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

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

Dental Care and Treatment

We cover:

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

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

a) the Injury was not caused, directly or indirectly by biting or chewing; and
b) all treatment is finished within 6 months of the date of the Injury.

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

For a Covered Person who is severely disabled or who is a Child under age 6, We cover:

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

Treatment for Temporomandibular Joint Disorder (TMJ)

We cover charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

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

We will cover charges for:
a) one baseline mammogram for a female Covered Person, age 35 - 39
b) one mammogram, every year, for a female Covered Person age 40 and older; and
c) in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's Practitioner.

Please note that mammograms are included under the Preventive Care provision. A female Covered Person may elect to apply any unused Preventive Care allowance for a mammogram. If a Covered Person has exhausted the available annual Preventive Care benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.

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

Subject to the American Cancer Society guidelines, and medical necessity as determined by the Covered Person's Practitioner in consultation with the Covered Person regarding methods to use, We will cover charges for:
a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

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

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

Please note that since colorectal cancer screening is included under the Preventive Care provision, a Covered Person may elect to apply any unused Preventive Care allowance for colorectal cancer screening. If a Covered Person has exhausted the available annual Preventive Care benefit, or elects not to use any available Preventive Care benefit to cover the colorectal cancer screening, the colorectal cancer screening may be covered subject to the terms of this Colorectal Cancer Screening Charges provision.

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

Subject to the stated limits, We cover the Therapy Services listed below when such services are provided to a Covered Person as an Outpatient We cover other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.

a. *Chelation Therapy* - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
b. *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
c. *Dialysis Treatment* - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
d. *Radiation Therapy* - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
e. *Respiration Therapy* - the introduction of dry or moist gases into the lungs.

[Subject to Our Pre-Approval,] We cover the Therapy Services listed below, subject to stated limitations:

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

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

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Repeal and New Rule, R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).
Amended by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).
See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).
Amended by R.2008 d.122, effective April 17, 2008.
See: 40 N.J.R 1744(a), 40 N.J.R. 2475(a).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Amended by R.2010 d.247, effective October 4, 2010.
See: 42 N.J.R. 2366(a), 42 N.J.R. 2632(b).

EXHIBIT B

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

[Carrier] HMO PLAN

INDIVIDUAL HEALTH MAINTENANCE ORGANIZATION (HMO)CONTRACT

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

EFFECTIVE DATE OF CONTRACT: [September 23, 2010]

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

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

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

[Secretary President]

[Include legal name, trade name, phone, fax and e-mail numbers by which consumers may contact the carrier, including at least one toll-free number for Members]

TABLE OF CONTENTS

Section **Page**

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Contract are:

Single Coverage Only	$
Two Adults	$
Adult and Child(ren) Coverage	$
Family Coverage.	$]

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

SCHEDULE OF SERVICES AND SUPPLIES	[Using Copayment]

THE SERVICES OR SUPPLIES COVERED UNDER THIS CONTRACT ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR PER [MEMBER], UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES	**COPAYMENTS [/COINSURANCE]:**
HOSPITAL SERVICES:	
INPATIENT	[$150, $300, $400, $500] Copayment/day for a maximum of 5 days/admission. Maximum Copayment [$1,500, $3,000, $4,000, $5,000]/Calendar Year. Unlimited days.
OUTPATIENT	[$15, $30, $40, $50] Copayment/visit
PRACTITIONER SERVICES RECEIVED AT A HOSPITAL:	
INPATIENT VISIT	$0 Copayment
OUTPATIENT VISIT	[$15, $30, $40, $50] Copayment/visit; no Copayment if any other Copayment applies.
EMERGENCY ROOM	$100 Copayment/visit/Member (waived if admitted within 24 hours)

Note: The Emergency Room Copayment is payable in addition to the applicable Copayment and Coinsurance, if any.

PRACTITIONER CHARGES FOR SURGERY:	
INPATIENT	$0 Copayment
OUTPATIENT	[$15, $30, $40, $50] Copayment/visit
[FACILITY CHARGES FOR OUTPATIENT SURGERY:	
AMBULATORY SURGERY CENTER	[$15, $30, $40, $50]
HOSPITAL OUTPATIENT DEPARTMENT	[$30, $60, $80, $100]]

[Note to carriers: Use this text if the copay differs based on the setting.]

[FACILITY CHARGES FOR OUTPATIENT SURGERY:	[$15, $30, $40, $50]]

[Note to carriers: Use this text if the copay is the same regardless of the setting.]

HOME HEALTH CARE	Unlimited days, if Pre-Approved; $0 Copayment.
HOSPICE SERVICES	Unlimited days, if Pre-Approved; $0 Copayment.
MATERNITY (PRE-NATAL CARE)	[at the option of the carrier, $25 or same amount as primary care physician copayment] Copayment for initial visit only; $0 Copayment thereafter.
BIRTHING CENTER SERVICES	[$15, $30, $40, $50] Copayment/visit
NON-BIOLOGICALLY BASED MENTAL ILLNESS AND SUBSTANCE ABUSE:	
OUTPATIENT	[$15, $30, $40, $50] Copayment/visit maximum 20 visits/Calendar Year.
INPATIENT	[$150, $300, $400, $500] Copayment/day for a maximum of 5 days per admission. Maximum Copayment: [$1,500, $3,000, $4,000, $5,000]/Calendar Year.

