CHAPTER 20

INDIVIDUAL HEALTH COVERAGE PROGRAM

Authority

N.J.S.A. 17:1-8.1, 17:1-15e and 17B:27A-2 et seq.; and P.L. 2008, c. 38.

Source and Effective Date

R.2011 d.163 and d.167, effective May 12, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a),
43 N.J.R. 143(a), 43 N.J.R. 1359(a).

Chapter Expiration Date

Chapter 20, Individual Health Coverage Program, expires on May 12, 2018.

Chapter Historical Note

Chapter 20, Individual Health Coverage Program, was adopted as emergency new rules by R.1993 d.344, effective June 14, 1993 (to expire August 13, 1993). See: 25 N.J.R. 2945(a). The concurrent proposal of Chapter 20 was adopted as R.1993 d.439, effective August 13, 1993, with changes effective September 7, 1993. See: 25 N.J.R. 2945(a), 25 N.J.R. 4180(a).

Subchapter 2, Individual Health Coverage Program Temporary Plan of Operation, was adopted as R.1993 d.550, effective October 14, 1993. See: 25 N.J.R. 4707(a), 25 N.J.R. 5244(a).

Subchapter 10, Performance Standards and Reporting Requirements, was adopted as R.1994 d.142, effective February 23, 1994. See: 26 N.J.R. 1202(a), 26 N.J.R. 1351(a).

Subchapter 11, Relief from Obligations Imposed by the Individual Health Insurance Reform Act, was adopted as R.1993 d. 654, effective December 30, 1993. See: 25 N.J.R. 4459(a), 25 N.J.R. 5930(b).

Subchapter 12, Eligibility for and Replacement of Standard Health Benefits Plans, was adopted as R.1994 d.54, effective December 30, 1993. See: 26 N.J.R. 87(a), 26 N.J.R. 804(a).

Subchapter 13, Certification of Non-Member Status, was adopted as R.1994 d.177, effective March 10, 1994. See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

Subchapter 17, Enrollment Status Report, was adopted as R.1994 d.53, effective December 30, 1993. See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).

Subchapter 18, Withdrawal of Carriers from the Individual Market and Withdrawal of Plan, Plan Option, or Deductible/Copayment Option, was adopted as R.1998 d. 339, effective July 6, 1998. See: 29 N.J.R. 2615(a), 30 N.J.R. 2502(a).

Pursuant to Executive Order No. 66(1978), Chapter 20, Individual Health Coverage Program, Subchapters 1 through 10, 12, 13, 17, 18 and Appendix Exhibits A through T, were readopted as R.1998 d.443, effective August 7, 1998, and Subchapter 11 was readopted as R.1998 d.454, effective August 13, 1998. Subchapter 19, Petitions for Rulemaking, and Subchapter 20, Appeals from Actions of the Board, were adopted as new rules by R.1998 d.443, effective August 7, 1998. See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a); 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In accordance with N.J.S.A. 52:14B-5.1d, the expiration date of Chapter 20, Individual Health Coverage Program, was extended by gubernatorial directive from August 7, 2003 to 270 days following Supreme Court decision in In re Health Coverage Program's Readoption of N.J.A.C. 11:20-1.1 et seq. See: 35 N.J.R. 2898(a).

Subchapter 22, Basic and Essential Health Care Services Plan, was adopted as R.2003 d.91, effective January 28, 2003. See: 34 N.J.R. 73(a), 35 N.J.R. 1290(a).

In accordance with N.J.S.A. 52:14B-5.1d, Chapter 20, Individual Health Coverage Program, expiration date was extended by gubernatorial directive from February 4, 2005 to July 4, 2005. See: 37 N.J.R. 778(a).

Subchapter 4, Standard Application Form; Subchapter 5, Standard Claim Form and Appendix Exhibits G, H, and I, expired effective July 4, 2005. See: 37 N.J.R. 2994(a).

Chapter 20, Individual Health Coverage Program, Subchapters 1 through 3, 6 through 10, 12, 17 through 20, 22 and Appendix Exhibits A through F, J through L, and Q through V, were readopted as R.2006 d.15, effective December 7, 2005, and Subchapter 11 was readopted as R.2006 d.16, effective December 7, 2005. Subchapter 12, Eligibility for and Replacement of Standard Health Benefits Plans and the Basic and Essential Health Care Services Plan, was repealed, and Subchapter 12, Purchase of a Standard Individual Health Benefits Plan or a Basic and Essential Healthcare Services Plan by a Person Covered under an Individual Plan or Eligible for or Covered under a Group Plan, was adopted as new rules by R.2006 d.15, effective January 3, 2006. Appendix Exhibit R, was repealed, by R.2006 d. 15, effective January 3, 2006. Subchapter 23, Rulemaking; Interested Parties; Public Notices; Interested Parties Mailing List, and Subchapter 24, Program Compliance, were adopted as new rules by R.2006 d.15, effective January 3, 2006. Appendix Exhibits A, C, E and U were repealed by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006). Exhibits A, C and E were adopted as new rules. See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 38 N.J.R. 1005(a); 37 N.J.R. 3022(a), 38 N.J.R. 332(a).

Exhibit H of the Appendix was adopted as new rules by R.2009 d.45, effective December 29, 2008. See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Subchapter 6, Individual Health Benefits Carriers Informational Rate Filing Requirement; Subchapter 7, Loss Ratio and Refund Reporting Requirements; and Subchapter 18, Withdrawal of Carriers from the Individual Market and Withdrawal of Plan, Plan Option, or Deductible/Copayment Option, were repealed by R.2009 d.45, effective December 29, 2008 (operative April 20, 2009). See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b), 41 N.J.R. 1875(a).

Subchapter 3A, Policy Forms; Subchapter 6, Individual Health Benefits Carriers Informational Rate Filing Requirements; Subchapter 7, Loss Ratio And Refund Reporting Requirements; and Subchapter 18, Withdrawals of Carriers from the Individual Market and the Withdrawal of Plan, Plan Option, or Deductible/Copayment Option, were adopted as new rules by R.2009 d.128, effective April 20, 2009. See: 41 N.J.R. 73(a), 41 N.J.R. 1866(c).

Subchapter 9, Exemptions, and Subchapter 10, Performance Standards and Reporting Requirements, expired on December 7, 2010.

In accordance with N.J.S.A. 52:14B-5.1b, Subchapters 1, 2, 3, 3A, 6, 7, 8, 11, 12, 17, 18, 19, 20, 22, 23 and 24, and Appendix Exhibits A through H and J through L were scheduled to expire on June 5, 2013. See: 43 N.J.R. 1203(a).

Chapter 20, Individual Health Coverage Program, Subchapters 1, 2, 3, 8, 12, 17, 19, 20, 22, 23 and 24, and Appendix Exhibits A through D, F, G, H, K and L, were readopted as R.2011 d.163, effective May 12, 2011; and Subchapters 3A, 6, 7, 11 and 18, and Appendix Exhibits E and J, were readopted as R.2011 d.167, effective May 12, 2011. See: Source and Effective Date. See, also, section annotations.

Subchapter 12, Purchase of a Standard Individual Health Benefits Plan or a Basic and Essential Healthcare Services Plan by a Person Covered Under an Individual Plan or Eligible for or Covered Under a Group Plan, was renamed Purchase of a Standard Health Benefits Plan by a Person Covered Under an Individual Plan or Covered Under a Group Plan by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014). See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).

Case Notes

New Jersey Individual Health Coverage Program Board of Directors did not violate authorized procedures for adopting or amending its regulations when it readopted Individual Health Coverage Program (IHCP) regulations; Board provided notice as required by statute, received written comments regarding proposed regulations, and prepared report that summarized and responded to comments and was published in New Jersey Register. In re N.J. IHCP, 353 N.J.Super. 494, 803 A.2d 639.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

11:20-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 et seq.), the Individual Health Insurance Reform Act, as amended. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-2 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Individual Health Coverage Program pursuant to N.J.S.A. 17B:27A-2 et seq.

(b) Provisions of the New Jersey Individual Health Insurance Reform Act and of this chapter shall be applicable to all carriers that are members of the Individual Health Coverage Program, as the term member is defined in this subchapter, and to such other carriers as the specific provisions of the statute and this chapter may state.

(c) Provisions of the New Jersey Individual Health Insurance Reform Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after August 1, 1993, except as the specific provisions of this chapter, the New Jersey Individual Health Insurance Reform Act, or applicable Federal laws state otherwise.

Petition for Rulemaking: Exhibit F.
See: 26 N.J.R. 862(a), 26 N.J.R. 1401(a), 26 N.J.R. 2488(a).
Petition for Rulemaking: Exhibit F.
See: 26 N.J.R. 4228(b), 26 N.J.R. 4452(d), 27 N.J.R. 1321(a).
Petition for Rulemaking: Exhibit F.
See: 26 N.J.R. 5119(a), 27 N.J.R. 946(d).
Petition for Rulemaking: Exhibits A through F.
See: 26 N.J.R. 5120(b), 27 N.J.R. 946(b).
Petition for Rulemaking: Exhibit D.
See: 28 N.J.R. 1315(a), 28 N.J.R. 2413(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "as amended" at the end of the first sentence; in (b), inserted "as the term member is defined in this subchapter" following "Coverage Program"; and in (c), substituted "August 1, 1993" for "November 30, 1992".
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
In (c), deleted "the statute and of" following "provisions of", and inserted ", the New Jersey Individual Health Insurance Reform Act, or applicable Federal laws".

11:20-1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

"Act" means the New Jersey Individual Health Insurance Reform Act, P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 through 16.5), as it may be amended and supplemented from time to time.

"Affiliated carriers" means two or more carriers that are treated as one carrier for purposes of complying with the Act because the carriers are subsidiaries of a common parent or one another.

"Annual open enrollment period" means the Federally-designated period of time each year during which:

1. Individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and

2. Individuals who already have coverage may replace current coverage with a different standard health benefits plan or standard health benefits plan with rider.

"Basic and essential health care services plan" means the health benefits plan set forth in N.J.S.A. 17B:27A-4.4 through 4.7.

"Board" means the Board of Directors of the New Jersey Individual Health Coverage Program established by the Act.

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to

provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. For purposes of this chapter, carriers that are affiliated carriers shall be treated as one carrier.

"Catastrophic plan" means a standard health benefit plan that is designed and offered in accordance with the requirements of Federal regulations at 45 CFR 156.155.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Community rated" means that the premium for all persons covered under a health benefits plan contract is the same, based on the experience of all persons covered by that contract, without regard to age, sex, health status, occupation and geographical location.

"Conversion health benefits plan" means a group conversion contract or policy issued on or after August 1, 1993 that is not subsidized by either:

1. A single charge or ongoing increase in premium rates chargeable to the group policy or contract, identifiable as an excess morbidity charge in the group rating formula to cover group conversion excess morbidity costs; or

2. A reduction in dividends or returns paid to a group policy or contract holder, identifiable as a charge to or reduction in the group dividend or return formula to cover group conversion excess morbidity costs.

"Deferral" means a deferment, in whole or in part, of payment by a member of any assessment issued by the IHC Program Board, granted by the Commissioner pursuant to N.J.S.A. 17B:27A-12a(3) and N.J.A.C. 11:20-11.

"Department" means the New Jersey Department of Banking and Insurance.

"Dependent" means:

1. The applicant's spouse;

2. The applicant's same-gender domestic partner as that term is defined in P.L. 2003, c. 246;

3. The applicant's civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships recognized in other jurisdictions if such relationships provide substantially all of the rights and benefits of marriage;

4. The applicant's child, legally-adopted child, step child, foster child including a child placed in foster care, or child under a court-appointed guardianship;

5. A child of the applicant's domestic partner subject to applicable terms of the individual health benefits plan;

6. A child of the applicant's civil union partner subject to applicable terms of the individual health benefits plan; or

7. Any other child over whom the applicant has legal custody or legal guardianship or with whom the applicant has a legal relationship or a blood relationship provided the child depends on the applicant for most of the child's support and maintenance and resides in the applicant's household.

"Director" means a Director of the Individual Health Coverage Program Board who, in accordance with N.J.S.A. 17B:27A-10 as amended by P.L. 1993, c.164, §5:

1. Has been elected by the members of the Individual Health Coverage Program and approved by the Commissioner;

2. Has been appointed by the Governor and confirmed by the Senate; or

3. Sits ex officio on the Board of Directors.

"Eligible person" means a person who is a resident of New Jersey who is not eligible to be covered under Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.), commonly referred to as "Medicare."

"Enrollment date" means the effective date of coverage under the individual health benefit plan.

"Essential health benefits" or "EHB" means the categories of health care services required to be covered in accordance with 45 CFR 156.110.

"Federally-qualified HMO" is a health maintenance organization which is qualified pursuant to the "Health Maintenance Organization Act of 1973," Pub. L. 93-222 (42 U.S.C. § 300e et seq.).

"Fiscal year" means the time period beginning on July 1st of each year and ending on June 30th of the following calendar year.

"Group health benefits plan" means a health benefits plan for groups of two or more persons.

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

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this chapter, health

benefits plan shall 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 (42 U.S.C. § 1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan. The term "health benefits plan" specifically includes:

1. Standard health benefits plans as defined in this section;

2. Closed blocks of business otherwise meeting the definition of health benefits plan;

3. Executive medical plans;

4. Student coverage which provides more than accident-only coverages;

5. All prescription drug plans whether or not written on a stand alone basis;

6. Plans that cover both active employees and retirees eligible for Medicare for which separate statutory reporting is not made by the carrier;

7. The basic and essential health care services plan; and

8. All other health policies, plans or contracts not specifically excluded.

"HMO" means a health maintenance organization authorized in accordance with N.J.S.A. 26:2J-1 et seq.

"Hospital confinement indemnity coverage" means coverage that is provided on a stand alone basis, contains no elimination period greater than three days, provides coverage for no less than 31 days during one period of confinement for each person covered under the policy, and provides no less than $40.00 but no more than $250.00 in daily benefits except that the benefit for the first day of hospital confinement may exceed $250.00 as long as the following formula is satisfied:

$$\frac{\text{1st day benefit—2nd day benefit}}{5} + \text{2nd day benefit} < \$250.00$$

"IHC Program" means the New Jersey Individual Health Coverage Program.

"Individual health benefits plan" means: (a) a health benefits plan for eligible persons and their dependents; and (b) a certificate issued to an eligible person which evidences coverage under a policy or contract issued to a trust or association, regardless of the situs of delivery of the policy or contract, if the eligible person pays the premium and is not being covered under the policy of contract pursuant to continuation of benefits provisions applicable under Federal or State law. The term "individual health benefits plan" shall include a policy, contract, or certificate evidencing coverage by a policy or contract issued to a trust or association, issued to an eligible person described in, but not limited to, the following examples: a student, except coverage issued to an institution of higher education for coverage of students and their dependents in New Jersey if such policy has been filed by the Commissioner as a discretionary group pursuant to N.J.S.A. 17B:27-49, an unemployed individual or part-time employee, except as may be provided pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21-7.3; a self-employed person; an employer, when he or she (and dependents) is the sole employee seeking coverage by a health benefits plan, except as may be provided pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21-7.6; any person who is the sole employee seeking coverage by a health benefits plan, except as may be provided pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21-7.6; and an employee who is one of several employees of the same employer who are covered by certificates, contracts or policies issued by the same carrier, trust or association, if the employer does not contribute to, and remit payment for, the coverage of such employees.

The term "individual health benefits plan" shall not include a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is an employee welfare benefit plan as defined by the "Employee Retirement Income Security Act of 1974" (29 U.S.C. §§ 1001 et seq.), to the extent that the Employee Retirement Income Security Act preempts the application of the Act to that plan.

"Initial enrollment period" means October 1, 2013, through March 31, 2014, which is the period during which applica-

tions for standard health benefits plans or standard health benefits plans with riders must be received by the carriers.

"Marketplace" means the Federally-facilitated exchange as defined in Federal regulations at 45 CFR 155.20, through which qualified individuals can purchase qualified health plans and obtain a determination of eligibility for a premium tax credit, cost-sharing reduction, or exemption from the requirement to purchase health insurance.

"Medicaid" means the program administered by the New Jersey Division of Medical Assistance and Health Services Program in the New Jersey Department of Human Services, providing medical assistance to qualified applicants, in accordance with P.L. 1968, c.413 (N.J.S.A. 30:4D-1 et seq.) and amendments thereto.

"Medical care" means amounts paid:

1. For the diagnosis, care, mitigation, treatment, or prevention of a disease, illness, or medical condition or for the purpose of affecting any structure or function of the body; and

2. Transportation primarily for and essential to medical care referred to in paragraph 1 above.

"Medicare" means coverage provided pursuant to Part A or Part B of Title XVIII of the Federal Social Security Act, Pub.L. 89-97 (42 U.S.C. §§ 1395 et seq.) and amendments thereto.

"Medicare Advantage" means policies and contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1853 of the Federal Social Security Act (42 U.S.C. §§1395 et seq.) and any amendments thereto.

"Member" means a carrier that issues or has in force health benefits plans in New Jersey. A member shall not include a carrier whose combined average Medicare, Medicaid and NJ FamilyCare enrollment represents more than 75 percent of its average total enrollment for all health benefits plans or whose combined Medicare, Medicaid and NJ FamilyCare net earned premium for the two-year calculation period represents more than 75 percent of its total net earned premium for the two-year calculation period. The average Medicare, Medicaid and NJ FamilyCare enrollment and average enrollment for all health benefits plans shall be calculated by taking the sum of these enrollment figures, as measured on the last day of each calendar quarter during the two-year calculation period, and dividing by eight.

"Minimum essential coverage" means any of the following types of coverage:

1. Government sponsored programs. Coverage under:

i. The Medicare program under Part A of Title XVIII of the Social Security Act;

ii. The Medicaid program under Title XIX of the Social Security Act;

iii. The Children's Health Insurance Program (CHIP) program under Title XXI of the Social Security Act;

iv. Medical coverage under Chapter 55 of Title 10, United States Code, including coverage under the TRICARE program;

v. A health care program under Chapter 17 or 18 of Title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary;

vi. A health plan under section 2504(e) of Title 22, United States Code (relating to Peace Corps volunteers); or

vii. The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. § 1587 note);

2. Employer-sponsored plan. Coverage under an eligible employer-sponsored plan;

3. Plans in the individual market. Coverage under a health plan offered in the individual market within a state;

4. Grandfathered health plan. Coverage under a grandfathered health plan; and

5. Other coverage. Such other health benefits coverage, such as a state health benefits high risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes.

Minimum essential coverage shall also include those additional types of coverage designated by the Secretary of the United States Department of Health and Human Services at 45 CFR 156.602, including, but not limited to: self funded student health coverage offered by an institution of higher education; Refugee Medical Assistance supported by the Administration for Children and Families; and Medicare Advantage plans.

"Modified community rated" means, with respect to coverage under standard health benefit plans, a rating system in which the premium for all persons covered under a policy or contract for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographical location, or any other factor or characteristic of covered persons, other than age.

The rating system provides that the premium rate charged by a carrier for the highest rated individual or class of individuals shall not be greater than 300 percent of the premium rate charged for the lowest rated individual or class of individuals purchasing the same individual health benefits plan. The rate differential among the premium rates charged to individuals covered under the same individual health benefits

plan shall be based on the actual or expected experience of persons covered under that plan; provided, however, that the rate differential may also be based upon age. The factors upon which the rate differential is applied shall be consistent with rules promulgated by the Commissioner, which include age classifications.

"NAIC" means the National Association of Insurance Commissioners.

"Net earned premium" means the premiums earned in this State on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Net earned premium shall include the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including premiums from any Medicare, Medicaid or NJ FamilyCare contracts with the State or federal government, but shall not include any premium associated with the benefits enumerated in Section 2 of Part C of the Premium Data Worksheet which is set forth as chapter Exhibit K, incorporated herein by reference.

"NJ FamilyCare" means the FamilyCare Health Coverage Program established pursuant to P.L. 2005, c. 156 (N.J.S.A. 30:4J-8 et al.).

"Open enrollment" means the offering of a health benefits plan to any eligible person on a guaranteed issue basis during the initial enrollment period or an annual open enrollment period.

"Plan" means the plan of operation of the IHC Program, an individual health benefits plan, or a group health benefits plan, as the context indicates.

"Plan sponsor" shall have the meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(16)(B)).

"Pre-existing condition" means for a plan issued or renewed prior to January 1, 2014, for a covered person age 19 or older a condition that, during a specified period of not more than six months immediately preceding the enrollment date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition or as to a pregnancy existing on the enrollment date of coverage.

"Premium earned" means premium received, adjusted for the changes in premium due and unpaid, and paid in advance, and unearned premium, net of refunds or dividends paid or credited to policyholders, but not reduced by dividends to stockholders or by active life reserves.

"Program" means the New Jersey Individual Health Coverage Program established pursuant to the Act.

"Qualified health plan" or "QHP" means a health benefits plan certified to meet the requirements specified at 45 CFR 156.200 et seq. for participation on a marketplace in accordance with 45 CFR 155.1000 et seq.

"Renewal date" means January 1 of the year immediately following the effective date of a policy and each succeeding January 1 thereafter.

"Resident" means a person whose primary residence is in New Jersey and who is present in New Jersey for at least six months of each calendar year, or, in the case of a person who has moved to New Jersey less than six months before applying for individual health coverage, who intends to be present in New Jersey for at least six months of each calendar year.

"Special enrollment period" means a period of time that is no less than 60 days following the date of a triggering event during which:

1. Individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and

2. Individuals who already have coverage are allowed to replace current coverage with a different standard health benefits plan or standard health benefits plan with rider.

"Standard health benefits plan" means a health benefits plan, including riders, if any, each of which is adopted by the IHC Program Board.

"Standard health benefits plan with rider" means a standard health benefits plan as amended with one or more optional benefit riders as permitted by N.J.A.C. 11:20-3.6.

"Stop loss" or "excess risk insurance" means an insurance policy designed to reimburse a self-funded arrangement for catastrophic, excess or unexpected expenses wherein neither the employees nor other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance for purposes of the Individual Health Insurance Reform Act, the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

1. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than $20,000 per covered person per plan year; and

2. If the policy establishes an aggregate attachment point or retention, that aggregate attachment point or retention shall not be less than 125 percent of expected claims per plan year.

"Subsidy" means a premium tax credit or a cost sharing reduction pursuant to 26 CFR 1.36B, 45 CFR 156.410, and 45 CFR 156.425.

"Triggering event" means an event that results in an individual becoming eligible for a special enrollment period. Triggering events are:

1. The date the eligible person loses eligibility for minimum essential coverage, or the eligible person's dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a QHP by the marketplace;

2. The date a dependent child's coverage ends as a result of attaining age 26 whether or not the dependent is eligible for continuing coverage in accordance with Federal or state laws;

3. The date a dependent child's coverage under a parent's group plan ends as a result of attaining age 31;

4. The effective date of a marketplace redetermination of an eligible person's subsidy, including a determination that an eligible person is newly eligible or no longer eligible for a subsidy;

5. The date an eligible person acquires a dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care;

6. The date an eligible person who is covered under a standard health benefits plan or standard health benefits plan with rider or group health benefits plan moves out of that plan's service area; and

7. The date of a marketplace finding that it erroneously permitted or denied an eligible person enrollment in a QHP.

8. The date the eligible person demonstrates to the marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

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

"Two-year calculation period" means a two calendar year period, the first of which shall begin January 1, 1997 and end December 31, 1998.

Amended by R.1994 d.54, effective December 30, 1993.
See: 26 N.J.R. 87(a), 26 N.J.R. 804(a).
Amended by R.1995 d.37, effective December 20, 1994.
See: 27 N.J.R. 41(b), 27 N.J.R. 371(b).
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 "Eligible person" and "Family unit".
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2000 d.142, effective March 6, 2000.
See: 32 N.J.R. 643(a), 32 N.J.R. 1253(c).
Rewrote "Member".
Amended by R.2001 d.55, effective January 17, 2001.
See: 33 N.J.R. 15(a), 33 N.J.R. 668(a).
Inserted "Medicare Plus Choice"; in "Net earned premium", inserted reference to Medicare Plus Choice enrollees; and in "Non-group persons", inserted reference to Medicare Plus Choice contract.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Added "Basic and essential health care services plan"; in "Health benefits plan", added new 7, recodified former 7 as 8; in "Non-group persons", inserted "a basic and essential health care services plan pursuant to P.L. 2001, c.368" preceding "Medicare"; deleted "Reimbursement for losses".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Deleted "Basic health benefits plan" and "Reasonable and customary"; amended "Dependent", "Director", "Eligible person", "Family unit", "Member", "NAIC", "Net earned premium", "Non-group persons", "Pre-existing condition", and "Resident"; added "Enrollment date", "Federally defined eligible individual", "Medicare Advantage", "NJ FamilyCare", and "NJ KidCare".
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).
In definition "Federally defined eligible individual", rewrote 1.
Amended by R.2008 d.122, effective April 17, 2008.
See: 40 N.J.R. 1744(a), 40 N.J.R. 2475(a).
Rewrote definitions "Dependent" and "Family unit".
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
In definition "Member", substituted "and" for a comma following the first two occurrences of "Medicaid", deleted "and NJ KidCare" following "FamilyCare" three times and inserted "and" following the last occurrence of "Medicaid"; added definition "Modified community rated"; rewrote definition "Net earned premium"; in definition "NJ FamilyCare", substituted "P.L. 2005, c. 156 (N.J.S.A. 30-4J-8 et al.) for "P.L. 2000, c. 71 (N.J.S.A. 30-4J-1 et seq.)"; and deleted definition "NJ KidCare".
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
In paragraph 7 of definition "Family unit", deleted ", who are members of the same household" following "plan"; and in definition "Pre-existing condition", inserted "for a covered person age 19 or older".
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
In definition "Act", inserted "New Jersey" and ", as it may be amended and supplemented from time to time"; in definition "Basic and essential health care services plan", substituted "set forth in" for "pursuant to P.L. 2001, c.368,"; in definition "Dependent", rewrote paragraph 4, deleted "or" from the end of paragraph 5, substituted "; or" for a period at the end of paragraph 6, and added paragraph 7; in definition "Individual health benefits plan", deleted the second semicolon following the second occurrence of "N.J.A.C. 11:21-7.6", and rewrote the second paragraph; in definition "Modified community rated", substituted "300" for "350", deleted "as set forth in N.J.A.C. 11:20-6. There may be a reasonable differential among the premium rates charged for different family structure rating tiers within an individual health benefits plan or different health benefits plans offered by a carrier" from the end of the second paragraph, and deleted the third paragraph; in definition "Pre-existing condition", inserted "for a plan issued or renewed prior to January 1, 2014,"; in definition "Standard health benefits plan", inserted "each of which is"; added definitions "Annual open enrollment period", "Catastrophic plan", " 'Essential health benefits' or 'EHB' ", "Initial enrollment period", "Marketplace", "Minimum essential coverage", " 'Qualified health plan' or 'QHP' ", "Special enrollment period", "Standard health benefits plan with rider", "Subsidy", and "Triggering event"; deleted definitions "Church plan", "Family unit", "Federally defined eligible individual", "Governmental plan", "Medicare cost and risk contracts", "Medicare Plus Choice", " 'Non-group persons' or 'non-group persons covered' ", and rewrote definitions "Eligible person", "Enrollment date", "Open enrollment", "Plan", and "Resident".
Amended by R.2014 d.190, effective November 17, 2014 (operative January 1, 2015).
See: 46 N.J.R. 2314(a), 46 N.J.R. 2416(b).
Rewrote definition "Annual open enrollment period"; and added definition "Renewal date".

11:20-1.3 Closing of noncomplying individual health benefits plan

(a) All coverage under individual health benefits plans delivered or issued for delivery with an effective date of August 1, 1993 or thereafter shall comply with this chapter.

(b) Health benefits plans not subject to the Act shall remain subject to the full review and approval of the Commissioner in accordance with N.J.S.A. 17B:26-1 et seq., N.J.S.A. 17:49-1 et seq., N.J.S.A. 17:48A-1 et seq., N.J.S.A. 17:48E-1 et seq., N.J.S.A. 26:2J-1 et seq. and rules promulgated pursuant thereto.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), deleted the first sentence; and in (b), inserted N.J.S.A. references.

11:20-1.4 Other laws of this State

All health benefits plans delivered or issued for delivery in New Jersey, as defined by this subchapter, shall be subject to the New Jersey Individual Health Insurance Reform Act, as well as all relevant statutes and rules of New Jersey not inconsistent with, amended or repealed by this Act.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Deleted "including individual standard health benefits plans" following "this subchapter".
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Inserted the second occurrence of "New Jersey".

11:20-1.5 (Reserved)

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Inserted "plans" following "health benefits".
Repealed by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Section was "Penalties".

11:20-1.6 Mission statement

The mission of the New Jersey Individual Health Coverage Program Board is to administer the New Jersey Individual Health Coverage Program in a manner aimed at increasing access to coverage, protecting consumers, educating key stakeholders in the marketplace and other interested persons, and promoting carrier participation in the market. This includes establishment and modification of standard plans for marketing to individuals and establishing and administering assessment mechanisms. It also includes the regulation of individual health coverage carriers in conjunction with the New Jersey Department of Banking and Insurance and New Jersey Department of Health and Senior Services.

Repeal and New Rule, R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Section was "Severability".

SUBCHAPTER 2. INDIVIDUAL HEALTH COVERAGE PROGRAM PLAN OF OPERATION

11:20-2.1 Purpose and structure

(a) The "IHC Program" created pursuant to the N.J.S.A. 17B:27A-2 to 16, as amended, has as its members all insurance companies, health service corporations, hospital service corporations, medical service corporations, and health maintenance organizations that issue or have in force health benefits plans in this State. The IHC Program's purpose is:

1. To assure the availability of standardized individual health benefits plans in New Jersey on an open enrollment, modified community-rated basis; and

2. To reimburse certain losses of member companies for the calendar year ending December 31, 1992 pursuant to N.J.S.A. 17B:27A-13, for each calendar year ending December 31, 1993 through December 31, 1996, and for each two-year calculation period through the 2007-2008 calculation period pursuant to N.J.S.A. 17B:27A-12, as amended.

(b) The Board of the IHC Program has been charged pursuant to the Act to administer the IHC Program reasonably and equitably under law.

(c) The IHC Program Plan of Operation sets forth as completely as possible the fair, reasonable and equitable manner in which the Board will administer the IHC Program under law.

(d) The Board shall consist of nine directors, including the Commissioner or his or her designee, who shall serve ex officio.

(e) The Board shall appoint an insurance producer licensed to sell health insurance pursuant to N.J.S.A. 17:22A-1 et seq. to advise the Board on issues related to sales of individual health benefits plans issued pursuant to the Act.

(f) Neither the Plan of Operation nor the IHC Program creates any contractual or other rights and obligations between the IHC Program and any entity or other person insured by any carrier.

(g) The IHC Program shall continue in existence subject to termination in accordance with the laws of this State or of the United States. In the event of enactment of a law or laws which, in the determination of the Board and the Commissioner, shall result in the termination of the IHC Program, the IHC Program shall terminate and conclude its affairs. Any funds or assets held by the IHC Program following the payment of all claims and expenses of the IHC Program shall be distributed to the member carriers at that time and in accordance with the then existing assessment formula.

(h) All documents or other communications directed to the Board shall be sent to the Executive Director of the IHC Program at the address set forth below. Communications sent by regular mail must be sent to the PO Box:

New Jersey Individual Health Coverage Program
20 West State Street, 11th Floor
PO Box 325
Trenton, NJ 08625-0325
Telephone: (609) 633-1882 x50302
Fax: (609) 633-2030

Administrative Change.
See: 27 N.J.R. 1423(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), rewrote the introductory paragraph 2; and in (h), updated the address.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Changed subchapter heading from "Individual Health Coverage Program Temporary Plan of Operation". In (c) and (f), deleted references to the Temporary Plan of Operation; rewrote (h).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
In (a)1, inserted "modified"; and in (a)2, substituted "through the 2007-2008 calculation period" for "thereafter".
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
In the address in (h), substituted "50302" for "50306".

11:20-2.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A-2 as amended, and N.J.A.C. 11:20-1, when used in this subchapter, shall have the meanings as defined therein, unless more specifically defined in (b) below or unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Action" means an action by the Board adopted, in the Board's discretion, in accordance with the procedures set forth either in the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., or in sections 7 and 8 of P.L. 1993, c.164. "Action" includes, but is not limited to: the establishment and modification of health benefits plans; procedures and standards for assessment of members and the apportionment thereof and policy form filings; and the promulgation or modification of policy forms. "Action" shall not include the hearing and resolution of contested cases, personnel matters or applications for exemptions.

"Plan" means the plan of operation of the IHC Program.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), deleted a P.L. reference; and in (b), deleted "Basic health benefits plan", Deferral", "Director", "Financially impaired", "HMO", "Reasonable administrative expenses", and "Standard health benefits plan" definitions.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), deleted "Temporary Plan".
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
In definition "Action" in (b), substituted "and" for a comma following "thereof", and deleted ", rate filings, evaluation of material submitted by carriers with respect to loss ratios, and establishment of refunds to policyholders or contract holders" following "form filings".

11:20-2.3 Powers of the IHC Program and Board

(a) The IHC Program shall have the general powers and authority granted under the laws of this State to insurance companies, health service corporations and health maintenance organizations licensed or approved to transact business in this State, except that the IHC Program shall not have the power to issue health benefits plans directly to either groups or individuals.

(b) The Board shall have the authority to do the following:

1. Define the provisions of standard health benefits plans in accordance with the requirements of the Act and the Plan of Operation;

2. Establish benefit levels, including any optional deductibles and copayments, and exclusions and limitations for standard health benefits plans in accordance with law;

3. Establish standard policy forms for standard health benefits plans and rider packages;

4. Establish a procedure for the joint distribution of information on standard health benefits plans issued pursuant to N.J.S.A. 17B:27A-4 as amended;

5. Establish reasonable guidelines for the purchase of new individual health benefits plans by persons who are already enrolled or insured by another individual health benefits plan;

6. Review filings submitted by carriers in accordance with the Act and rules promulgated pursuant thereto and the Plan of Operation;

7. Establish standards for a means test for standard health benefits plans issued pursuant to N.J.S.A. 17B:27A-4 as amended by P.L. 1993, c.164, section 3;

8. Make application on behalf of member carriers for benefits, subsidies, discounts or funds that may be provided either by any health care provider or under State or Federal law or regulation;

9. Appoint from among Board members appropriate legal, actuarial and other committees necessary to provide technical and other assistance in the operation of the IHC Program, in policy and other contract design and any other functions within the authority of the Board;

10. Enter into contracts which are necessary or proper to carry out the provisions and purposes of the Act and the Plan of Operation;

11. Employ or retain such persons, firms or corporations to perform such administrative functions as are necessary for the Board's performance of its duties;

12. Provide procedures for receiving oral and written comments from the public, which may include rules relating to the time and place of any public hearing, and for the length and format of testimony from individuals, groups and organizations;

13. Establish rules, conditions and procedures pertaining to the sharing of IHC Program administrative expenses among the members of the IHC Program;

14. Calculate assessments and assess member carriers their proportionate share of IHC administrative expenses in accordance with N.J.S.A. 17B:27A-12 and this Plan, and make advance interim assessments, as may be reasonable and necessary for organizational and reasonable operating expenses;

i. An interim assessment shall be credited as an offset against any regular assessment due following the close of the fiscal year;

ii. The Board may provide for other credits against assessments as appropriate;

15. Establish and maintain the appropriate accounts necessary to administer the IHC Program;

16. Impose interest penalties upon members for late payment of assessments as authorized by N.J.S.A. 17B:27A-10(f)(4);

17. Recommend to the Commissioner that actions be instituted in accordance with the Commissioner's authority to impose penalties for violations of the Act;

18. Sue or be sued, including taking any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the IHC Program or a member carrier;

19. Pursuant to P.L. 1993, c. 164, adopt "actions" necessary to execute the Board's powers pursuant to the provisions of N.J.S.A. 17B:27A-2 et seq.;

20. Borrow money to effect the purposes of the IHC Program;

i. Any notes or other evidence of indebtedness of the Program not in default shall be legal investments for carriers and may be carried as admitted assets; and

21. Contract for an independent actuary and any other professional services the Board deems necessary to carry out its duties under N.J.S.A. 17B:27A-2 et seq. as amended.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (b), substituted "authority" for "power" in the introductory sentence, deleted a P.L. reference in 4, and rewrote 6.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (b).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
In (b)6, deleted "rate filings and other" following "Review".
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
Deleted former (b)8; recodified former (b)9 through (b)22 as (b)8 through (b)21; in (b)13, deleted "losses and" preceding "administrative expenses"; and in (b)14, deleted "Program losses and" following "IHC" and "and estimated losses" following the second occurrence of "expenses".

11:20-2.4 Plan of Operation

(a) The Plan of Operation and amendments thereto shall become effective upon approval by the Commissioner and submission of final action to the Office of Administrative Law for publication. The Commissioner may amend the Plan of Operation by providing written notice to the Board of amendments and their effective dates and upon adoption of amendments in accordance with applicable law.

(b) Upon the submission of a Plan by the Board and approval of the Plan by the Commissioner pursuant to N.J.S.A. 17B:27A-10(d) and (e) as amended by P.L. 1993, c.164, section 6, the Commissioner shall rescind the Temporary Plan.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), substituted "the Office of Administrative Law" for "OAL"; and in (b), deleted "amend or" preceding "rescind".

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), substituted references to the permanent "Plan of Operation" for those to the "Temporary Plan" and substituted "approval" for "adoption"; section was "Temporary Plan of Operation".

11:20-2.5 Board of Directors

(a) The Board shall consist of nine Directors, including the Commissioner or his or her designee, who shall sit ex officio.

1. Four Directors shall be appointed by the Governor, with the advice and consent of the Senate.

i. One of the Governor's appointees shall be a representative of an employer, appointed upon the recommendation of a business trade association, who has experience in the management or administration of an employee health benefits plan. One of the Governor's appointees shall be a representative of organized labor, appointed upon the recommendation of the AFL-CIO, who has experience in the management or administration of an employee health plan. Two of the Governor's appointees shall be consumers of a health benefits plan who are reflective of the population in the State.

ii. The term of the initial appointment shall be for the period as set forth in the appointment.

2. Four Directors shall represent carriers and shall be elected by the members subject to the approval of the Commissioner.

i. To the extent a Carrier elected by the members is willing to serve on the Board, a representative of each of the following types of carrier shall be elected:

(1) A health service corporation or a domestic stock insurer which converted from a health service corporation pursuant to the provisions of P.L. 2001, c. 131 and is primarily engaged in the business of issuing health benefit plans in this State;

(2) A health maintenance organization;

(3) An insurer authorized to write health insurance in this State subject to Subtitle 17B of the New Jersey Statutes; and

(4) A foreign health insurance company authorized to do business in this State.

ii. The Board shall hold a meeting, at least annually, of the members of the IHC Program for the purpose of electing Directors to fill any vacancies among the Directors who represent carriers which exist or which will exist within 10 business days following the date of the election meeting pursuant to a resolution of the Board or the expiration of a Director's normal term of office.

(1) On or about 60 days prior to the date of the election meeting, the Board shall send written notice to the IHC Program members setting forth the time, date and place of the election meeting, stating the positions for which a vote is to be taken, soliciting written nominations of candidates for those positions, and stating the last date that written nominations shall be accepted, which shall be no less than 10 business days following the date of the written notice.

(2) Following the close of the nomination period, the Board shall determine from among the carriers nominated those carriers that are eligible and willing to serve in the position for which nominated. A carrier may be placed on the ballot for only one Board position, and may not hold more than one seat on the Board. If a carrier is nominated for two or more positions for which it is eligible, the carrier shall notify the Board before the election as to the single position for which it will accept the nomination, and be designated on the ballot.

(3) At least 30 calendar days prior to the date of the election meeting, the Board shall send a written notice to members setting forth the candidates to be considered for purposes of voting at the election meeting, along with a ballot by which the member carrier may vote via absentee ballot on or before the date specified by the Board, which shall be no earlier than three business days prior to the date of the election meeting.

(4) Affiliated carriers shall have no more than one vote for each position subject to vote and no two affiliated carriers shall serve on the Board at the same time.