Maximum of 30 days inpatient care/Calendar Year. Subject to Pre-Approval, unused Inpatient days may be exchanged for additional Outpatient visits, where each Inpatient day may be exchanged for two Outpatient visits.

THERAPEUTIC MANIPULATION	[$15, $30, $40, $50] Copayment/visit; maximum 30 visits/Calendar Year
PRE-ADMISSION TESTING	[$15, $30, $40, $50] Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance

PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES (OUTSIDE HOSPITAL)	[$15, $30, $40, $50] Copayment/visit.

Copayment does not apply if the services are Preventive Care services.

[SPECIALIST SERVICES	[$15, $30, $40, $50] Copayment/visit.]

[Note to carriers: Use this text if the specialist copay and the PCP copay are the same.]

[SPECIALIST SERVICES	[$30, $50, $60, $70] Copayment/visit]

[Note to carriers: Use this item if the specialist copay exceeds the PCP copay.]

REHABILITATION SERVICES	Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if Admission is immediately preceded by a Hospital Inpatient Stay.
SECOND SURGICAL OPINION	[$15, $30, $40, $50] Copayment/visit.
SKILLED NURSING FACILITY/ EXTENDED CARE CENTER	Unlimited days, if Pre-Approved; $0 Copayment.
THERAPY SERVICES	[$15, $30, $40, $50] Copayment/visit.
DIAGNOSTIC SERVICES	
INPATIENT	$0 Copayment
(OUTPATIENT)	[$15, $30, $40, $50] Copayment/visit

SCHEDULE OF SERVICES AND SUPPLIES

[Note to Carriers: This schedule illustrates the $30 copayment plan that must be offered by HMO carriers.]

THE SERVICES OR SUPPLIES COVERED UNDER THIS CONTRACT ARE SUBJECT TO ALL COPAYMENTS AND COINSURANCE AND ARE DETERMINED PER CALENDAR YEAR PER [MEMBER], UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES	**COPAYMENTS /COINSURANCE:**
HOSPITAL SERVICES:	
INPATIENT	$300 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $3,000/Calendar Year. Unlimited days.
OUTPATIENT	$30 Copayment/visit
PRACTITIONER SERVICES RECEIVED AT A HOSPITAL:	
INPATIENT VISIT	$0 Copayment
OUTPATIENT VISIT	$30 Copayment/visit; no Copayment if any other Copayment applies.
EMERGENCY ROOM	$100 Copayment/visit/Member (waived if admitted within 24 hours)

Note: The Emergency Room Copayment is payable in addition to the applicable Copayment and Coinsurance, if any.

PRACTITIONER CHARGES FOR SURGERY:	
INPATIENT	$0 Copayment
OUTPATIENT	$30 Copayment/visit
FACILITY CHARGES FOR OUTPATIENT SURGERY:	$15
HOME HEALTH CARE	Unlimited days, if Pre-Approved; $0 Copayment.
HOSPICE SERVICES	Unlimited days, if Pre-Approved; $0 Copayment.
MATERNITY (PRE-NATAL CARE)	[at the option of the carrier, $25 or same amount as primary care physician copayment] Copayment for initial visit only; $0 Copayment thereafter.
BIRTHING CENTER SERVICES	$30 Copayment/visit

NON-BIOLOGICALLY BASED MENTAL ILLNESS AND SUBSTANCE ABUSE:	
OUTPATIENT	$30 Copayment/visit maximum 20 visits/Calendar Year.
INPATIENT	$300 Copayment/day for a maximum of 5 days per admission. Maximum Copayment: $3,000/Calendar Year.

Maximum of 30 days inpatient care/Calendar Year. Subject to Pre-Approval, unused Inpatient days may be exchanged for additional Outpatient visits, where each Inpatient day may be exchanged for two Outpatient visits.

THERAPEUTIC MANIPULATION	$30 Copayment/visit; maximum 30 visits/Calendar Year
PRE-ADMISSION TESTING	$30 Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance
PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES (OUTSIDE HOSPITAL)	$30 Copayment/visit.

Copayment does not apply if services are Preventive Care services.

SPECIALIST SERVICES	$30 Copayment/visit.]
REHABILITATION SERVICES	Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if Admission is immediately preceded by a Hospital Inpatient Stay.
SECOND SURGICAL OPINION	$30 Copayment/visit.
SKILLED NURSING FACILITY/ EXTENDED CARE CENTER	Unlimited days, if Pre-Approved; $0 Copayment.
THERAPY SERVICES	$30 Copayment/visit.
DIAGNOSTIC SERVICES	
INPATIENT	$0 Copayment
(OUTPATIENT)	$30 Copayment/visit

SCHEDULE OF SERVICES AND SUPPLIES [Example Using Deductible, Coinsurance]

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

COPAYMENT	
For Primary Care Physician but not for Preventive Care Visits	[$15, $30, $40, $50] per visit
For Preventive Care	NONE
Maternity (pre-natal care)	[at the option of the carrier, $25 or same amount as primary care physician copayment] Copayment/initial visit.
For all other services and supplies	Copayment Not Applicable; Refer to the Deductible and Coinsurance sections
DEDUCTIBLE PER CALENDAR YEAR	
•For Preventive Care and immunizations and lead screening for children	NONE
•Maternity (pre-natal care)	NONE.
•for all other Covered Services and Supplies	
•Per Member	[$1,000, $2,500]
• Per Covered Family	[$2,000, $5,000.]
COINSURANCE	
PRESCRIPTION DRUG	50% Coinsurance
For Preventive Care:	NONE
For all services and supplies to which a Copayment does not apply	[10% - 50%, in 10% increments]
For all services and supplies to which a Copayment applies	None
EMERGENCY ROOM COPAYMENT	$100 Copayment/visit/Member (waived if admitted within 24 hours).

Note: The Emergency Room Copayment is payable in addition to the applicable Copayment, Deductible and Coinsurance.

MAXIMUM OUT OF POCKET

Maximum Out of Pocket means the annual maximum dollar amount that a Member must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, once the Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.

Exception: Coinsurance or copayments paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance or copayments must continue to be paid even after the Maximum Out of Pocket has been reached.

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

•Per Member per Calendar Year	[$7,500]
•Per Family per Calendar Year	[$15,000.]

Note: The Maximum Out of Pocket cannot be met with Non-Covered Charges.

LIMITATIONS ON SERVICES AND SUPPLIES

Home Health Care	Unlimited days, subject to Pre-Approval.
Hospice Services	Unlimited days, subject to Pre-Approval.
Non-Biologically-Based Mental Illness and Substance Abuse	
•Outpatient Visits	20 visits per Calendar Year.
•Inpatient Confinement	30 days per calendar year

[Subject to Pre-Approval, unused Inpatient days may be exchanged for additional Outpatient visits, where each Inpatient day may be exchanged for two Outpatient visits.]

Speech Therapy See below for the separate benefits available under the Diagnosis and Treatment of Autism or other Developmental Disabilities provision	30 visits per Calendar Year
Cognitive Rehabilitation Therapy	30 visits per Calendar Year
Physical Therapy See below for the separate benefits available under the Diagnosis and Treatment of Autism or other Developmental Disabilities provision	30 visits per Calendar Year
Occupational Therapy See below for the separate benefits available under the Diagnosis and Treatment of Autism or other Developmental Disabilities provision	30 visits per Calendar Year
Charges for physical, occupational and speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (limit applies separately to each therapy and is in addition to the therapy visits listed above)	30 visits
Charges for Applied Behavior Analysis per Calendar Year (the maximum benefit is subject to annual adjustment beginning in 2012)	[$36,000]
Charges for hearing aids for a Member age 15 or younger	$1,000 per hearing impaired ear per 24-month period
Therapeutic Manipulation	30 visits per Calendar Year
Skilled Nursing Facility/ Extended Care Center	Unlimited days, subject to Pre-Approval

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

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

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

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

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

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

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

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

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

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

PRE-EXISTING CONDITION. For a Member age 19 or older, an Illness or Injury which manifests itself in the six months before Your Enrollment Date, and for which:
a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your Enrollment Date; or
b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her Enrollment Date.

A pregnancy which exists on Your Enrollment Date is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.

PRE-EXISTING CONDITION LIMITATION. With respect to coverage of a Member who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:
a) approved for treatment of the [Member's] Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:
- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Drug Information; or
c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes Medically Necessary and Appropriate services associated with the administration of the drugs.
In no event will We pay for:
a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PREVENTIVE CARE. Services and supplies in connection with routine physical examinations, including laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening and Nicotine Dependence Treatment.

PRIMARY CARE PHYSICIAN (PCP). A [Network] Provider who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for pre and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who

supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; initiates a [Member]'s Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

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

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

PROVIDER. A recognized Facility or Practitioner of health care.

PUBLIC HEALTH PLAN., With respect to a person who is a Federally Defined Eligible Individual, means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

With respect to all other persons, Public Health Plan means any plan established or maintained by a State, the U.S. government, or any political subdivision of a State, or the U.S. government that provides health coverage to individuals who are enrolled in the plan.

REFERRAL. Specific direction or instruction from a [Member]'s Primary Care Physician [or Health Center] [or Care Manager] in conformance with our policies and procedures that directs a [Member] to a Facility or Practitioner for health care. [While HMO plans typically require [Members] to get a Referral from his or her Primary Care Physician [or Care Manager] in order to use the services of a Facility or a Practitioner, this HMO plan does NOT require Members to get a Referral.]

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) be approved for its stated purpose by Medicare.
In some places a Rehabilitation Center is called a "rehabilitation hospital."

RESIDENT. A person:
a) whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year, except as stated below; or
b) in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year, except as stated below.
Exception: For a Federally Defined Eligible Individual, We will not require a person to be present in New Jersey for at least six months of the Calendar Year, but We will require a person to provide proof that his or her primary residence is New Jersey.

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

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

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

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

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

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

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

SUBSTANCE ABUSE. Abuse of or addiction to drugs. Substance Abuse does not include abuse of or addiction to alcohol. Please see the definition of Alcohol Abuse.

Member believes he or she is not receiving the information to which the Member is entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.]