(5) Elections shall be by the highest number of those votes properly cast in person and absentee.

(6) The Board shall maintain a written record of each election, including copies of all notices sent, ballots received and the tally sheets in accordance with its record retention procedures set forth at N.J.A.C. 11:20-2.9.

iii. Prior to the Board's annual meeting set forth at (c) below, or no later than 30 calendar days subsequent to the date of the election meeting, whichever date is later, the Board shall send a written notice to IHC Program members of the names of the Directors of the Board, their respective designees, if any.

3. The Commissioner shall file with the Board a letter naming his or her designee, if any.

4. A carrier elected to the Board shall file with the Board a letter naming the person authorized to vote on behalf of the carrier and may name one or more alternates.

5. Appointed Directors shall promptly notify the Board of any change in circumstance that may affect the representative capacity in which they were appointed. Upon receipt of such notice, the Board shall notify the Governor of the appointed Director's change in circumstance.

6. The Directors representing carriers on the Board shall promptly notify the Board of any change in circumstance that may affect the representative capacity of the entity elected by the members. Upon receipt of such notice, the Board shall provide notice of the same to the members of the IHC Program.

7. Directors shall serve their terms of office until their replacements are duly appointed or elected, as appropriate.

(b) The Board shall elect a Chair from among its Directors, and may elect other officers it deems appropriate. As authorized by the Board, such officers may act as signatories on behalf of the Board and perform other ministerial functions necessary and proper to effectuate the actions of the Board.

(c) The Board shall hold an annual meeting at which it shall:

1. Elect officers of the Board;

2. Appoint Directors to committees of the Board; and

3. Take action on such other matters that it deems appropriate.

(d) A majority of the Directors shall constitute a quorum for the transaction of business.

1. Each Director shall have one vote. The acts of a majority of the Directors present at a meeting at which a quorum is present shall be the acts of the Board, except as provided in (d)2 below.

2. The affirmative votes of five Directors shall be required to act upon the following:

i. Amendments to the Plan of Operation;

ii. Amendments to the standard health benefits plans;

iii. Adoption of any actions, as defined by section 8 of P.L. 1993, c. 164, (N.J.S.A. 17B:27A-16.1) or amendments to the actions of the IHC Program;

iv. Removal of any Director from membership on any committee;

v. Recommendations by the Board to the Commissioner regarding amendments to the Act; and

vi. An assessment or interim assessment.

(e) All meetings of the Board at which a quorum is present, including special meetings, shall be subject to the provisions of the Open Public Meetings Act, N.J.S.A. 10:4-6 to 21.

(f) In addition to the annual meeting and any regularly scheduled meeting, the Board may hold special meetings upon the request of the Chair or of three or more Directors.

(g) Directors shall not receive compensation for attendance at Board and Committee meetings. Directors may be reimbursed for reasonable unreimbursed travel and other reasonable expenses incurred in attending Board and Committee meetings using the State Travel Regulations issued by the Department of the Treasury as a guide.

(h) The Board shall hold meetings either in person or by teleconference.

(i) The Board shall provide for the taking of written minutes of each Board meeting, including teleconferences and closed sessions, and distribute a copy of the minutes to the Directors. The Board shall retain the original of the minutes.

1. The staff of the Board shall take and maintain the written minutes of the proceedings of the Board meetings, including teleconferences and closed sessions. Board meeting minutes shall set forth as a minimum the following:

i. The time, date and place of the meeting;

ii. The names of all persons attending the meeting, the organizations they represent, if any, and the identity of the person presiding;

iii. A narrative describing what occurred at the meeting including subjects considered and actions taken;

iv. The recorded votes of each member on each matter including abstentions;

v. The complete text of any resolutions adopted by the Board; and

vi. Any other information required to be shown in the minutes by law.

(j) All Board members shall be subject to the State of New Jersey Uniform Ethics Code and any supplemental code of ethics the Board adopts.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), rewrote 2; in (c)2, deleted "and others persons"; rewrote (d)2iii; in (i), removed the requirement that copies of minutes be provided to the Commissioner.
Administrative correction.
See: 38 N.J.R. 1189(a).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Rewrote (j).

11:20-2.6 Committees

(a) The Board shall make appointments to standing and other committees from among Directors. Each of the standing committees shall include no more than four Directors, but the Chair may appoint additional Directors as needed subject to ratification by the Board at the next subsequent meeting.

(b) The Board may, by resolution:

1. Determine the size of a standing committee, appoint Directors, and fill a vacancy;

2. Appoint a Director to serve as an alternate member of any standing committee to act in the absence of a committee member with all the powers of such absent member;

3. Abolish any standing committee; and

4. Appoint or authorize the use of IHC Program staff, consultants, or other advisors to work with any standing committee.

(c) Committees may not take final action; however, within the scope of their purpose and duties, committees may make recommendations and reports to the Board for decision.

(d) Standing committees shall include the following:

1. A Technical Advisory Committee, which shall make recommendations to the Board with respect to:

i. Methods for calculating assessments;

ii. A uniform Audit Program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier; and

iii. Any other reports or recommendations to the Board as may be appropriate regarding the possible impact of suggested plan designs;

2. A Legal Committee, which shall make recommendations to the Board with respect to:

i. Rules to be promulgated by the Board pursuant to the Act;

ii. Amendments to the Plan of Operation and the various individual health benefits plans proposed by the Board;

iii. Any proposed amendments to the Act;

iv. Contracts and legal documents for the IHC Program;

v. All litigation and other disputes involving the IHC Program and its operations;

vi. Coordination with the Office of the Attorney General on matters relating to IHC Program operations; and

vii. Any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the IHC Program or a member.

3. A Marketing and Communications Committee, which shall make recommendations to the Board with respect to:

i. Rules for implementation and administration of the Act and standards to provide for the fair marketing and broad availability of individual health benefits plans to eligible persons;

ii. Marketing and communication plans for the IHC Program, as needed;

iii. Submissions by members of good faith marketing reports for the basic and essential health care services plan made pursuant to N.J.A.C. 11:20-22.6;

iv. Submissions of good faith marketing reports as required by N.J.A.C. 11:20-24.6 by those members that are small employer carriers demonstrating marketing of all of the standard health benefits plans the member elects to offer;

v. The insurance producer to be appointed by the Board pursuant to N.J.S.A. 17B:27A-10g, and assist in liaison efforts between the Board and the appointed producer; and

vi. Materials to be distributed to consumers or made available through the Internet which describe the individual health benefits plans available to eligible persons pursuant to the Act.

4. An Operations and Audit Committee, which shall make recommendations to the Board with respect to:

i. The engagement of independent financial consultants, including, but not limited to, examiners, auditors, accountants and actuaries;

ii. The Plan of Operation and amendments thereto;

iii. Standards of acceptability for the selection of auditing firms;

iv. The review of reports prepared by independent auditors and other audit-related matters the Board deems necessary;

v. Contracts which are necessary or proper to carry out the provisions and purposes of the Act and this Plan;

vi. Methods for calculating assessments; and

vii. Uniform audit program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier.

(e) The Board may by resolution establish and appoint other committees.

(f) All committee members shall be subject to the State of New Jersey Uniform Ethics Code and any supplemental code of ethics the Board adopts.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (d); and added a new (f).
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), deleted "and IHC Program members" in the first sentence; in (b), deleted 4 and recodified former 5 as 4; rewrote (d) and (f).

Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Rewrote (d)1; added new (d)3iv; recodified former (d)3iv and (d)3v as (d)3v and (d)3vi; and rewrote (f).
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
In (d)1ii, inserted "and" at the end; deleted former (d)1iii and (d)1iv; recodified former (d)1v as (d)1iii; in (d)4vi, inserted "and" at the end; in (d)4vii, deleted "; and" from the end; and deleted (d)4viii.

11:20-2.7 Financial administration

(a) The fiscal year of the IHC Program shall run from July 1 to June 30 of each year.

(b) All funds of the IHC Program shall be deposited into and disbursements made from the General Treasury in accordance with procedures established and approved by the Department of Treasury, Office of Management and Budget.

1. Monies pertaining to the IHC Program shall be deposited into a dedicated account within the State's General Fund.

2. Monies may be credited from the General Fund to IHC bank accounts upon request by the Board through the Department, which request shall include justification for the request with supporting documentation, and shall be pursuant to the approval of the Director of the Division of Budget and Accounting.

(c) Bank checking accounts shall be established separately in the name of the IHC Program and shall be approved by the Board.

1. The Board shall authorize individuals to sign checks on behalf of the Board.

2. All cash and other assets shall be invested in accordance with the investment policy developed and approved by the Board as permitted by applicable law.

i. All investment income earned on administrative assessment funds shall be credited to the IHC Program and shall be applied to reduce future administrative assessments of members of IHC Program except as provided in N.J.A.C. 11:20- 2.12(h).

ii. All investment income earned on loss assessment funds shall be credited to the IHC Program and shall be applied to reduce assessments of members of the IHC Program, except as provided in N.J.A.C. 11:20-2.17(a).

(d) No disbursements shall be made from IHC bank accounts without the approval of the Board, except that the Board may authorize the Executive Director to make disbursements of less than $1,000 per disbursement for administrative purposes as necessary for the efficient administration of the program.

(e) All financial records shall be kept in accordance with the State's prescribed policies and procedures. The Board shall maintain the books and records of the IHC Program at a location in New Jersey in a manner so that financial statements may be prepared to satisfy the Act and other requirements of New Jersey law.

1. The receipt and disbursement of cash for the IHC Program shall be recorded as it occurs.

2. Non-cash transactions shall be recorded when assets or liabilities should be realized by the IHC Program in accordance with generally accepted accounting principles.

3. Assets and liabilities of the IHC Program, other than cash, shall be accounted for and described in itemized records.

4. The net balance due to or from the IHC Program shall be calculated for each carrier either when deemed appropriate by the Board or when requested by the carrier. The Board shall maintain records of each carrier's financial transactions with the IHC Program as necessary to ensure compliance with the Act and Plan of Operation, which records shall include at least the following:

i. Net losses of the IHC Program based upon the assessments calculated in accordance with this Plan;

ii. Any adjustments as set forth in this Plan;

iii. Adjustments to the amount due to or from the IHC Program based upon corrections to carrier submissions;

iv. Interest charges due from a carrier for late payment of amounts due to the IHC Program; and

v. Other records required by the Board.

5. The Board shall maintain a general ledger which shall be used to produce the IHC Program's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger shall agree with the corresponding balances in subsidiary ledger journals.

(f) The Executive Director shall prepare an annual financial report to be delivered to the Commissioner and each member of the Board by December 31 of each year beginning in 1998. The annual report shall fairly present the financial condition of the IHC Program for the preceding fiscal year.

1. All accounts shall be reconciled and trial balances shall be determined monthly.

2. Financial statements in a form approved by the Board shall be prepared and delivered to each member of the Board and the Commissioner on a quarterly basis.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (c), rewrote 2; in (d), substituted "Executive Director" for "Interim Administrator or subsequently appointed Administrator"; and in (f), substituted "Executive Director" for "Interim Administrator or subsequently appointed Administrator" and changed the delivery deadline from September 30 of each year beginning in 1994 to December 31 of each year beginning in 1998 in the introductory paragraph, and substituted "Board" for "Technical Advisory Committee" in 2.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), inserted "into" following "shall be deposited" in the introductory paragraph; in (c), rewrote 2; in (d), substituted "as necessary for the efficient administration of the program" for "subject to such conditions as the Board may prescribe"; in (e)4, deleted reference to the Temporary Plan.
Amended by R.2006 d.445, effective December 18, 2006.
See: 38 N.J.R. 1159(a), 38 N.J.R. 5383(a).
In (c)2ii, substituted "(h)" for "(g)".
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
In (c)2ii, deleted "future loss" following "reduce", and substituted "(a)" for "(h), and except that interest earned on loss assessment funds due to a carrier shall be paid to that carrier to the extent that the investment income is earned during a subsequent loss assessment cycle in which the carrier is no longer seeking reimbursement".

11:20-2.8 Audits

(a) The Board shall have an annual audit of its operations conducted by a qualified independent certified public accountant.

1. The auditor shall be selected and approved by the Board through a competitive bidding process of certified public accountants qualified in New Jersey to perform audits of entities like the Board.

2. The annual audit shall include the following items:

i. A review of the handling and accounting of assets and monies of the IHC Program;

ii. A determination that administrative expenses have been properly allocated and are reasonable;

iii. A review of the internal financial controls of the IHC Program;

iv. A review of the annual financial report of the IHC Program; and

v. A review of the calculation by the IHC Program of any assessments of carriers for net losses.

3. A copy of the annual audit and related management letters shall be delivered to each Director and to the Commissioner. The annual audit report shall be reviewed by the Technical Advisory Committee or Operations and Audit Committee, or both Committees, which shall present its recommendations to the Board for implementation of findings and recommendations made by the auditor. The actions adopted shall be reported to the Commissioner.

(b) The Board may, from time to time, direct that a member carrier arrange, or the Board may arrange, to have an audit conducted by an independent certified public accountant and a copy of the audit report of the member carrier delivered to the Board. All information regarding an audit of a member carrier conducted pursuant to this subsection shall be confidential and protected from disclosure by the member carrier, by the auditing firm, by the Board and the Commissioner.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "or Operations Committee, or both Committees" following "Technical Advisory Committee" in 3; and added a new (c).
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), substituted "entities like the Board" for "the type of entity" in 1 and inserted "and Audit" following "Operations" in 3; in (c), rewrote the introductory paragraph and updated references to Exhibit K of the chapter Appendix throughout; in (c)1ii, added a comma following "including"; in (c)1iv, substituted "forth" for "for".
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
Deleted (c).

11:20-2.9 Records

(a) The Board shall provide for the maintenance and retention of its official records, and may delegate this function to the Executive Director.

(b) The Board's records shall consist of the following:

1. Minutes of all Board meetings;

2. Written reports and recommendations of committees to the Board;

3. Informational and other filings made by carriers with the Board pursuant to the Act or the Board's rules;

4. The rulemaking file on rules proposed or adopted by the Board, including all comments received;

5. The Plan of Operation and any amendments thereto;

6. Records concerning the election of Directors and appointment of committees and committee members;

7. Determinations on requests for exemption by carriers;

8. Other actions by the Board required by the Act; and

9. Such other specific records as the Board may from time to time direct or as may be required by law.

(c) The records set forth in (b) above shall be subject to public inspection and copying pursuant to N.J.S.A. 47:1A-1 et seq., except that information in filings determined by the Board or Department by regulation to be confidential and proprietary shall not be subject to public inspection and copying, and except that written communications of the Board, its staff, or committees, including, but not limited to, reports, opinions, and recommendations, where such communications contain discussion of litigation strategy, attorney-client advice or other privileged information, shall not be available for public inspection or copying.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), substituted "Executive Director" for "Interim Administrator and subsequently appointed Administrator"; in (b), deleted ", including rate and form filings, loss ratio filings, reports of net earned premium and reports of net paid losses" at the end of 3, deleted 8, and recodified former 9 and 10 as 8 and 9; and rewrote (c).
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (c), deleted "the Right to Know Law," following "pursuant to"; deleted (d).

11:20-2.10 Standard health benefits plans

(a) The Board shall establish the policy and contract forms and benefit levels (standard health benefits plans) to be made available by members.

1. In designing and amending the standard health benefits plans, the Board shall give consideration to the types of coverage currently in force and/or available in the marketplace, individual's preferences and the evolution of the marketplace towards managed care.

2. The Board shall discuss amendments to the standard policy forms at a meeting open to the public prior to any vote by the Board to adopt, or modify any aspect of, a standard health benefits plan design.

3. The Board shall hold a public hearing on the standard health benefits plans or any amendments thereto prior to adopting or changing a standard health benefits plan.

i. The Board shall provide to all members and interested parties reasonable advance notice of a public hearing in accordance with the procedures set forth in the Act as amended.

ii. The Board may establish procedures for a public hearing and publish them with the notice of the public hearing.

iii. The Board shall maintain a written record of any public hearing and make it available for inspection at the office of the Executive Director.

4. The Board shall adopt or amend a standard health benefits plan in accordance with the procedures set forth in the Act, as amended, or in accordance with the procedures set forth in the Administrative Procedures Act.

i. In accordance with the procedures for taking action set forth in the Act, as amended, the Board may adopt a standard health benefits plan or modifications thereto and thereafter shall address in writing such comments as were received within a reasonable period following the adoption of the proposed action. The Board shall give due consideration to all comments received. Pursuant to the Act as amended, the Board shall, within a reasonable period of time following submission of the comments, prepare for public distribution a report listing all parties who provided written submissions concerning the intended action, summarizing the content of the submissions and providing the Board's response to the data views and arguments contained in the submissions. A copy of the report shall be filed with the Office of Administrative Law for publication in the New Jersey Register.

(1) The Board shall identify whether it made a change in the action proposed at its own initiative or in response to one or more comments.

ii. Except as may be required by law, members shall implement amendments to the standard health benefits plans in the time prescribed by the Board.

5. The Board shall take action as necessary to keep the standard health benefits plans in compliance with State and Federal law.

6. No member shall issue or renew a standard health benefits plan or the basic and essential healthcare services plan until a rate filing has been filed with the Department in accordance with N.J.A.C. 11:20-6.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
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).
Rewrote (a) and (b).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Deleted the former introductory paragraph of (b); recodified former (b)1 as (a)6; and in (a)6, substituted "Department" for "Board".

11:20-2.11 (Reserved)

Repealed by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Section was "Assessment for 1992 total reimbursable net paid losses".

11:20-2.12 Assessments for administrative expenses and organizational and operating expenses

(a) Except as described in (a)4 below, every member shall be liable for a portion of the administrative expenses of the IHC Program. Within 90 days of approving a final audited statement of the IHC Program financial statements and the conclusion of all appeals of assessments for administrative expenses, the IHC Program Board shall notify each member by separate invoice of the dollar amounts being assessed against the member for its portion of the final administrative expense total for the applicable fiscal year or years. To the extent that an interim assessment has been made for that period, the notice shall provide reconciliation between the original invoice and the final invoice.

1. Such notice shall include a brief summary of the final administrative expenses and shall credit the member for any interim administrative expense assessments paid.

2. If a member has advanced a sum or sums of money to the IHC Program to cover some portion of the IHC Program's administrative expenses, those sums advanced shall be credited against the member's assessment amounts.

3. Each member's final assessment for administrative expenses shall be reduced by any deferral assessment paid by assessed carriers in proportion to the original assessment made to cover the deferred amount.

4. A member shall not be liable for an assessment that is less than the minimum assessment set forth in N.J.A.C. 11:20-2.18.

(b) The Board, at its discretion, may make an interim assessment on a monthly basis or such other periodic basis as necessary to ensure the availability of funds to meet operating expenses as well as to cover estimated losses.

(c) Through fiscal year 1997 (that is, July 1, 1996 through June 30, 1997), all members shall be assessed for a proportionate share of final administrative expenses for the fiscal year on the basis of the ratio of the member's health benefits plans net earned premiums for the calendar year which includes the first six months of the fiscal year to the total of all members health benefits plans net earned premiums for that same calendar year. Beginning with fiscal years 1998 and 1999, all members shall be assessed for a proportionate share of final administrative expenses for two-year fiscal periods on the basis of the ratio of the member's health benefits plans net earned premiums for the two-year calculation period which begins six months prior to the beginning of the first fiscal year to the total of all members' health benefits plans net earned premiums for that same two-year calculation period. Thus, for example, for fiscal years 1998 and 1999, all members will be assessed based on 1997 and 1998 net earned premium. Net earned premiums shall be determined as reported by each member to the IHC Program Board in the Exhibit K Assessment Report as set forth as Exhibit K of the Appendix to N.J.A.C. 11:20, and completed in accordance with N.J.A.C. 11:20-8. Should a member fail to submit an Exhibit K Assessment Report as required by N.J.A.C. 11:20-8, the member's market share shall be determined by the IHC Program Board based upon the premium set forth in the member's most recent Annual Statement or Statements, as appropriate, filed with the Department.

(d) Interim assessments beginning with fiscal years 1998 and 1999 shall be made on the same basis as in (c) above, but shall use the net earned premium from the preceding two-year calculation period.

(e) Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by the member wherein the dispute is settled in favor of the disputing member, shall be apportioned to other members on the same basis as set forth in (c) above.

(f) Assessment amounts are due and payable upon receipt by a member of an invoice for the assessment. Payment shall be by bank draft made payable to the Treasury-State of New Jersey, IHC Program, at the address set forth in N.J.A.C. 11:20-2.1(h).

1. Pursuant to N.J.S.A. 17B:27A-10(f)(4), members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. The interest rate shall be 1.5 percent per month of the assessment amount or any portion thereof not timely paid accruing from the date of the invoice for the assessment.

ii. Payment of an assessment, or portion of an assessment for which an interest penalty has accrued, shall include the interest penalty amount accrued as of the date of payment; otherwise, payment shall not be considered to be in full.

iii. Good faith errors that a member reports to the Board within 60 days of their occurrence shall not be subject to the interest penalty set forth in (f)1i above. If a member makes an error relating to or involving an assessment or any other error resulting in non-payment or underpayment of funds, the member shall make immediate payment of additional amounts due.

2. Members that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the IHC Program Board, shall identify the amount of the assessment in dispute and shall be liable for and make payment of the full amount of the assessment invoice when due, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that member, or, if a contested case, the IHC Program Board has rendered a final determination in favor of that member in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(g) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with procedures established by the Commissioner, which are set forth at N.J.A.C. 11:20-11.

1. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice pursuant to (f) above, to be held in an interest bearing account in accordance with the procedures set forth in (h) below pending final disposition by the Commissioner of the deferral request.

2. If the member withholds payment, as permitted pursuant to (g)1 above, and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth in (f)1 above, accruing from the date of the invoice for the assessment.

(h) The Executive Director shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for that purpose.

1. Amounts of assessment in dispute or subject to a deferral request shall not be disbursed by the Board until such time as the dispute has been settled or concluded with the disputing member, or until final disposition of the request for deferral by the Commissioner, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject

to a deferral request, may be disbursed by the Board immediately, along with any applicable interest penalty amounts paid or interest earned while held by the Board.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is resolved in favor of the disputing member, or a deferral is granted, shall be returned to the appropriate members within 15 days of the date that the Executive Director receives notice of the determination by the IHC Program Board or the Commissioner, as applicable, along with the proportionate amount of interest penalty, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held by the Board.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), rewrote introductory paragraph and added 4; in (c), updated references to Exhibit K of the chapter Appendix; in (f)1, added N.J.S.A. reference to the introductory paragraph and rewrote iii; in (f)2, added language requiring that members "identify the amount of the assessment in dispute"; in (g), added N.J.A.C. reference in the introductory paragraph; deleted references to an "escrow" account in (g) and (h); in (h)1, inserted "by the Board" following "may be disbursed".

11:20-2.13 (Reserved)

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Substituted "Executive Director at the address listed in N.J.A.C. 11:20-2.1(h)" for "Interim Administrator (or Administrator)".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Deleted "in order to preserve its right to any monies paid pursuant to the invoice of assessment" at the end of the paragraph.
Repealed by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
Section was "Notice of request for deferral".

11:20-2.14 Failure to pay assessments

If a member determined liable for an assessment fails to pay the full amount of the assessment and applicable interest, if any, within 60 days of the date of the invoice, and has neither submitted notice that it is seeking a deferral from the Commissioner, nor requested a hearing, the IHC Program Board may provide to the Commissioner a notice of the member's failure to make payment along with a recommendation to revoke the member's authority to write any health benefits plans or other health coverage in this State. A copy of this notice shall be sent to the member by registered mail at the same time that the notice is sent to the Commissioner. In accordance with the Act, failure to pay assessments shall be grounds for removal of a member's authority to write health coverage of any kind in this State.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Deleted "is" following "If a member" in the first sentence.

11:20-2.15 Penalties/adjustments and dispute resolutions

(a) A member seeking to challenge the amount of an assessment must do so within 20 days of receiving the notice of the assessment pursuant to the procedures for appeals set forth at N.J.A.C. 11:20-20.2.

(b) If the Board determines that the nature or extent of errors or conduct by a member evidence activity for which penalties or sanctions are appropriate, the Board shall refer the matter to the Commissioner, Attorney General, and/or other appropriate enforcement agency, for appropriate action including the assessment of any penalties and sanctions as provided by the Act, as well as any other penalties permitted by law. Nothing herein shall be construed to limit the authority of the Commissioner, the Attorney General or any law enforcement agency to take appropriate regulatory or enforcement action with respect to violations of law and regulations.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (a); deleted former (b) through (d); and recodified former (e) as (b).
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), inserted "any" following "the assessment of" in the first sentence.

11:20-2.16 Indemnification

(a) The participation in the IHC Program as a member, the establishment of rates, forms or procedures, or any other joint or collective action required by the Act shall not be the basis of any legal action, criminal or civil liability, or penalty against the IHC Program, member of the Board of Directors, employee of the Board, or any member carrier either jointly or separately except as otherwise provided in the Act.

(b) The Board shall not be liable for any obligation of the IHC Program. No Director, officer or employee of the Board shall be individually liable and no cause of action of any nature may arise against them, for any action taken or omission made by them unless their conduct was outside the scope of their employment or constituted a crime, actual fraud, actual malice or willful misconduct.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "employee of the Board" following "Directors".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), deleted "or the Department" following "of the Board" in the second sentence.

11:20-2.17 Assessments for total reimbursable net paid losses for two-year calculation periods beginning with 1997 and 1998 and ending with 2007 and 2008

(a) The Executive Director shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program

Board for assessments. The Board shall approve the disbursement of all funds then in the account, and any payments to those members determined by the IHC Program Board as having reimbursable net paid losses for two-year calculation periods through 2007/2008, when the net paid loss audit is complete. Disbursement shall be in proportion to the member's share of the total reimbursable net paid losses for that two-year calculation period, until such available funds have been paid out, or a member's reimbursable net paid losses for that two-year calculation period have been reimbursed, whichever comes first.

1. Amounts of loss assessment in dispute or subject to a deferral request, including any interest penalty paid by a member pursuant thereto, shall not be disbursed to members having reimbursable net paid losses for the applicable two-year calculation period, until such time as the dispute has been resolved against the disputing member, or the deferral denied, except that any portion of a loss assessment not in dispute or subject to a deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed to members having reimbursable net paid losses for the applicable two-year calculation period year.

2. Upon receipt of notice that amounts of loss assessment disputed or subject to deferral wherein the dispute is resolved in favor of the disputing member, or a deferral is granted, the Executive Director shall calculate the proportionate amount of interest, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held by the Board and provide notice to the member of the principal amount and interest amount. The Board shall calculate the amount to be returned to the member, which amount shall be paid within 30 days and shall include the payment of interest up until the date of the expected payment.

New Rule, R.1994 d.165, effective March 1, 1994.
See: 26 N.J.R. 1200(a), 26 N.J.R. 1507(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
The expiration date of N.J.A.C. 11:20-2.17, was extended by gubernatorial directive to December 31, 2005, in accordance with N.J.S.A. 52:14B-5.1d.
See: 37 N.J.R. 2884(a).
N.J.A.C. 11:20-2.17 expired on December 31, 2005.
New Rule, R.2006 d.445, effective December 18, 2006.
See: 38 N.J.R. 1159(a), 38 N.J.R. 5383(a).
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
Section was "Assessments for total reimbursable net paid losses for two-year calculation periods beginning with 1997 and 1998". Deleted former (a) through (g); recodified (h) as (a); in the introductory paragraph of (a), deleted "the" preceding the first occurrence of "two-year" and substituted "periods through 2007/2008" for the first occurrence of "period"; and in (a)1, deleted "in accordance with (h) above" from the end.

11:20-2.18 Minimum assessment

If the total amount of a member's assessment invoice would be less than $5.00 in the case of an administrative assessment, the member shall not be liable for that amount and that amount shall be reapportioned pursuant to N.J.A.C. 11:20-2.12. This provision shall apply to an invoice for administrative expenses issued pursuant to N.J.A.C. 11:20-2.12.

New Rule, R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Substituted "$10.00 in the case of either a loss assessment or both a loss assessment and an administrative assessment, or less than $5.00 in the case of an administrative assessment only" for "$20.00".
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
Deleted "$10.00 in the case of either a loss assessment or both a loss assessment and an administrative assessment, or less than" preceding "5.00", "only" following the fifth occurrence of "assessment", and "and 2.17 as appropriate" following the first occurrence of and ", an invoice for reimbursable net paid losses issued pursuant to N.J.A.C. 11:20-2.17, or a combined invoice for both administrative expenses and net paid losses" following the second occurrence of "N.J.A.C. 11:20-2.12".

SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 The standard health benefits plans

(a) The standard individual health benefits plans established by the Board contain the benefits, limitations and exclusions set forth in the Appendix to this chapter as follows:

1. Plan A/50, Appendix Exhibit A with pages identified as unique to Plan A/50;

2. Plan B, Appendix Exhibit A with pages identified as unique to Plan B;

3. Plan C, Appendix Exhibit A with pages identified as unique to Plan C;

4. Plan D, Appendix Exhibit A with pages identified as unique to Plan D; and

5. HMO Plan, Appendix Exhibit B.

(b) Members that offer individual health benefits plans in this State and members that offer small employer health benefits plans in this State pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21 shall offer at least three of the standard health benefits Plans A/50, B, C, D, and HMO as set forth in chapter Appendix Exhibits A and B, incorporated herein by reference with variable text as specified on the Explanation of Brackets, which is set forth as chapter Appendix Exhibit C, incorporated herein by reference, subject to the provisions set forth in (b)1 through 9 below and except as provided in (c) below.

1. Members shall offer Plan A/50 which is designated as the basic plan.

2. Members shall offer at least two of the Plans designated as Plans B, C, D and HMO.

3. Members offering Plan A/50, and at least two of the plans designated as Plans B, C, D, and HMO shall offer at least two of the selected plans B, C, and/or D if not also offering HMO, and at least one of the selected Plans B, C, and/or D if offering the HMO, with annual deductible provisions as follows:

i. For a network-based plan, the network per covered person annual deductible shall not exceed $2,500.

ii. For a plan without a network, the per covered person annual deductible shall not exceed the maximum out of pocket as defined in (b)5 below.

iii. For a plan to be offered as a catastrophic plan, the per covered person annual deductible shall equal the greatest permissible maximum out of pocket as defined in (b)5 below except the deductible shall be waived for three physician visits per calendar year and shall not apply to preventive health services.

iv. The corresponding per covered family annual deductible shall be an amount equal to two times the per covered person annual deductible, satisfied on an aggregate basis.

4. Members offering Plans A/50, B, C, and D may offer the plans with deductible provisions such that the plans may qualify as high deductible health plans:

i. In the case of single coverage, an amount to qualify as a High Deductible Health Plan under Internal Revenue Code §223(c)(2)(A) for the calendar year in which coverage is issued or renewed, per covered person;

ii. In the case of other than single coverage, an amount to qualify as a High Deductible Health Plan under Internal Revenue Code §223(c)(2)(A) for the calendar year in which coverage is issued or renewed, per covered family, with single and other than single deductibles accumulated in accordance with the requirements of Federal law.

5. When issued using deductible provisions set forth in (b)3 and 4 above, Plans A/50, B, C, and D shall contain maximum out of pocket provisions as follows:

i. The per covered person maximum out of pocket shall not exceed the maximum out of pocket specified in sections 223(c)(2)(A)(ii)(I) and 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986;

ii. The per covered family maximum out of pocket for Plans A/50, B, C and D shall be two times the per covered person maximum out of pocket, satisfied on an aggregate basis; and

iii. Deductible, coinsurance, and copayment under a standalone pediatric dental benefit plan issued to replace the pediatric dental benefits contained in Plans A/50, B, C, and D shall not count toward the maximum out of pocket.

6. Plan A/50 features 50 percent coinsurance, Plan B features 40 percent coinsurance, Plan C features 30 percent coinsurance, and Plan D may feature coinsurance of 20 percent or 10 percent.

(c) Members which are Federally-qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in lieu of offering at least three of Plans A/50, B, C, and D in (a) above. State qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in addition to at least two of Plans A/50, B, C, and D in (a) above. HMO carriers offering the HMO Plan may offer a copayment plan design set forth in (c)1 below and/or the HMO plan using deductible and coinsurance provisions set forth in (c)2 below. All options offered by the HMO member shall be made available to every eligible individual seeking coverage. Specifications for the use of copayments are set forth in (c)1 below. Specifications for the use of deductible and coinsurance are set forth in (c)2 below. Specifications for features that are common to plans that use copayment and plans that use deductible and coinsurance are set forth in (d) below.

1. Carriers issuing HMO plans with a Copayment Design shall use the copayments consistent with the copayments permitted in N.J.A.C. 11:22-5.5 with no copayment required for preventive care.

2. Carriers issuing HMO plans with a Deductible and Coinsurance Design shall use the copayments, cash deductible, and coinsurance consistent with the requirements of N.J.A.C. 11:22-5.3 through 5.5. The maximum out of pocket shall be consistent with the maximum out of pocket described in (b)5 above.

(d) Carriers issuing Plans A/50, B, C, D, and HMO shall include the following features which are common to all plans:

i. The emergency room copayment, which shall be paid in addition to other copayments, deductible and coinsurance, shall not exceed $100.00.

ii. Pediatric dental and pediatric vision benefits may be subject to cost sharing at the discretion of the carrier provided any copayments for providers who qualify as specialists do not exceed the copayment as permitted by N.J.A.C. 11:22-5.5.

iii. Prescription drugs may be subject to 50 percent coinsurance or other types of cost sharing provisions such as copayments.

(e) The standard health benefits Plans A/50, B, C, and D may be offered through or in conjunction with a selective contracting arrangement approved pursuant to P.L. 1993, c. 162, §22. The standard health benefits Plans A/50, B, C, and D may be offered with the same selective contracting arrangement by a carrier that is exempt from the requirements

of P.L. 1993, c. 162, §22, pursuant to N.J.A.C. 11:4-37.1(b), but is permitted to enter into agreements with participating providers pursuant to any statute. Plans issued through or in conjunction with an approved selective contracting arrangement and plans with selective contracting arrangement features issued by an entity exempt from the requirements of P.L. 1993, c. 162, §22 shall be subject to the following:

1. All of the requirements of N.J.A.C. 11:4-37.3(b)6;

2. The network annual deductible shall be no greater than $2,500 per covered person, and for a covered family shall equal two times the per covered person annual deductible, satisfied on an aggregate basis. If a carrier elects to use a common annual deductible for both network and non-network benefits, the network annual deductible amount shall apply to both network and non-network services and supplies;

3. The HMO Plan copayment amounts for physician visits and hospital confinements and the prescription drug coinsurance may be substituted for deductibles applicable to network benefits;

4. The coinsurance for network services shall be consistent with the coinsurance for one of Plans A/50, B, C, or D and the coinsurance for non-network services must be consistent with the coinsurance for one of Plans A/50, B, C, or D;

5. The network maximum out of pocket shall be no greater than the amount specified in (b)5 above per covered person, and for a covered family shall be no greater than two times the per covered person network maximum out of pocket. If a carrier elects to use a common maximum out of pocket for both network and non-network benefits, the network maximum out of pocket amount shall apply to both network and non-network services and supplies;

6. If a separate non-network deductible is included, the non-network annual deductible shall be two times or three times the network annual deductible per covered person, and for a covered family shall equal two times the per covered person annual deductible, satisfied on an aggregate basis; and

7. If a separate non-network maximum out of pocket is included, the non-network maximum out of pocket shall be two times or three times the network maximum out of pocket per covered person, and for a covered family shall equal two times the per covered person maximum out of pocket.

(f) Network plans as permitted in (d) above and HMO plans may feature a tiered network.

1. If the deductibles for tier 1 and tier 2 are separately satisfied, the sum of the tier 1 deductible and the tier 2 deductible shall not exceed $2,500.

2. If the tier 1 deductible may be separately satisfied and is also applied toward the tier 2 deductible, the tier 2 deductible shall not exceed $2,500.

3. If the tier 1 and tier 2 maximum out of pocket amounts are separately satisfied, the sum of the tier 1 maximum out of pocket and the tier 2 maximum out of pocket shall not exceed the maximum out of pocket specified in sections 223(c)(2)(A)(ii)(I) and 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986.

4. If the tier 1 maximum out of pocket may be separately satisfied and is also applied toward the tier 2 maximum out of pocket, the tier 2 maximum out of pocket shall not exceed the maximum out of pocket specified in sections 223(c)(2)(A)(ii)(I) and 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986.

Amended by R.1995 d.531, effective October 2, 1995.
See: 27 N.J.R. 1127(a), 27 N.J.R. 3793(b).
Amended by R.1997 d.3, effective December 5, 1996.
See: 28 N.J.R. 4856(a), 29 N.J.R. 138(a).
Inserted new (b)2; recodified former (b)2 as (b)3; and, in (c), inserted reference to (b)2 deductible options.
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).
Substituted Plan B for Plan A as the "The Basic Health Benefits Plan" and amended deductible and copayment amounts.
Amended by R.1998 d.26, effective January 5, 1998.
See: 29 N.J.R. 1089(a), 30 N.J.R. 237(a).
Inserted (d)6.
Administrative correction.
See: 30 N.J.R. 1318(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
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).
In (a), substituted "Individual" for "Basic" in 2, and added 7; in (b), inserted a reference to Plan A/50, deleted a reference to Plan E, inserted a reference to Exhibit U and substituted a reference to Exhibit D for a reference to Exhibit E in the introductory paragraph, deleted a reference to Plans B and E in the introductory paragraph of 1, and inserted a reference to Plans A/50 and B in the introductory paragraph of 2; in (c), substituted a reference to Plans A/50, B, C, and D for a reference to Plans B through E in the first sentence, and added 3; and in (d), inserted a reference to Plan A/50 in the first sentence, substituted a reference to Exhibit D for a reference to Exhibit E in 2, inserted a reference to $30.00 copayment levels in 3, and deleted ", and Plan E shall have an out-network level of 99 percent" at the end of 4.
Amended by R.1999 d.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
In (b)3, rewrote i and ii.
Amended by R.2002 d.95, effective March 18, 2002 (operative August 1, 2002).
See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).
Added (b)4.
Amended by R.2002 d.331, effective October 7, 2002.
See: 34 N.J.R. 1786(a), 34 N.J.R. 3527(a).
In (b)4, substituted "may" for "shall".
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Amended by R.2005 d.160, effective April 22, 2005.
See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).
In (b), added iii through vi in 3.
Repeal and New Rule 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).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Rewrote (b); in the introductory paragraph of (c), inserted "offering at least three of" and "at least two of", and substituted "(a)" for "(b)" and "$30.00" for "$15.00"; in (c)1i and (c)1ii(1), substituted "$300.00" for "$150.00" and "$30.00" for "$15.00"; in (c)2i(4) and (d)5, substituted "no greater than $7,500" for "5,000"; in (d)2, substituted "no greater than" for "$1,000 or"; in (d)5, substituted "no greater than two times the per covered person network maximum out of pocket" for "$10,000"; and added (e).
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Rewrote the section.

11:20-3.2 Sample schedule page text

(a) The standard plans set forth in Appendix Exhibits A and B include sample schedule page text. The sample schedule pages highlight some covered services. Carriers may include additional covered services on the schedule. Features included on one sample schedule page may be included on any schedule page, as appropriate to the plan design being offered.

(b) The standard plans set forth in Appendix Exhibit A may be issued to a covered person who qualifies for a cost sharing reduction. Carriers may include cost sharing amounts on the schedule that are appropriate to the cost sharing reduction a covered person receives.

Repeal and New Rule, 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.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
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).
In (a), inserted a reference to Exhibit U; and in (b), deleted a reference to Exhibit E, and substituted a reference to Exhibit D for a reference to Exhibit E.
Repeal and New Rule 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).
Section was "Policy forms".
Repealed by R.2009 d.45, effective December 29, 2008 (operative April 20, 2009).
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b), 41 N.J.R. 1875(a).
Section was "Certification of Compliance".
New Rule, R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Section was "Reserved".

11:20-3.3 Compliance and variability rider

(a) Members may incorporate regulatory changes required to be made to the standard policy forms, standard HMO contract, and standard riders through the use of the Compliance and Variability Rider as set forth as Exhibit D of the Appendix, incorporated herein by reference, if the Board has indicated in the rule adoption of the regulatory changes to the standard policy forms that Compliance and Variability Riders may be used. Carriers may only use the Compliance and Variability Rider to incorporate Board designated text for the period of time specified by the Board in the rule adoption of the regulatory changes to the standard policy forms.

(b) Members may make any changes to the standard policy forms, standard HMO contract, or standard riders promulgated by the Board consistent with the permitted as variable text set forth in Exhibits A and B of the Appendix to this Chapter, as described in the Explanation of Brackets, Exhibit C, through the use of the Compliance and Variability Rider as set forth as Exhibit D of the Appendix.

(c) Members may incorporate text for benefits required to be offered to the Policyholder through the use of the Compliance and Variability Rider as set forth as Exhibit D of the Appendix, if the Board has indicated in the rule adoption of the regulatory changes to the standard policy forms to address the mandated offer that carriers may issue the optional coverage by rider in lieu of including the coverage in the standard policy forms. For example, coverage for autologous bone marrow transplant, as required to be offered pursuant to P.L. 1995, c. 100, may be included using the Compliance and Variability Rider.

(d) Members may address the cost sharing reduction amounts referred to in N.J.A.C. 11:20-3.2(b) on the Compliance and Variability Rider.

(e) Members may not use the Compliance and Variability rider to accomplish benefit modifications as outlined in N.J.A.C. 11:20-3.6.

New Rule, R.1996 d.542, effective December 2, 1996.
See: 28 N.J.R. 3704(a), 28 N.J.R. 5075(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (b), inserted "as described in the Explanation of Brackets, Exhibit T," following "Chapter".
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).
In (b), substituted a reference to Exhibit U for a reference to Exhibit F.
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).
In (a) and (b), substituted "Members" for "Notwithstanding the requirements of N.J.A.C. 11:20-3.2, members", rewrote references to all Exhibits and added (c).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Added (d).
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Added new (d); and recodified former (d) as (e).

11:20-3.4 (Reserved)

New Rule, 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).
Former N.J.A.C. 11:20-3.4, recodified as N.J.A.C. 11:20-3.5.
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Rewrote (a).

Repealed by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Section was "Plan update rider".

11:20-3.5 Basic and essential health care services plan

The basic and essential health care services plan established by the Legislature contains the benefits, limitations, and exclusions set forth in N.J.S.A. 17B:27A-4.5. Rules regarding this plan are set forth at N.J.A.C. 11:20-22. A specimen policy form is set forth in Appendix Exhibit F. The basic and essential health care services plan shall not be issued after December 31, 2013.

New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
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).
Substituted "N.J.S.A. 17B:27A-4.5. Rules regarding this plan are set forth at N.J.A.C. 11:20-22" for "N.J.S.A. 11:20-22" and substituted "Exhibit F" for "Exhibit V".
Recodified from N.J.A.C. 11:20-3.4 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.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Inserted a comma following "limitations", and inserted the last sentence.

11:20-3.6 Optional benefit riders to standard plans

(a) Members may offer riders that revise the coverage offered by Plans A/50, B, C, D, and HMO, subject to the provisions set forth in (a)1 through 8 below.

1. Before a member may sell a rider or amendment thereof that increases any benefits or increases the actuarial value of Plans A/50, B, C, D, or HMO, the member shall file the rider or amendment thereof with the Board for informational purposes.

2. For purposes of optional benefit riders filed pursuant to (a)1 above, "coverage" offered by Plans A/50, B, C, D, or HMO means:

i. The types and extent of services and supplies described in the "Covered Charges," "Covered Charges with Special Limitations" and "Exclusions" sections of Plans A/50, B, C, and D or the "Covered Services and Supplies" and "Non-Covered Services and Supplies" sections of the HMO plan;

ii. Deductibles, coinsurance, copayments, maximum out of pocket, network maximum out of pocket and non-network maximum out of pocket of Plans A/50, B, C, D and HMO as applicable (including, but not limited to, deductible provisions such as deductible waiver, year-end deductible carry-over, and first dollar coverage), and their applicability in situations involving common accident.

3. For purposes of optional benefit riders filed pursuant to (a)1 above, "coverage" offered by Plans A/50, B, C, D, or HMO does not include:

i. Provider networks;

ii. Coverage which is specifically excluded from the definition of "health benefits plan" in N.J.A.C. 11:20-1.2, except for dental coverage where the additional dental coverage is subject to the standard plan's deductible and coinsurance or copayment schedule, as applicable; or

iii. Benefits which are other than those provided under a "health benefits plan" as defined at N.J.A.C. 11:20-1.2.

4. In addition to (a)1, 2 and 3 above, any benefit rider or amendments thereof shall be subject to the provisions of N.J.S.A. 17B:27A-4 and 17B:27A-6.

5. The inclusion of an optional benefit rider with Plan A/50, B, C, D or HMO creates Plan A/50, B, C, D or HMO as amended by the rider and the Plan continues to be Plan A/50, B, C, D or HMO. The inclusion of an optional benefit rider does not create another standard plan.

6. An individual seeking to purchase Plan A/50, B, C, D or HMO must be given the opportunity to purchase Plan A/50, B, C, D or HMO without a rider or with any rider that is available to amend the plan being purchased.

7. A member making an informational filing to the Board pursuant to (a)1 above shall:

i. Submit one copy of the filing and any related materials to the Board at the address specified at N.J.A.C. 11:20-2.1;

ii. Submit one copy of the rider or riders which amend the standard plans, which rider or riders shall include cross-references to the standard plan provisions or sections and/or pages which are being modified;

iii. Specify whether the rider or amendment thereof is to be used in connection with standard health benefit Plans A/50, B, C, D or HMO and provide clear and conspicuous notice of such on the forms submitted for each rider;

iv. The standard plan language shall not be altered, and the benefit modifications shall appear only on the rider or riders;

v. Submit the standard plan page or pages which are affected by the rider or riders marked to identify which provisions are affected by the rider or riders; and

vi. Submit a certification signed by a duly authorized officer of the member that states clearly:

(1) That the rider or amendment thereof increases a benefit or benefits and does not include a decrease of any benefits or decrease in the actuarial value of standard health benefits Plan A/50, B, C, D, or HMO;

(2) That the filing is complete and in accordance with all the requirements of this subsection and applicable New Jersey statutes and regulations;

(3) That the member will offer the rider or amendment thereof to any individual seeking to purchase the health benefits plan it modifies;

(4) That a rate filing for the rider has been made with the Commissioner pursuant to N.J.A.C. 11:20-6; and

(5) If amending a plan, or a plan and a rider or riders, sold through or in conjunction with a selective contracting arrangement, that the plan as ridered continues to comply with the requirements set forth in N.J.A.C. 11:4-37.3(b)6 and 11:24-14.4(c), as applicable.

8. The Board shall notify a member in writing of its determination of whether an informational filing is complete and in compliance with the requirements of this subchapter within 45 days of the Board's receipt of the member's submission of a rider. If the Board does not notify a member of its determination with respect to an informational filing within 45 days of the Board's receipt of the submission, the informational filing shall be deemed complete and in compliance.

i. If an informational filing is incomplete or not in compliance, the notification shall provide the reasons the filing is incomplete or not in compliance and what additional information needs to be submitted by the member. The member shall provide the Board with the necessary information such that the filing will be complete and in compliance. Upon receipt of notice from the Board that a filing is incomplete or not in compliance, the member shall not sell the rider until the member has received written notice from the Board that the informational filing is complete and in compliance.

ii. If the Board takes no action within 45 days of receipt by the Board of a member's submission of information requested by the Board, the filing shall be deemed to be complete and in compliance.

New Rule, R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

11:20-3.7 Plan or plan option withdrawal by IHC Board

(a) If the IHC Board promulgates rules withdrawing a plan, plan option, or deductible/copayment option, a carrier shall cease issuing that plan, plan option, or deductible/copayment option within 90 days after the rules take effect.

(b) If the IHC Board promulgates rules withdrawing a plan, plan option, or deductible/copayment option, a carrier shall nonrenew that individual plan, plan option, or deductible/copayment option pursuant to the procedures set forth in (c) and (d) below.

(c) Not more than 60 days after the Board has promulgated rules withdrawing a plan, plan option, or deductible/copayment option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, a carrier shall mail a notice of nonrenewal by mail to every policy or contractholder. Following the initial notice of nonrenewal to each policy or contractholder, the carrier shall send a subsequent notice of the nonrenewal to each policy or contractholder which notice shall be included with a monthly premium bill or premium notice issued prior to the date of nonrenewal, or, where no monthly premium statement is transmitted, send a notice at least 30 days prior to nonrenewal. Nonrenewal notices for policy or contractholders shall contain the following information:

1. A statement that the IHC Board has withdrawn the plan, plan option, or deductible/copayment option from the individual health benefits market;

2. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

3. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of N.J.A.C. 11:20-3.7;

4. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

5. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan, plan option, or deductible/copayment option withdrawal; and

6. The name, address and telephone number of the employee of the carrier who may be contacted for assistance and information regarding the withdrawal.

(d) Not more than 60 days after the Board has promulgated regulations withdrawing a plan, plan option, or deductible/copayment option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, a carrier shall mail a notice of nonrenewal to the producer of record, if any, for each policy or contract. Nonrenewal notices for producers shall contain the following information:

1. A statement that the IHC Board has withdrawn the plan, plan option, or deductible/copayment option from the individual health benefits market;

2. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

3. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of N.J.A.C. 11:20-3.7;

4. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

5. The name, address and telephone number of the employee of the carrier who may be contacted for assistance and information regarding the withdrawal; and

6. The date upon which the carrier will begin to cease the issuance of the plan, plan option, or deductible/copayment option.

New Rule, R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

SUBCHAPTER 3A. POLICY FORMS

11:20-3A.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers seeking to enter the individual plan market and carriers issuing plans in the individual plan market shall file individual policy or contract forms with the Commissioner and certify to the Commissioner that the health benefit plans to be used by the carrier are in substantial compliance with provisions in the approved individual plans, as required by N.J.S.A. 17B:27A-7d.

(b) This subchapter applies to all carriers, whether or not affiliated with other carriers doing business in the individual plan market in New Jersey, that seek to offer and are offering individual plans pursuant to the IHC Act.

11:20-3A.2 Certification of Compliance

(a) Before marketing, issuing or renewing any of the standard policy forms, a member shall file with the Department, the Certification of Compliance set forth in the Appendix to this subchapter as Exhibit E, incorporated herein by reference. Each affiliated carrier must file a separate Certification of Compliance. A Certification of Compliance must be filed upon entry into the individual market and annually on or before March 1.

(b) Carriers that submit an Exhibit E Certification of Compliance may issue and make effective individual health benefits plans upon filing such Certification with the Department and may continue to do so until such time as the filing is disapproved in writing by the Department. The Department may disapprove an Exhibit E Certification of Compliance if the Certification is inaccurate or incomplete.

(c) Any carrier whose Certification of Compliance is disapproved may file an appeal of the Department's determination and request a hearing within 20 days of receipt of written notification of the Department's final determination.

11:20-3A.3 Basic and essential health care services plan policy form

(a) Before a member may offer or issue the basic and essential health care services plan policy form, the member shall submit the information set forth below to the Department at Department of Banking and Insurance, Life and Health, Basic and Essential Health Care Services Plan Form Filing, 20 West State Street, P.O. Box 325, Trenton, New Jersey 08625.

1. One copy of the policy form for the basic and essential health care services plan, unless filing a certification as set forth in (b)1 below; and

2. A certification signed by a duly authorized officer of the member that states that:

i. The member will make the basic and essential health care services plan available to eligible persons and will make a good faith effort to market the plan;

ii. Rates for the basic and essential health care services plan have been submitted pursuant to the requirements of N.J.A.C. 11:20-6; and

iii. The benefits in the policy form being submitted include all of the coverages enumerated in section 2.a. of P.L. 2001, c. 368, but do not include any additional benefits.

(b) The Department makes available to members a specimen policy form for the basic and essential health care services plan, set forth in chapter Appendix Exhibit F, incorporated herein by reference. The Department has determined that the plan set forth in Exhibit F includes the coverages required for a basic and essential health care services plan.

1. Members that choose to use the plan specimen policy form as set forth in Exhibit F shall submit, in lieu of a copy of the basic and essential health care services plan policy form, a certification, signed by a duly authorized officer of the company, stating that the company is using the basic and essential health care services plan specimen policy form as included in Exhibit F, including the carrier name, and similar variable text, as appropriate. The certification regarding use of the specimen policy form shall also include the statements required by (a)2 above.

2. Members that choose to use the plan specimen policy form as set forth in Exhibit F with some modi-

fications to the text shall submit the form, redlined to show any differences between the submitted form and the form as contained in Exhibit F. The redlined text of the form shall be submitted with the information set forth in (b)1 above.

(c) The Department shall notify a member in writing of its determination whether the policy form filing is approved within 30 days of the date the filing is received. If the Board does not notify a member of its determination with respect to the filing within 30 days of the date the filing is received, the filing shall be deemed approved.

SUBCHAPTERS 4 THROUGH 5. (RESERVED)

SUBCHAPTER 6. INDIVIDUAL HEALTH BENEFITS CARRIERS INFORMATIONAL RATE FILING REQUIREMENTS

11:20-6.1 Purpose and scope

The purpose of this subchapter is to establish informational rate filing requirements and procedures for members issuing or renewing individual health benefits plans pursuant to section 3 of the Act (N.J.S.A. 17B:27A-4) as well as the basic and essential health care services plan pursuant to P.L. 2001, c. 368.

11:20-6.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings defined by the Act, N.J.A.C. 11:20-1.2, or as further defined below, unless the context clearly indicates otherwise.

"Informational filing" means a submission by a carrier of rate manuals which specify the plans offered, premium rates, all factors to be used in the calculation of premium rates, and a detailed actuarial memorandum supporting the calculation of the rates including a certification by a qualified member of the American Academy of Actuaries, the Society of Actuaries, or the Casualty Actuarial Society, all supporting data for the premium rates and such other information as specified in this subchapter.

11:20-6.3 Informational rate filing requirements

(a) All members issuing standard health benefits plans on a new contract or policy form and the basic and essential health care services plan shall make, prior to issuing any standard health benefits plan (or rider for a standard health benefits plan), or basic and essential health care services plan (or rider for a basic and essential plan), an informational rate filing with the Department, which shall include the following supporting data:

1. Rate manuals specifying the standard health benefits plans and the basic and essential health care services plan, with riders, if any, offered. The manuals shall not include references to, or premiums containing assumptions based upon, an individual's claims experience, underwriting, substandard ratings, occupational limitations or any other factors prohibited by the Act, except that the rates for a standard plan and any riders thereto may consider age as permitted by N.J.S.A. 17B:27A-2 and 6a and the rates for the basic and essential health care services plan and any riders thereto may consider age, gender and geography, as permitted by N.J.S.A. 17B:27A-4.5 and N.J.A.C. 11:20-6.5;

2. Monthly premium rates and any factors used in the calculation of the premium rates and the effective dates for the rates. The premium rates may be for a period of effective dates not to exceed 12 months from the initial effective date. Unless a carrier amends the rate filing to specify an alternative effective date, carriers shall use the rates shown in the rate filing as of the stated effective date. Rates may be developed on different rate tiers for: single; two adults; adult/child(ren); and family. A description of the rating methodology or plan and the numerical value of the classification factors used in determining a policyholder's rates that addresses the use of the factors of age, gender (basic and essential only) and geography (basic and essential only) as discussed in (a)2i, ii and iii below. The filing shall include:

i. The numerical value of the classification factors utilized in the calculation of an individual's premium rate or rates, limited to: age, gender, geographic location, effective date, and rating tier of each covered adult in accordance with the factors set forth in N.J.A.C. 11:20-6.5;

ii. A written description which may include elementary formulas of the rating method so that a knowledgeable member of the public may understand how to translate the basic rates into the rates charged for an individual policy; and

iii. A detailed example calculation, in the proposal format used by the carrier, including any rider option(s), showing all the steps to develop premiums for a policy and demonstrating the adjustment, if any, to achieve the required 350 percent maximum ratio between premiums for the highest rated individual policyholder and the lowest rated individual policyholder in the State;

3. A detailed actuarial memorandum, which shall include the following:

i. The monthly rates being submitted for each period addressed in the rate filing along with factors or actual rates for quarterly or semi-annual modes, if such modes are available;

ii. Identification of the plans and riders affected, using the alphabet name if indemnity or PPO, and the

copay and coinsurance, if applicable, if HMO, and using a descriptive code for each rider;

iii. Application of the rates to new business and renewal business, including a description of the application of any limits on renewal increases pursuant to N.J.S.A. 17B:27A-3;

iv. The duration of the rate guarantee period, and if none, so state;

v. A sample of the notice(s) that will be sent to policyholders to advise them of a rate change, including any adjustments for limits pursuant to N.J.S.A. 17B:27A-3;

vi. The anticipated loss experience and the assumptions used in developing such anticipated loss experience, including:

(1) Historical experience. The historical experience should specify enrollment, premium, claims and loss ratio data from the period used in the development of the anticipated loss ratio, where the period should be at least 12 months. If premiums are based on some other experience base, the enrollment, premium, claims, and loss ratio data for that other experience base;

(2) Medical cost trend assumptions, for each plan or type of benefit;

(3) Plan relativity assumptions, if a carrier uses plan relativity assumptions in calculating anticipated loss experience;

(4) Any other factors used in developing the anticipated loss experience, such as selection factors or adjustments to experience of other plans; and

(5) The anticipated enrollment, premium, claims, and loss ratio for the rating period;

vii. Specific identification of the administrative expense, premium tax and commission payment assumptions, and other margins;

viii. Specification of the percentage change(s) in rates as compared to the prior rating period; and the prior year and the average change for all plans; and

ix. The anticipated distribution by age and family tier (in the case of standard plans) or age, gender, location, and family tier (in the case of basic and essential plans);

4. A certification signed by a member of the American Academy of Actuaries, Society of Actuaries, or Casualty Actuarial Society, which shall include the following:

i. A statement that the informational filing is complete and complies with all of the requirements of this section;

ii. A statement that the carrier's loss ratio is expected to be at least 80 percent for standard plans over the rating period, and at least 80 percent for basic and essential plans over the rating period; and

iii. A statement that the rating methodology will not produce rates (for each rate tier) for the highest rated policyholder which are greater than 350 percent of the rates (for each rate tier) for the lowest rated policyholder for each plan and rider option; and

5. Such other information or data as may be required or requested by the Department to analyze the adequacy of the rate filing submitted.

(b) Any member which seeks to change its rates for its standard health benefits plans (including riders) or its basic and essential health care services plan (including riders) shall, prior to the effective date of the revised rates, submit to the Department an informational rate filing, which shall include all the supporting data set forth in (a) above.

(c) Unless a carrier submits an amended rate filing to specify an alternate effective date, carriers shall use the rates shown in the rate filing as of the stated effective date.

11:20-6.4 Informational rate filing procedures

(a) A member shall file one copy of the informational rate filing with the Department pursuant to N.J.A.C. 11:20-6.3(a) or (b) at the following address:

New Jersey Dept. of Banking and Insurance
Life & Health Actuarial: IHC Rate Filings
PO Box 325
20 West State Street
Trenton, NJ 08625

(b) If the Commissioner determines that an informational filing filed pursuant to N.J.A.C. 11:20-6.3(a) or (b) is incomplete but in substantial compliance with N.J.S.A. 17B:27A-2 et seq., the Commissioner shall provide written notice to the member specifying those portions of the filing which are deficient and the information required to be submitted or resubmitted by the member.

(c) Within 30 days of receipt of a written notice as referenced in (b) above, the member shall provide the Department with the information required to complete the filing. Failure to provide this information may result in the imposition of penalties specified in N.J.S.A. 17B:27A-43 and/or revision of rates to the last filed rate.

(d) If the Commissioner determines that a filing is incomplete and not in substantial compliance, that the rates are inadequate, or that the rates are unfairly discriminatory, the Commissioner shall provide written notice to the member specifying the information required to be submitted, and specifying in addition the basis for the finding that the filing is not in substantial compliance, or, if applicable, that the rates are inadequate or unfairly discriminatory. The rate filing

shall not become effective until the Commissioner has confirmed in writing that the basis for disapproval is cured.

(e) Upon the issuance of a notice as set forth in (d) above, the member shall submit any additional information required to make the filing complete in accordance with (c) above. A carrier may appeal the Commissioner's determination that the filing is not in substantial compliance or that the rates are inadequate or unfairly discriminatory and request a hearing within 20 days of receipt of the written notice set forth in (d) above.

11:20-6.5 Permissible rate classification factors

(a) A carrier shall not differentiate premium rates charged to different individuals except on the basis of age (in the case of standard plans and riders) and age, gender, and geography (in the case of basic and essential plans and riders) in accordance with the following restrictions:

1. Age factor categories shall be limited to the following increments: 19 and under; 20-24; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; and 65 and over.

2. Geographic categories shall be limited to six territories, each consisting of the areas covered by the first three digits of the U.S. Postal Service zip codes or the counties listed below. A carrier shall determine which territory applies to a policyholder on the basis of the address of the policyholder's place of residence. The six territories are the following:

i. Territory A consists of zip codes 070-073 or Essex, Hudson and Union counties;

ii. Territory B consists of zip codes 074-076 or Bergen and Passaic counties;

iii. Territory C consists of zip codes 077-079 or Monmouth, Morris, Sussex and Warren counties;

iv. Territory D consists of zip codes 088-089 or Hunterdon, Middlesex and Somerset counties;

v. Territory E consists of zip codes 081, 085-086 or Burlington, Camden and Mercer counties; and

vi. Territory F consists of zip codes 080, 082-084 and 087 or Atlantic, Cape May, Ocean, Salem, Cumberland and Gloucester counties.

(b) Notwithstanding (a) above, a carrier may differentiate premium rates on the basis of family structure according to only the following four rating tiers:

1. Single;

2. Two adults;

3. Adult and child(ren); and

4. Family.

SUBCHAPTER 7. LOSS RATIO AND REFUND REPORTING REQUIREMENTS

11:20-7.1 Purpose

The purpose of this subchapter is to implement the loss ratio and refund reporting requirements of the Act.

11:20-7.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings defined by the Act, N.J.A.C. 11:20-1.2, or as further defined below, unless the context clearly indicates otherwise.

"Claims paid" means a dollar amount determined in accordance with statutory annual statement reporting and consistent with N.J.A.C. 11:20-8.5(c), adjusted as required by this subchapter.

"Preceding calendar year" means the calendar year immediately preceding the reporting year.

"Reporting year" means the year in which the loss ratio report is required to be filed with the Board.

11:20-7.3 Filing of Loss Ratio Report

(a) Each member that had a standard health benefits plan or a basic and essential health care services plan in force during the preceding calendar year shall file with the Commissioner an annual Loss Ratio Report on the form appearing as Exhibit J in the Appendix to this chapter, incorporated herein by reference. Affiliated carriers shall file a separate report for each carrier that had standard health benefits plans or the basic and essential health care services plans in force during the preceding calendar year plus a combined report reflecting the combined data for all affiliated carriers.

(b) The Report shall be filed on the basis of the combined total of the standard health benefits plans and the basic and essential health care services plans written by the member.

(c) The Report shall be completed and filed with the Board on or before August 15 of the reporting year for the preceding calendar year.

11:20-7.4 Contents of the Loss Ratio Report

(a) A Loss Ratio Report form set forth at Appendix Exhibit J shall be completed by August 15 of each year by each member and shall include the following information with respect to standard health benefits plans and basic and essential health care services plans:

1. The reporting member's name and address;

2. The member's net earned premium for the preceding calendar year; and

3. A statement of the member's total losses incurred consisting of:

i. Claims paid during the preceding calendar year, regardless of the year incurred;

ii. Less residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year;

iii. Less claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year as reported in the preceding calendar year's Loss Ratio Report;

iv. Plus claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year;

v. Plus residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year;

4. The member's loss ratio (determined by dividing the total losses incurred in (a)3 above by the net earned premium as determined in (a)2 above) calculated as a percentage to one decimal place (for example, 81.2 percent); and

5. Certification by a member of the Society of Actuaries, Casualty Actuarial Society, or American Academy of Actuaries that the information provided in the Loss Ratio Report is accurate, complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A-9 in accordance with this section.

(b) The residual reserve reported in (a)3ii and v above shall be calculated as 3.3 percent of the combination of (a)3i, iii and iv above.

11:20-7.5 Refund plan

(a) If the loss ratio determined in N.J.A.C. 11:20-7.4 is less than 80 percent, the member shall include with the Report a plan to be approved by the Commissioner for a refund to policy and contractholders of an amount equal to the difference between 80 percent of reported premiums and reported claims.

(b) The refund plan shall conform with the following:

1. Refunds shall be made to all contractholders who were covered for any period during the preceding calendar year whose refund is $5.00 or greater.

2. The refund amount per contractholder may be determined by multiplying the earned premium from each contractholder's standard health benefits plan and rider or basic and essential health care services plan and rider by the percentage resulting from dividing the total refund calculated in accordance with (a) above by the carrier's total net earned premium from the standard health benefits plans and basic and essential health care services plans, or on the basis of a practical and equitable alternative formula proposed by the carrier and approved by the Commissioner.

3. Refund payments shall be made within 60 days of written approval of the refund plan by the Commissioner.

11:20-7.6 Unclaimed loss ratio refunds

(a) Any loss ratio refund issued by a carrier to a policy or contractholder pursuant to this subchapter which remains unclaimed by that policy or contractholder shall be deemed abandoned two years from the date upon which the Commissioner approves the refund plan as set forth in N.J.A.C. 11:20-7.5(b).

(b) Refunds deemed abandoned pursuant to (a) above shall be subject to all applicable provisions of the Uniform Unclaimed Property Act, N.J.S.A. 46:30B-1 et seq., including, but not limited to, N.J.S.A. 46:30B-30, 46, 47, 49, 50 and 57. All carriers shall follow the procedures set forth in the Uniform Unclaimed Property Act with respect to the disposition of refunds deemed abandoned.

(c) Carriers which comply with the applicable provisions of the Uniform Unclaimed Property Act and this subchapter shall be relieved of liability to the extent of any unclaimed refunds upon payment of any unclaimed refunds to the State administrator designated pursuant to the Uniform Unclaimed Property Act.

11:20-7.7 Certification of loss ratio refunds

Within 30 days of issuing refunds to all policy or contractholders for a specific calendar year, any carrier required to provide a loss ratio refund pursuant this subchapter shall provide a certification to the Commissioner at the address in N.J.A.C. 11:20-6.4(a), stating the following: "The loss ratio refund, as set forth in the Loss Ratio Report, was issued by (name of company) to all policy or contractholders eligible for reimbursement with refund checks mailed, or premiums credited, on (date)."

SUBCHAPTER 8. THE IHC PROGRAM ASSESSMENT REPORT

11:20-8.1 Scope and applicability

(a) This subchapter sets forth reporting and certification requirements for premium data of Program members and other carriers with reportable accident and health premium in New Jersey.

(b) This subchapter shall apply to all carriers with reportable accident and health premium in New Jersey for any portion of the two-year calculation period for which reports under this subchapter are required to be filed.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), deleted "annual" preceding "reporting"; and in (b), substituted "two-year calculation period" for "calendar year".
Repeal and New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Section was " Scope and applicability".
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
In (a), deleted "and non-group enrollment" following "premium" and deleted the second sentence.

11:20-8.2 Filing of the assessment report form

(a) Every carrier with reportable accident and health premium in New Jersey shall file the Exhibit K Assessment Report form and a copy of the Exhibit K Part C Premium Data Worksheet, which are set forth as Exhibit K in the Appendix to this chapter, incorporated herein by reference, on or before April 1 of the year immediately following every two-year calculation period.

(b) If a carrier with reportable accident and health premium in New Jersey is an affiliated carrier, the Exhibit K Assessment Report and the Part C Premium Data Worksheet shall be filed as follows:

1. Each affiliated carrier shall file one copy of the Exhibit K Part C Premium Data Worksheet whether or not that affiliated carrier reported accident and health premium in New Jersey during the two-year calculation period.

2. The combined affiliated carriers, identified using a single carrier name, shall file one copy of the Exhibit K Assessment Report. The information specified on the Exhibit K Assessment Report shall be the aggregated information supplied on the Premium Data Worksheets for all affiliated carriers.

3. The Exhibit K Assessment Report along with the Premium Data Worksheet(s) shall be filed together. For example, a carrier with three affiliates with reportable accident and health premium in New Jersey but only two of which issue non-group coverage, shall file one Exhibit K Assessment Report with the aggregated information for all affiliated carriers and three copies of the Exhibit K Part C Premium Data Worksheet.

(c) Certified Exhibit K Assessment Reports shall be submitted either by facsimile, with paper copy to follow by mail, or by hand delivery to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Administrative Change.
See: 27 N.J.R. 1423(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), changed the report filing deadlines; and rewrote (b).
Repeal and New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Section was "Filing of the market share and net paid gain or (loss) report form".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (a); in (b)3, added "Exhibit K" preceding "Assessment Report" in the second sentence; rewrote (b)4; rewrote (c).
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
In (a), substituted "and" for a comma following "form" and deleted "and a copy of the Exhibit K Part D Enrollment Data Worksheet," preceding "which"; in the introductory paragraph of (b), substituted "and" for a comma following "Report" and deleted "and the Part D Enrollment Data Worksheet" preceding "shall"; deleted former (b)2; recodified former (b)3 and (b)4 as (b)2 and (b)3; in (b)2, deleted "and the Enrollment Data Worksheets for those affiliated carriers with non-group person enrollment" from the end; and in (b)3, deleted "and the Enrollment Data Worksheet(s)" preceding the first occurrence of "shall" and ", and two copies of the Exhibit K Part D Enrollment Data Worksheet" from the end, and substituted "and" for a comma following "carriers".

11:20-8.3 Calculation of net earned premium and determination of program membership for the two-year calculation period

(a) In Part C of the Exhibit K Assessment Report, each member shall set forth its total net earned premium from plans issued, continued or renewed for all affiliated carriers during the preceding two-year calculation period. Net earned premium reported in Part C of Exhibit K shall be consistent with the data set forth on the Exhibit K Part C Premium Data Worksheet(s).

(b) In Part C of the Exhibit K Assessment Report, each carrier with no net earned premium in the preceding two-year calculation period shall assert its status as a non-member by checking the box designated for non-members on the Exhibit K Assessment Report. Carriers either with no net earned premium or whose Section 3 Calculation of Net Earned Premium on the Exhibit K Part C Premium Data Worksheet is equal to 0 are non-members.

(c) Every carrier, whether a member or not, shall complete an Exhibit K Part C Premium Data Worksheet for each affiliate and shall attach each Worksheet to its Exhibit K Assessment Report.

1. In Section 1 of the Premium Data Worksheet, the carrier shall report the total accident and health premium reported on its annual statement blank for each calendar year of the two-year calculation period.

2. In Section 2 of the Premium Data Worksheet, the carrier shall report the total net earned premium in each calendar year of the two-year calculation period for each of the excepted types of coverage which are specifically identified in Section 2 of the Worksheet.

3. In Section 3 of the Premium Data Worksheet, the carrier shall calculate the affiliate's net earned premium by subtracting the total excepted premium totals reported in Section 2 from the accident and health premium totals reported in Section 1 of the Worksheet.

4. The carrier shall report the aggregated two-year net earned premium on Exhibit K Part C by taking the sum of

each affiliate's two-year net earned premium total as calculated on the Exhibit K Part C Premium Data Worksheet.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (a).
Amended by R.2001 d.55, effective January 17, 2001.
See: 33 N.J.R. 15(a), 33 N.J.R. 668(a).
In the introductory paragraph of (a), inserted N.J.A.C. reference, and in (a)1, inserted ", but not be limited to,".
Repeal and New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Section was "Net earned premium".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (b); in (c), added "Assessment Report" at the end.

11:20-8.4 (Reserved)

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Repeal and New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Section was "Calculation of covered non-group persons".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b)1, substituted "two adults" for "husband and wife" throughout and substituted "composite" for "compromise"; in (b)4, substituted "Medicare Advantage," for "and".
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
In (b)1, inserted "issued prior to August 1, 1993, all modified community rated persons issued on or after August 1, 1993"; in (b)2, inserted "modified"; and in (b)3, deleted "NJ KidCare Part A recipients and" following "including" and "NJ KidCare" following "through".
Repealed by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
Section was "Calculation of average non-group enrollment for the two-year calculation period".

11:20-8.5 (Reserved)

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Rewrote the section.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), rewrote the introductory paragraph; in (c), added "Assessment Report" following "Exhibit K" in the third sentence; in (d), in the third sentence, added "Assessment Report" following "Exhibit K" and deleted the space between "not" and "withstanding"; in (d)2, added quotation marks around "Mean funds".
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
In the introductory paragraph of (a), inserted "up to and including the 2007-2008 calculation period which shall be the final period for which loss reimbursement may be sought".
Repealed by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
Section was "Calculating net paid losses or gains".

11:20-8.6 Certifications

In Part D of the Exhibit K Assessment Report, the Chief Financial Officer, or other duly authorized officer of the carrier, shall certify that the Exhibit K Assessment Report and all Exhibit K Part C Premium Data Worksheets filed with the IHC Board are accurate and complete and conform with the requirements of this subchapter. Every duly authorized officer who provides a certification for the reporting required under this subchapter shall be responsible for errors contained therein.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "gain" preceding "(loss)" throughout; and rewrote (b).
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Rewrote (a); in (b)1, substituted "the assessment" for "Exhibit K" following "reported on".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), inserted "Exhibit K" before the second occurrence of "Assessment Report"; rewrote (b).
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
Deleted designation (a); deleted (b); and substituted "D" for "F" and "and" for a comma following "Report" and deleted ", and all Exhibit K Part D Enrollment Data Worksheets" preceding "filed".

Case Notes

Health insurer became member of Individual Health Coverage Program subject to assessment for share of program losses upon receiving certificate of authority to operate as health maintenance organization (HMO) in state, regardless of status of its application for approval as federally qualified HMO. Matter of Individual Health Coverage Program Final Administrative Orders Nos. 96-01 and 96-22, 302 N.J.Super. 360, 695 A.2d 371 (N.J.Super.A.D. 1997).

11:20-8.7 Failure to file Exhibit K Assessment Report

Failure to file in a timely manner the Exhibit K Assessment Report and certification required by this subchapter shall result in the Board's using the premium set forth in the member's most recent Annual Statements filed with the Department as the premium base to calculate that member's market share allocation of assessments for that calculation period.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "gain" preceding "(loss)" in the introductory sentence.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (a), substituted "the Assessment Report" for "market share and net paid gain (loss) report" in the introductory paragraph.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote the section; section was "Penalties for failure to file market share and net paid loss report".
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
Deleted designation (a); and substituted "certification" for "certifications" and "for that calculation period" for "for reimbursement of losses and minimum number of non-group persons".

11:20-8.8 (Reserved)

New Rule, R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (b), inserted "gain" preceding "(loss)" in the first sentence; and in (c), substituted "two-year calculation period" for "calendar year".
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (b), substituted "Assessment Report" for "market share and net paid gain (loss)report"; in (c), added the second sentence.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (b) and (c).
Repealed by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
Section was "Audits".

11:20-8.9 (Reserved)

New Rule, R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Substituted "receipt of written notification of the Board's" for "the date that the IHC Program Board notifies the member of its".
Repealed by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
Section was "Hearings".

SUBCHAPTERS 9 THROUGH 10. (RESERVED)

SUBCHAPTER 11. RELIEF FROM OBLIGATIONS IMPOSED BY THE INDIVIDUAL HEALTH INSURANCE REFORM ACT

11:20-11.1 Purpose and scope

(a) This subchapter establishes the informational and procedural requirements for members requesting relief from obligations to pay assessments pursuant to N.J.S.A. 17B:27A-12 (including assessments for IHC Program losses and administrative expenses), or to offer coverage or accept applications to provide a standard health benefits plan to eligible persons, pursuant to N.J.S.A. 17B:27A-8.

(b) This subchapter applies to all members of the IHC Program.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
In (a), deleted an N.J.S.A. reference.

11:20-11.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A-2 and N.J.A.C. 11:20-1, when used in this subchapter, shall have the meanings as defined therein, unless more specifically defined in (b) below or unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Applicant" means the member seeking a deferral of its obligation to pay assessments or a waiver of its obligation to offer coverage and accept applications pursuant to N.J.S.A. 17B:27A-2 et seq.

"Financially impaired" means a member that is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations, or a member which is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Relief" means a deferral of obligations imposed pursuant to N.J.S.A. 17B:27A-12, or a waiver of obligations pursuant to N.J.S.A. 17B:27A-8, as applicable.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
In (b), deleted "which, after December 20, 1993" following "member" in "Financially impaired" definition; and deleted an N.J.S.A. reference in "Relief" definition.

11:20-11.3 Application procedures and filing format

(a) Any member seeking relief may submit such request to the Department at any time, except that requests for relief from payment of assessments pursuant to N.J.S.A. 17B:27A-12a(3) shall be submitted to the Department no later than 15 days following the due date of payment of the assessment.

(b) All requests outlined in this subchapter shall be accompanied by a statement averring a need for relief from the obligation(s), as the case may be, including supporting documentation as set forth in N.J.A.C. 11:20-11.4, and shall specify the statutory and regulatory basis for such relief. A single filing may request relief from more than one obligation, but shall specify each obligation from which relief is sought.

(c) Each request shall be in loose leaf form inserted into standard two-ring or three-ring binders tabbed or otherwise indexed to correspond to the exhibits set forth in N.J.A.C. 11:20-11.4. The loose leaf sheets used in the request shall be eight and one-half inches wide and 11 inches long and punched for two-ring or three-ring binders, as appropriate.

(d) All members requesting relief pursuant to this subchapter shall submit five copies of each request in the format set forth in (c) above.

individual health benefits plans issued pursuant to N.J.S.A. 17B:27A-2 et seq. The projections shall assume the same rate of assessment as in the first two-year calculation period for the subsequent two-year calculation period, and shall include projections of the applicant's operating results containing the information and in the format set forth in the following:

i. For life and health insurers, the balance sheet and summary of operations exhibits of the statutory annual statement filed by the insurer;

ii. For property and casualty insurers, the balance sheet and Underwriting and Investment Exhibit of the statutory annual statement filed by the insurer;

iii. For health service corporations, the balance sheet and Underwriting and Investment Exhibit of the statutory annual statement filed by the health service corporation; and

iv. For health maintenance organizations, the balance sheet and statement of revenue, expenses and net worth of the annual statement filed by the health maintenance organization;

11. A description of any relief from obligations imposed by this State or any other state granted or in effect within the preceding 12 months, and the basis upon which such relief was granted;

12. A non-refundable filing fee of $1,000, unless the applicant is in rehabilitation or conservation at the time of filing pursuant to N.J.S.A. 17B:32-31 et seq. or such similar law of the applicant's state of domicile; and

13. Any other information the Commissioner may deem relevant to the consideration of the request.

(b) An applicant asserting that the Department's review of its request should be evaluated on a particular basis (that is, pre-pooled, post-pooled, consolidated or unconsolidated), shall submit a written statement which sets forth the specific reasons, with supporting documentation, if any, for which it believes evaluation on a particular basis is appropriate to that applicant, and the specific reasons, with supporting documentation, if any, for which evaluation on other bases would be inappropriate.

(c) All filings shall be accompanied by the following certification signed by the chief financial officer of the applicant: "I, _____, certify that the attached filing complies with all requirements set forth in N.J.A.C. 11:20-11 and that all of the information it contains is true and accurate. I further certify that I am authorized to execute this certification on behalf of the applicant."

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
In (a), deleted an N.J.S.A. reference in the introductory paragraph and rewrote 10.
Amended by R.2006 d.16, effective January 3, 2006.
See: 37 N.J.R. 3022(a), 38 N.J.R. 332(a).
In (a)1iv, added "and email address" following "telefax number"; in (a)6, added ", signed by an actuary who is a member of the American Academy of Actuaries,"; in (a)9, substituted "the 12 months" for "the period beginning January 1 in the year of the filing to the quarterly statement"; in (b) and (c), made minor grammatical changes.