APPEAL PROCEDURE
NOTE TO CARRIERS: Insert Appeals Procedure text here. The Appeal Procedure text must satisfy the requirements of N.J.A.C. 11:24-8.5 et seq. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

CONTINUATION OF CARE

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

We shall assure continued coverage of covered services at the contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the [Member] to continue treatment with the terminated health care professional.

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

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

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

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

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

If a [Member] is admitted to a health care Facility on the date this Contract is terminated, We shall continue to provide benefits for the [Member] until the date the [Member] is discharged from the Facility or exhaustion of the [Member's] benefits under this Contract, whichever occurs first.

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

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

[COVERAGE PROVISION

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

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

[Family Deductible Limit
This Contract has a family deductible limit of two Cash Deductibles for each Calendar Year. Once [Members] in a family meet the family Cash Deductible in a Calendar Year, We provide coverage for Covered Services and Supplies for all Members who are part of the covered

family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Contract.]

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

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

NOTE: There is no Coinsurance credit from previous coverage. In addition, there is no Deductible or Coinsurance carryover into the next Calendar Year.]

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

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

Exception: Coinsurance or copayments paid for covered prescription drugs do not count toward the Maximum Out of Pocket. Such coinsurance or copayments must continue to be paid even after the Maximum Out of Pocket has been reached.

[Note to carriers: The Coverage Provision section is only to be included in plans where coverage is subject to deductible and coinsurance.]

COVERED SERVICES & SUPPLIES

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

(a) **OUTPATIENT SERVICES.** The following services are covered [only] at the Primary Care Physician's office [or Health Center] [or other Network Facility or Practitioner's office] selected by a [Member] [, or elsewhere upon prior written Referral by a [Member]'s Primary Care Physician [or Health Center] [or the Care Manager]]:

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

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

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

9. **Durable Medical Equipment** when ordered by a [Member]'s Primary Care Physician and arranged through Us.
10. [Subject to Our Pre-Approval, as applicable,]**Prescription Drugs** including **contraceptives which require a Practitioner's prescription**, and insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Network Provider.
    [A prescription or refill will not include a prescription or refill that is more than:
    a) the greater of a 90 day supply or 100 unit doses for each prescription or refill; or

b) the amount usually prescribed by the [Member's] Network Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.]
[We have identified certain Prescription Drugs for which Pre-Approval is required. We will provide the list of Prescription Drugs for which Pre-Approval is required to You. We will give at least 30 days advance written notice to You before revising the list of Prescription Drugs to add a Prescription Drug to the list.

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

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

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

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

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

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

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

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

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

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

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

h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

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

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

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

20) Hearing Aids We cover charges for medically necessary services incurred in the purchase of a hearing aid for a Member age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months subject to a maximum amount payable for each hearing aid of $1,000. Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The deductible, coinsurance or copayment as applicable to a [physician visit to a non Specialist Doctor] [PCP visit] for treatment of an Illness or Injury will apply to a hearing aid and the medically necessary services incurred in the purchase of a hearing aid.

21) **Mammogram Screening** We will provide coverage for:
a) one baseline mammogram for a female [Member], age 35 - 39
b) one mammogram, every year, for a female [Member] age 40 and older; and
c) in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's Practitioner.

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

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

1. Semi-private room and board accommodations

Except as stated below, We provide coverage for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.

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

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

We provide such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the Inpatient care.

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

2. Private accommodations [will be provided only when Pre-Approved by Us]. If a [Member] occupies a private room without [such] certification [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Facility of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Network Hospice, Network Hospital, Network Rehabilitation Center or Network Skilled Nursing Facility and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF YOUR MARRIAGE OR DOMESTIC PARTNERSHIP OR CIVIL UNION ENDS

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

Exceptions

No former Spouse may use this conversion right:

a) if he or she is eligible for Medicare;

b) if it would cause him or her to be excessively covered; This may happen if the Spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage. or

c) [if he or she permanently relocates outside the Service Area.]

HOW AND WHEN TO CONVERT

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

THE CONVERTED CONTRACT

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

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
Amended by R.1999 d.382, effective October 8, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2682(a), 31 N.J.R. 3339(a).
Recodified from N.J.A.C. 11:20 Appendix Exhibit F and amended by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).
Former N.J.A.C. 11:20 Appendix Exhibit B, repealed.
Amended by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).
See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).
Amended by R.2008 d.122, effective April 17, 2008.
See: 40 N.J.R. 1744(a), 40 N.J.R. 2475(a).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Amended by R.2010 d.247, effective October 4, 2010.
See: 42 N.J.R. 2366(a), 42 N.J.R. 2632(b).

EXHIBIT C

EXPLANATION OF BRACKETS

Plans A/50 through D
(Appendix Exhibit A)

All text which is enclosed in brackets [ ] is variable. Enclosure in Brackets does **not** give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following ways.

a) Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC]
b) Some areas of variability are noted with brief italicized explanations within the text. Examples include: use of high deductible health plan text and specialist copay.
c) Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d) Some areas of variability are subject to ranges and parameters specified in statute and/or regulation
e) Some areas of variability are determined by the election made by a Carrier.
f) Some areas of variability are determined by the delivery system (i.e., indemnity or PPO)

Note: Due to the complexity of issuing plans through or in conjunction with an approved Selective Contracting Arrangement, commonly known as PPO plans, explicit guidance is set forth in item 15 below.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is generally consistent with the order of appearance in the policy forms.