11:20-11.5 Confidentiality of request for relief

(a) All data or information contained in the request for relief filed pursuant to this subchapter shall be confidential and shall not be subject to public disclosure or copying pursuant to the "Right to Know" law, N.J.S.A. 47:1A-1 et seq., or the common law right to know, except for the following items, but only upon written, specified request and following 10 days written notice by the Department to the member/applicant:

1. N.J.A.C. 11:20-11.4(a)1i and ii—cover letter with name of applicant and describing relief sought;

2. N.J.A.C. 11:20-11.4(a)1iv—name, title, telephone number and telefax number of person familiar with the filing;

3. N.J.A.C. 11:20-11.4(a)3—most recent financial examination report;

4. N.J.A.C. 11:20-11.4(a)5i and ii—list of members of holding company system and intercompany transactions for period preceding date of filing;

5. N.J.A.C. 11:20-11.4(a)8—annual statement filed immediately preceding date of filing;

6. N.J.A.C. 11:20-11.4(a)12—non-refundable filing fee; and

7. N.J.A.C. 11:20-11.4(a)13—additional information required by the Commissioner to evaluate a particular filing.

Amended by R.2006 d.16, effective January 3, 2006.
See: 37 N.J.R. 3022(a), 38 N.J.R. 332(a).
Added "or the common law right to know," to introductory paragraph (a).

11:20-11.6 Disposition of request for relief

(a) When the Commissioner determines pursuant to N.J.S.A. 17B:27A-8 or 17B:27A-12a(3), as applicable, that the member does not have the financial reserves necessary to underwrite additional coverage or is or would be placed in a financially impaired condition through fulfillment of a coverage or assessment obligation or obligations, the Commissioner shall notify the member that its duty to fulfill the applicable obligation shall be waived, or deferred in whole or in part, as appropriate. If the Commissioner defers in whole or in part a member's obligation to pay assessments pursuant to N.J.S.A. 17B:27A-12a(3), the member shall remain liable to the IHC Program for the amount deferred.

(b) The Commissioner shall find that a member is or would be financially impaired if:

1. The member has been placed in rehabilitation or conservation pursuant to N.J.S.A. 17B:32-31 et seq. or such similar law of the member's state of domicile;

2. The Commissioner finds that the member is in a hazardous financial condition, as determined pursuant to N.J.A.C. 11:2-27; or

3. The Commissioner finds that fulfillment of the obligation(s) from which relief is sought would place the member in a hazardous financial condition, as determined pursuant to N.J.A.C. 11:2-27.

(c) Any waiver or deferral from a particular obligation granted by the Commissioner pursuant to this subchapter shall be for a specified period as set forth in the notice granting the request, but shall not exceed 12 months from the date of the notice. Any member seeking to continue a waiver or deferral shall file a separate request for relief in accordance with this subchapter no later than 45 days prior to the expiration of the waiver or deferral period set forth in the original notification granting the request. Such a request shall also include a detailed explanation of all actions the applicant has taken and intends to take to cure the financial impairment. Failure to file a properly completed request for relief within the time prescribed shall result in the expiration of the waiver or deferral at the expiration of the period set forth in the original notification granting the request. Nothing herein shall be construed as limiting or prohibiting any member from applying for relief at any time in accordance with this subchapter.

(d) If the Commissioner grants a request for a deferral of payment of an assessment, the terms of the deferral shall include the requirement that the member shall pay to the Board an additional amount representing the loss to the Board of the time value of the assessment for the period of the deferral.

1. In calculating the additional amount to be paid, the member shall use the annual interest rate on one-year U.S. Treasury bills as of the date the assessment was due and payable.

2. In calculating the additional amount to be paid, the period of deferral shall begin on the date that payment of the assessment was due and payable and end on the date the amount deferred is paid to the Board.

3. The payment of the additional amount set forth in (d) above shall be in lieu of payment by the member of any interest or penalty on the amount deferred, which otherwise may be required under any other rule.

4. The requirement to pay an additional amount as provided in (d) above shall not apply when the reason for granting the deferral is that the member is in rehabilitation or conservation.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In (a), inserted "does not have the financial reserves necessary to underwrite additional coverage or" in the first sentence and deleted an N.J.S.A. reference.

11:20-11.7 Hearings

(a) A member may request a hearing on a determination by the Commissioner within 20 days from the date of receipt of such determination as expressly permitted by the chapter as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, daytime telephone number, fax number and e-mail address of a contact person familiar with the matter;

ii. A copy of the Commissioner's determination;

iii. A statement requesting a hearing; and

iv. A concise statement listing the disputed adjudicative facts warranting a hearing and describing the basis for the member's contention that the Commissioner's findings of fact are erroneous.

2. The Commissioner may, after receipt of a properly completed request for a hearing, provide for an informal conference between the member and such personnel of the Department as the Commissioner may direct, to determine whether there are disputed adjudicative facts.

3. The Commissioner shall, within 30 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case, pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

i. If the Commissioner finds that the matter constitutes a contested case, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

ii. If the Commissioner finds that the matter does not constitute a contested case, the Commissioner, with the approval of the Director of the Office of Administrative Law, may, transmit the matter to the Office of Administrative Law for a hearing consistent with N.J.A.C. 1:1-21.

iii. If the Commissioner finds that there are no good-faith disputed adjudicative facts and the matter may be decided on the documents filed, the Commissioner may notify the applicant in writing as to the final disposition of the matter.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In (a), inserted "listing the material facts in dispute and" in 1iv and added a new 3ii.

Amended by R.2006 d.16, effective January 3, 2006.
See: 37 N.J.R. 3022(a), 38 N.J.R. 332(a).
Rewrote the section.

11:20-11.8 Notice to the IHC Program

Members requesting relief pursuant to this subchapter shall concurrently provide written notice of all such requests to the IHC Program through the Executive Director. Members shall also provide written notice to the IHC Program of all dispositions of such requests by the Commissioner, within 15 days of such disposition. All such notices shall be sent to the address set forth at N.J.A.C. 11:20-2.1(h).

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
Inserted "written" preceding "notice" throughout, and substituted "Executive Director" for "Interim Administrator or Administrator, as appropriate".
Amended by R.2006 d.16, effective January 3, 2006.
See: 37 N.J.R. 3022(a), 38 N.J.R. 332(a).
Deleted "of" from the section heading; added the last sentence.

11:20-11.9 Exceptions for health maintenance organizations due to lack of capacity

(a) Any member health maintenance organization (HMO) asserting that it is not required to offer coverage or accept applications pursuant to the requirements of the Act because it does not have the capacity to enroll additional members, pursuant to N.J.S.A. 17B:27A-8a, shall file the following information with the Commissioner:

1. A cover letter stating:

i. The name of the member HMO;

ii. A statement that the member is not required to offer coverage or accept applications pursuant to the Act because it does not have the capacity in its facilities to enroll additional members, and the basis for that assertion, with supporting documentation, certified by the president or duly authorized officer of the member;

iii. The number of the member's current individual and group members, listed by provider and classified by the provider's specialty, which shall be updated annually each year the member asserts a waiver pursuant to N.J.S.A. 17B:27A-8a; and

iv. A certification signed by the president or duly authorized officer that the member, pursuant to N.J.S.A. 17B:27A-8a:

(1) Will not offer coverage to or accept any new group members. Individual additions to existing groups shall not be considered new group members; and

(2) Upon denying individual health benefits coverage, will not offer such coverage in the individual market for a period of 180 days after the date the coverage is denied.

(b) The member shall concurrently file the information required pursuant to (a) above with the IHC Program.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
Rewrote (a)1iv.

11:20-11.10 Other actions by the Commissioner

Nothing in this subchapter shall be construed as limiting the Commissioner's authority to take such action with respect to insurers, health service corporations or health maintenance organizations as may be authorized by law, including, but not limited to, placing an insurer, health service corporation or health maintenance organization in rehabilitation, liquidation or conservation pursuant to N.J.S.A. 17B:32-31 et seq.

11:20-11.11 Penalties

Failure to comply with this subchapter, including all notice requirements set forth herein, may result in the denial of relief requested and imposition of penalties as authorized by law, including any actions that may be taken by the Board pursuant to N.J.S.A. 17B:27A-2 et seq. and the IHC Program Plan of Operation, including, but not limited to, imposition of an interest penalty for assessments due from the member and a recommendation by the Board to remove the member's authority to issue any health benefits plans in this State.

SUBCHAPTER 12. PURCHASE OF A STANDARD HEALTH BENEFITS PLAN BY A PERSON COVERED UNDER AN INDIVIDUAL PLAN OR COVERED UNDER A GROUP PLAN

11:20-12.1 Purpose and scope

This subchapter sets forth the standards for purchasing a standard health benefits plan or a standard health benefits plan with rider by a person who is covered under an individual plan or a group health benefits plan.

Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Rewrote the section.

11:20-12.2 (Reserved)

Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Added definition "Special open enrollment period".
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
Deleted definition "Special open enrollment period".
Repealed by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Section was "Definitions".

11:20-12.3 Replacement during initial enrollment period

(a) A person who is covered under a standard health benefits plan, or a standard health benefits plan with rider, a basic and essential health care services plan, a basic and essential health care services plan with rider, or a group health benefits plan may elect to replace the plan or the coverage with a standard individual health benefits plan or a standard individual health benefits plan with a rider. The application must be received during the initial enrollment period.

(b) The effective date of the replacement plan will be January 1 if the application is received by December 31, 2013. The effective date will be the first of the following month for applications received January 1, 2014, through March 31, 2014. In addition, carriers may permit effective dates as of the 15th of the month in January, February, and March.

(c) The standard health benefits plan, or a standard health benefits plan with rider, a basic and essential health care services plan, a basic and essential health care services plan with rider, or a group health benefits plan coverage must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan or coverage will terminate the existing plan or coverage as of the midnight on the day before the effective date of the replacement plan if the existing carrier is notified of the replacement within 30 days after the effective date of the replacement plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan is not before the effective date of the replacement plan, the replacement plan shall be of no force and effect and premium paid shall be refunded.

Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
In (b), inserted "filed" twice.
Repeal and New Rule, R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Section was "Covered under an individual plan: replacement at any time".

11:20-12.4 Replacement during annual open enrollment period

(a) Except as stated in N.J.A.C. 11:20-12.5 with respect to the special enrollment period, a person who is covered under a standard health benefits plan, standard health benefits plan with rider, or group health benefits plan may only elect during the annual open enrollment period to replace the plan or coverage with a standard health benefits plan or a standard health benefits plan with rider. The application must be received during the annual open enrollment period.

(b) The effective date of the replacement plan will be January 1 of the year following the annual open enrollment period.

(c) The existing standard health benefits plan, standard health benefits plan with a rider, or group health benefits plan coverage must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan will terminate the existing plan or coverage as of the midnight on the day before the effective date of the replacement plan if the existing carrier is notified of the replacement within 30 days after the effective date of the replacement plan. The new carrier issuing the replacement plan may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan or coverage is not before the effective date of the replacement plan, the replacement plan shall be of no force and effect and premium paid shall be refunded.

Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Section was "Covered under an individual plan: replacement only during Open Enrollment Period". In (a), (b), (c) and (d), inserted "or Special Open Enrollment Period"; in (c), substituted "an indemnity, preferred provider (PPO) or point of service (POS)" for "non-HMO" and "a non-HMO"; added new (e); recodified former (e) through (h) as (f) through (i); in (f), inserted "or Special Open Enrollment Period"; in (g), deleted "items" preceding "(a)" and inserted "and no later than April 1, 2009 in the case of the Special Open Enrollment Period"; and in (i), substituted "(b), (d), (e) and (f)" for "(b) (d) and (e)".
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
Section was "Covered under an individual plan: replacement only during Open Enrollment Period or Special Open Enrollment Period". Deleted "or Special Open Enrollment Period" following "Open Enrollment Period" throughout; and in (g), deleted "and no later than April 1, 2009 in the case of the Special Open Enrollment Period" from the end.
Amended by R.2011 d.254, effective September 13, 2011 (operative November 1, 2011).
See: 43 N.J.R. 1813(a), 43 N.J.R. 2668(a).
In (a), substituted "Except as stated below, a" for "A" and inserted the last sentence.
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Section was "Covered under an individual plan: replacement only during Open Enrollment Period". Rewrote the section.

11:20-12.4A (Reserved)

New Rule, R.2011 d.254, effective September 13, 2011 (operative November 1, 2011).
See: 43 N.J.R. 1813(a), 43 N.J.R. 2668(a).
Repealed by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Section was "Terminated an individual plan during the 31 days prior to the application for or enrollment in another individual health benefits plan: replacement only during Open Enrollment Period".

11:20-12.5 Replacement during special enrollment period

(a) A person covered under a standard health benefits plan or a standard individual health benefits plan with a rider or group health benefits plan may enroll for coverage under a different standard health benefits plan or standard individual health benefits plan with a rider during a 60-day special enrollment period that follows a triggering event.

(b) The effective date of the new standard health benefits plan or standard health benefits plan with a rider will be the first of the month following the date the carrier receives the application. In addition to the first of the month effective date, carriers may permit the effective date to be the 15th of the month following the date the carrier receives the application. However, the effective date of coverage issued following a triggering event of birth, adoption, including placement for adoption, or placement in foster care shall be the date of birth, adoption, or placement for adoption or the date of placement in foster care.

Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
In (a), substituted "Period or Special Open Enrollment Period" for "period", and inserted "or no later than April 1, 2009 in the case of the Special Open Enrollment Period"; and in (d), inserted the second sentence.
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).
In (a), deleted "or Special Open Enrollment Period" following the first occurrence of "Open Enrollment Period" and "or no later than April 1, 2009 in the case of the Special Open Enrollment Period" following the second occurrence of "Open Enrollment Period"; and in (d), deleted the second sentence.
Repeal and New Rule, R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Section was "Covered under or eligible to participate in a group health benefits plan".

SUBCHAPTERS 13 THROUGH 16. (RESERVED)

SUBCHAPTER 17. ENROLLMENT STATUS REPORT

11:20-17.1 Purpose and scope

(a) This subchapter provides for the quarterly and annual submission of enrollment status reports by all members of the IHC Program, and sets forth the procedures and format for those reports.

(b) This subchapter applies to all members of the IHC Program that issue or renew standard health benefits plans or the basic and essential health care services plans to individuals.

Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (b), inserted "or renew" following "issue" and "or the basic and essential health care services plans" following "benefits plans".

11:20-17.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A-2 and N.J.A.C. 11:20-1, when used in this subchapter, shall have the meanings as defined therein, unless more specifically defined in (b) below or unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Enrollment status report" means a complete and accurate document that is prepared and filed in accordance with the requirements of this subchapter and sets forth the information in the format of Part 1 of Exhibit L for the quarterly submission and Part 2 of Exhibit L for the annual submission in the Appendix to this chapter, which is incorporated herein by reference.

"Insured" or "insured individual" means any individual covered under an individual health benefits plan.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (b), added new "Conversion", "Insured" or "insured individual" and "Replacement contract" definitions.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), deleted "Conversion" and "Replacement contract" and rewrote "Insured".

11:20-17.3 Filing requirements

(a) Every member of the IHC Program issuing or renewing standard health benefits plans and the basic and essential health care services plan shall complete and file with the Board the enrollment status reports required by this subchapter.

(b) Members shall file enrollment status reports on a quarterly basis reflecting the information set forth in N.J.A.C. 11:20-17.4 and in the format of Part 1 of Exhibit L which shall reflect data as of March 31, June 30, September 30 and December 31 of each year.

(c) Members shall file enrollment status reports on an annual basis reflecting the number of contracts by zip code category, and insured persons by age and gender category in the format of Part 2 of Exhibit L which shall reflect data as of December 31 of the prior year.

(d) Members shall submit completed enrollment status reports to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h) no later than 45 days following the end of the quarter or end of the year (for annual reporting purposes).

(e) Affiliated carriers shall submit the enrollment status reports only on a combined basis. Each affiliated carrier shall be identified on the report.

Administrative Change.
See: 27 N.J.R. 1423(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (a), inserted "or renewing" following "issuing"; rewrote (b) and (c); and deleted (f).
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (a), inserted "and the basic and essential health care services plans" following "standard health benefits plan".

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), deleted "hard copy" following "Members shall file"; in (c), substituted "gender" for "sex" and "the prior" for "each".

11:20-17.4 Contents of the enrollment status report

(a) Members shall report the following information on a quarterly basis on the enrollment status report form set forth as Part 1 of Exhibit L in the Appendix, separately for each of the standard health benefits plans, broken out into indemnity or PPO or POS for Plans A/50, B, C and D, the HMO plans reported by copay or coinsurance, as well as indemnity, PPO, EPO or HMO coverage under the basic and essential health care services plan, and, if applicable, the individual health benefits plans issued on a community rated, open enrollment basis prior to August 1, 1993:

1. In section A of Part 1 of Exhibit L, Report By Contracts shall be calculated by adding the number of contracts in force at the beginning of the period to the number of contracts issued during the period, and subtracting the number of contracts lapsed during the period.

i. Contracts issued shall be reported according to previous insured status. Previous insured status shall be separated into three categories: previously insured, previously uninsured, and unknown. Previous insured status shall be obtained from the section of the application that requires the applicant to indicate if the applicant had previous coverage. If the response is yes, then the contract shall be reported as previously insured. If the response is no, then the contract shall be reported as previously uninsured. If the question has not been answered, the contract shall be reported as unknown.

2. In section B of Part 1 of Exhibit L, Report By Persons Insured shall be calculated by adding the number of persons insured at the beginning of the period and the number of new insureds during the period, and subtracting the number of insureds lapsed during the period.

i. The number of lives insured should be reported in this section. For those members who do not maintain actual dependent data, the following factors shall be used to convert contracts to persons insured: single = 1; two adults = 2; adult and child(ren) = 2.8; family = 3.9;

3. In section C of Part 1 of Exhibit L, Report of Contracts By Rating Tier shall be reported separately by rating tier, that is: single; two adults; adult and child(ren); and family; and

4. In section D of Part 1 of Exhibit L, Report of Contracts By Deductible/Copayment Option, shall be reported separately by the required and permitted deductible options for Plans A/50, B, C, and D or the required and permitted copayment options for the HMO Plan. Members issuing PPO or POS plans shall report according to the copayment or deductible applicable to network physician visits. Members issuing HMO plans that include deductible and coinsurance provisions shall report according to the deductible applicable to services and supplies for which coinsurance applies. Members issuing basic and essential health care plans shall report contracts for plans issued with and without riders.

(b) Members shall report the following information on an annual basis on the enrollment status report form set forth at Part 2 of Exhibit L in the Appendix, separately for each of the standard health benefits plans, broken down by indemnity or PPO or POS for Plans A/50, B, C and D, the HMO plans, as well as the indemnity, PPO, POS or EPO or HMO basic and essential health care services plan, both with and without any rider:

1. In section A of Part 2 of Exhibit L, Report of Inforce Contracts by Zip Code, categorized by Territory A – F or the first three digits of the zip code;

2. In section B of Part 2 of Exhibit L, Report of insured males, separated by age distribution as of December 31 of the previous year;

3. In section C of Part 2 of Exhibit L, Report of insured females, separated by age distribution as of December 31 of the previous year; and

4. In section D of Part 2 of Exhibit L, Report of Contracts as amended by one or more optional benefit riders.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (a) and (b).
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).
In (a) and (b), inserted references to indemnity for Plan A/50 in the introductory paragraphs.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (a) and (b), inserted references to indemnity or HMO coverage under the basic and essential health services plan following "HMO plans" in the introductory paragraph.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote the section.
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
In the introductory paragraph of (a), (a)4 and the introductory paragraph of (b), inserted "or POS"; in the introductory paragraph of (b), inserted ", POS"; in (b)2, deleted "and" from the end; in (b)3, substituted "; and" for a period at the end; and added (b)4.

11:20-17.5 (Reserved)

Repealed by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Section was "Penalties".

SUBCHAPTER 18. WITHDRAWALS OF CARRIERS FROM THE INDIVIDUAL MARKET AND THE WITHDRAWAL OF PLAN, PLAN OPTION, OR DEDUCTIBLE/COPAYMENT OPTION

11:20-18.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers issuing plans pursuant to the IHC Act may cease doing business in the individual plan market in this State. Additionally, this subchapter establishes the requirements and procedures by which carriers may cease issuing and renewing: all individual plans; a specific plan, by issuing the same plan through a different delivery mechanism; a specific plan option, by offering an alternative approved plan option; or a specific deductible/copayment option that is optional pursuant to N.J.A.C. 11:20-3.1.

(b) This subchapter applies to all carriers, whether or not affiliated with other carriers doing business in the individual plan market in New Jersey, that seek to cease offering or renewing individual plans issued pursuant to the IHC Act, and carriers that seek to cease issuing a specific standard plan, plan option, or deductible/copayment option as permitted herein.

11:20-18.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings set forth in the Act or at N.J.A.C. 11:20-1.2, unless defined below or unless the context clearly indicates otherwise:

"Cease doing business" for purposes of this subchapter means market withdrawal.

"Individual plan" means a plan developed by the Individual Health Coverage Program Board offered pursuant to N.J.S.A. 17B:27A-4b and the basic and essential health care services plan developed by the Legislature and offered pursuant to P.L. 2001, c. 368, including any rider offered with such a plan.

"Market withdrawal" means a carrier's, or one or more affiliated carriers', cessation of the issuance of all individual plans and nonrenewal of all in force individual plans and pre-reform plans upon their respective anniversary dates without the carrier's offering a replacement with an individual plan.

"Plan option withdrawal" means a carrier's cessation of the issuance of an individual plan option, and the nonrenewal of all in force individual plans issued with that option upon their respective anniversary dates.

"Plan withdrawal" means a carrier's cessation of the issuance of one of the individual plans, and the nonrenewal of all in force individual plans of that type upon their respective anniversary dates.

"Pre-reform plan" means an individual health benefits plan issued in New Jersey prior to August 1, 1993.

"State" means the State of New Jersey.

11:20-18.3 Carrier cancellation of individual plans

No carrier with in force individual plans shall cancel an individual plan, except in accordance with N.J.S.A. 17B:27A-6, or nonrenew an individual plan upon the plan's anniversary date, except in accordance with N.J.A.C. 11:20-18.5, 18.6, or 18.7.

11:20-18.4 Cessation of offer and issuance of individual plans

(a) No carrier with in force individual plans shall cease to offer and issue all of its individual plans to an eligible person unless the Commissioner has determined pursuant to N.J.S.A. 17B:27A-8b and N.J.A.C. 11:20-11 that the carrier does not have the financial resources necessary to underwrite additional coverage, and it has provided written notice to:

1. The IHC Board at least 30 days before it intends to cease offering and issuing individual plans. Upon receipt of such notice, the Board shall no longer distribute the carrier's filed rates in conjunction with the Individual Health Coverage Program Buyer's Guide; and

2. Its individual plan policyholders, in conjunction with each notice of an adjustment of rates provided to such policyholders following the date the carrier ceases to offer and issue such plans. The notice to policyholders shall state that:

i. The carrier intends to cease offering and issuing individual plans in New Jersey;

ii. The carrier will continue to renew the policyholder's health benefits plan at the policyholder's option; and

iii. The policyholder may obtain information about individual health benefits plans offered by other carriers by calling 1-800-838-0935 for a free Individual Health Coverage Program Buyer's Guide or may obtain information on the Department of Banking and Insurance website at: www.nj.gov/dobi/reform.htm.

(b) A carrier that notifies the Board under this section shall continue to renew all in force individual plans until it obtains the Department's approval for market withdrawal in accordance with N.J.A.C. 11:20-18.5.

(c) A carrier that has ceased offering and issuing individual plans pursuant to N.J.S.A. 17B:27A-8b and N.J.A.C. 11:20-11, but has not withdrawn from the market in accordance with N.J.A.C. 11:20-18.5, may resume offering and issuing standard individual health benefits plans to eligible persons after it has notified the Department and the Board, in writing, that it intends to resume offering individual plans.

Upon receipt of such notice, the Board shall distribute the carrier's filed rates in conjunction with the Individual Health Coverage Program Buyer's Guide.

(d) A carrier with in force individual plans that has ceased to offer and issue all of its individual plans pursuant to this section shall nevertheless continue to comply with all other provisions of the law.

11:20-18.5 General provisions for market withdrawal

(a) No carrier with in force individual plans, whether or not affiliated with other carriers doing business in the individual plan market in New Jersey, shall refuse to issue or refuse to renew an individual plan, except in accordance with N.J.S.A. 17B:27A-6, or in accordance with N.J.A.C. 11:20-18.4 or 18.6, unless the carrier receives approval from the Commissioner to withdraw all of its individual plans and pre-reform plans in accordance with the provisions of this subchapter.

(b) A carrier that seeks to withdraw shall file with the Department an application for market withdrawal in the format described in (c) below. A carrier with more than one affiliated carrier doing business in the individual plan market in New Jersey may apply for market withdrawal on behalf of one or more affiliated carriers. Until the withdrawal process is complete, the withdrawing carrier shall continue to be governed by N.J.S.A. 17B:27A-2 et seq. and all rules promulgated thereunder, including, but not limited to, the minimum loss ratio and policyholder refund requirements and liability for a proportionate share of assessments for reimbursable losses and administrative expenses.

(c) The application for market withdrawal shall be sent to the Department at Department of Banking and Insurance, Life and Health, IHC Withdrawal, 20 West State Street, P.O. Box 325, Trenton, New Jersey 08625, and shall include the following information:

1. The name of the carrier seeking to withdraw;

2. The name, address, telephone number, and fax number of the carrier's representative responsible for the application for market withdrawal;

3. A statement, describing with specificity, the carrier's reasons for withdrawing from the individual market in this State;

4. A statement of the carrier's percentage market share in the individual plan market, if known, including its most recent policy or contract count and annual amount of direct premium earned and written;

5. A statement indicating whether the carrier has applied for an exemption pursuant to N.J.A.C. 11:20-9 in the two-year calculation period during which the application for market withdrawal was filed;

6. A copy of the carrier's most recent loss ratio filing submitted pursuant to N.J.A.C. 11:20-7;

7. A copy of the carrier's most recent enrollment status report filed pursuant to N.J.A.C. 11:20-17;

8. A statement indicating whether the carrier has any affiliated carriers writing any health benefits plans in this State, the names of such affiliated carriers and the lines of insurance written, and whether any such affiliated carriers will continue to offer individual plans after the carrier's withdrawal;

9. A statement indicating whether the carrier is withdrawing from other lines of business in this State, and if so, the lines from which it is withdrawing, its authority do so, and whether it has sought and obtained approval for such withdrawal;

10. A statement indicating whether the carrier has guaranteed rates to its policyholders and for what period of time;

11. A copy of the proposed nonrenewal notices the applicant intends to send to its policy or contractholders if the application for market withdrawal is approved. Nonrenewal notices for policy or contractholders shall contain the following information:

i. That the carrier has elected to withdraw;

ii. The date upon which the policy or contract shall be nonrenewed;

iii. That the policy or contract is being nonrenewed under the authority of this subchapter;

iv. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the plan nonrenewal;

v. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan nonrenewal;

vi. A statement that a person who fails to obtain subsequent individual coverage within 31 days of the nonrenewal may be subject to a pre-existing condition exclusion period of 12 months; and

vii. A statement that, pursuant to N.J.S.A. 17B:27A-6, all carriers offering individual plans must issue coverage to any individual who requests coverage, meets the eligibility requirements, and pays the required premium for the coverage;

12. Copies of the proposed nonrenewal notices the applicant intends to send to its producers if the application for market withdrawal is approved. Nonrenewal notices for producers shall contain the following information:

i. That the carrier has elected to withdraw;

ii. The date upon which the policies or contracts shall be nonrenewed;

iii. That the policies or contracts are being nonrenewed under the authority of this subchapter;

iv. The name, address and telephone number of the employee of the carrier who may be contacted for assistance and information regarding the plan nonrenewal;

v. A statement that a person who fails to obtain subsequent individual coverage within 31 days of the nonrenewal may be subject to a pre-existing conditions exclusion period of 12 months;

vi. A statement that, pursuant to N.J.S.A. 17B:27A-6, all carriers offering individual plans must issue coverage to any individual who requests coverage, meets the eligibility requirements, and pays the required premium for the coverage; and

vii. The date upon which the carrier will begin to nonrenew all individual plans and pre-reform plans;

13. An explanation of whether the carrier has any in-force small employer health benefits plans and, if so, a statement of whether the carrier has filed a notice of intent to withdraw from the small employer market with the Department; and

14. Any additional information which the carrier believes is relevant for the Department to review the carrier's application for market withdrawal.

(d) The Department shall not begin its evaluation of an application for market withdrawal until the applicant has complied with the requirements contained in this section for its submission.

1. Within 45 days of receipt of an application for market withdrawal or a subsequent amendment thereto, filed pursuant to (c) above, the Department shall provide written notice to the carrier indicating that the filing is complete or incomplete. If the Department determines that the filing is incomplete, the Department's written notice shall identify the information that was not provided.

2. Following receipt of a complete application for market withdrawal filed pursuant to (c) above, the Department either shall approve or disapprove the application in writing within 60 days of the date of the Department's written notice to the carrier indicating that the filing is complete.

i. In determining whether to approve or disapprove a carrier's application for market withdrawal, the Department shall consider the following factors:

(1) Whether a sufficient number of carriers necessary to sustain a competitive market would continue to offer individual health benefits plans following the carrier's withdrawal;

(2) Whether the withdrawing carrier's policy or contractholders would be able to replace their health benefits plan with the same or similar plan offered by another carrier at a comparable rate;

(3) Whether the withdrawing carrier reported net paid losses in the preceding two-year period;

(4) Whether a carrier's anticipated losses in the current calendar year would jeopardize its financial solvency;

(5) Whether an affiliated carrier intends to continue to offer individual health benefits plans;

(6) Whether the withdrawing carrier intends to continue to offer health benefits plans in New Jersey, or in other states; and

(7) Any other factors deemed relevant and appropriate by the Commissioner.

3. The Commissioner shall approve an application for market withdrawal unless it is determined, based on the factors listed in (d)2i(1) through (7) above, that the carrier's withdrawal would be unjust, unfair, inequitable, or contrary to law or public policy.

i. If the Commissioner approves an application for market withdrawal, the Department shall notify the carrier in writing and the carrier shall proceed to institute a withdrawal pursuant to (e) below.

ii. If the Commissioner disapproves an application for market withdrawal, the Department shall provide, in writing, the reasons for the disapproval. A carrier may appeal the Commissioner's determination and request a hearing within 20 days of receipt of written notification of the Commissioner.

(e) A carrier that has received approval of its application for market withdrawal shall:

1. Not more than 60 days after the date of the Department's approval letter, cease issuing individual plans;

2. Not less than 180 days in advance of the effective date of the nonrenewal on the anniversary date of the policy or contract, mail a notice, in the same format and with the same content submitted to and approved by the Department pursuant to (c)11 above, to every individual plan and pre-reform plan policy or contractholder, informing the policy or contractholder that the policy or contract will be nonrenewed on the anniversary date. This initial notice to each policy or contractholder shall include a copy of the Individual Health Coverage Buyer's Guide and current premium comparison chart. A carrier shall begin to send notices of nonrenewal not more than 60 days after the date of the Department's approval letter;

3. Following the mailing of the initial notice to each policy or contractholder, send a subsequent notice confirming the nonrenewal to each individual plan and pre-reform

plan policy or contractholder, which notice shall be included with a monthly premium bill or premium notice issued prior to the date of nonrenewal or, where no monthly premium statement is transmitted, at least 30 days prior to nonrenewal;

4. Not less than 180 days in advance of the effective date of the nonrenewal on the anniversary date of the policy or contract, mail a notice, in the same format and the same content submitted to and approved by the Department pursuant to (c)12 above, to the producer of record, if any, for each policy or contract; and

5. Not more than 10 days after receipt of the Department's approval letter, send a letter to the IHC Board at the address in N.J.A.C. 11:20-2.1, requesting to purchase copies of the IHC Program Buyer's Guide and price comparison chart and requesting a quantity sufficient to comply with the requirement that each policy or contractholder receive a copy of the Buyer's Guide and current premium comparison chart with the initial notice of nonrenewal. Alternatively, the carrier may arrange to obtain from the IHC Board a copy of the Buyer's Guide and price comparison chart to reproduce at its own cost a sufficient quantity of copies. Carriers shall not alter the text or format of the Buyer's Guide or premium comparison chart in any way.

11:20-18.6 General provisions for withdrawal of plan, plan option, or deductible/copayment option

(a) No carrier shall cease to issue or nonrenew an individual plan, plan option, or deductible/copayment option required or permitted to be offered by N.J.A.C. 11:20-3.1 until the carrier submits a notice of intent to withdraw a plan, plan option, or deductible/copayment option to the Department and the Commissioner approves such withdrawal in accordance with the provisions of this subchapter.

(b) A carrier may cease to issue and nonrenew an individual plan pursuant to this section only if:

1. The deductible/copayment option is not required to be offered pursuant to N.J.A.C. 11:20-3.1(b); or

2. In the case of a deductible/copayment option required to be offered pursuant to N.J.A.C. 11:20-3.1, the carrier meets its obligations to offer at least three standard individual plans and required deductible/copayment options either by offering the plans as indemnity plans or by making the plan or plans available through or in conjunction with a selective contracting arrangement to all New Jersey residents.

(c) A carrier may cease to issue and nonrenew a standard plan option pursuant to this section by offering another approved plan option. Examples of plan options include, but are not limited to, a carrier's option to offer autologous bone marrow transplant coverage in either the policy or contract or in a rider, and an HMO's option to offer plans subject to deductible and coinsurance provisions.

(d) A carrier that seeks to withdraw a plan, plan option, or deductible/copayment option pursuant to this section shall provide the Department with written notification of its intent to withdraw a plan, plan option, or deductible/copayment option. The notice of intent to withdraw a plan, plan option, or deductible/copayment option shall be sent to the Department at the address set forth in N.J.A.C. 11:20-6.4(a), and shall include the following information:

1. The name of the carrier;

2. The name, address, telephone number, and fax number of the carrier's representative responsible for the application for plan, plan option or deductible/copayment option withdrawal;

3. A specific description of the reasons the carrier is withdrawing the plan, plan option, or deductible/copayment option;

4. A statement of the number of in force plans affected by the withdrawal;

5. Copies of the carrier's most recent enrollment status report filed pursuant to N.J.A.C. 11:20-17;

6. Copies of a nonrenewal notice the applicant intends to send to its policy or contractholders. Nonrenewal notices for policy or contractholders shall contain the following information:

i. A statement that the carrier has elected to nonrenew the plan, plan option, or deductible/copayment option;

ii. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

iii. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of this subchapter;

iv. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

v. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan, plan option, or deductible/copayment option withdrawal; and

vi. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the plan, plan option, or deductible/copayment option withdrawal; and

7. Copies of the proposed nonrenewal notices the applicant intends to send to its producers. Nonrenewal notices for producers shall contain the following information:

i. A statement that the carrier has elected to nonrenew the plan, plan option, or deductible/copayment option;

ii. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

iii. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of this subchapter;

iv. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

v. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the withdrawal; and

vi. The date upon which the carrier will begin to cease to issue the plan, plan option, or deductible/copayment option.

(e) The Department shall review the notice of intent to withdraw a plan, plan option, or deductible/copayment option to determine whether it complies with the filing requirements of (d) above. The Department shall notify the carrier within 30 days of receipt of a notice of intent to withdraw a plan, plan option or deductible/copayment option, of any deficiencies and the requirements which are necessary to bring the notice into compliance with this section. The Department shall notify the carrier in writing that the withdrawal is either approved or disapproved.

(f) A carrier which has submitted a notice of intent to withdraw a plan, plan option, or deductible/copayment option shall:

1. Not more than 60 days following the Commissioner's approval of a plan, plan option, or deductible/copayment option withdrawal cease issuing the individual plan, plan option, or deductible/copayment option;

2. Not more than 60 days following the Commissioner's approval of a plan, plan option, or deductible/copayment option withdrawal, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, plan option, or deductible/copayment option, mail a notice, in the same format submitted to the Department pursuant to (d)6 above, to every policy or contractholder, informing the policy or contractholder that the plan, plan option, or deductible/copayment option will be nonrenewed on the anniversary date;

3. Following the initial notice to each policy or contractholder, send a subsequent notice confirming the nonrenewal to each policy or contractholder, which notice shall be included with a monthly premium bill or premium notice issued prior to the date of nonrenewal or, where no monthly premium statement is transmitted, send a notice at least 30 days prior to nonrenewal; and

4. Not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan or plan option, or deductible/copayment option, mail a notice, in the same format submitted to the Department pursuant to (d)7 above, to the producer of record, if any, for each policy or contract.

11:20-18.7 Restrictions on writings

A carrier that ceases to do business pursuant to N.J.A.C. 11:20-18.5 shall be prohibited from writing new individual plans and new small employer plans in New Jersey for a period of five years beginning on the termination date of the last standard individual health benefits plan not renewed.

11:20-18.8 Election to offer at least three plans, effect on in force-plans

(a) A carrier issuing all of the standard individual plans in the IHC market on and before January 4, 2009 that elects to offer at least three but not all of the standard individual plans after January 4, 2009, as permitted by N.J.S.A. 17B:27A-4b, that has in-force business in the plan or plans that it elects to no longer offer may:

1. Withdraw the plan or plans it elects to no longer offer pursuant to N.J.A.C. 11:20-18.6;

2. Convert the in-force business in the plan or plans it no longer offers pursuant to N.J.A.C. 11:20-24.7; or

3. Make a one-time election to continue to renew the in-force business in the plan or plans it chooses to no longer offer; provided:

i. The carrier notifies the Department in writing on or before March 1, 2009 of the plan or plans for which it will renew in-force business but which it will no longer offer; and

ii. The carrier does not withdraw such plan or plans pursuant to N.J.A.C. 11:20-18.6 until such time as the rate cap for in-force individual business established at N.J.S.A. 17B:27A-3a expires.

11:20-18.9 Other policy or contractholder rights unaffected

Nothing in this subchapter shall be construed to contravene any rights of policy or contractholders concerning other obligations set forth in a policy or contract issued by a carrier.

SUBCHAPTER 19. PETITIONS FOR RULEMAKING

11:20-19.1 Scope

This subchapter shall apply to all petitions to the Board by interested persons to adopt a new rule, or amend or repeal any existing rule by the Board, pursuant to N.J.S.A. 52:14B-4(f).

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote the section.

11:20-19.2 Procedure for petitioner

(a) Any person who wishes to petition the Board to adopt a new rule or amend or repeal any existing rule shall submit to the Board, in writing, the following information:

1. Name, address, phone, fax, and email address of the petitioner;

2. The substance or nature of the rulemaking which is requested, which may include suggested text of the proposed new rule, amended rule or repealed rule;

3. The reasons for the request and the petitioner's interest in the request;

4. References to the statutory authority of the Board to take the requested action; and

5. A caption at the top of the document identifying it as a petition for rulemaking pursuant to N.J.S.A. 52:14B-4(f) and this subchapter.

(b) The petition shall be sent to the Executive Director at the address in N.J.A.C. 11:20-2.1(h).

(c) Within 30 days of its receipt of a petition for rulemaking, the Board shall review the same to ascertain if the submission complies with the requirements of (a) above and, in the event that the Board determines that the submission is not in substantial compliance with (a) above, the Board shall notify the petitioner of such noncompliance and of the particular deficiency or deficiencies in the submission on which the decision of the Board was based. The Board shall also advise the petitioner that any deficiencies may be corrected and the petition may be resubmitted for further consideration.

(d) Any document submitted to the Board which is not in substantial compliance with (a) above shall not be deemed to be a petition for rulemaking requiring further Board action pursuant to N.J.S.A. 52:14B-4(f).

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (a), recodified (b)-(c) as (c)-(d), added new (b); in former (c), substituted "rulemaking" for "a rule".