1. The Health Care Quality Act requires carriers to specify the legal name, trade name, e-mail and fax numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
2. Although the schedule pages specify the plan letter in the upper right corner this identification is intended solely to identify which plan letter the page illustrates. Carriers need not specify the plan letter on the schedule pages of plans being issued.
3. Deductible, and Co-Payments, as offered by the carrier, may be elected by the Policyholder, subject to the availability specified in regulation.
4. There are sample PPO schedule pages. There are corresponding provisions in the benefit provisions.
5. The list of services and supplies for which pre-approval is required includes some new items, included in brackets: specified therapies, therapeutic manipulation, exchange of non-biologically based mental illness inpatient days and prescription drugs. The benefit provisions for these services and supplies also includes text in brackets concerning pre-approval. Carriers that elect to require pre-approval for these services and supplies must include them on the list on the schedule page in addition to using the pre-approval text in the benefit provision.
6. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the policy form.
7. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option delivery system.
8. The text describing provider compensation in the PPO section contains a number of bracketed words and phrases. Include the words and phases that describe the arrangement carrier has with network providers.
9. The continuation of care text must be included in all plans that use networks.
10. The treatment of hemophilia provision includes variable text that would only be included in PPO plans.
11. The prescription drugs provision includes variable text that would be included by carriers that require pre-approval for specified drugs.
12. The therapy services provision includes variable text that would be included by carriers that require pre-approval for certain therapy services.
13. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. For Carriers electing to include the optional cancer treatment benefits as part of the standard forms, the list of services for which Pre-Approval is required, as it appears in the Schedule of Benefits, must be modified to omit the item for autologous bone marrow transplant and associated dose intensive chemotherapy.
14. The Centers of Excellence Features provisions may be omitted. If included in the policy, the text must conform to the text of the standard form.
15. Carriers that issue plans through or in conjunction with an approved Selective Contracting Arrangement must consider the following when creating the plan documents:
    a. The policy and certificate documents contain "SAMPLE" schedule page text. The dollar amounts for the deductibles and copayments are purely illustrative. Refer to N.J.A.C. 11:20-3.1(d) for direction as to which amounts may be substituted for those in the example. For plans that utilize a copay feature, the copays replace the cash deductible for the particular service, and benefits following the copay must be paid at 100%. The dollar amounts for the copays must be consistent with those that an HMO carrier may use. ($15, $30, $40 or $50)
    b. Include the specific page of text describing the PPO mechanism, with specification of the name of the network or provider organization.
16. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
17. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.

[NON- [NETWORK] [-PARTICIPATING] PROVIDER. A Provider which is not a [Network] [Participating] Provider.] *[Note to carriers: Include if issued as a plan with network or participating providers.]*

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

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

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

[POLICY]. This agreement, [the [Policy] Coverage Schedule,] [Your I.D. card,] any riders, amendments or endorsements, the application signed by You and the Premium schedule.

[POLICY]HOLDER. The person who purchased this [Policy].

PRACTITIONER. A person [Carrier] is required by law to recognize who:
a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and
b) provides services which are within the scope of his or her license or certificate.

PRE-EXISTING CONDITION. For a Covered Person age 19 or older, an Illness or Injury which manifests itself in the six months before Your coverage under this [Policy] starts, and for which:
a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your Enrollment Date; or
b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her Enrollment Date.

A pregnancy which exists on Your Enrollment Date is also a Pre-Existing Condition. However, complications of pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.
See the section of this [Policy] called "Pre-Existing Condition Limitations" for details on how this [Policy] limits the benefits for Pre-Existing Conditions.

PRE-EXISTING CONDITION LIMITATION. With respect to coverage of a Covered Person who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information.

PREMIUM DUE DATE. The date on which a Premium is due under this [Policy].

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

[PRIMARY CARE PHYSICIAN (PCP). A [Network] [Participating] Provider who is a Practitioner specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for OB/GYN services only),] or pediatrics who supervises, coordinates and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.] *[Note to carriers: Include if issued as a managed care plan that uses a PCP.]*

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

PROVIDER. A recognized Facility or Practitioner of health care in accordance with the terms of this [Policy].

PUBLIC HEALTH PLAN. With respect to a person who is a Federally Defined Eligible Individual means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

With respect to all other persons, Public Health Plan means any plan established or maintained by a State, the U.S. government, or any political subdivision of a State, or the U.S. government that provides health coverage to individuals who are enrolled in the plan.

[**REFERRAL.** Specific direction or instructions from Your Primary Care Physician [or care manager] in conformance with Our policies and procedures that directs a Covered Person to a Facility or Practitioner for health care.]
[Note to carriers: Carriers that issue this plan as an HMO should include this definition.]

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people.

RESIDENT. A person:
a) whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
b) in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year, except as stated below.

Exception: For a Federally Defined Eligible Individual, We will not require a person to be present in New Jersey for at least six months of the Calendar Year, but We will require a person to provide proof that his or her primary residence is New Jersey.