11:20-19.3 Procedure of the Board

(a) Upon receipt of a petition in compliance with N.J.A.C. 11:20-19.2, the Board shall file, within 15 days, a notice of petition with the Office of Administrative Law for publication in the New Jersey Register. The notice shall include:

1. The name of the petitioner;

2. The substance or nature of the rulemaking action which is requested;

3. The problem or purpose which is the subject of the request; and

4. The date the petition was received.

(b) Within 60 days of receiving the petition in compliance with N.J.A.C. 11:20-19.2, the Board shall mail to the petitioner, and file with the Office of Administrative Law for publication in the New Jersey Register, a notice of action on the petition which shall include:

1. The name of the petitioner;

2. The New Jersey Register citation for the notice of petition, if that notice appeared in a previous New Jersey Register;

3. Certification by the Board that the petition was duly considered pursuant to law;

4. The nature or substance of the Board's action upon the petition; and

5. A brief statement of reasons for the Board's action.

(c) The Board's action on a petition may include:

1. Denying the petition and providing a written statement of the Board's reasons to the petitioner, and including such reasons in its notice of action;

2. Granting the petition and initiating a rulemaking proceeding within 90 days of the granting of the petition; or

3. Referring the matter for further deliberations which shall be concluded within 90 days of referring the matter for further deliberations. Upon conclusion of such further deliberations, the Board shall either deny the petition and provide a written statement of its reasons or grant the petition and initiate a rulemaking proceeding within 90 days.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), revised the timeframe in which the Board shall respond to a petition for rulemaking from 30 to 60 days; rewrote (c).

SUBCHAPTER 20. APPEALS FROM ACTIONS OF THE BOARD

11:20-20.1 Scope

This subchapter shall apply to all appeals from Board determinations and requests for hearing as expressly provided pursuant to this chapter.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote the section.

11:20-20.2 Appeals procedures

(a) A member may request a hearing on a final determination by the Board within 20 days from the date of receipt of such final determination as expressly permitted by this chapter as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, daytime telephone number, and fax number of a contact person familiar with the matter;

ii. A copy of the Board's determination;

iii. A statement requesting a hearing; and

iv. A concise statement listing the disputed adjudicative facts warranting a hearing and describing the basis for the member's contention that the Board's findings of fact are erroneous.

2. The Board, after receipt of a properly completed request for a hearing, may provide for an informal conference between the member and the staff and/or members of the Board, to determine whether there are disputed adjudicative facts.

3. The Board shall, within 30 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

i. If the Board finds that the matter constitutes a contested case, it may transmit the matter to the Office of Administrative Law for a hearing consistent with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

ii. If the Board finds that the matter does not constitute a contested case, it may, with the approval of the Director of the Office of Administrative Law, transmit the matter to the Office of Administrative Law for a hearing consistent with N.J.A.C. 1:1-21.

iii. If the Board finds that there are no good-faith disputed adjudicative facts and the matter may be decided on the documents filed, the Board may notify the applicant in writing as to the final disposition of the matter.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), rewrote the introductory paragraph and 1iv; in (a)2, substituted "disputed adjudicative facts" for "material issues of fact in dispute"; in (a)3, substituted "30" for "45" in the introductory paragraph, rewrote i and ii, and added iii.

SUBCHAPTER 21. (RESERVED)

SUBCHAPTER 22. BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN

11:20-22.1 Purpose and scope

(a) This subchapter implements provisions of P.L. 2001, c.368 (N.J.S.A. 17B:27A-4.4 through 4.7), an Act that supplements the Individual Health Insurance Reform Act, P.L. 1992, c. 161. This subchapter establishes procedures and standards for carriers to meet their obligations under P.L. 2001, c.368, and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the P.L. 2001, c.368. The other subchapters in this chapter should be consulted for procedures and standards that also have application to the basic and essential health care services plan required by P.L. 2001, c.368.

(b) The provisions of this subchapter shall be applicable to all carriers that are members of the Individual Health Coverage Program, as the term "member" is defined in N.J.A.C. 11:20-1.2 and N.J.S.A. 17B:27A-2.

(c) The provisions of this subchapter shall be applicable to the marketing, sale, issue and administration of all basic and essential health care services plans.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), in the last sentence, substituted "The" for "Carriers should consult the" and added "should be consulted" following "in this chapter"; in (b), added quotes around the word "member" and changed the N.J.A.C. reference; in (c), deleted "on or after January 1, 2003" at the end of the paragraph.

11:20-22.2 Definitions

Words and terms contained in N.J.S.A. 17B:27A-2 et seq., when used in this chapter, shall have the meanings as defined in the N.J.S.A. 17B:27A-2 et seq., and N.J.A.C. 11:20-1.2 unless the context clearly indicates otherwise, or as such words and terms are further defined by this subchapter, as follows:

"Copayment" means a specified dollar amount which a person covered under a basic and essential health care services plan must pay for certain charges covered under such plan. A covered person may be required to pay an amount in excess of the copayment if the charge the provider bills exceeds the reasonable and customary charge.

"Good faith effort" means the demonstrated efforts a carrier undertakes to make the basic and essential health care services plan available to residents of New Jersey, as evaluated by the Board pursuant to the standards set forth in this subchapter.

"Modified community rated" means that the premium for all persons covered under a health benefits plan contract is the same, based on the experience of all persons covered by that contract, except that a rate differential may be applied on the basis of age, gender and geography, as detailed in section 2.c of P.L. 2001, c.368, and in this subchapter.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In the introductory paragraph, updated the N.J.A.C. reference.

11:20-22.3 Obligation to offer a basic and essential health care services plan

(a) Every member that writes individual health benefits plans in New Jersey shall offer the basic and essential health care services plan through December 31, 2013. No member shall offer the basic and essential healthcare services plan as of January 1, 2014, or thereafter.

(b) Members that write individual health benefits plans as HMO coverage and as indemnity coverage may choose to offer the basic and essential health care services plan as an HMO plan or as an indemnity plan and are not required to write the plan as both an HMO plan and as an indemnity plan. Carriers that choose to offer the basic and essential health care services plan as an indemnity plan may include provisions to create an indemnity-based preferred provider organization (PPO) plan or an exclusive provider organization (EPO) plan.

Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Rewrote (a).

11:20-22.4 (Reserved)

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).
In (a)2i and ii, added "and" at the end; in (b), substituted "Exhibit F" for "Exhibit V" and "Exhibit E" throughout".
Repealed by R.2009 d.45, effective December 29, 2008 (operative April 20, 2009).
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b), 41 N.J.R. 1875(a).
Section was "Filing the basic and essential health care services plan policy form".

11:20-22.5 Riders to amend the basic and essential health care services plan

(a) Members may develop optional benefit riders to amend the basic and essential health care services plan provided the riders increase the benefits provided under the basic and essential health care services plan and do not contain any feature that would represent a decrease in the coverage or the actuarial value of the plan. The enhanced or additional rider benefits must be included in a manner which will avoid adverse selection to the extent possible. No new optional benefit riders may be developed after December 31, 2013.

(b) Before a member may offer or issue a rider to amend the basic and essential health care service plan, the member shall file the rider with the Board for approval. The member shall submit:

1. A copy of the rider to amend the basic and essential health care services plan to the Board at the address specified at N.J.A.C. 11:20-2.1(h);

2. A copy of the provision from the basic and essential health care services plan that the rider is amending, notated to highlight the area of the change;

3. A certification signed by a duly authorized officer of the member that states clearly that:

i. The member shall make the basic and essential health care services plan available to residents of New Jersey and will make a good faith effort to market the plan both with and without the rider;

ii. Rates for the rider amending the basic and essential health care services plan have been submitted pursuant to the requirements of N.J.A.C. 11:20-6;

iii. The rider increases a benefit or benefits and does not decrease any benefits or the actuarial value of the basic and essential health care services plan;

iv. The member shall offer the rider in a manner which will avoid adverse selection to the extent possible;

v. None of the ridered benefits exceed the benefits in the standard Plan A/50 through Plan D plans, or HMO plan, as applicable (benefits would include any benefits set forth in the standard Plan A/50 through Plan D "Covered Charges" or "Charges Covered with Special Limitations" sections of the policy or set forth in the standard HMO "Covered Services and Supplies" section of the contract); and

vi. If an HMO, none of the ridered benefits are provided with a copayment that is lower than the lowest HMO copayment option allowed by the Board's rules; and

4. A comprehensive list of benefits in the proposed rider compared with the carrier's standard A/50 through D plan or standard HMO plan, as applicable.

(c) The Board shall notify a member in writing of its determination whether the rider filing is approved within 30 days of the date the filing is received. If the Board does not notify a member of its determination with respect to the filing within 30 days of the date the filing is received, the filing shall be deemed approved.

(d) A member seeking to challenge the Board's disapproval of a rider filing must do so within 20 days of receiving the notice of the disapproval pursuant to the procedures for appeals set forth at N.J.A.C. 11:20-20.2.

(e) A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) no

later than 60 days following the close of each calendar quarter. The final quarterly report shall be due March 1, 2015.

1. For standard indemnity plans, standard PPO plans, standard POS plans, standard HMO plans, basic and essential health care services plans issued without a rider, and all basic and essential health care services plans issued with a rider, the carrier shall submit, for each type of plan:

i. Earned premium for the calendar quarter;

ii. Paid claims for the calendar quarter;

iii. New business enrollment reporting both the number of contracts and number of lives for the calendar quarter, which shall include the enrollment of persons who applied for and were issued coverage, whether or not the persons were new customers to the carrier or had coverage under other plans issued by the carrier and terminated the prior plans in favor of the plan for which application was made; and

iv. Total enrollment (total in force) reporting both number of contracts and number of lives as of the last day of the calendar quarter.

(f) A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) no later than 90 days following the close of the calendar year. The final annual report shall be due April 1, 2015.

1. For standard indemnity plans, standard PPO plans, standard POS plans, standard HMO plans, basic and essential health care services plans, plans issued without a rider, and all basic and essential health care services plans issued with a rider, the carrier shall submit, for each type of plan:

i. Earned premium for the calendar year; and

ii. Incurred claims for the calendar year.

(g) The Board shall evaluate the filings to determine whether the carrier has avoided adverse selection to the extent possible.

(h) If the Board finds that a carrier's rider has resulted in adverse selection, then the carrier shall cease issuing the rider within 60 days of receipt of the Board's written determination letter, but shall continue to renew the plan and rider for contractholders that had already purchased the plan with the rider.

(i) A member seeking to challenge the Board's finding that the rider has resulted in adverse selection must do so within 20 days of receiving the Board's written determination pursuant to the procedures for appeals set forth at N.J.A.C. 11:20-20.2.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (b)1, substituted "A" for "One"; in (b)3, added iv-vi; added (b)4; added (d)-(i).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In (e)1 and (f)1, inserted ", standard POS plans".
Amended by R.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).

In (e)1iv, substituted a period for "; and" at the end; and deleted (e)2.
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).

In (a), inserted the last sentence; in the introductory paragraph of (e), inserted "than" and the last sentence; and in the introductory paragraph of (f), substituted ". The final annual report shall be due April 1, 2015." for a colon at the end.

11:20-22.6 Good faith effort to market the basic and essential health care services plan

(a) In order for the Board to determine whether a member has made a good faith effort to market the basic and essential health care services plan, as required by section 2g of P.L. 2001, c.368 (N.J.S.A. 17B:27A-4.5g), every member shall submit to the Board, at the address specified at N.J.A.C. 11:20-2.1(h), on or before May 1 of each year a report detailing the activities the member undertook during the prior calendar year to market the basic and essential health care services plan. Members may satisfy the requirement by marketing the plan as an HMO plan, a PPO plan, an EPO plan, or as an indemnity plan. The final report required under this section shall be due May 1, 2014.

(b) The report shall include only those marketing activities which were in direct support of the sale of the basic and essential health care services plan during the prior year, even if the effective date of the policy issued as a result of the activities was in the reporting year.

(c) The Board will review the report submitted by each member to determine whether the member has demonstrated that it made a good faith effort to market the basic and essential health care plan and provide written notice of its determination to the member within 45 days of a completed filing.

1. The Board will find that a carrier has marketed in good faith if:

i. The carrier provides evidence that that it has included the basic and essential health care services plan on the carrier's standard application in the prior calendar year;

ii. The carrier provides evidence that it has undertaken at least one marketing effort in direct support of the sale of the basic and essential health care services plan during the prior calendar year. Examples of marketing efforts include, but are not limited to: print media such as newspapers and magazines; marketing through licensed producers, where the efforts to encourage the producer to sell the plan can be demonstrated through use of notices, brochures, faxes or other communications advising the producers of the availability of the plan; or

information specific to the basic and essential health care services plan on the carrier's website. Members may undertake one or more of these marketing efforts, or may use any other method that is in direct support of the sale of the basic and essential health care services plan; and

iii. The carrier provides a certification in which it certifies that it either did or did not use any New Jersey individual market marketing materials during the prior year that identified a list of plan choices. If the carrier did use any marketing materials that included a list of plan choices, the carrier shall provide evidence that the basic and essential health care services plan was listed as one of the plan choices.

2. A member will be found to have not to have made a good faith effort if the report does not meet the standards set forth in (c)1 above or if the member fails to submit a report by May 1 of each year.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Rewrote (a); in (c)1ii, deleted "may" in the second sentence; in (c)1iii, substituted "provides a certification in which it certifies that it either did or did not use any" for "certifies whether it used any".
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
In (a), inserted the last sentence.

11:20-22.7 Penalties

Members found not to have demonstrated that they satisfied the requirement to make a good faith effort to market the plan will be subject to the provisions of N.J.S.A. 17B:30-1.

SUBCHAPTER 23. RULEMAKING; INTERESTED PARTIES; PUBLIC NOTICES; INTERESTED PARTIES MAILING LIST

11:20-23.1 Purpose and scope

(a) The purpose of N.J.A.C. 11:20-23.2 through 23.5 is to establish the procedures that the Board uses in rulemaking made pursuant to the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The purpose of N.J.A.C. 11:20-23.6 is to establish procedures for public notice regarding Board meetings. The purpose of N.J.A.C. 11:20-23.7 is to establish the procedures that the Board uses in placing parties and entities on the Board's in interested parties mailing list.

(b) N.J.A.C. 11:20-23.2 through 23.5 shall apply only to rulemaking of the Board made pursuant to New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and shall not apply to rules made pursuant to N.J.S.A. 17B:27A-16.1, a special rulemaking procedure set forth in the IHC Act. N.J.A.C. 11:20-23.7 shall apply to any person that wishes to be placed on the Board's interested parties mailing list.

11:20-23.2 Public notice regarding proposed rulemaking

(a) The Board shall provide the following types of public notice for rule proposals pursuant to the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30:

1. The rule proposal shall be filed with the Office of Administrative Law for publication in the New Jersey Register;

2. The notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the substance of the proposed rulemaking, shall be posted and made available electronically on the Department of Banking and Insurance web site at: http://www.njdobi.org and in the Department of Banking and Insurance's Library, which is located on the 1st Floor 20 West State Street, Trenton, NJ 08625.

3. The news media maintaining a press office in the State House Complex shall be provided notice of the rule proposal, as posted and made available electronically on the New Jersey Department of Banking and Insurance web site; and

4. Notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the substance of the proposed rulemaking, shall be made available to the Board's list of interested parties by e-mail or hard copy.

11:20-23.3 Extension of the public comment period

(a) The Board, pursuant to the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, may extend the time for submission of public comments on a proposed rulemaking, at its discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, shall extend the time for submission of public comments for an additional 30-day period, if, within 30 days of the publication of a notice of proposal, sufficient public interest is demonstrated in an extension of time to submit comments.

(c) The Board shall determine that a sufficient public interest for the purpose of extending the public comment period has been demonstrated if any of the following has occurred:

1. Comments received indicate a previously unrecognized impact on a regulated entity or persons; or

2. Comments received raise unanticipated issues related to the notice of proposal.

11:20-23.4 Conducting a public hearing

(a) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, may conduct a public hearing on a proposed rulemaking, at its discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, shall conduct a public hearing if sufficient public interest has been demonstrated.

(c) A person interested in having a public hearing held on a notice of proposal shall submit an application within 30 days following the publication of the notice of proposal in the New Jersey Register in a form prescribed by the Board, to the Executive Director at the address listed in N.J.A.C. 11:21-1.3. The application shall contain the following information:

1. The person's name, address, telephone number, agency or association (if applicable);

2. The citation and title of the proposed rule and the date the notice of proposal was published in the New Jersey Register; and

3. The reasons a public hearing regarding the notice of proposal is considered necessary pursuant to (d) below.

(d) The Board shall determine that sufficient public interest has been demonstrated for the purpose of holding a public hearing if the application demonstrates that additional data, findings and/or analysis regarding the notice of proposal are necessary for the Board to review prior to adoption of the proposal in order to ensure that the notice of proposal does not violate the intent of the statutory law.

11:20-23.5 Public notice of new rules, amendments, repeals or adoptions

The Board shall provide notice of new rules, amendments, repeals or adoptions by posting these rules on its website at http://www.nj.gov/dobi/reform.htm and to the news media maintaining a press office in the State House complex.

11:20-23.6 Public notice regarding board meetings

(a) The Board shall adopt an annual schedule of regular meetings to be held by it the following calendar year.

(b) The Board may schedule meetings in addition to those set forth in the annual schedule.

(c) The Board shall provide public notice for all meetings by:

1. Posting a notice at the office of the Secretary of State;

2. Posting a notice at the office of the Board at the address set forth at N.J.A.C. 11:20-2.1(h);

3. Posting of a notice on the Department of Banking and Insurance web site at: http://www.njdobi.org; and

4. Posting of the notice in two newspapers of general circulation designated by the Board.

11:20-23.7 Board mailing list of interested parties

(a) For the purpose of disseminating information about the IHC Program, including, but not limited to, information about meeting dates and rulemaking made pursuant to either the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. or N.J.S.A. 17B:27A-16.1, the Board shall maintain a mailing list of member carriers and other interested parties.

1. The mailing list of members shall be based upon the members addresses filed with its most recently filed Exhibit K Assessment Report.

i. Upon any change in name or mailing address, a member carrier shall notify the Board in writing no later than 10 days from the date the new name or address becomes effective.

ii. Unless the Board is notified otherwise as provided in (a)1i above, the name and mailing address of a member shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member.

2. Persons other than member carriers who wish to receive communications from the Board, including, but not limited to, proposed rules, actions and public notices, may send a written request to the IHC Board at the address set forth at N.J.A.C. 11:20-2.1(h) to be placed on the Board's mailing list as an interested party. Until the Board receives written notice of a change in name or address from an interested party, communications mailed to the name and address on file shall be deemed to be properly received. The Board shall not charge any fee for placement upon the mailing list, but the Board may charge a fee for copies of communications from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.

SUBCHAPTER 24. PROGRAM COMPLIANCE

11:20-24.1 Purpose and scope

(a) This subchapter sets forth the standards all carriers must meet in offering and issuing standard health benefits plans and standard health benefits plans with riders to eligible persons off the marketplace in New Jersey.

(b) This subchapter sets forth requirements with which carriers must comply in administering standard health benefits plans and standard health benefits plans with riders in New Jersey.

Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Rewrote the section.

11:20-24.2 Eligibility, issuance, and continued coverage

(a) The policyholder of a standard health benefits plan or a standard health benefits plans with rider shall be a resident, as defined at N.J.A.C. 11:20-1.2. A carrier may require reasonable proof of residency. A dependent of the policyholder may be a nonresident of New Jersey, but is not eligible to be covered under the policy if he or she resides outside of the United States.

(b) An eligible person may apply for coverage under a standard health benefits plan or standard health benefits plan with rider during:

1. The initial enrollment period;

2. An annual open enrollment period; or

3. A special enrollment period.

(c) An eligible person may apply for coverage under a catastrophic plan only if:

1. The person is either under 30 years old as of the date the coverage would take effect; or

2. The person has received a certificate of exemption through the marketplace.

(d) After obtaining coverage under a standard health benefits plan or standard health benefits plan with rider, a covered person may elect to retain his or her coverage if he or she later becomes eligible for or covered under Medicare.

(e) After obtaining coverage under a catastrophic plan, a covered person may elect to retain his or her coverage until the effective date of a marketplace redetermination of exemption eligibility that finds the person is no longer eligible for an exemption or until the end of the plan year in which the person attains age 30, whichever occurs first.

(f) A carrier shall issue a standard health benefits plan or standard health benefits plan with rider to any eligible person who requests it and pays the premiums therefor, except that an HMO carrier may refuse to issue coverage to an eligible person that does not live in the carrier's approved service area, and except as provided in N.J.A.C. 11:20-11 and 12.

Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
In (b), inserted "or a group health plan".
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Section was "Eligibility and issuance". Rewrote the section.

11:20-24.2A Triggering events that result in special enrollment periods

(a) A special enrollment period begins on the date of the triggering event and continues for 60 days. During this period, an eligible person may apply for coverage for himself or herself and his or her eligible dependents.

(b) The dates listed below are triggering events. A loss of coverage resulting from nonpayment of premium, fraud, or misrepresentation of material fact shall not be a triggering event.

1. The date the eligible person loses eligibility for minimum essential coverage, or the eligible person's dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan (QHP) by the marketplace;

2. The date a dependent child's coverage ends as a result of attaining age 26 whether or not the dependent is eligible for continuing coverage in accordance with Federal or State laws;

3. The date a dependent child's coverage under a parent's group plan ends as a result of attaining age 31;

4. The effective date of a marketplace redetermination of an eligible person's subsidy, including a determination that an eligible person is newly eligible or no longer eligible for a subsidy;

5. The date an eligible person acquires a dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care;

6. The date an eligible person who is covered under a standard health benefits plan or standard health benefits plan with rider or group health benefits plan moves out of that plan's service area;

7. The date of a marketplace finding that it erroneously permitted or denied an eligible person enrollment in a qualified health plan (QHP); and

8. The date the eligible person demonstrates to the marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

(c) For purposes of 2014 only, enrollment in a non-calendar year standard health benefits plan, standard health benefits plan with rider, basic and essential health care services plan, or basic and essential healthcare service plan with rider creates a limited enrollment period 30 days prior to the date the policy year ends. If an eligible person does not make a selection of new coverage before the policy year ends, the eligible person shall be considered to have experienced a loss of minimum essential coverage, as stated in (b)1 above, as of the date the policy year ends.

(d) The carrier may require proof of the triggering events listed in (b) above.

New Rule, R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).

11:20-24.3 Payment of premium

(a) A carrier may offer a credit card or debit card payment option or an automatic checking withdrawal option to individuals for the monthly or quarterly payment of premiums. In the event that a carrier elects to offer an automatic checking withdrawal option, the carrier shall offer the same option to all individuals.

(b) A carrier may offer a discount to individuals that pay premium on a quarterly basis.

(c) A carrier shall accept payment in the form of a check, a money order, a cashier's check, or cash.

Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
In (a), inserted "or debit card".

11:20-24.4 Effective date of coverage

(a) A carrier, prior to issuing an individual health benefits plan, may require the following:

1. A completed individual application form;

2. Proof of the applicant's residency;

3. If a person is applying during a special enrollment period, evidence of the triggering event;

4. If a person is applying for a catastrophic plan and is not under age 30, a copy of the certificate of exemption from the marketplace; and

5. Premium payment not to exceed one month's premium, which shall be refunded to the individual if the health benefits plan is not issued by the carrier.

(b) With respect to applications submitted during the initial open enrollment period, the effective date of coverage shall be January 1 if the application is received by December 31, 2013. The effective date will be the first of the following month for applications received January 1, 2014, through March 31, 2014. In addition, carriers may permit effective dates as of the 15th of the month.

(c) With respect to applications submitted during the annual open enrollment period, the effective date of coverage shall be January 1 of the following calendar year if the application is received prior to January 1. Whenever the annual open enrollment period extends beyond December 31, the effective date of coverage shall be the first of the month following the date the application is received. In addition, a carrier may permit effective dates as of the 15th of the month.

(d) With respect to applications submitted during the special enrollment period, the effective date of coverage shall be the 1st of the month following the date the carrier receives the application. In addition to the 1st of the month effective date, carriers may permit the effective date to be the 15th of the month following the date the carrier receives the application. However, the effective date of coverage issued following a triggering event of birth, adoption, including placement for adoption, or placement in foster care shall be the date of birth, adoption, or placement for adoption or the date of placement in foster care.

Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Added (d).
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Rewrote the section.
Amended by R.2014 d.190, effective November 17, 2014 (operative January 1, 2015).
See: 46 N.J.R. 2314(a), 46 N.J.R. 2416(b).
Rewrote (c).

11:20-24.5 Paying benefits

(a) Except as stated in (b) below for prosthetic and orthotic appliances, in paying benefits for covered services under the terms of the individual health benefits plans provided on an out-of-network basis by health care providers not subject to capitated or negotiated fee arrangements, carriers shall pay covered charges for services based on the allowed charges or actual charges except as required by applicable law including, but not limited to, N.J.A.C. 11:22-5.6(b). Allowed charge means a standard based on the Prevailing Healthcare Charges System profile for New Jersey or other state when services or supplies are provided in such state, published and available from the Ingenix, Inc., 12125 Technology Drive, Eden Prairie, Minnesota 55344.

1. The maximum allowed charge shall be the 80th percentile of the profile.

2. Carriers shall update their databases within 60 days after receipt of periodic updates released by Ingenix.

(b) In paying benefits for prosthetic and orthotic appliances as required by P.L. 2007, c. 345, reimbursement shall be at the same rate as reimbursement for such appliances under the Federal Medicare reimbursement schedule, whether the benefits are provided on a network or out-of-network basis. However, if the carrier's contract rate with a network provider of orthotic and prosthetic appliances exceeds the Medicare reimbursement rate, the carrier's contract rate should be paid.

Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Rewrote the introductory paragraph of (a); in (a)1, substituted "allowed" for "allowable" and deleted "based on" following "be"; and added (b).

11:20-24.6 Good faith effort to market individual health benefits plans

(a) In order for the Board to determine whether a member that is a small employer carrier as defined in N.J.S.A. 17B:27A-17 has offered and made a good faith effort to

market the standard health benefits plans pursuant to N.J.S.A. 17B:27A-19a, every small employer carrier shall submit to the Board, at the address specified at N.J.A.C. 11:20-2.1(h), on or before May 1 of each year, a report detailing the activities the small employer carrier undertook during the prior calendar year to market at least three of the standard health benefits plans, whether through the marketplace or off the marketplace, or in the case of a Federally qualified HMO, the standard individual HMO plan. If a member offers one or more standard health benefits plans with rider, the member may include information regarding efforts to market the standard health benefits plan with rider in the report.

(b) The report shall include only those marketing activities which were in direct support of the sale of individual health benefits plans whether through the marketplace or off the marketplace during the prior year, even if the effective date of the policy issued as a result of the activities was in the reporting year.

(c) The Board will review the report submitted by each member to determine whether the small employer carrier has demonstrated that it made a good faith effort to market the standard individual health benefits plans including standard health benefits plans with rider, if applicable, and provide written notice of its determination to the member within 45 days of a completed filing.

1. The Board will find that a small employer carrier has marketed in good faith if:

i. The carrier provides evidence that it listed at least three standard individual health benefits plans, or in the case of a Federally qualified HMO, the HMO plan, on the carrier's standard application for individual coverage in the prior calendar year; and

ii. The carrier provides evidence that it has undertaken at least one marketing effort in direct support of the sale of the standard individual health benefits plans or standard health benefits plans with rider during the prior calendar year. Examples of marketing efforts include, but are not limited to: print media such as newspapers and magazines; marketing through licensed producers, where the efforts to encourage the producer to sell the plan can be demonstrated through use of notices, brochures, faxes, or other communications advising the producers of the availability of the plans; or information specific to the standard individual health benefits plans on the carrier's website. Carriers may undertake one or more of these marketing efforts, or may use any other method that is in direct support of the sale of the standard individual health benefits plans.

2. A small employer carrier will be found to have not made a good faith effort if the report does not meet the standards set forth in (c)1 above or if the member fails to submit a report by May 1 of each year.

(d) Small employer carriers found not to have demonstrated that they satisfied the requirement to make a good faith effort to market the plans will be required to withdraw from the small employer market pursuant to N.J.A.C. 11:21-16 within 60 days following receipt of a determination from the Board that the carrier was found to have not made a good faith effort to market the standard individual health benefits plans.

New Rule, R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Rewrote (a), in (b), inserted "whether through the marketplace or off the marketplace"; in the introductory paragraph of (c), inserted "including standard health benefits plans with rider, if applicable,"; in (c)1i, inserted "and" at the end"; in (c)1ii, inserted "or standard health benefits plans with rider", inserted a comma following "faxes", and substituted a period for "; and" at the end; and deleted (c)1iii.

11:20-24.7 (Reserved)

New Rule, R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Repealed by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Section was "Conversion of in force contracts".

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: [January 1, 2016]]
[Note to Carriers: Omit Effective Date here if included below]

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]

[[Covered Person]: Jane Doe
Identification Number: 125689
Effective Date: January 1, 2016
[Product Name: XXXX]]
[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 [PLAN A/50]

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and	
lead screening for children	NONE
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
For all other Covered Charges	
Per Covered Person	[dollar amount not to exceed Maximum Out of Pocket Amount]
Per Covered Family	[2 times per Covered Person dollar amount]

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. 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%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and	
Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[an amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per Calendar Year	[an amount equal to 2 times the per Covered Person amount]

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

SCHEDULE OF INSURANCE [PLAN B]

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and	
lead screening for children	NONE
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
For all other Covered Charges	
Per Covered Person	[dollar amount not to exceed Maximum Out of Pocket Amount]
Per Covered Family	[2 times per Covered Person dollar amount]

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. 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%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and	
Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[an amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year	[an amount equal to 2 times the per Covered Person amount]

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

SCHEDULE OF INSURANCE **[PLAN C]**

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and	
lead screening for children	NONE
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
For all other Covered Charges	
Per Covered Person	[dollar amount not to exceed Maximum Out of Pocket Amount]
Per Covered Family	[2 times per Covered Person amount]

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. 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%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and	
Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[an amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year	[an amount equal to 2 times the per Covered Person amount]]

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

SCHEDULE OF INSURANCE **[PLAN D]**

Calendar Year Cash Deductible	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
For all other Covered Charges	
Per Covered Person	[dollar amount not to exceed Maximum Out of Pocket Amount]
Per Covered Family	[2 times per Covered Person dollar amount]
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. 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%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other Covered Charges	[20%] [10%]

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

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

Per Covered Person per Calendar Year	[an amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year	[an amount equal to 2 times the per Covered Person amount]

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

SCHEDULE OF INSURANCE **Example High Deductible health plan text that could be used in conjunction with an 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
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE

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%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
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:

[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	**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
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
for all other Covered Charges	
Per Covered Person	[dollar amount not to exceed the amount permitted by N.J.A.C. 11:20-3.1(b)3i]
Per Covered Family	[2 times per Covered Person dollar amount]
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

Per Covered Person	[Dollar amount equal to 2 times the network deductible]
Per Covered Family	[Dollar amount equal to 2 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. 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.

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

For Preventive Care:	0%
For Prescription Drugs	[30%]
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
• if treatment, services or supplies are given by a Network Provider	10%
• if treatment, services or supplies are given by a Non-Network Provider	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. 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 covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. 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.

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

Per Covered Person per Calendar Year	[An amount not to exceed 2 times the Network maximum]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the Covered Person maximum]

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

SCHEDULE OF INSURANCE **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	[dollar amount not to exceed $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	[dollar amount not to exceed the amount permitted by N.J.A.C. 11:20-3.1(b)3i]
Per Covered Family	[2 times per Covered Person dollar amount]]

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
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
for all other Covered Charges	
Per Covered Person	[Dollar amount equal to 2 times the Network Deductible]
Per Covered Family	[Dollar amount equal to 2 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. 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.

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

For Preventive Care:	0%
For Prescription Drugs	[30%]
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	10%
• if treatment, services or supplies are given by a Non-Network Provider	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. 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 covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. 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.

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

Per Covered Person per Calendar Year	[An amount not to exceed 2 times the network maximum]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person maximum]

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

SCHEDULE OF INSURANCE

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 — [dollar amount not to exceed $50]
Maternity Care (pre-natal visits) — NONE

Calendar Year Cash Deductible
For treatment, services and supplies given by a **Network** or **Non-Network** Providers, except for services listed in the Copayment section
Per Covered Person — [dollar amount not to exceed the amount permitted by N.J.A.C. 11:20-3.1(b)3i]
Per Covered Family — [2 times per Covered Person dollar amount]

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. 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.

The **Coinsurance** for this Policy is as follows:
For Preventive Care: — 0%
For Prescription Drugs — [30%]
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)
V2500 – V2599 Contact Lenses — [50%]
Optional lenses and treatments — [50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)
Preventive, Diagnostic and Restorative services — 0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services — [20%]
Orthodontic Treatment — [50%]]
For all other services and supplies:
• if treatment, services or supplies are given by a Network Provider — 10%
• if treatment, services or supplies are given by a Non-Network Provider — 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. 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.
The **Network Maximum Out of Pocket** for this Policy is as follows:
Per Covered Person per Calendar Year — [An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year — [Dollar amount equal to 2 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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. 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.

The **Non-Network Maximum Out of Pocket** for this Policy is as follows:
Per Covered Person per Calendar Year — [An amount not to exceed 2 times the network maximum]
Per Covered Family per Calendar Year — [Dollar amount equal to 2 times the per Covered Person maximum]
Note: The Non-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	[dollar amount not to exceed $50]
Maternity Care (pre-natal visits)	NONE
Hospital Confinement	[an amount equal to 10 times the above copayment per day, up to an amount equal to 5 times the per day copay per confinement, an amount equal to 10 times the per day copay 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 services listed under the Copayment section and Prescription Drugs	
Per Covered Person	[dollar amount not to exceed the amount permitted by N.J.A.C. 11:20-3.1(b)3i]
[Per Covered Family	[2 times per Covered Person amount]
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
second surgical opinion	NONE
for all other Covered Charges	
Per Covered Person	[Dollar amount equal to 2 times the Network Deductible]
[Per Covered Family	[Dollar amount equal to 2 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. 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.

The **Coinsurance** for the Policy is as follows:	
For Preventive Care:	0%
For Prescription Drugs	[30%]
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other services and supplies:	
• if treatment, services or supplies are given by a Network Provider	0%
• if treatment, services or supplies are given by a Non-Network Provider	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. 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 covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
[Per Covered Family per Calendar Year	[Dollar amount equal to 2 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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. 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.

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

Per Covered Person per Calendar Year	[An amount not to exceed 2 times the Network Maximum]
[Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person Maximum.]

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

SCHEDULE OF INSURANCE **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	NONE
for immunizations and lead screening for children	NONE
Maternity Care (pre-natal visits)	NONE
for all other Covered Charges	
Per Covered Person	[dollar amount not to exceed the amount permitted by N.J.A.C. 11:20-3.1(b)3i]
Per Covered Family	[2 times per Covered Person dollar amount]

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
second surgical opinion	NONE
for all other Covered Charges	
Per Covered Person	[Dollar amount equal to 2 times the network deductible]
Per Covered Family	[Dollar amount equal to 2 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. 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.

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

For Preventive Care:	0%
For Prescription Drugs	[30%]
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%

Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
• if treatment, services or supplies are given by a Network Provider	10%
• if treatment, services or supplies are given by a Non-Network Provider	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. 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 covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. 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.

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

Per Covered Person per Calendar Year	[An amount not to exceed 2 times the Network Maximum]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person Maximum.]

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

SCHEDULE OF INSURANCE **EXAMPLE EPO (with PCP Copayment)**

IMPORTANT: Except in case of Emergency <u>all</u> services and supplies must be provided by a Network Provider.

Copayment

Primary Care Physician Visits	[dollar amount not to exceed $50]
[Specialist Visits	an amount not to exceed $75]
[Telemedicine Visits	[dollar amount not to exceed $50]]
[E-Visits	[dollar amount not to exceed $50]]
[Virtual Visits	[dollar amount not to exceed $50]]
Maternity Care(pre-natal visits)	NONE
[All [other] Practitioner Visits	an amount not to exceed $50 if PCP; $75 if specialist and subject to N.J.A.C. 11:22-5.5(a)11 for other practitioners]
[Hospital Confinement	[an amount equal to 10 times the above PCP copayment per day, up to an amount equal to 5 times the per day copay per confinement, an amount equal to 10 times the per day copay per Calendar Year]]

Calendar Year Cash Deductible

For treatment, services and supplies for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
[for Prescription Drugs	NONE, $250]
for visits subject to copayment	NONE
for all other Covered Charges	

Per Covered Person	[dollar amount not to exceed the amount permitted by N.J.A.C. 11:20-3.1(b)3i]
Per Covered Family	[2 times per Covered Person dollar amount]

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.
[Note, this Policy limits the amount a Covered Person is required to pay for each 30-day supply of a prescription. See the Prescription Drug Coinsurance Limit.]

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

For Preventive Care:	0%
For Primary Care Physician Visits	0%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For treatment, services or supplies given by any other Network Provider	[20%, 30%, 40%, 50%][, **except as stated below**]
[For Prescription Drugs	50%] [See the Prescription Drug Coinsurance Limit below.]
[For Prescription Drugs	
Generic Drugs	an amount not to exceed $25 per 30 day supply
Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit]
Non-Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit]]

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

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

Per Covered Person per Calendar Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the per Covered Person maximum]

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

[Prescription Drug Coinsurance Limit:	[$125] per 30 day supply]
[Prescription Drug Coinsurance Limit:	
Preferred Drugs	[$125] per 30 day supply
Non-Preferred Drugs	[$250] per 30 day supply]

SCHEDULE OF INSURANCE **EXAMPLE EPO (with Copayments for most services)**

IMPORTANT: Except in case of Emergency <u>all</u> services and supplies must be provided by a Network Provider.

Calendar Year Cash Deductible	
For treatment, services and supplies for Preventive Care	NONE
for immunizations and lead screening for children	NONE
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
[for Prescription Drugs	NONE, [$250]]
for all other Covered Charges	
Per Covered Person	[dollar amount not to exceed the amount permitted by N.J.A.C. 11:20-3.1(b)3i]]
Per Covered Family	[an amount equal to 2 times the per covered person amount]

Copayment
The following copayments apply after the Cash Deductible is satisfied.

For Preventive Care	NONE
Primary Care Physician (PCP) Visits [when care is provided by a Member's pre-selected PCP]	[dollar amount not to exceed $50]
Primary Care Physician (PCP) Visits [when care is not provided by a Member's pre-selected PCP]	[dollar amount not to exceed $50]
[Specialist Visits	an amount not to exceed $75]
[Maternity Care (Pre-natal visits)	NONE
[All [other] Practitioner Visits	an amount not to exceed $50 if PCP; $75 if specialist and subject to N.J.A.C. 11:22-5.5(a)11 for other practitioners]
[Hospital Confinement	[an amount equal to 10 times the above pre-selected PCP copayment per day, up to an amount equal to 5 times the per day copay per confinement, an amount equal to 10 times the per day copay per Calendar Year]]
Home Health Care	an amount consistent with N.J.A.C. 11:22-5.5(a)11
[Complex Imaging Services	[$100] per service]
[[All other] Radiology Services	[$50, 75] per service]
[Laboratory Services	None]
[Emergency Room Visit	$100]
[Outpatient Surgery	$250]
[Inpatient Surgery	$500]
[Prescription Drugs]	
[Retail Pharmacy	
For Generic Drugs	not to exceed amount specified in N.J.A.C. 11:22-5.5] per 30-day supply
For Brand Name Drugs	not to exceed amount specified in N.J.A.C. 11:22-5.5] per 30-day supply]
[Mail Order Pharmacy	
For Generic Drugs	not to exceed amount permitted by N.J.A.C. 11:22-5.5] per 90-day supply
For Brand Name Drugs	not to exceed amount permitted by N.J.A.C. 11:22-5.5] per 90-day supply]
[Retail Pharmacy	
For Generic Preferred Drugs	not to exceed amount specified in N.J.A.C. 11:22-5.5] per 30-day supply
For Brand Name Preferred Drugs	not to exceed amount specified in N.J.A.C. 11:22-5.5] per 30-day supply]
For Brand Name Non-Preferred Drugs	not to exceed amount specified in N.J.A.C. 11:22-5.5] per 30-day supply]
[Mail Order Pharmacy	
For Generic Preferred Drugs	not to exceed amount permitted by N.J.A.C. 11:22-5.5] per 90-day supply
For Brand Name Preferred Drugs	not to exceed amount permitted by N.J.A.C. 11:22-5.5] per 90-day supply]
For Brand Name Non-Preferred Drugs	not to exceed amount specified in N.J.A.C. 11:22-5.5] per 90-day supply]

[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)

Eye exam (one per Calendar Year)	NONE
Eyeglass lenses (one pair per Calendar Year)	NONE
Standard frames (one pair per 12 month period)	NONE
Standard contact lenses	$100]

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.