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

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SKILLED NURSING FACILITY. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are:
a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

[SPECIALIST PRACTITIONER. A Practitioner who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine or pediatrics.] *[Note to carriers: Include if issued as a managed care plan that uses these terms.]*

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

SUBSTANCE ABUSE. Abuse of or addiction to drugs. Substance Abuse does **not** include abuse of or addiction to alcohol. Please see the definition of Alcoholism.

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare.

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

SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:
a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have permanent operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written, back-up arrangements with a local Hospital for Emergency care.

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

A Facility is not a Surgical Center if the Facility is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are

[Benefits] for Outpatient care [are] [is] subject to the payment of the Alcohol and Substance Abuse Coinsurance, as shown on the Coverage Schedule. [Benefits are] [Coverage is] limited, as shown on the Coverage Schedule. *Note*: The Coverage Limits for Alcohol and Substance Abuse are separate from the Coverage Limits for Hospital Confinement.

Treatment may be furnished by a Hospital or Substance Abuse Center.

Anesthetics and the administration of anesthesia: We cover anesthetics and their administration.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes:
a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Biologically–based Mental Illness: We [pay benefits] [provide coverage] for the treatment of a Biologically-based Mental Illness, if such treatment is prescribed by a Practitioner. But We do not [pay] [cover] [for] Custodial Care, education, or training. [Benefits] [Coverage] for Inpatient care [are] [is] subject to the payment of the Copayment for Inpatient care for Biologically Based Mental Illness as shown on the Coverage Schedule. Benefits for Outpatient care are subject to the payment of Coinsurance, as shown on the Coverage Schedule. [Benefits are] [Coverage is] limited, as shown on the Coverage Schedule. *Note*: The Coverage Limits for Biologically Based Mental Illness are separate from the Coverage Limits for Hospital Confinement.

Blood and blood plasma: We cover blood, blood products and blood transfusions.

Complications of Pregnancy: We cover treatment for the complications of pregnancy.

Diagnostic Tests: We cover Inpatient and Out-of Hospital diagnostic testing. Benefits for Out-of Hospital Diagnostic Tests are limited, as shown in the Coverage Schedule.

Dialysis: We cover charges for Inpatient and Outpatient dialysis. This includes hemodialysis and peritoneal dialysis.

Emergency Room Services: Coverage for Emergency includes coverage of trauma services at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgement of the attending Practitioner, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another Facility. Benefits for Emergency Room Services are subject to the payment of the Copayment as shown on the Coverage Schedule. We also provide coverage for a medical screening examination provided upon a Covered Person's arrival in a Hospital, as required to be performed by the Hospital in accordance with Federal law, but only as necessary to determine whether an emergency medical condition exists. [Please note that the "911" emergency response system may be used whenever a Covered person has a potentially life-threatening condition. Information on the use of the "911" system is included in the identification card.] *[Note to carriers: Include this text for managed care plans.]*

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Practitioner's fees connected with Hospital care, general acute care, delivery of a child, Surgery, laboratory fees, prescription drugs, dressings and splints.

[Benefits] [Coverage] for Inpatient care [are] [is] subject to the payment of the Copayment for Hospital Confinement as shown on the Coverage Schedule. *Note*: The Coverage Limits for Hospital Confinement are separate from the Coverage Limits for Alcohol and Substance Abuse and Biologically Based Mental Illness.

If You [incur charges] [receive services or supplies] as an Inpatient in a Special Care Unit, We cover the [charges] [services or supplies] the same way We cover other Hospital [charges] [services or supplies].

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered [Charges] [Services or Supplies].

We cover charges for treatment rooms, operating rooms and delivery rooms.

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

Intravenous Solutions: We cover intravenous solutions administered while an Inpatient or in an Outpatient setting.

Oxygen: We cover charges for oxygen and the administration of oxygen.

Practitioner Charges for Outpatient and Ambulatory Surgery: We cover Practitioner charges for Outpatient and ambulatory Surgery. [Benefits] [Coverage] for Outpatient and ambulatory Surgery [are] [is] subject to the payment of the Copayment as shown on the Coverage Schedule. We do not cover Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly. We also cover dressings and splints.

Practitioner Charges for Visits: We cover Practitioner charges for visits to treat a diagnosed Illness or Injury. Benefits are limited, as shown on the Coverage Schedule. We also cover dressings and splints.

Pregnancy: As stated in the Hospital Charges section, We cover Practitioner's fees for the delivery of a Child and charges for the use of the delivery room.

Pre-Admission Testing: We cover x-rays and laboratory tests in connection with pre-admission testing needed for a planned Hospital admission or Surgery. We cover these tests if:
a) the tests are done within seven days of the planned admission or Surgery; and
b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

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

We only cover the Therapy Services listed below.
Radiation Therapy - the treatment of disease by x-ray, radium, cobalt, or high-energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following Illness, Injury or loss of limb; or treatment related to a Biologically-based Mental Illness to develop a physical function.
Hydrotherapy – the medical use of water in the treatment of certain diseases.

We cover Radiation Therapy and Physical Therapy when it is provided on an Inpatient basis and on an Outpatient basis. We only cover Hydrotherapy when it is provided on an Inpatient basis. Benefits for Outpatient Physical Therapy are subject to the payment of the Copayment shown on the Coverage Schedule. Benefits are limited as shown on the Coverage Schedule.