[Note, this Policy limits the amount a Covered Person is required to pay for each 30-day supply of a prescription. See the Prescription Drug Coinsurance Limit.]

The **Coinsurance** for this Policy is as follows:	
For Preventive Care:	0%
For Primary Care Physician Visits	0%
For treatment, services or supplies given by a Network Provider	[0 %, 20%, 30%, 40%, 50%][, **except as stated below**]
[For Prescription Drugs	50%] [See the Prescription Drug Coinsurance Limit below.]
[For Prescription Drugs	
Generic Drugs	an amount not to exceed $25 per 30 day supply
Preferred Drugs	50%[;subject to Prescription Drug Coinsurance Limit]
Non-Preferred Drugs	50%[; subject to Prescription Drug Coinsurance Limit]]
[For Durable Medical Equipment	50%]

[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]

[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.

The **Maximum Out of Pocket** for this Policy is as follows:	
Per Covered Person per Calendar Year	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]
Per Covered Family per Calendar Year	[Dollar amount equal to 2 times the Covered Person maximum]

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

[Prescription Drug Coinsurance Limit:	$[125] per 30 day supply]

[Prescription Drug Coinsurance Limit:	
Preferred Drugs	$[125] per 30 day supply
Non-Preferred Drugs	$[250] per 30 day supply]

SCHEDULE OF INSURANCE **Example EPO High Deductible health plan text that could be used in conjunction with an HSA**

IMPORTANT: Except in case of Emergency <u>all</u> services and supplies must be provided by a Network Provider.

Calendar Year Cash Deductible for Preventive Care for immunizations and lead screening for children as detailed in the Immunizations and Lead Screening provision	NONE
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE

•for all other Covered Charges

[per Covered Person	[an amount to qualify as a high deductible health plan under Internal Revenue Code section 223]
[per Covered Family	[an amount to qualify as a high deductible health plan under Internal Revenue Code section 223]

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%
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
For all other Covered Charges	[20%, 30%, 40%, 50%][**,except as stated below.**]
[For Prescription Drugs	50%] [See the Prescription Drug Coinsurance Limit below

[For Prescription Drugs

Generic Drugs	an amount not to exceed $25 per 30 day supply
Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit]
Non-Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit]]

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:

[per Covered Person	[an amount permitted under Internal Revenue Code 223]
[per Covered Family	[an amount permitted under Internal Revenue Code 223]

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

[Prescription Drug Coinsurance Limit:	$[125] per 30 day supply]

[Prescription Drug Coinsurance Limit:

Preferred Drugs	$[125] per 30 day supply
Non-Preferred Drugs	$[250] per 30 day supply]

SCHEDULE OF INSURANCE **EXAMPLE EPO**

(Example EPO High Deductible health plan text that could be used in conjunction with an HSA using deductible followed by copays and 100% coinsurance)

IMPORTANT: Except in case of Emergency all services and supplies must be provided by a Network Provider.

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

second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
•for all other Covered Charges	
[per Covered Person	[an amount to qualify as a high deductible health plan under Internal Revenue Code section 223]
[per Covered Family	[an amount to qualify as a high deductible health plan under Internal Revenue Code section 223]

Copayment

The following copayments apply after the Cash Deductible is satisfied.

For Preventive Care	NONE
Primary Care Physician (PCP) Visits [when care is provided by a Member's pre-selected PCP]	[dollar amount not to exceed $50]
[Specialist Visits	an amount not to exceed $75]
[Maternity Care(pre-natal visits)	NONE
[Urgent Care Services	an amount consistent with N.J.A.C. 11:22-5.5(a)11]
[All [other] Practitioner Visits	an amount not to exceed $50 if PCP; $75 if specialist and subject to N.J.A.C. 11:22-5.5(a)11 for other practitioners]
[Complex Imaging Services:]	[an amount not to exceed $100 per service]
[[All other] Radiology Services	[$50, 75] per service]
[Laboratory services	None]
[Emergency Room Visit	$100]
[Outpatient Surgery	$250]
[Inpatient Surgery	$500]

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 Durable Medical Equipment	50%]
[Vision Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Covered Person turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
[For Prescription Drugs	50%] [See the Prescription Drug Coinsurance Limit below.]
[For Prescription Drugs	
Generic Drugs	an amount not to exceed $25 per 30 day supply
Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit]
Non-Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit]]
For all other Network services and supplies	0%

Maximum Out of Pocket

Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out

of Pocket. Once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.

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

Per Covered Person per Calendar Year:	[An amount not to exceed $[6,850 or amount permitted by 45 C.F.R. 156.130]]
Per Covered Family per Calendar Year:	[Dollar amount equal to 2 times the per Covered Person maximum.]

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

[Prescription Drug Coinsurance Limit: $[125] per 30 day supply]

[Prescription Drug Coinsurance Limit:

Preferred Drugs	$[125] per 30 day supply
Non-Preferred Drugs	$[250] per 30 day supply]

SCHEDULE OF INSURANCE **EXAMPLE EPO (Example Catastrophic Plan – single coverage)**

IMPORTANT: Except in case of Emergency <u>all</u> services and supplies must be provided by a Network Provider.

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
Maternity Care (pre-natal visits)	NONE
For three physician visits per year:	NONE
•for all other Covered Charges [per Covered Person	[the greatest amount permitted by section 223(c)(2)(A)(ii)(I)]

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%

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

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

Per Covered Person per Calendar Year:	[the greatest amount permitted by section 223(c)(2)(A)(ii)(I)]

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

SCHEDULE OF INSURANCE
Example EPO with a Tiered Network (Note to carriers: Dollar amounts are illustrative; amounts carriers include must be within permitted ranges. A Tiered Network design may be included with any of the plans that have network benefits.)

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

SERVICES	[Tier 1]	[Tier 2]
Calendar Year Cash Deductible for treatment services and supplies for:		
Preventive Care	NONE	NONE
Immunizations and Lead Screening for Children	NONE	NONE

SERVICES	[Tier 1]	[Tier 2]
Second Surgical opinion	NONE	NONE
Maternity care (pre-natal visits)	NONE	NONE
Prescription Drugs [Generic Drugs] [Preferred Drugs] [Non-Preferred Drugs]		[$250] [$50] [$100] [$150]
[All other Covered Charges Per Covered Person Per Covered Family *(Use above deductible for separate accumulation..)*	 $1,000 $2,000	 $1,500 $3,000]
[All other Covered Charges Per Covered Person Per Covered Family *(Use above if Tier 1 deductible can be satisfied independently; Tier 1 accumulates toward Tier 2)*	 $1,000 $2,000	 $2,500 $5,000
Copayment applies after the Cash Deductible is satisfied		
Preventive Care	NONE	NONE
Primary Care Physician	N/A See Tier 2	$30
Services	**Tier 1**	**Tier 2**
Visits [when care is provided by the pre-selected PCP]		
Specialist Visits [and PCP visits if the PCP was not pre-selected]	$30	$50
Maternity Care (Pre-natal visits)	NONE	NONE
All Other Practitioner Visits	N/A See Tier 2	$30
Hospital Confinement	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
Extended Care and Rehabilitation	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
[Complex Imaging Services See Definition	N/A See Tier 2	$100 per procedure]
[[All other] radiology services	N/A See Tier 2	$75 per procedure]
Laboratory Services	NONE	$30 per visit
Emergency Room Visit	$50	$100
Outpatient Surgery	$100	$250
Inpatient Surgery	$250	$500
Coinsurance (See definition below)		

SERVICES	[Tier 1]	[Tier 2]
Preventive Care	NONE	NONE
Prescription Drugs	N/A See Tier 2	50%
[Generic Drugs]		[10%]
[Preferred Drugs]		[20%]
[Non-Preferred Drugs]		[50%]
Durable Medical Equipment	N/A See Tier 2	50%
[Maximum Out of Pocket Per Calendar Year (See definition below)		
Per Covered Person	$2,000	$4,400
Per Covered Family *(Use above for separate accumulation.)*	$4,000	$8,800]
[Maximum Out of Pocket Per calendar Year (See definition below)		
Per Covered Person	$2,000	$6,850 or amount permitted by 45 C.F.R. 156.130
Per Covered Family	$4,000	
Use above if Tier 1 MOOP can be satisfied independently; Tier 1 accumulates toward Tier 2)		$13,200 or 2X per person amount]

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.

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

SCHEDULE OF INSURANCE (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.

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][including Specialty Pharmaceuticals][and certain injectable drugs]
- [Services and/or prescription drugs to enhance fertility]
- [Complex Imaging Services]
- [V2500 – V2599 Contact Lenses]]

[For more information regarding the services for which We require Pre-Approval, consult our website at [www.xxx.com]]

[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.]

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

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

Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech therapy per Calendar Year 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 Note: These services are habilitative services in that they are provided to help develop rather than restore a function. The 30-visit limit does not apply to the treatment of autism. (limit applies separately to each therapy and is in addition to the therapy visits listed above)	30 visits

[Charges for 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. If coverage is issued as an EPO delete the Preventive care limits text in its entirety

Charges for hearing aids for a Covered Person age 15 or younger	one hearing aid per hearing impaired ear per 24-month period

[Non-Network Vision benefits for a Covered Person through the end of the month in which he or she turns age 19 are subject to the following limits:

Exam	$30 per Calendar Year

Single Vision lenses	$25 per Calendar Year
Bifocal lenses	$35 per Calendar Year
Trifocal lenses	$45 per Calendar Year
Lenticular lenses	$45 per Calendar Year
Elective Contact lenses	$75 per Calendar Year
Medically Necessary Contact lenses	$225 per Calendar Year
Frames	$30 per Calendar Year]
Maximum Benefit (for all Illnesses and Injuries)	Unlimited

PREMIUM RATES

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

DEFINITIONS

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

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

Allowed Charge 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.

Annual open enrollment period means the designated period of time each year during which:
a) individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and

b) individuals who already have coverage may replace current coverage with a different standard health benefits plans or standard health benefits plan with rider.

[**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.]

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

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

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

Board means the Board of Directors of the New Jersey Individual Health Coverage Program, appointed and elected under the laws of New Jersey.
[Brand Name Drug means: a) a Prescription Drug as determined by the Food and Drug Administration; and b) protected by the trademark registration of the pharmaceutical company which produces them.]

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

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

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

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

[Complex Imaging Services means any of the following services:
a) Computed Tomography (CT),
b) Computed Tomography Angiography (CTA),
c) Magnetic Resonance Imaging (MRI),
d) Magnetic Resonance Angiogram (MRA),
e) Magnetic Resonance Spectroscopy (MRS)
f) Positron Emission Tomography (PET),
g) Nuclear Medicine including Nuclear Cardiology.]

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

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

Covered Charges are Allowed Charges for the types of services and supplies described in the **Covered Charges** 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."

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][through the end of the month in which he or she attains age 26].

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

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

In addition to the Dependent children described above, any other child over whom You have legal custody or legal guardianship [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.)
[Note to carriers: Text in brackets in the above paragraph may be deleted by carriers when selling coverage through the Marketplace that are concerned with covering such children in the absence of being able to apply the household requirement.]

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 and hearing aids which are covered through age 15. Items such as walkers, wheelchairs and hearing aids are examples durable medical equipment that are also habilitative devices.
Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

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

Eligible Person means a person who is a Resident of New Jersey who is not covered under Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. § 1395 et. seq.) (Medicare). [An eligible person must be a U.S. Citizen, National or lawfully present in the United States.]
Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of Substance Abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn child.

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

[E-Visit means a visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with [Carrier] to offer E-visit services and Covered Persons who are established patients of the Provider.]

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.

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

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

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

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

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

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

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

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

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

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

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

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

[**Mail Order Program** means a program under which a Covered Person can obtain Prescription Drugs from:
a) a Participating Mail Order Pharmacy by ordering the drugs through the mail or
b) a Participating Pharmacy that has agreed to accept the same terms, conditions, price and services as a Participating Mail Order Pharmacy.]

[**Maintenance Drug** means only a Prescription Drug used for the treatment of chronic medical conditions.]

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

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

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.

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

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

[Network] Provider means a Provider which has an agreement [directly or indirectly] with Us to provide Covered Services or Supplies. You will have access to up-to-date lists of [Network] Providers.

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

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

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

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

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

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

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

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

[Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is:
a) equipped to provide Prescription Drugs through the mail; or
b) is a Participating Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement.]

[Participating Pharmacy means a licensed and registered pharmacy operated by Us or with whom We have signed a pharmacy services agreement.]

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

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

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

Policyholder means the person who purchased this Policy.

Practitioner means a person We are required by law to recognize who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.
For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

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

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

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

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

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

Examples of preventive care include, but are not limited to: routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, 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. [Tribal Provider means those providers listed in 25 U.S.C. 1603, including the Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization.]

[**Referral** 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."

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

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

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

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

Schedule means the **Schedule of Insurance** contained in this Policy.

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a 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 (see Extended Care Center.)

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

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

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

Special enrollment period means a period of time that is no less than 60 days following the date of a triggering event during which:

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

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

[**Specialty Pharmaceuticals** are oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while under treatment. These Prescription Drugs [must be] [may be] dispensed through specialty pharmaceutical providers.

Examples of Prescription Drugs that are considered Specialty Pharmaceuticals include some orally administered anti-cancer Prescription Drugs and those used to treat the following conditions: Crohn's Disease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple

Sclerosis; Hepatitis C; Rheumatoid Arthritis; and Gaucher's Disease. [Carrier] will provide a complete list of Specialty Phamaceuticals. The list is also available on [Carrier's] website.

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

Substance Abuse means abuse of or addiction to drugs or alcohol.

Substance Abuse Centers are Facilities that mainly provide treatment for people with substance abuse 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; or
b) approved for its stated purpose by Medicare.

Surgery means:

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

[Telemedicine means a telephone consultation between a Provider that has contracted with [Carrier] to offer telemedicine services for Covered Persons.

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

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

a) The date an Eligible Person loses eligibility for minimum essential coverage, or the Eligible Person's Dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace.
b) The date a Dependent child's coverage ends as a result of attaining age 26 whether or not the Dependent is eligible for continuing coverage in accordance with federal or state laws.
c) The date a Dependent child's coverage under a parent's group plan ends as a result of attaining age 31.
d) The effective date of a marketplace redetermination of an Eligible Person's subsidy, including a determination that an Eligible Person is newly eligible or no longer eligible for a subsidy.
e) The date an Eligible Person acquires a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
f) The date an Eligible Person who is covered under an individual health benefits plan or group health benefits plan moves out of that plan's service area.
g) The date of a court order that requires coverage for an Eligible Person.
h) The date of a marketplace finding that it erroneously permitted or denied an Eligible Person enrollment in a qualified health plan.
i) The date the Eligible Person demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

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

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

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

[Virtual Visit means a visit with a Provider that has contracted with [Carrier] to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the Covered Person and the Provider.]

[We, Us, Our and **[Carrier]** mean [Carrier].]

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

ELIGIBILITY

Types of Coverage

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

- **Single Coverage** - coverage under this Policy for only one person.

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

Who is Eligible

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

You may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Policy, such a child may stay eligible for Dependent health benefits past this Policy's age 26 limit for eligible Dependents.
The child will stay eligible as long as the child is and remains unmarried and incapable of earning a living, if: a) the child's condition started before he or she reached this Policy's age limit; b) the child became covered under this Policy or any other policy or contract before the child reached the age limit and stayed continuously covered or covered after reaching such limit; and c) the child depends on You for most of his or her support and maintenance.

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

The child's coverage ends when Your coverage ends.

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

Adding dependents to this Policy

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

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

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

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

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

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

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

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

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

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

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

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

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The XYZ Health Care Network, and the [Carrier]

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to date lists of [XYZ Health Care Network] preferred providers. The up-to-date lists will be furnished automatically, without charge.

Use of the network is strictly voluntary, but We generally pay a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, We generally pay a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

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 provide 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.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to Us. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

This Policy also has utilization review features. See the **Utilization Review Features** section for details.

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

See the Schedule for specific benefit levels, payment rates and payment limits.

If You have any questions after reading Your Policy, You should call Us.

[[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 [Carrier's] 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 a PPO.]

POINT OF SERVICE PROVISIONS

[Use if referral is required.]

Definitions

a) ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects 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 provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies. [Network benefits are shown as [Tier 1] and [Tier 2].]
d) ***Non-Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.
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 requires that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits. The Covered Person will have access to up-to date lists of [XYZ] PO Providers.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

The Primary Care Practitioner (PCP)
The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person must obtain an authorized Referral from his or her PCP before he or she visits another Practitioner or Facility. Except in case of Urgent Care or an Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Non-Network Benefits.

We provide Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. We pay Non-Network Benefits when covered services and supplies are not authorized by the PCP. However, if the PCP obtains approval from Us and refers a Covered Person to a Non-Network Provider for a service or supply, the service or supply shall be covered as a Network service or supply and We are fully responsible for payment to the Provider and the Covered Person is only responsible for any applicable Network level Copayment, Coinsurance or Deductible for the service or supply.

If services or supplies are obtained from [XYZ] Providers even though they are not authorized by the PCP, the Covered Person will be eligible for Non-Network Benefits although the [XYZ] provider's charges and the Covered Person's liability are limited to the negotiated fee for the service or supply.]

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 PCP, he or she must present his or her ID card and pay the Copayment, if applicable. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment, if applicable, to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to Us.]

A female Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care without Referral from her PCP. She must obtain authorization from her PCP for other services.

Non-Network Services
If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. Except as stated below, for services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Non-Network Benefits. ***Exception***: 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 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, 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. [Network benefits are shown as [Tier 1] and [Tier 2].]
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.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

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.]

[EXCLUSIVE PROVIDER ORGANIZATION (EPO) PROVISIONS
[Use if referral is required.]

Definitions
a) ***Primary Care Provider*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] 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) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)
The Provider Organization for this Policy is the [XYZ] Provider Organization. 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. Except in the case of Urgent Care or a medical Emergency, a Covered Person must obtain covered services and supplies from Network PO Providers to receive benefits under this Policy. Services and supplies obtained from Providers that are not Network PO Providers will generally not be covered.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

The Primary Care Practitioner (PCP)
The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person must obtain an authorized Referral from his or her PCP before he or she visits another Practitioner or Facility. Except in case of Urgent Care or an Emergency, if the Covered Person does not comply with these requirements, he or she will not be eligible for benefits under this EPO policy.

We provide Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. If the PCP obtains approval from Us and refers a Covered Person to a Non-Network Provider for a service or supply, the service or supply shall be covered as a Network

service or supply and We are fully responsible for payment to the Provider and the Covered Person is only responsible for any applicable Network level Copayment, Coinsurance or Deductible for the service or supply.

If services or supplies are obtained from [XYZ] Providers but have not been authorized by the PCP, the Covered Person will not be eligible for 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 PCP, he or she must present his or her ID card and pay the Copayment, if applicable. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment, if applicable, to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to Us.]

A female Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care without Referral from her PCP. She must obtain authorization from her PCP for other services.

Emergency Services

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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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.

Service Area
[Carrier must include a description of the Service Area, as required by N.J.A.C. 11:24-17.3(a)11]

[[Different] providers in [Carrier's] Network have agreed to be paid [in different ways by [Carrier]. 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 [Carrier's] primary care physicians or any other Provider in [Carrier's] Network are compensated, please call [Carrier] 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 Indemnity EPO.]

[EXCLUSIVE PROVIDER ORGANIZATION (EPO) PROVISIONS
[Use if no referral is required.]

Definitions
a) ***Primary Care Provider*** (PCP) Under this Policy a Covered Person does not have to select a PCP, but is encouraged to do so. If selected, the PCP will supervise and coordinate the Covered Person's health care in the [XYZ Network] for example, by providing referrals to specialists. Even if a PCP is selected, a Covered Person can choose any specialist he or she wants to use. [Whether or not a PCP is selected any office visit to a PCP who qualifies as a PCP is subject to the applicable PCP copayment.] [But if a Covered Person goes to a Practitioner other than a selected PCP a higher copayment will generally apply.] [Carrier] 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) ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)
The Provider Organization for this Policy is the [XYZ] Provider Organization. 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. Except in the case of Urgent Care or a medical Emergency, a Covered Person must obtain covered services and supplies from Network PO Providers to receive benefits under this Policy. Services and supplies obtained from Providers that are not Network PO Providers will generally not be covered.

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]

The Primary Care Provider (PCP)
Under this Policy a Covered Person does not have to select a PCP, but is encouraged to do so. The PCP is available to supervise and coordinate the Covered Person's health care in the [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 applicable Copayment, if any. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to Us.]

Emergency Services

In the case of Urgent Care or an Emergency, a Covered Person may go to a [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 [Carrier] within 48 hours, or as soon as reasonably possible, [Carrier] 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.

Service Area
[Carrier must include a description of the Service Area, as required by N.J.A.C. 11:24-17.3(a)11]

[[Different] providers in [Carrier's] Network have agreed to be paid [in different ways by [Carrier]. 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 [Carrier's] primary care physicians or any other Provider in [Carrier's] Network are compensated, please call [Carrier] 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 Indemnity EPO.]
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 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 professional. In case of pregnancy of a Covered Person, coverage of services for the terminated health care professional shall continue to the postpartum evaluation of the Covered Person, up to six weeks after the delivery. With respect to pregnancy, Medical Necessity and Appropriateness shall be deemed to have been demonstrated.

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

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

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

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

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

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

HEALTH BENEFITS INSURANCE

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

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

BENEFIT PROVISION

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

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

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

Once the Cash Deductible is met, We pay benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what We pay is based on all the terms of this Policy.]
[Note to carriers: Use the above deductible text for indemnity plans that are not high deductible health plans that could be used in conjunction with an HSA.]

[This Policy has two different Cash Deductibles. One is for treatment, services or supplies given by a Network Provider. The other is for treatment, services or supplies given by a Non-Network Provider. Each Cash Deductible is shown in the Schedule.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Non-Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a Non-Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Neither Cash Deductible can be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet either Cash Deductible. What We pay is based on all the terms of this Policy.]

[Note to carriers: Use the above deductible text for PPO plans that are not high deductible health plans that could be used in conjunction with an HSA.]

[Please note: There are separate Cash Deductibles for [Tier 1] and [Tier 2] as shown on the Schedule of Insurance.]

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider. Each Cash Deductible is shown in the Schedule.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a [Tier 1] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a [Tier 2] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 2] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet either Cash Deductible. What We pay is based on all the terms of this Policy.]
(Use the above text if the Tier 1 and Tier 2 deductibles accumulate separately and independently.)

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider as well as for treatment, services or supplies given by a [Tier 1] Network that are applied to the [Tier 1] Deductible. Each Cash Deductible is shown in the Schedule.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a [Tier 1] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Each Calendar Year, the sum of the Covered Charges for each Covered Person for treatment, services or supplies from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before We pay benefits for [Tier 1] and [Tier 2] Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a [Tier 1] or a [Tier 2] Network Provider, while insured by this Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet either Cash Deductible. What We pay is based on all the terms of this Policy.]
(Use the above text if the Tier 1 deductible can be satisfied separately and allows a covered person to be in benefit for further Tier 1 covered charges and is also applied toward the satisfaction of the Tier 2 deductible.)

[Family Deductible Limit
This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once Covered Persons in a family meet the family Cash Deductible in a Calendar Year, We pay benefits for other Covered Charges incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What We pay is based on all the terms of this Policy.]
[Family Deductible Limit
The Family Deductible is a cumulative Deductible for all family members for each Calendar Year.

When the Covered Person and each covered Dependent incurs Covered Charges that apply towards the Individual Deductible, these Covered Charges will also count toward the Family Deductible Limit. The Family Deductible Limit can be met by a combination of family members with no single individual within the family contributing more than the individual deductible limit amount in a calendar year. Once this Family Deductible is met in a Calendar Year, We provide coverage for all Covered Charges for all Covered Persons who are part of the covered family, less any applicable Coinsurance or Copayment, for the rest of the Calendar Year.]

[Note to carriers, use one of the above text for Family Deductible Limit for a plan that is not a high deductible health plan that could be used in conjunction with an HSA.]

[Family Deductible Limit
This Policy has two different family deductible limits. One is for treatment, services or supplies given by a Network Provider. The other is for treatment services or supplies given by a Non-Network Provider.

There is a family deductible limit of two Cash Deductibles for Covered Charges for treatment, services or supplies given by a Network Provider for each Calendar Year. Once Covered Persons in a family meet two times the Cash Deductible for treatment, services or supplies given by a Network Provider, We pay benefits for other such Covered Charges incurred by any member of that covered family, less any applicable Coinsurance, or Copayments, for the rest of that Calendar Year.

There is a family deductible limit of two Cash Deductibles for Covered Charges for treatment, services or supplies given by a Non-Network Provider for each Calendar Year. Once Covered Persons in a family meet two times the Cash Deductible for treatment, services or supplies given by a Non-Network Provider, We pay benefits for other such Covered Charges incurred by any member of that covered family, less any applicable Coinsurance, or Copayments, for the rest of that Calendar Year.

What We pay is based on all the terms of this Policy.]
[Note to carriers, use one of the above text for Family Deductible Limit for a PPO plan that is not a high deductible health plan that could be used in conjunction with an HSA.]

[Family Deductible Limit
The Family Deductible is a cumulative Deductible for all family members for each Calendar Year.

Tier 1 Family Deductible Limit
When the Covered Person and each covered Dependent incurs Covered Charges that apply towards the Tier 1 Individual Deductible, these Covered Charges will also count toward the Family Deductible Limit. The Family Deductible Limit can be met by a combination of family members with no single individual within the family contributing more than the Tier 1 individual deductible limit amount in a calendar year. Once this Tier 1 Family Deductible is met in a Calendar Year, We provide coverage for all Tier 1 Covered Charges for all Covered Persons who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of the Calendar Year.

Tier 2 Family Deductible Limit
When the Covered Person and each covered Dependent incurs Covered Charges that apply towards the Tier 1 and Tier 2 Individual Deductible, these Covered Charges will also count toward the Family Deductible Limit. The Family Deductible Limit can be met by a combination of family members with no single individual within the family contributing more than the Tier 2 individual deductible limit amount in a calendar year. Once this Tier 2 Family Deductible is met in a Calendar Year, We provide coverage for all Tier 1 and Tier 2 Covered Charges for all Covered Persons who are part of the covered family, less any applicable Coinsurance or Copayments, for the rest of the Calendar Year.]

[Note to carriers: The above text may be used for plans that feature Tier 1 and Tier 2.]

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

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

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

[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. 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.

*[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 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. 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 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.

[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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. 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.

[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.

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

[Tier 1] and [Tier 2] Maximum Out of Pocket
[Please note: There are separate Maximum Out of Pocket amounts for [Tier 1] and [Tier 2] as shown on the Schedule of Insurance.]

[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] 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 [Tier 1] Network covered services and supplies for the remainder of the Calendar Year.

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

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 2] Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the [Tier 2] 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 [Tier 2] Network covered services and supplies for the remainder of the Calendar Year.

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

[[Tier 1] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 1] Network Maximum Out of Pocket. Once the [Tier 1] 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 [Tier 1] Network covered services and supplies for the remainder of the Calendar Year.

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

[Tier 2] Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all [Tier 1] Network **and** [Tier 2] Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the [Tier 2] Network Maximum Out of Pocket. Once the [Tier 2] 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 [Tier 1] Network or [Tier 2] Network covered services and supplies for the remainder of the Calendar Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] and [Tier 2] covered services and supplies for the remainder of the Calendar Year.
(Use the above text if the Tier 1 MOOP can be met separately and the Tier 1 MOOP is also applied toward the satisfaction of the Tier 2 MOOP.)

[The Cash Deductible:
For Single Coverage Only
Each Calendar Year, You must have Covered Charges that exceed the per Covered Person Cash Deductible before We pay any benefits to You for those charges. The per Covered Person Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by You while insured can be used to meet the Cash Deductible.

Once the per Covered Person Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance, for the rest of that Calendar Year. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Limit:
For Other than Single Coverage
The per Covered Person Cash Deductible is **not** applicable. This Policy has a per Covered Family Cash Deductible which applies in all instances where this Policy provides coverage that is not single only coverage. Once any combination of Covered Persons in a family meets the Per Covered Family Cash Deductible shown in the Schedule, We pay benefits for other Covered Charges incurred by any member of the covered family, less any Coinsurance, for the rest of that Calendar Year.

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 and Copayments 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 or Copayments will be required for such Covered Person for the rest of the Calendar Year.

In the case coverage which is other than single coverage, for a Covered Person, the per Covered Person Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments 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 or Copayments 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 and Copayments 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 or Copayment will be required for members of the covered family for the rest of the Calendar Year.]

[Note to carriers: Use the above text for cash deductible, family limit and MOOP if the plan is issued as a high deductible health plan that could be used in conjunction with 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 childbirth and newborn care coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the in-patient care.
[As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

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

We will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, [subject to this Policy's **Emergency Room Copayment Requirement** section] *[note to carriers: delete this emergency room copayment phrase if the plan does not require an Emergency Room Copayment].*

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

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

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

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

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

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

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

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

Home Health Care Charges
Subject to Our Pre-Approval, when home health care can take the place of Inpatient care, We cover such care furnished to a Covered Person under a written home health care plan. We cover all Medically Necessary and Appropriate services or supplies, such as:

a) Routine Nursing care furnished by or under the supervision of a registered Nurse;
b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Policy if the Covered Person had been in a Hospital; and
i) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services.

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

a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. Home health care is covered **only** in situations where continuing hospitalization or confinement in a Skilled Nursing Facility or Rehabilitation Center would otherwise have been required if Home Health Care were not provided.
b. The services and supplies must be:
   1. ordered by the Covered Person's Practitioner;
   2. included in the home health care plan: and
   3. furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.
   The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term (no more than three-day) basis.
c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once every 60 days.
d. We do not pay for:
   1. services furnished to family members, other than the patient; or
   2. services and supplies not included in the home health care plan.

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

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

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

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

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

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

We cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts. We also cover treatment of the physical complications of mastectomy, including lymphedemas.

Second Opinion Charges
We cover Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. We cover such charges if the Practitioners who give the opinions:
a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

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

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

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

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal Illness or terminal Injury.
"Terminally Ill" or "terminally Injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

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

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

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

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

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

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

Inpatient or day treatment may be furnished by any [Network] Provider that is licensed, certified or State approved facility, including but not limited to:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Center; or
e) a Substance Abuse Center.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Orthotic or Prosthetic Appliances
We pay benefits for Covered Charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Covered Person's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a [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.

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

[We will reduce benefits by 50% with respect to charges to enhance fertility which are not Pre-Approved by Us provided that benefits would otherwise be payable under 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. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.] Under this Policy 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.

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

In no event will We pay for:
a. drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed, except as stated above.
And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.

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

[If a Covered Person brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the 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: *Include* if the plan is a *managed care plan*)

[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)

[If a Covered Person purchases a Brand Name Drug when there is a Generic Prescription Drug alternative, [Carrier] will cover the Generic Prescription Drug subject to the applicable cost sharing, whether Deductible, Coinsurance or Copayment. Except as stated below, the Covered Person is responsible for the difference between the cost of the Brand Name Drug and the generic Prescription Drug. Exception: if the provider states "Dispense as Written" on the prescription the Covered Person will be responsible for the applicable cost sharing for the Brand Name Prescription Drug.]

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

After the Copayment is paid, [Carrier] will pay the Covered Charge in excess of the Copayment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the Covered Person is insured. What [Carrier] pay[s] is subject to all the terms of the[Policy.]

[A Covered Person and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable Copayment for a Preferred Drug. [Carrier] will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

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

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

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

[The Policy only pays benefits for Prescription Drugs which are:

a) prescribed by a Practitioner (except for insulin)

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

c) needed to treat an Illness or Injury Covered under this Policy.

Such charges will not include charges made for more than:

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

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

c) the amount usually prescribed by the Covered Person's Practitioner.

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

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

[Note to carriers: If a carrier elects to include audit procedures in the policy, include your specific audit procedures as an additional paragraph.]

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

[Note to carriers: Carriers may include information regarding the pharmacy benefit manager, quantity and supply limit rules, appeals procedures and policies regarding refills and vacation overrides.]

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

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

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

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

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

[If a Carrier uses a different procedure to comply with the requirements of P.L. 2011, c.188 the Carrier should omit the above paragraph and insert text consistent with the Carrier's procedure. The bracketed sentence in the Prescription Drugs provision should be included if consistent with the Carrier's procedure.]

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.]

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

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

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

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

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury was not caused, directly or indirectly by biting or chewing; and
b) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

[Dental Benefits

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

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

Diagnostic Services

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

a) *Clinical oral evaluations once* every 6 months *
   1. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
   2. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
   3. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
   4. Limited oral evaluations that are problem focused
   5. Detailed oral evaluations that are problem focused
b) Diagnostic Imaging with interpretation
   1. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   3. Additional films/views needed for diagnosing can be provided as needed.
   4. Bitewings, periapicals, panoramic and cephlometric radiographic images
   5. Intraoral and extraoral radiographic images
   6. Oral/facial photographic images
   7. Maxillofacial MRI, ultrasound
   8. Cone beam image capture
c) Tests and Examinations
d) Viral culture
e) Collection and preparation of saliva sample for laboratory diagnostic testing
f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
g) Oral pathology laboratory
   1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   3. Other oral pathology procedures, by report

Preventive Services

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

a) Dental prophylaxis once every 6 months*
b) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*
c) Fluoride varnish once every 3 months for children under the age of 6
d) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.
e) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal

1. fixed – unilateral and bilateral
2. removable – bilateral only
3. recementation of fixed space maintainer
4. removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

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

Restorative service to include:

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

Endodontic Services

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

Endodontic service to include:

a) Therapeutic pulpotomy for primary and permanent teeth
b) Pulpal debridement for primary and permanent teeth
c) Partial pulpotomy for apexogensis
d) Pulpal therapy for anterior and posterior primary teeth
e) Endodontic therapy and retreatment
f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
g) Apexification: initial, interim and final visits
h) Pulpal regeneration
i) Apicoectomy/Periradicular Surgery
j) Retrograde filling

k) Root amputation
l) Surgical procedure for isolation of tooth with rubber dam
m) Hemisection
n) Canal preparation and fitting of preformed dowel or post
o) Post removal

Periodontal Services

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

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

Prosthodontic Services

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

Prosthodontic services to include:

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

5. Surgical stents
6. Radiation carrier
7. Fluoride gel carrier
8. Commissure splint
9. Surgical splint
10. Topical medicament carrier
11. Adjustments, modification and repair to a maxillofacial prosthesis
12. Maintenance and cleaning of maxillofacial prosthesis

j) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
Covered services include: implant body, abutment and crown.

k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
3. Considerations and requirements noted for single crowns apply
4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
5. Abutment teeth must be periodontally sound and have a good long term prognosis
6. Repair and recementation

l) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

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

a) Extraction of teeth:
1. Extraction of coronal remnants – deciduous tooth,
2. Extraction, erupted tooth or exposed root
3. Surgical removal of erupted tooth or residual root
4. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications

b) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.

c) Other surgical Procedures
1. Oroantral fistula
2. Primary closure of sinus perforation and sinus repairs
3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
4. Surgical access of an unerupted tooth
5. Mobilization of erupted or malpositioned tooth to aid eruption
6. Placement of device to aid eruption
7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
8. Surgical repositioning of tooth/teeth
9. Transseptal fiberotomy/supra crestal fiberotomy
10. Surgical placement of anchorage device with or without flap
11. Harvesting bone for use in graft(s)

d) Alveoloplasty in conjunction or not in conjunction with extractions

e) Vestibuloplasty

f) Excision of benign and malignant tumors/lesions

g) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies

h) Destruction of lesions by electrosurgery

i) Removal of lateral exostosis, torus palatinus or torus madibularis

j) Surgical reduction of osseous tuberosity

k) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.

l) Surgical Incision
1. Incision and drainage of abcess - intraoral and extraoral
2. Removal of foreign body
3. Partial ostectomy/sequestrectomy
4. Maxillary sinusotomy

m) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.

n) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
2. Manipulation under anesthesia
3. Condylectomy, discectomy, synovectomy

4. Joint reconstruction
5. Services associated with TMJD treatment require prior authorization

o) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
p) Arthroscopy
q) Occlusal orthotic device – includes placement and removal to same provider
r) Surgical and other repairs
1. Repair of traumatic wounds – small and complicated
2. Skin and bone graft and synthetic graft
3. Collection and application of autologous blood concentrate
4. Osteoplasty and osteotomy
5. LeFort I, II, III with or without bone graft
6. Graft of the mandible or maxilla – autogenous or nonautogenous
7. Sinus augmentations
8. Repair of maxillofacial soft and hard tissue defects
9. Frenectomy and frenoplasty
10. Excision of hyperplastic tissue and pericoronal gingiva
11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
12. Emergency tracheotomy
13. Coronoidectomy
14. Implant – mandibular augmentation purposes
15. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

Orthodontic Services

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

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

Orthodontic service to include:

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

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

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

Adjunctive General Services

a) Palliative treatment for emergency treatment – per visit
b) Anesthesia
1. Local anesthesia NOT in conjunction with operative or surgical procedures.

2. Regional block
3. Trigeminal division block.
4. Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires hospitalization or general anesthesia. 2 hour maximum time
5. Intravenous conscious sedation/analgesia – 2 hour maximum time
6. Nitrous oxide/analgesia
7. Non-intravenous conscious sedation – to include oral medications

c) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
- One unit equals 15 minutes of additional time
- Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
  - Office or Clinic maximum – 2 units
  - Inpatient/Outpatient hospital – 4 units
  - Skilled Nursing/Long Term Care – 2 units

d) Consultation by specialist or non-primary care provider

e) Professional visits
- House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
- Hospital or ambulatory surgical center call
  - For cases that are treated in a facility.
  - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
  - General anesthesia and outpatient facility charges for dental services are covered
  - Dental services rendered in these settings by a dentist not on staff are considered separately
- Office visit for observation – (during regular hours) no other service performed

f) Drugs
- Therapeutic parenteral drug
  - Single administration
  - Two or more administrations - not to be combined with single administration
- Other drugs and/or medicaments – by report

g) Application of desensitizing medicament – per visit

h) Occlusal guard – for treatment of bruxism, clenching or grinding

i) Athletic mouthguard covered once per year

j) Occlusal adjustment
- Limited - (per visit)
- Complete (regardless of the number of visits), once in a lifetime

k) Odontoplasty

l) Internal bleaching]

Note to carriers: the above Dental benefits provision is variable and may be deleted as explained in the Explanation of Brackets. If the provision is deleted include the following heading such that the under age 6 provision would be part of the Dental Care and Treatment provision.

[Additional benefits for a child under age 6]
For a Covered Person who is severely disabled or who is a child under age 6, We cover:
a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires Hospitalization or general anesthesia.

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

Mammogram Charges
We cover charges made for mammograms provided to a 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– who is 40 years of age
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.

In addition, if the conditions listed below are satisfied after a baseline mammogram We will cover charges for:
a) an ultrasound evaluation;
b) a magnetic resonance imaging scan;
c) a three-dimensional mammography; and
d) other additional testing of the breasts.

The above additional charges will be covered if one of following conditions is satisfied.
a) The mammogram demonstrates extremely dense breast tissue;

b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
c) If the female Covered Person has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Covered Person's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision. [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.] [Note to Carriers: Include the variable text for plans that provide non-network benefits]

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

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

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

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

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

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

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

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

[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.
g. *Speech Therapy* -except as stated below, treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes. Exception: For a Covered Person who has been diagnosed with a biologically-based mental illness, speech therapy means treatment of a speech impairment.
Coverage for Speech Therapy is limited to 30 visits per Calendar Year.

h. *Occupational Therapy* - except as stated below, treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living. Exception: For a Covered Person who has been diagnosed with a biologically-based mental illness, occupational therapy means treatment to develop a Covered Person's ability to perform the ordinary tasks of daily living.

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

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

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

[We will reduce benefits by 50% with respect to charges for Cognitive Rehabilitation Therapy, Speech Therapy, Occupational Therapy or Physical Therapy which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.]