Wellness Benefit: We cover wellness services and supplies. Wellness services and supplies include but are not limited to: routine physical examinations, diagnostic services, vaccinations, inoculations, x-ray, mammography, pap smear, bone density testing, nicotine dependence treatment, screening tests related to wellness services. Benefits are limited as shown on the Coverage Schedule.

X-Rays: We cover x-rays to diagnose an Illness or Injury. X-Rays done on an Outpatient basis are subject to the limit for Outpatient diagnostic tests as shown on the Coverage Schedule. Except as covered under the Wellness benefit section of this [Policy], We do not pay for x-rays done as part of routine physical checkups.

Pre-Existing Condition Limitations: If You are age 19 or older, We do not cover services for Pre-Existing Conditions until You have been covered by this [Policy] for twelve months. See the "Definitions" section of this [Policy] for the definition of a Pre-Existing Condition.

EXCEPTION: The Pre-Existing Conditions Limitation does **not** apply to a Federally Defined Eligible Individual, as defined in this [Policy], provided he or she applies for coverage within 63 days of termination of the prior coverage. If coverage is not issued as a result of the application, the period from the Enrollment Date to the date the application is declined is excluded from the period without coverage.

In addition, this limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. The Pre-Existing Conditions Limitations do not apply to a Dependent who is a newborn Child, an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 31 days after birth, adoption, or placement for adoption or to any Dependent Child who is under age 19. Additionally, this limitation does not apply to any new benefits mandated by statute or regulation once You have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

Continuity of Coverage
The Pre-Existing Condition limitation does **not** apply to a Covered Person who was covered under Creditable Coverage provided there has been no more than 31 days lapse in coverage, measured from the last date the Creditable Coverage was in force on a premium paying basis, for a condition covered by that Creditable Coverage, if the Covered Person: has been treated or diagnosed by a Practitioner for a condition under that Creditable Coverage; or satisfied a 12 month Pre-Existing Condition limitation.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

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

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

[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].

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

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

Penalties for Non-Compliance
As a penalty for non-compliance, We reduce what We pay for covered professional charges for Surgery by 50%] if:
a) the Covered Person does not request a pre-surgical review; or
b) [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d) [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this [Policy's] Cash Deductible or Coinsurance.

EXCLUSIONS

The following are <u>not</u> Covered [Charges] [Services or Supplies] under this [Policy]. We will <u>not</u> pay for any charges incurred for, or in connection with:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not Medically Necessary and Appropriate.

Ambulance

[Any charge to the extent it exceeds the Allowed Charge] *[Note to carriers: Carriers may omit this exclusion if issued as an HMO plan.]*

[Any service provided without prior written Referral by the Member's Primary Care Physician [or Care Manager] except as specified in this Contract.] *[Note to carriers: Include if issued as a plan that requires referrals.]*

Any service or supply not specifically included in the Covered [Charges] [Services and supplies] section of this [Policy].

Birthing center charges

Blood or blood plasma which is replaced by You

Broken appointments

Casts, braces, trusses, prosthetic devices, orthopedic footwear and crutches

Chemotherapy

Christian Science

Completion of claim forms

Conditions related to behavior problems or learning disabilities

Cosmetic Surgery, except as stated in this [Policy]; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes

Custodial Care or domiciliary care

Dental care or treatment, including appliances and dental implants

Drugs and surgical procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood

Durable medical equipment

Education or training while You are confined in an institution that is primarily an institution for learning or training

Experimental or Investigational treatments, procedures, Hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this [Policy]

Eye examinations to determine the need for (or changes of) eyeglasses or lenses of any type; eyeglasses, contact lenses, and all fittings, except as otherwise specified in this [Policy]; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy or lasik surgery

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility

Food and food products

Hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them

Herbal medicine

Home health care

Hospice care

Hypnotism

Except as stated below, Illness or Injury which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

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

Infusion therapy

Local anesthesia charges billed separately by a Practitioner for surgery he or she performed on an Outpatient basis

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

Marriage, career or financial counseling, sex therapy or family therapy

Nicotine Dependence Treatment, except as provided for under the wellness benefit

Non - Prescription Drugs or supplies

Nutritional counseling and related services

Outpatient Hospital services, except as specifically covered under this [Policy]

Outpatient laboratory tests, except as provided under the Wellness Benefit or the Pre-Admission Testing benefit.

Pregnancy, including charges for pre and post natal care, except Practitioner charges for delivery and charges for the delivery room are covered. Complications of pregnancy are also covered.

Prescription drugs obtained while not confined in a Hospital

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the [Policy] provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will give You written notice if this happens but it will never be more than 120 days from the date after We receive Your request for review.

[Include the Claims Procedures provision in plans that require the submission of claims.]

[APPEALS PROCEDURE

The Appeal Procedure text must satisfy the requirements of N.J.A.C. 11:24-8.5 et seq. or N.J.A.C. 11:24A-3.4 et seq., as appropriate. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

GRIEVANCE PROCEDURE
[Carriers must include the disclosure requirements set forth in N.J.A.C. 11:24A-3.2]

[Note to carriers: Include the following member provisions if coverage is issued as an HMO plan.]