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

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

Diagnosis and Treatment of Autism and Other Developmental Disabilities
We provide coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

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

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

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

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

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

If a Covered Person:

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

the portion of the family cost share attributable to such services is a Covered Charge under this Policy. The deductible, coinsurance or copayment as applicable to a [physician visit to a non Specialist Doctor] [PCP visit] for treatment of an Illness or Injury will apply to the family cost share.

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

Preventive Care
We cover charges for routine physical examinations including related laboratory tests and x-rays. We also cover charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, lead screening, bone density testing, colorectal cancer screening, and Nicotine Dependence Treatment. [But We limit what We pay each Calendar Year to:

a) $750 per Covered Person for a Dependent child for the first year of life;
b) $500 per Covered Person for all other Covered Persons.]

These charges are not subject to the Cash Deductible or Coinsurance or Copayment, if any. [The $750 and $500 limits do not apply if a Covered Person uses a Network Provider.]
Note to carriers: If coverage is a network only plan the dollar limit text should be deleted.

Immunizations and Lead Screening
We will cover charges for:

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

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

[Note to Carriers: Use this text for plans that are not used in conjunction with an HSA]

Immunizations and Lead Screening
We will cover charges for:
screening by blood measurement for lead poisoning for children, including confirmatory blood lead testing and medical evaluation as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
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.

Charges for screening by blood measurement for lead poisoning for children as specified in item a) above and all childhood immunizations as specified in item b) above are not subject to the Cash Deductible. Charges for 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 as specified in item a) above are subject to the Cash Deductible.

[Note to Carriers: Use this text for plans that are used in conjunction with an HSA]

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

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

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

Hearing aids are habilitative devices.

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

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

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

Therapeutic Manipulation
[Subject to Our Pre-Approval,] We cover therapeutic manipulation up to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge. **[We will reduce benefits by 50% with respect to charges for Therapeutic Manipulation which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.]**

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

g) Heart Valve
h) Pancreas
i) Intestine
j) Allogeneic Bone Marrow
k) [Autologous Bone Marrow and Associated Dose Intensive Chemotherapy **only** for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
- SCID
- WISCOT Aldrich]

l) Subject to Our Pre-Approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. **[We will reduce benefits by 50% with respect to charges for such treatment of breast cancer which are not Pre-Approved by Us provided that benefits would otherwise be payable under this Policy.]**
l) [Autologous Bone Marrow transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
m) Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

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

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

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

IMPORTANT NOTICE

[This Policy has utilization review features. Under these features, [ABC - Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Us]. These features must be complied with if a Covered Person:
a) is admitted as an Inpatient to a Hospital, or
b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the **Utilization Review Features** section for details.]

[This Policy has Specialty Case Management. Under this provision, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether case management may be available and appropriate. See the **Specialty Case Management** section for details.]

[This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom We have entered into agreements. See the **Centers of Excellence Features** section for details.]

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

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

[UTILIZATION REVIEW FEATURES

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

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

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

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

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

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

[REQUIRED HOSPITAL STAY REVIEW

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

Notice of Hospital Admission Required
We require notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section We reduce what We pay for covered Hospital charges as a penalty.

Pre-Hospital Review
All non-Emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission
b) the anticipated length of stay and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

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

Emergency Admission
[ABC] must be notified of all Emergency admissions by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day or as soon as possible after the admission occurs.
When [ABC] is notified [by phone,] they require the following information:
a) the Covered Person's name, social security number and date of birth;
b) the Covered Person group plan number;
c) the reason for the admission
d) the name and location of the Hospital
e) when the admission occurred; and
f) the name of the Covered Person's Practitioner.

Continued Stay Review
The Covered Person or his or her Practitioner, must request a continued stay review for any Emergency admission. This must be done at the time [ABC] is notified of such admission.

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

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an Emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;

b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

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

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

[Penalties for Non-Compliance
In the case of a non-Emergency Hospital admission, as a penalty for non-compliance. We reduce what We pay for covered Hospital charges, by 50% if:
a) the Covered Person does not request a pre-hospital review; or
b) the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d) [ABC] does not authorize the Hospital admission.

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

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

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, We reduce what We pay for covered Hospital charges incurred after the authorized length of stay ends [by 50%] as a penalty for non-compliance.

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

[REQUIRED PRE-SURGICAL REVIEW

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

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

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

When [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 Maximum Out of Pocket, Cash Deductible or Coinsurance.]

[SPECIALTY CASE MANAGEMENT

Important Notice: No Covered Person is required, in any way, to accept a Specialty Case Management Plan recommended by [DEF].

Definitions
"Specialty Case Management" means those services and supplies which meet both of the following tests:
a) They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
b) While there are other covered services and supplies available under this Policy for the Covered Person's condition, the services and supplies We offer to make available under the terms of this provision would not otherwise be payable under this Policy.

Please note: We have sole Discretion to determine whether to consider Specialty Case Management for a Covered Person.

"Catastrophic Illness or Injury" means one of the following:
a) head injury requiring an Inpatient stay
b) spinal cord Injury
c) severe burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) chemical dependency
l) mental, nervous and psychoneurotic disorders
m) any other Illness or Injury determined by [DEF] or Us to be catastrophic.

Specialty Case Management Plan
[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop a Specialty Case Management Plan.

A Specialty Case Management Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a) the Covered Person, or his or her legal guardian, if necessary;
b) the Covered Person's attending Practitioner; and
c) [Us].

The Specialty Case Management Plan includes:
a) treatment plan objectives;
b) course of treatment to accomplish the stated objectives;
c) the responsibility of each of the following parties in implementing the plan: [DEF]; attending Practitioner; Covered Person; Covered Person's family, if any; and
d) estimated cost and savings.

If We, [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on a Specialty Case Management Plan, the services and supplies required in connection with such Specialty Case Management Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon Specialty Case Management treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Specialty Case Management Plan will be considered in the accumulation of any Calendar Year maximums.

Exclusion
Specialty Case Management does not include services and supplies that We determine to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions
"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges
In order for charges to be Covered Charges, the Center of Excellence must:
a) perform a Pre-Treatment Screening Evaluation; and
b) determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.]]
EXCLUSIONS

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

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

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

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

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

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

[Broken appointments.]

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

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

Completion of claim forms.

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

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

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

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

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

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

Extraction of teeth, except as otherwise stated in this Policy.

Services or supplies for or in connection with:

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

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

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

Except as stated in the Newborn Hearing Screening and Hearing Aids provisions, Services or supplies related to ***hearing aids and hearing exams*** to determine the need for hearing aids or the need to adjust them.

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

Services or supplies related to ***hypnotism***.

Services or supplies necessary because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.
Except as stated below, ***Illness*** **or** ***Injury***, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.
Exception: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

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

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

Services and supplies related to ***marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services,*** except as otherwise stated in this Policy.

Charges for ***missed appointments.***

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

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

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

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

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

[The following exclusions apply specifically to **Outpatient** coverage of ***Prescription Drugs***
a) Charges to administer a Prescription Drug.
b) Charges for:
- immunization agents,
- allergens and allergy serums
- biological sera, blood or blood plasma, [unless they can be self-administered].

c) Charges for a Prescription Drug which is: labeled "Caution — limited by Federal Law to Investigational use"; or experimental.
d) Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.
e) Charges for refills dispensed after one year from the original date of the prescription.
f) Charges for Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, misused, stolen, broken or destroyed
g) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
h) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:

- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Hospice
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home
  or similar institution
- a provider's office.

i) Charges for:
- therapeutic devices or appliances
- hypodermic needles or syringes, except insulin syringes
- support garments; and
- other non-medical substances, regardless of their intended use.

j) Charges for vitamins, except Legend Drug vitamins.
k) Charges for drugs for the management of nicotine dependence.
l) Charges for topical dental fluorides.
m) Charges for any drug used in connection with baldness.
n) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the
o) Covered Person taking part in the commission of a felony.
p) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
q) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
r) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] [is/are] legally required to pay it, [Carrier] will.
s) Charges for drugs covered under Home Health Care; or Hospice Care section of the [Policy.]
t) Except as stated below, charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws. **Exception**: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.
u) Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.

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

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

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

[y) Life Enhancement Drugs for the treatment of sexual dysfunction, (e.g. Viagra).]

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

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

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

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

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

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

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

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

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

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

Exception: This exclusion does not apply to military retirees, their Dependents and the Dependents of active duty military personnel who are covered under both this Policy and under military health coverage and who receive care in facilities of the Uniformed Services.
- provided outside the United States other than in the case of Emergency and except as provided below with respect to a full-time student.

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

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

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

[Telephone consultations [except as stated in the Practitioner's Charges for Non-Surgical Care and Treatment provision].]

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

Transplants, except as otherwise listed in this Policy.

Transportation, travel.

Vision therapy.

Vitamins and dietary supplements.

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

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

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

COORDINATION OF BENEFITS AND SERVICES

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

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

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

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

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

Allowed Charge: An amount that is not more than allowance for the service or supply as determined by Us, based on a standard which is most often charged for a given service by a Provider within the same geographic area .

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

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

For purposes of determining plans with which this plan can coordinate, Plan does not include:
a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the Covered Person, except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident –type coverage;
f) A State plan under Medicaid.

PRIMARY AND SECONDARY PLAN
We consider each plan separately when coordinating payments.

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

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

This Policy shall not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:
a) the basis on which the Primary Plan and the Secondary Plan pay benefits; and
b) whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Allowed Charge (AC), or some similar term. This means that the provider bills a charge and the Covered Person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on an allowed charge is called an "AC Plan."

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

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

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

Primary Plan is AC Plan and Secondary Plan is AC Plan
The Secondary Plan shall pay the lesser of:
a) the difference between the amount of the billed charges and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan
If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
The total amount the provider receives from the Primary plan, the Secondary plan and the Covered Person shall not exceed the fee schedule of the Primary Plan. In no event shall the Covered Person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is AC Plan and Secondary Plan is Fee Schedule Plan
If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:
a) the difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
The Covered Person shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the Covered Person has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the primary and Secondary Plans are less than the provider's billed charges. In no event shall the Covered Person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is AC Plan
If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is AC Plan or Fee Schedule Plan
If the Primary Plan is an HMO or EPO plan that does not allow for the use of non-network providers except in the event of Urgent Care or Emergency Care and the service or supply the Covered Person receives from a non-network provider is not considered as Urgent Care or Emergency Care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or AC Plan
If the Covered Person receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

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

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

[Note to carriers: This paragraph should only be included in plans issued as HMO or EPO coverage.]

SERVICES FOR AUTOMOBILE RELATED INJURIES

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

Definitions
"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

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

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

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

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

Determination of primary or secondary coverage.
This Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under this Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Policy may be primary for one Covered Person, but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.
This Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the Policyholder's plan. In that case this Policy will be primary.

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

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

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

GENERAL PROVISIONS

AMENDMENT

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

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

No change in the Policy is valid unless the change is shown in one of the following ways:
a) it is shown in an endorsement on it signed by one of Our officers.
b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called **Conformity With Law**, it is shown in an amendment to it that is signed by one of Our officers.
c) if a change is required by Us, it is accepted by the Policyholder, as evidenced by payment of a premium on or after the effective date of such change.
d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by one of Our officers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PAYMENT OF PREMIUMS - GRACE PERIOD
<u>The following paragraph only applies to Covered Persons who are NOT recipients of the premium tax credit and Covered Persons who are recipients of the premium tax credit but have not paid at least one full month's premium during the calendar year</u>

Premiums are to be paid by You to Us. They are due on each premium due date. You may pay each premium other than the first within 31 days of the premium due date. Those days are known as the grace period. You are liable to pay premiums to Us from the first day the Policy is in force in order for this Policy to be considered in force on a premium paying basis. You will be liable for the payment of the premium for the time the Policy stays in effect. If any premium is not paid by the end of the grace period, [this Policy will continue in force without premium payment during the grace period and this Policy will end when the grace period ends.][coverage will end as of the end of the period for which premium has been paid. You may be responsible for the payment of charges incurred for services or supplies received during the grace period.]

<u>The following paragraph only applies to Covered Persons who ARE recipients of the premium tax credit who have paid at least one full month's premium during the calendar year</u>

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

effect. We will notify the Federal Department of Health and Human Services that You have not paid the required premium by the premium due date. We will also notify the Providers for the pended claims that the claims may be denied.

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

REINSTATEMENT
If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Policy. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Policy will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the forty-fifth day following the date for the conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. [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 Covered Person shall have the same rights under the Policy as before the end of the grace period.

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

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

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

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

All statements will be deemed representations and not warranties.

RENEWAL PRIVILEGE – TERMINATION

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

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

We have the right to non-renew this Policy on the Renewal Date following written notice to the Policyholder for the following reasons:
a) subject to 180 days advance written notice, We cease to do business in the individual health benefits market;
b) subject 90 days advance written notice, We cease offering and non-renew a particular type of Health Benefits Plan in the individual market provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may become eligible for coverage;
c) subject 90 days advance written notice, the Board terminates a standard plan or a standard plan option; [or]
d) [with respect to coverage issued through the marketplace, decertification of the plan].

The advance written notice for non-renewal for the reasons stated in items a, b and c above shall comply with the requirements of N.J.A.C. 11:20-18. Any notice provided in the event of item [d] above will be subject to marketplace requirements, if any.

<u>During or at End of Grace Period - Failure to Pay Premiums</u>: If any premium is not paid by the end of its grace period, the Policy will end as described in the Grace Period provision.
<u>Termination by Request</u> - 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 Renewal Date, unless coverage is terminated on or before the Renewal Date due to one of the following circumstances:

a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as described in the Grace Period provision.)
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].)
c) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)

d) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the individual Health Benefits Plan takes effect, provided We receive notice of the replacement within 30 days after the effective date of the new plan.)
e) With respect to a catastrophic plan, the date of a marketplace redetermination of exemption eligibility that finds the Covered Person is no longer eligible for an exemption, or until the end of the plan year in which the Covered Person attains age 30, whichever occurs first.

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

A Dependent's coverage ends when 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

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

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

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

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

Exceptions
No former Spouse may use this conversion right:
if he or she is eligible for Medicare;
b) if it would cause him or her to be excessively covered. This may happen if the Spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will Determine if excessive coverage exists using Our standards for excessive coverage.
HOW AND WHEN TO CONVERT
The conversion period means the 31 days after the date this coverage ends. The former Spouse must apply for the individual contract in writing and pay the first premium for such contract during the conversion period. Evidence of good health will not be required.

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

CLAIMS PROVISIONS

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

[NOTICE OF LOSS
A claimant should send a written notice of claim to Us within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When We receive the notice, We will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date We received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. If the form is not received within such time, the claimant may provide written proof of claim to Us on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

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

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

PAYMENT OF CLAIMS
We will pay all benefits to which the claimant is entitled as soon as We receive written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as We receive due proof of the death to one of the following:
a) his or her estate;
b) his or her Spouse;
c) his or her parents;
d) his or her children;

e) his or her brothers and sisters; or
f) any unpaid provider of health care services.

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

PHYSICAL EXAMS

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

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).
Amended by R.2012 d.167, effective September 13, 2012 (operative January 1, 2013).
See: 44 N.J.R. 2237(a), 44 N.J.R. 2365(a).
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Amended by R.2014 d.190, effective November 17, 2014 (operative January 1, 2015).
See: 46 N.J.R. 2314(a), 46 N.J.R. 2416(b).
Amended by R.2015 d.095, effective May 12, 2015.
See: 47 N.J.R. 1234(a), 47 N.J.R. 1326(a).
Amended by R.2015 d.174, effective January 1, 2016.
See: 47 N.J.R. 2625(a), 47 N.J.R. 2873(a).

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: [January 1, 2016]]
[Note to Carriers: Omit Effective date here if included below]

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]

[[Member]: Jane Doe
Identification Number: 125689
Effective Date: January 1, 2016
[Product Name: XXXX]]

[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

SCHEDULE OF PREMIUM RATES

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

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

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	[$100 to $500] Copayment/day for a maximum of 5 days/admission. Maximum Copayment [dollar amount equal to 10 times the per day copayment]/Calendar Year. Unlimited days.
OUTPATIENT	[amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment/visit

PRACTITIONER SERVICES RECEIVED AT A HOSPITAL:

INPATIENT VISIT	$[0] Copayment
OUTPATIENT VISIT	amount consistent with N.J.A.C. 11:22-5.5(a)]] 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.

[URGENT CARE [amount consistent with N.J.A.C. 11:22-5.5(a)]]

PRACTITIONER CHARGES FOR SURGERY:

INPATIENT	$0 Copayment
OUTPATIENT	[amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit

[FACILITY CHARGES FOR OUTPATIENT SURGERY:

AMBULATORY SURGERY CENTER	[amount consistent with N.J.A.C. 11:22-5.5(a)]]
HOSPITAL OUTPATIENT DEPARTMENT	[amount consistent with N.J.A.C. 11:22-5.5(a)]]]

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

[FACILITY CHARGES FOR OUTPATIENT SURGERY:[amount consistent with N.J.A.C. 11:22-5.5(a)]]]
[Note to carriers: Use this text if the copay is the same regardless of the setting.]

HOME HEALTH CARE	Unlimited days, if Pre-Approved; $[amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment per [visit] [day].
HOSPICE SERVICES	Unlimited days, if Pre-Approved; $0 Copayment.

MATERNITY (PRE-NATAL CARE) NONE

BIRTHING CENTER SERVICES	[amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit
THERAPEUTIC MANIPULATION	[amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit; maximum 30 visits/Calendar Year
PRE-ADMISSION TESTING	[amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit.
PRESCRIPTION DRUGS	[50% Coinsurance] [copays consistent with N.J.A.C. 11:22-5.5(a) may be substituted for coinsurance]
PRIMARY CARE PROVIDER SERVICES (OUTSIDE HOSPITAL)	[amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit.

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

[SPECIALIST SERVICES	[amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit.]

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

[SPECIALIST SERVICES	[amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit]

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

[TELEMEDICINE VISITS	[dollar amount not to exceed $50]]
[E-VISITS	[dollar amount not to exceed $50]]
[VIRTUAL VISITS	[dollar amount not to exceed $50]]
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	[amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit.
SKILLED NURSING FACILITY/ EXTENDED CARE CENTER	Unlimited days, if Pre-Approved; [amount consistent with N.J.A.C. 11:22-5.5(a)] Copayment per day.
THERAPY SERVICES	[amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit.
[COMPLEX IMAGING SERVICES	[amount consistent with N.J.A.C. 11:22-5.5(a)]]
[ALL OTHER] DIAGNOSTIC SERVICES	
INPATIENT	$0 Copayment
(OUTPATIENT)	[$amount consistent with N.J.A.C. 11:22-5.5(a)]] Copayment/visit

MAXIMUM OUT OF POCKET

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

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

- •Per Member per Calendar Year — [$6,850 or amount permitted by 45 C.F.R. 156.130]
- •Per Family per Calendar Year [$2X per member amount.]

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

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 Provider but not for Preventive Care Visits	[amount consistent with N.J.A.C. 11:22-5.5(a)]] per visit
For Preventive Care	NONE
Maternity (pre-natal care)	NONE
For Prescription Drugs	Copayments consistent with N.J.A.C. 11:22-5.5]
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.
•Second Surgical Opinion	
•for all other Covered Services and Supplies	
•Per Member	[dollar amount not to exceed the amount permitted by N.J.A.C. 11:20-3.1(b)3i]
• Per Covered Family	amount equal to 2 times the per member amount.]
COINSURANCE	
[For Prescription Drugs	50%]
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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Covered Services and Supplies for the remainder of the Calendar Year.

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

•Per Member per Calendar Year	[$6,850 or amount permitted by 45 C.F.R. 156.130]
•Per Family per Calendar Year	[$2X per member amount.]

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

LIMITATIONS ON SERVICES AND SUPPLIES

Home Health Care	Unlimited days, subject to Pre-Approval.
Hospice Services	Unlimited days, subject to Pre-Approval.
Speech Therapy See below for the separate benefits available under the Diagnosis and Treatment of Autism or other Developmental Disabilities provision	30 visits per Calendar Year
Cognitive Rehabilitation Therapy	30 visits per Calendar Year
Physical Therapy See below for the separate benefits available under the Diagnosis and Treatment of Autism or other Developmental Disabilities provision	30 visits per Calendar Year
Occupational Therapy See below for the separate benefits available under the Diagnosis and Treatment of Autism or other Developmental Disabilities provision	30 visits per Calendar Year
Charges for physical, occupational and speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision Note: These services are habilitative services in that they are provided to help develop rather than restore a function. The 30-visit limit does not apply to the treatment of autism.	
(limit applies separately to each therapy and is in addition to the therapy visits listed above)	30 visits
Charges for hearing aids for a Member age 15 or younger	one hearing aid per hearing impaired ear per 24-month period
Therapeutic Manipulation	30 visits per Calendar Year
Skilled Nursing Facility/ Extended Care Center	Unlimited days, subject to Pre-Approval

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

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

SCHEDULE OF SERVICES AND SUPPLIES

Example HMO with a Tiered Network (Note to carriers: Dollar amounts are illustrative; amounts carriers include must be within permitted ranges.)

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

SERVICES	[Tier 1]	[Tier 2]]
Calendar Year Cash Deductible for treatment services and supplies for:		
Preventive Care	NONE	NONE
Immunizations and Lead Screening for Children	NONE	NONE
Second Surgical opinion	NONE	NONE
Maternity care (pre-natal visits)	NONE	NONE
Prescription Drugs [Generic Drugs] [Preferred Drugs] [Non-Preferred Drugs]		[$250] [$50] [$100] [$150]
[All other Covered Services and Supplies Per Member Per Covered Family *(Use above deductible for separate accumulation..)*	 $1,000 $2,000	 $1,500 $3,000]
[All other Covered Services and Supplies Per Member Per Covered Family *(Use above if Tier 1 deductible can be satisfied independently; Tier 1 accumulates toward Tier 2)*	 $1,000 $2,000	 $2,500 $5,000
Copayment applies after the Cash Deductible is satisfied		
Preventive Care	NONE	NONE
Primary Care Provider Visits [when care is provided by the pre-selected PCP]	N/A See Tier 2	$30
Specialist Visits [and PCP visits if the PCP was not pre-selected]	$30	$50
Maternity Care (Pre-natal visits)	NONE	NONE
All Other Practitioner Visits	N/A See Tier 2	$30
Hospital Confinement	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
Extended Care and Rehabilitation	$300 per day up to $1500 per confinement; up to $3000 per year	$500 per day up to $3000 per confinement; up to $5000 per year
[Complex Imaging Services See Definition	N/A See Tier 2	$100 per procedure]
[[All other] radiology services	N/A See Tier 2	$75 per procedure]
Laboratory Services	NONE	$30 per visit
Emergency Room Visit	$50	$100

SERVICES	[Tier 1]	[Tier 2]]
Outpatient Surgery	$100	$250
Inpatient Surgery	$250	$500
Coinsurance (See definition below) Preventive Care	NONE	NONE
Prescription Drugs	N/A See Tier 2	50%
[Generic Drugs]		[10%]
[Preferred Drugs]		[20%]
[Non-Preferred Drugs]		[50%]
Durable Medical Equipment	N/A See Tier 2	50%
[Maximum Out of Pocket Per Calendar Year (See definition below) Per Member	$2,000	$4,400
Per Covered Family	$4,000	$8,700]
(Use above for separate accumulation.)		
[Maximum Out of Pocket Per calendar Year (See definition below) Per Member	$2,000	$6,850 or amount permitted by 45 C.F.R. 156.130
Per Covered Family	$4,000	
Use above if Tier 1 MOOP can be satisfied independently; Tier 1 accumulates toward Tier 2)		$2X per member amount]]

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

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

SCHEDULE OF INSURANCE	**Example High Deductible health plan text that could be used in conjunction with an 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	
second surgical opinion NONE	
Maternity Care (pre-natal visits) NONE	
For all other Covered Charges	
[per Member	[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 Member. 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%
[Vision Benefits (for Covered Persons through the end of the month in which the Member turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Member turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
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:

[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 **EXAMPLE High Deductible health plan text that could be used in conjunction with an HSA using deductible followed by copays and 100% coinsurance)**

IMPORTANT: Except in case of Emergency <u>all</u> services and supplies must be provided by a Network Provider.

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
second surgical opinion	NONE
Maternity Care (pre-natal visits)	NONE
•for all other Covered Charges	
[per Covered Person	[an amount to qualify as a high deductible health plan under Internal Revenue Code section 223]
[per Covered Family	[an amount to qualify as a high deductible health plan under Internal Revenue Code section 223]

Copayment

The following copayments apply after the Cash Deductible is satisfied.

For Preventive Care	NONE
Primary Care Provider (PCP) Visits [when care is provided by a Member's pre-selected PCP]	[dollar amount not to exceed $50]
[Specialist Visits	an amount not to exceed $75]
[Maternity Care(pre-natal visits)	NONE
[Urgent Care Services	an amount consistent with N.J.A.C. 11:22-5.5(a)11]
[All [other] Practitioner Visits	an amount not to exceed $50 if PCP; $75 if specialist and subject to N.J.A.C. 11:22-5.5(a)11 for other practitioners]
[Complex Imaging Services:	[an amount not to exceed $100 per service]

[[All other] Radiology Services	[$50, 75] per service]
[Laboratory services	None]
[Emergency Room Visit	$100]
[Outpatient Surgery	$250]
[Inpatient Surgery	$500]

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 Durable Medical Equipment 50%]	
[Vision Benefits (for Covered Persons through the end of the month in which the Member turns age 19)	
V2500 – V2599 Contact Lenses	[50%]
Optional lenses and treatments	[50%]]
[Dental Benefits (for Covered Persons through the end of the month in which the Member turns age 19)	
Preventive, Diagnostic and Restorative services	0%
Endodontic, Periodontal, Prosthodontic and Oral and Maxillofacial Surgical Services	[20%]
Orthodontic Treatment	[50%]]
[For Prescription Drugs	50%] [See the Prescription Drug Coinsurance Limit below.]
[For Prescription Drugs	
Generic Drugs	an amount not to exceed $25 per 30 day supply
Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit]
Non-Preferred Drugs	[50%][; subject to Prescription Drug Coinsurance Limit]]
For all other Network services and supplies	0%

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

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

Per Covered Person per Calendar Year:	[An amount not to exceed $[6,850]]
Per Covered Family per Calendar Year:	[Dollar amount equal to 2 times the per Covered Person maximum.]

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

[Prescription Drug Coinsurance Limit:	$[125] per 30 day supply]
[Prescription Drug Coinsurance Limit:	
Preferred Drugs	$[125] per 30 day supply
Non-Preferred Drugs	$[250] per 30 day supply]

DEFINITIONS

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

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

[ALLOWED CHARGE. An amount that is not more than the [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 Contract. For charges that are not determined by a negotiated fee schedule, the [Member] 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. A certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by applicable state and local law.

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

It must carry out its stated purpose under all relevant state and local laws and be either:
a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for ambulatory care; or
b) approved for its stated purpose by Medicare.

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

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

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

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

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

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

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

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

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

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

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

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

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

CONTRACTHOLDER. The person who purchased this Contract.

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

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

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

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

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

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

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

DEPENDENT.
Your:
a) Spouse;
b) Dependent child [who is under age 26] [through the end of the month in which he or she attains age 26].

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

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

We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any other child over whom You have legal custody or legal guardianship[or with whom You have a legal relationship or a blood relationship] is considered a Dependent child under this Contract provided the child depends on You for most of the child's support and maintenance[and resides in Your household]. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance,[residency in Your household, blood relationship or legal relationship,] in Our Discretion.)]
[Note to carriers: Text in brackets in the above paragraph may be deleted by carriers when selling coverage through the Marketplace that are concerned with covering such children in the absence of being able to apply the household requirement.]

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

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

DEVELOPMENTAL DISABILITY or DEVELOPMENTALLY DISABLED. A severe, chronic disability that:
a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
b) is manifested before the [Member]:

1. attains age 22 for purposes of the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision;
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 [Member's] need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:
a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKG's, EEG's, and other electronic diagnostic tests.

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

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

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily and customarily for a medical purpose;
c) is generally not useful to a[Member] in the absence of an Illness or Injury; and
d) suitable for use in the home.

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

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

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

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

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

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

[E-VISIT. A visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with Us to offer E-visit services and Members who are established patients of the Provider.]

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

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

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

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a [Member]'s particular condition.
Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a [Member]'s particular condition, as explained below.
We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

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

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

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.
In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

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

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

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

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

EXTENDED CARE CENTER. See Skilled Nursing Facility.

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

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

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

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

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

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

following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health plan.

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

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

HOSPICE. A Provider which provides palliative and supportive care for terminally Ill or terminally Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be approved for its stated purpose by Medicare; or
b) it is accredited for its stated purpose by the Joint Commission, the Community Health Accreditation Program or the Accreditation Commission for Health Care.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited as a Hospital by the Joint Commission, or
b) be approved as a Hospital by Medicare.

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

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

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

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

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Organizations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin. But We only cover drugs which are:
a) approved for treatment of the [Member's] Illness or Injury by the Food and Drug Administration;

b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Member's] and recognized as appropriate medical treatment for the [Member's] diagnosis or condition in one or more of the following established reference compendia:
- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Drug Information; or

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

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

In no event will We pay for:

a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or

b)any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PREVENTIVE CARE. Preventive care means:

a) Evidence based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services task Force with respect to the Member;

b) Immunizations for routine use for Members of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Member;

c) Evidence–informed preventive care and screenings for Members who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;

d) Evidence–informed preventive care and screenings for female Members as included in the comprehensive guidelines supported by the Health Resources and Services Administration; and

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

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

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

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

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

PROVIDER. A recognized Facility or Practitioner of health care. [Tribal Provider means those providers listed in 25 U.S.C. 1603, including the Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization.]

REFERRAL. Specific direction or instruction from a [Member]'s Primary Care Provider in conformance with our policies and procedures that directs a [Member] to a Facility or Practitioner for health care. [While HMO plans typically require [Members] to get a Referral from his or her Primary Care Provider 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."

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

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

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

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

SPECIAL ENROLLMENT PERIOD. A period of time that is no less than 60 days following the date of a triggering event during which:
a) individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and
b) individuals who already have coverage are allowed to replace current coverage with a different standard health benefits plans or standard health benefits plan with rider.

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

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

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

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

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

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

SUBSTANCE ABUSE CENTER. A Facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

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

[TEMEMEDICINE. A telephone consultation between a Provider that has contracted with Us to offer telemedicine services for Members.

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

TRIGGERING EVENT. An event that results in an individual becoming eligible for a Special Enrollment Period. Triggering events are:
a) The date an Eligible Person loses eligibility for minimum essential coverage, or the Eligible Person's Dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace.
b) The date a Dependent child's coverage ends as a result of attaining age 26 whether or not the Dependent is eligible for continuing coverage in accordance with federal or state laws.
c) The date a Dependent child's coverage under a parent's group plan ends as a result of attaining age 31.
d) The effective date of a marketplace redetermination of an Eligible Person's subsidy, including a determination that an Eligible Person is newly eligible or no longer eligible for a subsidy.
e) The date an Eligible Person acquires a dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
f) The date an Eligible Person who is covered under an individual health benefits plan or group health benefits plan moves out of that plan's service area.
g) The date of a marketplace finding that it erroneously permitted or denied an Eligible Person enrollment in a qualified health plan.
h) The date of a court order that requires coverage for an Eligible Person.
i) The date the Eligible Person demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

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

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

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

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

[WE, US, OUR. [Carrier].

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

ELIGIBILITY

Types of Coverage

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

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

Who is Eligible

The Contractholder -You, if You are an Eligible Person, [who lives in the designated Service Area in the State of New Jersey].
Spouse - Your Spouse [who lives, resides or works in the designated Service Area in the State of New Jersey.], who is an Eligible Person **except:** a Spouse need not be a Resident; [but must be a U.S. Citizen, National or lawfully present in the United States].**Child** - Your child [who lives, resides or works in the designated Service Area in the State of New Jersey.], who is an Eligible Person and who qualifies as a Dependent, as defined in this Contract, **except:** a child need not be a Resident;[but must be a U.S. Citizen, National or lawfully present in the United States].

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

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

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

The child's coverage ends when Your coverage ends.

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

Adding dependents to this contract

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

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

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

Newborn Children - We will cover Your newborn child for 31 days from the date of birth without additional premium. Coverage may be continued beyond such 31-day period as stated below:
You must: a) give written notice to enroll the newborn child; and b) pay any additional premium required for Dependent child coverage within 60 days after the date of birth for coverage to continue beyond the initial 31 days.
If the notice is not given and the premium is not paid within such 60-day period, the newborn child's coverage will end at the end of such 31-day period. You may apply for coverage for the Child during an Annual Open Enrollment Period or during any applicable Special Enrollment Period.

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

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

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

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

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

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

[MEMBER] PROVISIONS

THE ROLE OF A [MEMBER'S] PRIMARY CARE PROVIDER
A [Member's] Primary Care Provider provides basic health maintenance services and coordinates a [Member's] overall health care. Anytime a [Member] needs medical care, the [Member] should contact his or her Primary Care Provider and identify himself or herself as a [Member] of this program.

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

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

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

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

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

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

[[Some of the] Providers are classified as [Tier 1] and [Tier 2]. The cost sharing (copayment, deductible and/or coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers. [In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be necessary to select a PCP who has admitting privileges at the Tier 1 Hospital when hospitalization becomes necessary.]]]

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

all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

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

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

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

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

Except in the case of an Emergency, a [Member] will not be eligible for any services provided by anyone other than a [Member's] Primary Care Provider (including but not limited to Specialist Services) if a [Member] has not been Referred by his or her Primary Care Provider. Referrals must be obtained prior to receiving services and supplies from any Practitioner other than the [Member's] Primary Care Provider.]
[Note to Carrier: Omit this Referral Forms text if the plan does not require members to get a referral.]

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

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

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

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

If We give the [Member] such written notice:

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

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

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

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

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

PROVIDER PAYMENT
[[Different] providers in Our Network have agreed to be paid [in different ways by Us. A Member's Provider may be paid] [each time he or she treats the Member ("fee for service"] [, or may be paid] [a set fee for each month for each Member whether or not the Member actually receives services ("capitation")] [, or may receive] [a salary]. [These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Member satisfaction, quality of care, and control of costs and use of services among them.] If a Member desires additional information about how Our Primary Care Providers or any other Provider in Our Network are compensated, please call Us at [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], 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 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 Schedule lists Copayments, Deductible Amounts, and/or Coinsurance as well as Maximum Out of Pocket Amounts. These terms are explained below. [The Copayments, Deductible Amounts, Coinsurance and Maximum Out of Pocket amounts for [some] Network services are listed under [Tier 1] and [Tier 2]. The Copayment, Deductible and/or Coinsurance) is lower for use of [Tier 1] Providers than for [Tier 2] Providers.]]

[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.]

[Please note: There are separate Cash Deductibles for [Tier 1] and [Tier 2] as shown on the Schedule of Insurance and Premium Rates.]

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider. Each Cash Deductible is shown in the Schedule.

Each Calendar Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Each Calendar Year, each Member must have Covered Services and Supplies from a [Tier 2] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 2] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(Use the above text if the Tier 1 and Tier 2 deductibles accumulate separately and independently.)

[The [Tier 1] Deductible is for treatment, services or supplies given by a [Tier 1] Network Provider. The other is for treatment, services or supplies given by a [Tier 2] Network Provider as well as for treatment, services or supplies given by a [Tier 1] Network that are applied to the [Tier 1] Deductible. Each Cash Deductible is shown in the Schedule.

Each Calendar Year, each Member must have Covered Services and Supplies from a [Tier 1] Network Provider that exceed the Cash Deductible before We pay benefits for those types of Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such [Tier 1] Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Each Calendar Year, the sum of the Covered Services and Supplies for each Member from a [Tier 2] Network Provider and those from a [Tier 1] Provider must exceed the [Tier 2] Cash Deductible before We pay benefits for [Tier 1] and [Tier 2] Covered Services and Supplies to that Member. Only Covered Services and Supplies incurred by the Member for treatment, services or supplies from a [Tier 1] or a [Tier 2] Network Provider, while covered by this Contract, can be used to meet this Cash Deductible. Once the Cash Deductible is met, We pay benefits for other such Covered Services and Supplies above the Cash Deductible incurred by that Member, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Neither the [Tier 1] nor the [Tier 2] Cash Deductible can be met with Non-Covered Services and Supplies. Only Covered Services and Supplies incurred by the Member while covered by this Contract can be used to meet either Cash Deductible. What We pay is based on all the terms of this Contract.]
(Use the above text if the Tier 1 deductible can be satisfied separately and allows a Member to be in benefit for further Tier 1 Covered Services and Supplies and is also applied toward the satisfaction of the Tier 2 deductible.)

[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 unless the Member is entitled to a cost sharing reduction under Federal law and as a result of an eligibility change replaces a prior contract issued by Us with this Contract where both contracts have the same classification of 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. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Covered Services or Supplies for the remainder of the Calendar Year.

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

[Tier 1] and [Tier 2] Maximum Out of Pocket
[Please note: There are separate Maximum Out of Pocket amounts for [Tier 1] and [Tier 2] as shown on the Schedule.]

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

Once any combination of Members in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] Network Covered Services and Supplies for the remainder of the Calendar Year.

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

Once any combination of Members in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no 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.]

(Use the above Tier 1 and Tier 2 text if the MOOPS accumulate separately.)

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

Once any combination of Members in a family meet an amount equal to two times the [Tier 1] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] Covered Services and Supplies for the remainder of the Calendar Year.

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

Once any combination of Members in a family meet an amount equal to two times the [Tier 2] individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for [Tier 1] and [Tier 2] Covered Services and Supplies for the remainder of the Calendar Year.
(Use the above text if the Tier 1 MOOP can be met separately and the Tier 1 MOOP is also applied toward the satisfaction of the Tier 2 MOOP.)

[The Cash Deductible:
For Single Coverage Only
Each Calendar Year, You must have Covered Charges that exceed the per Member Cash Deductible before We pay any benefits to You for those charges. The per Member Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by You while insured can be used to meet the Cash Deductible.

Once the per Member Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance, for the rest of that Calendar Year. But all charges must be incurred while You are insured by this Contract. And what We pay is based on all the terms of this Contract including benefit limitations and exclusion provisions.

Family Deductible Limit:
For Other than Single Coverage
The per Member Cash Deductible is **not** applicable. This Contract has a per Covered Family Cash Deductible which applies in all instances where this Contract provides coverage that is not single only coverage. Once any combination of Covered Persons in a family meets the Per Covered Family Cash Deductible shown in the Schedule, We pay benefits for other Covered Charges incurred by any member of the covered family, less any Coinsurance, for the rest of that Calendar Year.

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

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

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

COVERED SERVICES & SUPPLIES

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

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

1. **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate. [We also cover Telemedicine charges.] [We also cover E-Visit charges.] [We also cover Virtual Visit charges.]
2. **Home visits** by a [Member]'s Primary Care Provider.
3. **Preventive Care, including but not limited to Periodic health examinations** such as:
   a. Well child care from birth including immunizations;
   b. Routine physical examinations, including eye examinations;
   c. Routine gynecologic exams and related services;
   d. Routine ear and hearing examination; and
   e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a [Member]'s employment).
4. **Diagnostic Services.**
5. **Casts and dressings.**
6. **Ambulance service** when certified in writing as Medically Necessary and Appropriate by a [Member]'s Primary Care Provider and Pre-Approved by Us.
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 Provider and arranged through Us. Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.
10. [Subject to Our Pre-Approval, as applicable,]**Prescription Drugs** including **contraceptives which require a Practitioner's prescription**, and insulin syringes and insulin needles, glucose test strips and lancets, colostomy bags, belts and irrigators when obtained through a Network Provider. [Maintenance Drugs may be obtained from a Participating Mail Order Pharmacy.]

[A prescription or refill will not include a prescription or refill that is more than:
a) the greater of a 90 day supply or 100 unit doses for each prescription or refill; or
b) the amount usually prescribed by the [Member's] Network Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.]

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

[If a Member brings a prescription for a Prescription Drug for which We require Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the 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.

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

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

After the Copayment is paid, We will cover the Covered Service and Supply in excess of the Copayment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the [Member] is insured. What We pay is subject to all the terms of the [Contract.]
[A[Member] and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable copayment for a Preferred Drug. We will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

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

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

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

The Contract only pays benefits for Prescription Drugs which are:
a) prescribed by a Practitioner (except for insulin)
b) dispensed by a Participating Pharmacy [or by a [Participating Mail Order Pharmacy]]; and
c) needed to treat an Illness or Injury covered under this Contract.

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

A charge will be considered to be incurred at the time the Prescription Drug is received.
[[We will arrange for audits that will take place at a time mutually agreeable to the Participating Pharmacy [and the Participating Mail Order Pharmacy] or the pharmacist and the auditor. The audits shall only include the review of documents relating to persons and prescription plans reimbursable by Us.]
[Note to carriers: If a carrier elects to include audit procedures in the policy, include your specific audit procedures as an additional paragraph.]
[We will not restrict or prohibit, directly or indirectly, a Participating Pharmacy [or a [Participating Mail Order Pharmacy] from charging the Member for charges that are in addition to charges for the Prescription Drug, for dispensing the Prescription Drug or for prescription counseling provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and the purchaser's out-of-pocket cost for those services has been disclosed to the Member prior to dispensing the drug.]
[Note to carriers: Carriers may include information regarding the pharmacy benefit manager, quantity and supply limit rules, appeals procedures and policies regarding refills and vacation overrides.]

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

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

For the purpose of this benefit:
"inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;
"low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and
"medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Practitioner.
15. **Specialized non-standard infant formulas** are covered to the same extent and subject to the same terms and conditions as coverage is provided under this [Contract] for Prescription Drugs. We cover specialized non-standard infant formulas provided:
a) The child's Practitioner has diagnosed the child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
b) The child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.
We may review continued Medical Necessity and Appropriateness of the specialized infant formula.
16. Unless otherwise provided in the Charges for the Treatment of Hemophilia section below, **Blood, blood products, blood transfusions** and the cost of testing and processing blood. But We do not cover blood which has been donated or replaced on behalf of the Member.
17. **Charges for the Treatment of Hemophilia.** The Providers in Our Network providing Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia shall comply with standards adopted by the Department of Health and Senior Services in consultation with the Hemophilia Association of New Jersey.

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

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

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

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

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

High risk for colorectal cancer means a [Member] has:
a) A family history of: familial adenomatous polyposis, 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 Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

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

Hearing aids are habilitative devices.

21) **Mammogram Screening** We will provide coverage for:
a) one baseline mammogram for a female [Member], –who is 40 years of age;
b) one mammogram, every year, for a female [Member] age 40 and older; and
c) in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's Practitioner.
In addition, if the conditions listed below are satisfied after a baseline mammogram We will cover charges for:
a) an ultrasound evaluation;
b) a magnetic resonance imaging scan;
c) a three-dimensional mammography; and
d) other additional testing of the breasts.

The above additional charges will be covered if one of following conditions is satisfied.
a) The mammogram demonstrates extremely dense breast tissue;
b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
c) If the female Member has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Covered Person's Practitioner.

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

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

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

[If a Carrier uses a different procedure to comply with the requirements of P.L. 2011, c.188 the Carrier should omit the above paragraph and insert text consistent with the Carrier's procedure. The bracketed sentence in the Prescription Drugs provision should be included if consistent with the Carrier's procedure.]

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

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

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

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

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

1. Semi-private room and board accommodations

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

a) a minimum of 72 hours following a modified radical mastectomy; and

b) a minimum of 48 hours following a simple mastectomy.

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

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

a) up to 48 hours of inpatient care in a Network Hospital following a vaginal delivery; and

b) a minimum of 96 hours of Inpatient care in a Network Hospital following a cesarean section.

We provide childbirth and newborn coverage subject to the following:

a) the attending Practitioner must determine that Inpatient care is medically necessary; or

b) the mother must request the Inpatient care.

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

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

14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services; We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts. We also cover treatment of the physical complications of mastectomy, including lymphedemas.

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

(d) **BENEFITS FOR MENTAL ILLNESSE OR SUBSTANCE ABUSE .**
We cover treatment for Mental Illness or Substance Abuse the same way We would for any other illness, if such treatment is prescribed by a [Network] Provider [upon prior written referral by a [Member]'s Primary Care Provider]. We do not pay for Custodial care, education or training.

Inpatient or day treatment may be furnished by any [Network] Provider that is licensed, certified or State approved facility, including but not limited to:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Center; or
e) a Substance Abuse Center.

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

1. A [Member]'s Primary Care Provider is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a [Member]'s health, [Member] shall call a [Member]'s Primary Care Provider [or Us] prior to seeking Emergency treatment.
2. We will cover the cost of Emergency medical and hospital services performed within or outside our service area without a prior written Referral only if:
a. Our review Determines that a [Member]'s symptoms were severe and delay of treatment would have been detrimental to a [Member]'s health, the symptoms occurred suddenly, and [Member] sought immediate medical attention.
b. The service rendered is provided as a Covered Service or Supply under this Contract and is not a service or supply which is normally treated on a non-Emergency basis; and
c. We and the [Member]'s Primary Care Provider are notified within 48 hours of the Emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the Emergency services within 30 days. A [Member] shall be responsible for payment for services received unless We Determine that a [Member]'s failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event a [Member] is Hospitalized in a Non-Network Facility, coverage will only be provided until the [Member] is medically able to travel or to be transported to a Network Facility. If the [Member] elects to continue treatment with Non-Network Providers, We shall have no responsibility for payment beyond the date the [Member] is Determined to be medically able to be transported.
In the event that transportation is Medically Necessary and Appropriate, We will cover the amount We Determine to be the Allowed Charge cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior written Referral to a Network Provider.
4. Coverage for Emergency services includes only such treatment necessary to treat the Emergency. [Any elective procedures performed after a [Member] has been admitted to a Facility as the result of an Emergency shall require prior written Referral or the [Member] shall be responsible for payment.]
5. The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if a [Member] is admitted as an Inpatient to the Hospital as a result of the Emergency.
6. Coverage for Emergency and Urgent Care include coverage of trauma services at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgement of the attending physician, the Member is medically stable, no longer requires critical care, and can be safely transferred to another Facility. We also provides coverage for a medical screening examination provided upon a Member's arrival in a Hospital, as required to be performed by the Hospital in accordance with Federal law, but only as necessary to determine

whether an Emergency medical condition exists. . [Please note that the "911" Emergency response system may be used whenever a Member has a potentially life-threatening condition. Information on the use of the "911" system is included on the identification card.]

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

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

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

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

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

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

f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.
Coverage for Cognitive Rehabilitation Therapy is limited to 30 visits per Calendar Year.

g. *Speech Therapy* -except as stated below, treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes. Exception: For a [Member] who has been diagnosed with a biologically-based mental illness, speech therapy means treatment of a speech impairment.
Coverage for Speech Therapy is limited to 30 visits per Calendar Year.

h. *Occupational Therapy* - except as stated below, treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living. Exception: For a [Member] who has been diagnosed with a biologically-based mental illness, occupational therapy means treatment to develop a [Member's] ability to perform the ordinary tasks of daily living.
Coverage for Occupational Therapy is limited to 30 visits per Calendar Year.

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

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

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

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

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

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

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

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

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

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

If a Member:

a) is eligible for early intervention services through the New Jersey Early Intervention System; and
b) has been diagnosed with autism or other developmental disability; and

c) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services
the portion of the family cost share attributable to such services is a covered service under this Contract. The deductible, coinsurance or copayment as applicable to a [physician visit to a non Specialist Doctor] [PCP visit] for treatment of an Illness or Injury will apply to the family cost share.

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

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

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

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

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

b. The services and supplies must be:
   1. ordered by the [Member's] Practitioner;
   2. included in the home health care plan: and
   3. furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.
   The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term (no more than three-day) basis.

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

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

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

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

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

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

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

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

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

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

(k) [Dental Benefits

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

- Dental services are available from birth with an age one dental visit encouraged.
- A second opinion is allowed.

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

Diagnostic Services

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

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

b) Diagnostic Imaging with interpretation
   1. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   3. Additional films/views needed for diagnosing can be provided as needed.
   4. Bitewings, periapicals, panoramic and cephlometric radiographic images
   5. Intraoral and extraoral radiographic images
   6. Oral/facial photographic images
   7. Maxillofacial MRI, ultrasound
   8. Cone beam image capture

c) Tests and Examinations

d) Viral culture

e) Collection and preparation of saliva sample for laboratory diagnostic testing

f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services

g) Oral pathology laboratory
   1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   3. Other oral pathology procedures, by report

Preventive Services

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

a) Dental prophylaxis once every 6 months*

b) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*

c) Fluoride varnish once every 3 months for children under the age of 6

d) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.

e) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
   1. fixed – unilateral and bilateral
   2. removable – bilateral only
   3. recementation of fixed space maintainer
   4. removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite

restorations are placed on the same tooth.

- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

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

Endodontic Services

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

Endodontic service to include:

a) Therapeutic pulpotomy for primary and permanent teeth
b) Pulpal debridement for primary and permanent teeth
c) Partial pulpotomy for apexogensis
d) Pulpal therapy for anterior and posterior primary teeth
e) Endodontic therapy and retreatment
f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
g) Apexification: initial, interim and final visits
h) Pulpal regeneration
i) Apicoectomy/Periradicular Surgery
j) Retrograde filling
k) Root amputation
l) Surgical procedure for isolation of tooth with rubber dam
m) Hemisection
n) Canal preparation and fitting of preformed dowel or post
o) Post removal

Periodontal Services

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

a) Surgical services
    1. Gingivectomy and gingivoplasty
    2. Gingival flap including root planning
    3. Apically positioned flap
    4. Clinical crown lengthening

5. Osseous surgery
6. Bone replacement graft – first site and additional sites
7. Biologic materials to aid soft and osseous tissue regeneration
8. Guided tissue regeneration
9. Surgical revision
10. Pedicle and free soft tissue graft
11. Subepithelial connective tissue graft
12. Distal or proximal wedge
13. Soft tissue allograft
14. Combined connective tissue and double pedicle graft

b) Non-Surgical Periodontal Service
1. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
2. Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
3. Full mouth debridement to enable comprehensive evaluation
4. Localized delivery of antimicrobial agents

c) Periodontal maintenance

Prosthodontic Services

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

Prosthodontic services to include:

a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature

b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
1. Resin base and cast frame dentures including any conventional clasps, rests and teeth
2. Flexible base denture including any clasps, rests and teeth
3. Removable unilateral partial dentures or dentures without clasps are not considered

c) Overdenture – complete and partial

d) Denture adjustments –6 months after insertion or repair

e) Denture repairs – includes adjustments for first 6 months following service

f) Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service

g) Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service

h) Precision attachment, by report

i) Maxillofacial prosthetics - includes adjustments for first 6 months following service
1. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
2. Obturator prosthesis: surgical, definitive and modifications
3. Mandibular resection prosthesis with and without guide flange
4. Feeding aid
5. Surgical stents
6. Radiation carrier
7. Fluoride gel carrier
8. Commissure splint
9. Surgical splint
10. Topical medicament carrier
11. Adjustments, modification and repair to a maxillofacial prosthesis
12. Maintenance and cleaning of maxillofacial prosthesis

j) Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
Covered services include: implant body, abutment and crown.

k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.

2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
3. Considerations and requirements noted for single crowns apply
4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
5. Abutment teeth must be periodontally sound and have a good long term prognosis
6. Repair and recementation

l) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

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

a) Extraction of teeth:
   1. Extraction of coronal remnants – deciduous tooth,
   2. Extraction, erupted tooth or exposed root
   3. Surgical removal of erupted tooth or residual root
   4. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
b) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
c) Other surgical Procedures
   1. Oroantral fistula
   2. Primary closure of sinus perforation and sinus repairs
   3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
   4. Surgical access of an unerupted tooth
   5. Mobilization of erupted or malpositioned tooth to aid eruption
   6. Placement of device to aid eruption
   7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
   8. Surgical repositioning of tooth/teeth
   9. Transseptal fiberotomy/supra crestal fiberotomy
   10. Surgical placement of anchorage device with or without flap
   11. Harvesting bone for use in graft(s)
d) Alveoloplasty in conjunction or not in conjunction with extractions
e) Vestibuloplasty
f) Excision of benign and malignant tumors/lesions
g) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
h) Destruction of lesions by electrosurgery
i) Removal of lateral exostosis, torus palatinus or torus madibularis
j) Surgical reduction of osseous tuberosity
k) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
l) Surgical Incision
   1. Incision and drainage of abcess - intraoral and extraoral
   2. Removal of foreign body
   3. Partial ostectomy/sequestrectomy
   4. Maxillary sinusotomy
m) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
n) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
   1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
   2. Manipulation under anesthesia
   3. Condylectomy, discectomy, synovectomy
   4. Joint reconstruction
   5. Services associated with TMJD treatment require prior authorization
o) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
p) Arthroscopy
q) Occlusal orthotic device – includes placement and removal to same provider
r) Surgical and other repairs
   1. Repair of traumatic wounds – small and complicated
   2. Skin and bone graft and synthetic graft
   3. Collection and application of autologous blood concentrate
   4. Osteoplasty and osteotomy
   5. LeFort I, II, III with or without bone graft
   6. Graft of the mandible or maxilla – autogenous or nonautogenous
   7. Sinus augmentations
   8. Repair of maxillofacial soft and hard tissue defects
   9. Frenectomy and frenoplasty

10. Excision of hyperplastic tissue and pericoronal gingiva
11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
12. Emergency tracheotomy
13. Coronoidectomy
14. Implant – mandibular augmentation purposes
15. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

Orthodontic Services

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

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

Orthodontic service to include:

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

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

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

Adjunctive General Services

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

e) Professional visits
- House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
- Hospital or ambulatory surgical center call
  - For cases that are treated in a facility.
  - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
  - General anesthesia and outpatient facility charges for dental services are covered
  - Dental services rendered in these settings by a dentist not on staff are considered separately
- Office visit for observation – (during regular hours) no other service performed

f) Drugs
- Therapeutic parenteral drug
  - Single administration
  - Two or more administrations - not to be combined with single administration
- Other drugs and/or medicaments – by report

g) Application of desensitizing medicament – per visit
h) Occlusal guard – for treatment of bruxism, clenching or grinding
i) Athletic mouthguard covered once per year
j) Occlusal adjustment
- Limited - (per visit)
- Complete (regardless of the number of visits), once in a lifetime

k) Odontoplasty
l) Internal bleaching]

Note to carriers: the above Dental benefits provision is variable and may be deleted as described in the Explanation of Brackets If the provision is deleted include the following heading such that the under age 6 provision would be part of the Dental Care and Treatment provision.

[Additional benefits for a child under age 6]
For a Member who is severely disabled or who is a child under age 6, We cover:
a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Contract which requires Hospitalization or general anesthesia.

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

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

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

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

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

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

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

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

NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS CONTRACT.

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

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

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

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless [Member] is being transferred to another Inpatient health care Facility.
Blood or blood plasma which is replaced by or for a [Member].

[Broken appointments.]

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

Completion of claim forms.

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

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

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

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

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

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

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

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

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

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

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

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

Services or supplies related to **hypnotism.**

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

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

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

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

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

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

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

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

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

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

a) Charges to administer a Prescription Drug.

b) Charges for:
- immunization agents,
- allergens and allergy serums
- biological sera, blood or blood plasma, [unless they can be self-administered].

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

d) Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.
e) Charges for refills dispensed after one year from the original date of the prescription.

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

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

h) Charges for a Prescription Drug which is to be taken by or given to the [Member], in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Hospice
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home
  or similar institution
- a provider's office.

i) Charges for:
- therapeutic devices or appliances
- hypodermic needles or syringes, except insulin syringes

- support garments; and
- other non-medical substances, regardless of their intended use.

j) Charges for vitamins, except Legend Drug vitamins.

k) Charges for drugs for the management of nicotine dependence.

l) Charges for topical dental fluorides.

m) Charges for any drug used in connection with baldness.

n) Charges for drugs needed due to conditions caused, directly or indirectly, by a [Covered Person] taking part in a riot or other civil disorder; or the

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

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

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

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

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

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

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

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

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

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

[y) Life Enhancement Drugs for the treatment of sexual dysfunction, (e.g. Viagra).]

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

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

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

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

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

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

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

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the [Member] asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a [Member] would not have been charged if he or she did not have health care coverage;

d) for which the Member has no legal obligation to reimburse the Provider;
e) provided by or in a Government Hospital except as stated below, or unless the services are for treatment:
of a non-service Emergency; or
by a Veterans' Administration Hospital of a non-service related Illness or Injury;
Exception: This exclusion does not apply to military retirees, their Dependents and the Dependents of active duty military personnel who are covered under both this Contract and under military health coverage and who receive care in facilities of the Uniformed Services.

Stand-by services required by a Provider.

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

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a [Member]'s sex; services and supplies arising from complications of sex transformation.

[Telephone consultations. [except as stated in the Outpatient Services provision].]]

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

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a **war**, or an act of war, if the Illness or Injury occurs while the [Member] is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Member is serving in such forces and is outside the home area
Weight reduction or control, including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, except as otherwise provided in the Surgical Treatment of Morbid Obesity section of this Contract.

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

COORDINATION OF BENEFITS AND SERVICES

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

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

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

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

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

Allowed Charge: An amount that is not more than allowance for the service or supply as determined by Us, based on a standard which is most often charged for a given service by a Provider within the same geographic area .

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

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

For purposes of determining plans with which this plan can coordinate, Plan does not include:
a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the [Member], except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident –type coverage;
f) A State plan under Medicaid.

PRIMARY AND SECONDARY PLAN
We consider each plan separately when coordinating payments.

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

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

This Contract shall not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:
a) the basis on which the Primary Plan and the Secondary Plan pay benefits; and
b) whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Allowed Charge (AC), or some similar term. This means that the provider bills a charge and the Member may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on an allowed charge is called an "ACPlan."

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

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

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan, and "EPO" refers to Exclusive Provider Organization.
Primary Plan is AC Plan and Secondary Plan is AC Plan
The Secondary Plan shall pay the lesser of:
a) the difference between the amount of the billed charges and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan
If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
The total amount the provider receives from the Primary plan, the Secondary plan and the Member shall not exceed the fee schedule of the Primary Plan. In no event shall the Member be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is AC Plan and Secondary Plan is Fee Schedule Plan
If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:
a) the difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.
The Member shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the Member has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the primary and Secondary Plans are less than the provider's billed charges. In no event shall the Member be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is AC Plan
If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

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

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or AC Plan
If Member receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

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

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

[Note to carriers: This paragraph should only be included in plans issued as HMO or EPO coverage.]

SERVICES FOR AUTOMOBILE RELATED INJURIES

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

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

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:
a) this Contract;
b) PIP; or
c) OSAIC.
"Eligible Services" means services provided for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Copayments, if any or Coinsurance.

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

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

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

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

If there is a dispute as to which policy is primary, this Contract will pay benefits or provide services as if it were primary.
Services this Contract will provide if it is primary to PIP or OSAIC.
If this Contract is primary to PIP or OSAIC it will provide benefits for eligible expenses in accordance with its terms.

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

GENERAL PROVISIONS

AMENDMENT

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

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

No change in the Contract is valid unless the change is shown in one of the following ways:
a) it is shown in an endorsement on it signed by one of Our officers.
b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of this Contract called **Conformity With Law**, it is shown in an amendment to it that is signed by one of Our officers.
c) if a change is required by Us, it is accepted by the Contractholder, as evidenced by payment of a premium on or after the effective date of such change.
d) if a written request for a change is made by the Contractholder, it is shown in an amendment to it signed by the Contractholder and by one of Our officers.

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

CLERICAL ERROR - MISSTATEMENTS
No clerical error nor programming or systems error by the Contractholder or by Us in keeping any records pertaining to coverage under this Contract will reduce a [Member]'s Coverage. Neither will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of premiums will be made.
Premium adjustments involving return of unearned premium to the Contractholder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PAYMENT OF PREMIUMS - GRACE PERIOD
<u>The following paragraph only applies to [Members] who are NOT recipients of the premium tax credit and [Members] who are recipients of the premium tax credit but have not paid at least one full month's premium during the calendar year</u>

Premiums are to be paid by You to Us. They are due on each premium due date. You may pay each premium other than the first within 31 days of the premium due date. Those days are known as the grace period. You are liable to pay premiums to Us from the first day the Contract is in force in order for this Contract to be considered in force on a premium paying basis. You will be liable for the payment of the premium for the time the Contract stays in effect. If any premium is not paid by the end of the grace period, [this Contract will continue in force without premium payment during the grace period and this Contract will end when the grace period ends.][coverage will end as of the end of the period for which premium has been paid. You may be responsible for the payment of charges incurred for services or supplies received during the grace period.]

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

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

REINSTATEMENT
If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Contract. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Contract will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the forty-fifth day following the date for the conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. [Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the

maximum allowed by law.] The reinstated Contract shall cover only loss resulting from Injury or Illness that begins more than 10 days after the date of reinstatement. In all other respects, We and the Member shall have the same rights under the Contract as before the end of the grace period.

PREMIUM RATE CHANGES

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

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

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

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

STATEMENTS

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

All statements will be deemed representations and not warranties.

RENEWAL PRIVILEGE – TERMINATION

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

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

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

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

The advance written notice for non-renewal for the reasons stated in items a, b and c above shall comply with the requirements of N.J.A.C. 11:20-18. Any notice provided in the event of item [d] above will be subject to marketplace requirements, if any.

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

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

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

a) You have failed to pay premiums in accordance with the terms of the Contract, or We have not received timely premium payments; ([Coverage will end as described In the Grace Period provision.]
b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract; (Coverage will end [as of the effective date][immediately].)
c) with respect to a Member other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
d) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the individual Health Benefits Plan takes effect, provided We receive notice of the replacement within 30 days after the effective date of the new plan.)
e) [You no longer reside, live or work in the Service Area, or in an area for which We are authorized to do business, provided that coverage is terminated uniformly without regard to any Health Status-Related Factor of Members.]
f) with respect to a catastrophic plan, the date of a marketplace redetermination of exemption eligibility that finds the Member is no longer eligible for an exemption, or until the end of the plan year in which the Member attains age 30, whichever occurs first.

TERMINATION OF DEPENDENT COVERAGE

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

A Dependent's coverage ends when the Dependent is no longer a Dependent, as defined in the Contract. Coverage ends at 12:01 a.m. on the date the first of these events occurs.

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

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

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

CONVERSION RIGHTS FOR DIVORCED SPOUSES

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

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

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

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

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).
Amended by R.2012 d.167, effective September 13, 2012 (operative January 1, 2013).
See: 44 N.J.R. 2237(a), 44 N.J.R. 2365(a).
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).
Amended by R.2014 d.190, effective November 17, 2014 (operative January 1, 2015).
See: 46 N.J.R. 2314(a), 46 N.J.R. 2416(b).
Amended by R.2015 d.095, effective May 12, 2015.
See: 47 N.J.R. 1234(a), 47 N.J.R. 1326(a).
Amended by R.2015 d.174, effective January 1, 2016.
See: 47 N.J.R. 2625(a), 47 N.J.R. 2873(a).

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 the policy form text or in this Explanation of Brackets. 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, POS or EPO)
g) Some areas of variability apply to the limited circumstance of plans to be issued in the Marketplace created under the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152 (Marketplace).

Note: Due to the complexity of issuing plans through or in conjunction with an approved Selective Contracting Arrangement, commonly known as PPO, POS and EPO plans, explicit guidance is set forth in item 21 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, POS and EPO schedule pages. There are corresponding provisions in the benefit provisions.
5. The sample schedule pages illustrate a variety of cost sharing features with combinations of copayments, deductibles and coinsurance. Designs illustrated on one sample page may be included in other schedule pages. For example, some of the sample pages illustrate specific cost sharing applied to pediatric dental and vision benefits. Similar text may be included in other schedule pages. In addition, coinsurance percentages necessary to achieve a cost sharing reduction through the marketplace may be used even in such percentages are not illustrated on the same schedules.
6. One of the schedule pages illustrates a tiered network design. Carriers should adapt the schedule page to illustrate the services for which a tiered network design is applicable. Additional variable text addressing a tiered network is included in the PPO, POS and EPO descriptions and other coverage sections of the policy.
7. The definition of Eligible Person and the Who is Eligible provision contain bracketed text addressing PPACA's requirement that the person must be a U.S. citizen, national or lawfully present in the United States to be covered under a policy offered in the Marketplace. Such variable text applies in the limited circumstance of plans issued in the Marketplace. Such bracketed text must not be included in plans otherwise issued in New Jersey.
8. The list of services and supplies for which pre-approval is required includes some new items, included in brackets: specified therapies, therapeutic manipulation, 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. The provision may include information regarding the website.
9. 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.
10. 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 PPO, POS or EPO delivery system.
11. The definitions section includes definitions that would be included if a carrier offers a mail order pharmacy program
12. The text describing provider compensation in the PPO, POS and EPO section contains a number of bracketed words and phrases. Include the words and phases that describe the arrangement carrier has with network providers.
13. The continuation of care text must be included in all plans that use networks.
14. The Deductible Credit provision includes variable text regarding cost sharing reduction that would be included for policies issued on the Marketplace. Such variable text must not be included in plans otherwise issued in New Jersey.
15. The treatment of hemophilia provision includes variable text that would only be included in network-based plans.
16. The prescription drugs provision includes variable text that would be included by carriers that require pre-approval for specified drugs.
17. The therapy services provision includes variable text that would be included by carriers that require pre-approval for certain therapy services.
18. The Dental Benefits text is enclosed in brackets. For policies sold on the Marketplace the Dental Benefits provision may be excluded if the Marketplace offers a standalone dental plan with a pediatric dental essential health benefit. Such bracketed text must be included in plans

otherwise issued in New Jersey unless a carrier is reasonably assured that an individual has obtained such pediatric dental coverage through a marketplace-certified stand-alone dental plan. Dental benefits may be limited to services provided by a network provider.

19. 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.
20. 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.
21. 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, POS or EPO mechanism, with specification of the name of the network or provider organization.
22 The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
23. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.

HMO Contract
(Appendix Exhibit B)

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], [Contractholder], and [ABC].
b) Some areas of variability are noted with brief explanations within the text.
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 apply to the limited circumstance of plans to be issued in the Marketplace created under the Patient Protection and Affordable Care Act (Marketplace). In those instances, the variations must not be included in plans otherwise issued in New Jersey.

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

1. The Health Care Quality Act requires carriers to specify the legal name, trade name fax and e-mail 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. 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 contract form.
3. The definition of Eligible Person and the Who is Eligible provision contain bracketed text addressing PPACA's requirement that the person must be a U.S. citizen, national or lawfully present in the United States to be covered under a policy offered in the Marketplace. Such variable text applies in the limited circumstance of plans issued in the Marketplace. Such bracketed text must not be included in plans otherwise issued in New Jersey.
4. The definitions section includes definitions that should be included if a carrier offers a mail order pharmacy program.
5. The sample schedule pages illustrate a variety of cost sharing features with combinations of copayments, deductibles and coinsurance. Designs illustrated on one sample may be included in other schedule pages. For example, some of the sample pages illustrate specific cost sharing applied to pediatric dental and vision benefits. Similar text may be included in other schedule pages.
6. One of the schedule pages illustrates a tiered network design. Carriers should adapt the schedule page to illustrate the services for which a tiered network design is applicable.
7. Co-Payments may be elected by the Contractholder, subject to the availability specified in regulation.
8. Deductible, coinsurance and maximum out of pocket provisions may be included. Applicable text to address the deductible, coinsurance and maximum out of pocket features must be included on the schedule page and in the benefit provisions.
9. The Contract includes referral text in brackets to allow the plan to be offered as a "gated" HMO or as a "non-gated" HMO.
10. The Deductible Credit provision that would be included for a deductible/coinsurance HMO plan design includes variable text regarding cost sharing reduction that would be included for policies issued on the Marketplace. Such variable text must not be included in plans otherwise issued in New Jersey
11. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include.
12. OB/GYNs can be considered Primary Care Physicians.
13. Transfer of Primary Care Physician can occur according to carrier administration, but may not be more restrictive to the member than stated in the form.
14. Carriers should include variable material contained in the Provider Payment section to correctly address the compensation arrangement the carriers have with the network.
15. Carriers that wish to apply pre-approval requirements to the Prescription Drugs coverage should include the variable pre-approval text.

16. The Dental Benefits text is enclosed in brackets. For policies sold on the Marketplace the Dental Benefits provision may be excluded if the Marketplace offers a standalone dental plan with a pediatric dental essential health benefit. Such bracketed text must be included in plans otherwise issued in New Jersey unless a carrier is reasonably assured that an individual has obtained such pediatric dental coverage through a marketplace-certified stand-alone dental plan.

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.3, effective December 5, 1996.
See: 28 N.J.R. 4856(a), 29 N.J.R. 138(a).
Substantially amended Exhibit C.
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.450, effective October 20, 1997.
See: 29 N.J.R. 3411(a), 29 N.J.R. 4461(b).
Amended alternate option for sections III and V.
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.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(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).
Amended by R.2005 d.160, effective April 22, 2005.
See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(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.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
Amended by R.2013 d.130, effective October 1, 2013 (operative January 1, 2014).
See: 45 N.J.R. 2310(a), 45 N.J.R. 2385(a).

EXHIBIT D

[Carrier]
AMENDMENT

[Policyholder]

[Effective date]
[

]
This Amendment is part of the [Policy]. Except as stated above, nothing in this Amendment changes or affects any of the terms of the [Policy]. [Carrier shall insert its standard amendment closure and signature blocks.]

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).
Petition for Rulemaking: Exhibit D.
See: 28 N.J.R. 1315(a).
Public Notice: Action on petition for rulemaking.
See: 28 N.J.R. 2413(b).
Amended by R.1997 d.3, effective December 5, 1996.
See: 28 N.J.R. 4856(a), 29 N.J.R. 138(a).
Substantially amended Exhibit D.
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.450, effective October 20, 1997.
See: 29 N.J.R. 3411(a), 29 N.J.R. 4461(b).
Amended alternate options for Sections III and V.
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.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(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).
Amended by R.2005 d.160, effective April 22, 2005.
See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).
Recodified from N.J.A.C. 11:20 Appendix Exhibit S 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 D, repealed.

Exhibit K Part C Premium Data Worksheet for the Two-Year Calculation Period ___

Name of Affiliate: _____ Name of Carrier on Exhibit K: _____

Carriers shall complete and return this page for each affiliate along with Exhibit K.

Section 1: Total A&H Premium	Premium for ___	Premium for ___	Two-Year Total
Amount of Accident & Health Premium on New Jersey NAIC Statement Blank:	$	$	$

Section 2: List of Excepted Benefits and Premium	Premium for ___	Premium for ___	Two-Year Total
a. Medicare Advantage and Medicare + Choice coverage and Medicare Demonstration and Medicare Part D Coverage	$	$	$
b. contracts funded pursuant to the "Federal Employee Health Benefits Act of 1959," 5 U.S.C. § § 8901-8914	$	$	$
c. excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan	$	$	$
d. Medicare supplement policies or contracts	$	$	$
e. non-expense incurred specified disease coverage	$	$	$
f. coverage only for accident, disability income insurance, or any combination	$	$	$
g. coverage issued as a supplement to liability insurance	$	$	$
h. liability insurance, including general liability insurance and automobile liability insurance	$	$	$
i. workers' compensation or similar insurance	$	$	$
j. automobile medical payment insurance	$	$	$
k. credit-only insurance	$	$	$
l. coverage for on- site medical clinics	$	$	$
m. other similar insurance coverage, as specified in federal regs., under which benefits for medical care are secondary or incidental to other insurance benefits	$	$	$
n. limited scope dental or vision benefits*	$	$	$
o. benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof *	$	$	$
p. such other similar, limited benefits as are specified in federal regulations*	$	$	$
q. 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	$	$	$
r. coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.)	$	$	$
s. similar supplemental coverage provided to coverage under a group health plan	$	$	$
Total excepted premium:	$	$	$

*include as an excepted benefit if the coverage is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of the plan.

Section 3: Calculation of "Net Earned Premium"	Premium for ___	Premium for ___	Two-Year Total
Net Earned Premium = (Section 1 premium – Section 2 premium)	$	$	$

Repeal and New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Section was "Exhibit K: New Jersey Individual Health Coverage Program; Carrier Market Share and Net Paid Gain (Loss) Report".
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(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.2011 d.163, effective June 6, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).

New Jersey Individual Health Coverage Program
Quarterly Enrollment Report - Part 1 of Exhibit L

Carrier:
Respondent:
Phone: Fax:
Email:

Quarter Reported:

A. Report by Contracts	Issued Prior to 8/1/93	Standard Plans													Basic & Essential Plans		Totals
		Plan A/50		Plan B		Plan C		Plan D		HMO Plans					Indemnity, PPO/EPO	HMO Plans	
		Indemnity	PPO	Indemnity	PPO	Indemnity	PPO	Indemnity	PPO	Copay	50% Coins	40% Coins	30% Coins	20% Coins			
I. Contracts Inforce Beginning of Period	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
II. Contracts Issued During Period		-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
1. Contracts Issued to Previously Insured Individuals		-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
2. Contracts Issued to Previously Uninsured Individuals		-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Contracts Issued with Unknown Prior Insured Status		-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
III. Contracts Lapsed During Period	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
IV. Contracts Inforce End of Period (I+II-III)*	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
B. Report by Persons Insured																	
I. Insureds Beginning of Period	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
II. New Insureds During Period	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
III. Insureds Lapsed During Period	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
IV. Insureds End of Period (I+II-III)	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
C. Report of Contracts by Rating Tier																	
I. Single Contracts	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
II. Two Adult Contracts	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
III. Adult and Child(ren) Contracts	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
IV. Family Contracts	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
V. Contracts Inforce End of Period (I+II+III+IV)*	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-
D. Report of Contracts by Deductible/Copayment Option																	
I. Contracts with $1,000 Deductible		-	-	-	-	-	-	-	-		-	-	-	-			-
II. Contracts with $2,500 Deductible		-	-	-	-	-	-	-	-		-	-	-	-			-
III. Contracts with $5,000 Deductible		-	-	-	-	-	-	-	-		-	-	-	-			-
IV. Contracts with $10,000 Deductible		-	-	-	-	-	-	-	-								-
V. Contracts with $15 Copay			-		-		-		-	-							-
VI. Contracts with $30 Copay			-		-		-		-	-							-
VII. Contracts with $40 Copay			-		-		-		-	-							-
VIII. Contracts with $50 Copay			-		-		-		-	-							-
IX. Contracts with HDHP Deductibles (MSA provisions) - *renewal business only*							-		-								-
X. Contracts with HDHP Deductibles (HSA Provisions)		-	-	-	-	-	-	-	-								-
XI. Contracts Issued as Basic & Essential Plans - without any rider															-	-	-
XII. Contracts Issued as Basic & Essential Plans - with a rider															-	-	-
XIII. Contracts with $500 Deductible, $10 or $20 Copay - *runoff business only*								-	-	-							-
XIV. Contracts Inforce End of Period (I+II+III+IV+V+VI+VII+VIII+IX)*	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-

% of Contracts Issued to Persons Previously Uninsured	-

Revised 5/31/05

[*NOTE: A.IV = C.V = D.XIV]

New Jersey Individual Health Coverage Program
Annual Enrollment Report - Part 2 of Exhibit L

Carrier:	
Respondent:	
Phone:	Fax:
Email:	

Year Reported:

	Standard Plans													Basic & Essential Plans				
	Plan A/50			Plan B			Plan C			Plan D			HMO	Indemnity,	Indemnity,	HMO	HMO	Total
	Indemnity	PPO	POS	Indemnity	PPO	POS	Indemnity	PPO	POS	Indemnity	PPO	POS	Plans	PPO/EPO with rider	PPO/EPO w/o rider	with rider	w/o rider	Plans
A. Report of Inforce Contracts by Zip Code																		
Territory A (070-073)	-			-		-	-		-	-		-	-	-			-	-
Territory B (074-076)	-			-		-	-		-	-		-	-	-			-	-
Territory C (077-079)	-			-		-	-		-	-		-	-	-			-	-
Territory D (088-089)	-			-		-	-		-	-		-	-	-			-	-
Territory E (081, 085-086)	-			-		-	-		-	-		-	-	-			-	-
Territory F (080, 082-084, 087)	-			-		-	-		-	-		-	-	-			-	-
Total	-			-		-	-		-	-		-	-	-			-	-
B. Report of Insured Males																		
Age 0-24	-			-		-	-		-	-		-	-	-			-	-
Age 25-29	-			-		-	-		-	-		-	-	-			-	-
Age 30-34	-			-		-	-		-	-		-	-	-			-	-
Age 35-39	-			-		-	-		-	-		-	-	-			-	-
Age 40-44	-			-		-	-		-	-		-	-	-			-	-
Age 45-49	-			-		-	-		-	-		-	-	-			-	-
Age 50-54	-			-		-	-		-	-		-	-	-			-	-
Age 55-59	-			-		-	-		-	-		-	-	-			-	-
Age 60-64	-			-		-	-		-	-		-	-	-			-	-
Age 65-69	-			-		-	-		-	-		-	-	-			-	-
Age 70 & Over	-			-		-	-		-	-		-	-	-			-	-
Total	-			-		-	-		-	-		-	-	-			-	-
C. Report of Insured Females																		
Age 0-24	-			-		-	-		-	-		-	-	-			-	-
Age 25-29	-			-		-	-		-	-		-	-	-			-	-
Age 30-34	-			-		-	-		-	-		-	-	-			-	-
Age 35-39	-			-		-	-		-	-		-	-	-			-	-
Age 40-44	-			-		-	-		-	-		-	-	-			-	-
Age 45-49	-			-		-	-		-	-		-	-	-			-	-
Age 50-54	-			-		-	-		-	-		-	-	-			-	-
Age 55-59	-			-		-	-		-	-		-	-	-			-	-
Age 60-64	-			-		-	-		-	-		-	-	-			-	-
Age 65-69	-			-		-	-		-	-		-	-	-			-	-
Age 70 & Over	-			-		-	-		-	-		-	-	-			-	-
Total	-			-		-	-		-	-		-	-	-			-	-
D. Report of Plans as Amended by Riders																		
Number of Plans																		

Revised 9/9/08

New Rule, R.1994 d. 53, effective December 30, 1993.
See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).
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.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
Amended by R.2002 d.95, effective March 18, 2002 (operative August 1, 2002).
See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

EXHIBIT M

(RESERVED)

New Rule, 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).
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).
Repealed by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Was "PPO Standard Plan Provisions".

EXHIBIT N

(RESERVED)

New Rule, 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).
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).
Repealed by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Was "POS Standard Plan Provisions".

EXHIBIT O

(RESERVED)

New Rule, 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).

Repealed by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Was "PPO/POS Schedule".

EXHIBIT P

(RESERVED)

New Rule, 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).

Repealed by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Was "PPO/POS Schedule".

EXHIBIT Q

(RESERVED)

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).
Administrative Change.
See: 27 N.J.R. 1423(a).
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).
Administrative Correction.
See: 38 N.J.R. 1005(a).
Repealed 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).
Exhibit was "Certification of Compliance with New Jersey Individual Health Benefits Plans".

EXHIBIT R

(RESERVED)

New Rule, 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).
Repealed by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Section was "Mandated Offer Rider".

EXHIBIT S

(RESERVED)

New Rule, R.1996 d.542, effective December 2, 1996.
See: 28 N.J.R. 3704(a), 28 N.J.R. 5075(a).

Recodified to N.J.A.C. 11:20 Appendix Exhibit D 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).

EXHIBIT T

(RESERVED)

New Rule, 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.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
Amended by R.2005 d.160, effective April 22, 2005.
See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).
Administrative Correction.
See: 38 N.J.R. 1005(a).
Repealed 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).
Exhibit was "Explanation of Brackets for Individual Health Coverage Standard Plans and Application".

EXHIBIT U

(RESERVED)

New Rule, 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).
Amended by R.2002 d.95, effective March 18, 2002 (operative August 1, 2002).
See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).
Repealed 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).

EXHIBIT V

(RESERVED)

New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Recodified to N.J.A.C. 11:20 Appendix Exhibit F 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).