MEMBER PROVISIONS

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

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

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

INABILITY TO PROVIDE SERVICE
In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Network] [Participating] Providers or entities with whom We have arranged for services under this [Policy], or similar causes, the rendition of medical or hospital benefits or other services provided under this [Policy] 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. In the event We cannot provide or arrange for any services for three or more days We will refund premium for that period for which no services are available.

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

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

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

APPEAL PROCEDURE
NOTE TO CARRIERS: Insert Appeals Procedure text here. The Appeal Procedure text must satisfy the requirements of N.J.A.C. 11:24-8.5 et seq. The text must include specific information regarding the Stage 1, Stage 2 and External Appeals process.

MEDICAL NECESSITY
Members will receive designated benefits under the [Policy] only when Medically Necessary and Appropriate. We may Determine whether any benefit provided under the [Policy] was Medically Necessary and Appropriate, and We have the option to select the appropriate [Network] [Participating] Facility to render services if hospitalization is necessary. Decisions as to Medical Necessity and Appropriateness are subject to review by the Quality Assessment Committee of HMO or its physician designee. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the [Policy] that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a Practitioner referred in writing by the Primary Care Physician [or Care Manager] without notifying the Member that such benefit would not be covered under this [Policy].

REFERRAL FORMS
You can be referred for Specialist Services by Your Primary Care Physician [or Care Manager].

You will be responsible for the cost of all services provided by anyone other than Your Primary Care Physician (including but not limited to Specialist Services) if You have not been referred by Your Primary Care Physician [or Care Manager].

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

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

REPORTS AND RECORDS
HMO is entitled to receive from any provider of services to a Member such information HMO deems is necessary to administer this [Policy] subject to all applicable confidentiality requirements as defined in this [Policy]. By accepting coverage under this [Policy], [Policy]holder, for the [Policy]holder, and for all Dependents covered hereunder, authorizes each and every Practitioner who renders services to Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and medical condition of Member and render reports pertaining to same to Us upon request and to permit copying of Member's records by Us.

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN
When You first obtain this coverage, You and each of Your Dependents must select a Primary Care Physician.

You select a Primary Care Physician from Our Practitioners Directory; this choice is solely Yours. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, You will be notified and given an opportunity to make another Primary Care Physician selection.

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

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

PREMIUM RATE CHANGES
The Premium rates in effect on the Effective Date are shown in the [Premium Rates and Provisions section of the Policy] [Policy's Schedule of Premium Rates]. We have the right to prospectively change Premium rates as of any of these dates:
a) any premium due date;
b) any date that the extent or nature of the risk under the Policy is changed:
- by amendment of the Policy; or
- by reason of any provision of law or any government program or regulation;

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

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

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

All statements will be deemed representations and not warranties.

TERM OF THE POLICY - RENEWAL PRIVILEGE – TERMINATION

This Policy is issued for a term of one (1) year from the Effective Date shown on the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. Plan Years will be measured as stated in the definition of Plan Year. All periods of insurance hereunder will begin and end at 12:01 am. Eastern Standard Time.

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

We have the right to non-renew this Policy on the Policy Anniversary date following 180 days advance written notice to the Policyholder for the following reasons:
a) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
b) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual market provided We act uniformly without regard to any Health Status-Related Factor of Members or persons who may become eligible for coverage; or
c) the Board terminates a standard plan or a standard plan option.

During or at End of Grace Period - Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end [when that period ends.] [as of the end of the period for which premium has been paid.]
Termination by Request - If You want to replace this Policy with another Individual Health Benefits Plan, You must give us notice of the replacement within 30 days after the effective date of the new Plan. This Policy will end as of 12:01 a.m. on the effective date of the new Plan and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

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

a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; ([Coverage will end as of the end of the grace period.] [Coverage will end as of the end of the period for which premium has been paid.]
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date] [immediately].)

c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan; (Coverage will end immediately.)
d) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new plan.)

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

A Dependent's coverage ends when the Dependent becomes eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or the Dependent is no longer a Dependent, as defined in the Policy. Coverage ends at 12:01 a.m. on the date the first of these events occurs.

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

THE CONTRACT
The entire Contract consists of:
[a the forms shown in the Table of Contents as of the Effective Date;
b)] the Policyholder's application, a copy of which is attached to the Policy;
[c)] any riders, [endorsements] or amendments to the Policy.

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

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

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

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

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

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

Amended by R.1994 d.614, effective November 17, 1994 (operative January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).
Petition for Rulemaking.
See: 26 N.J.R. 5120(b).
Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).
Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).
Amended by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1999 d.382, effective October 8, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2682(a), 31 N.J.R. 3339(a).
Recodified from N.J.A.C. 11:20 Appendix Exhibit V and amended by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).
Former N.J.A.C. 11:20 Appendix Exhibit F, recodified as N.J.A.C. Appendix Exhibit B.
Amended by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).
See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).
Amended by R.2008 d.122, effective April 17, 2008.
See: 40 N.J.R. 1744(a), 40 N.J.R. 2475(a).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Amended by R.2010 d.248, effective October 4, 2010.
See: 42 N.J.R. 2369(a), 42 N.J.R. 2633(a).