CHAPTER 21

SMALL EMPLOYER HEALTH BENEFITS PROGRAM

Authority

N.J.S.A. 17B:27A–17 et seq.

Source and Effective Date

R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

Executive Order No. 66(1978) Expiration Date

Chapter 21, Small Employer Health Benefits Program, expires on September 25, 2003.

Chapter Historical Note

Chapter 21, Small Employer Health Benefits Program, was adopted as R.1993 d.553, effective October 15, 1993. See: 25 N.J.R. 3599(a), 25 N.J.R. 5253(a).

Subchapter 14, Declaration and Approval of Reinsuring or Risk-Assuming Carrier Status, was adopted as R.1993 d.551, effective October 15, 1993. See: 25 N.J.R. 4572(a), 25 N.J.R. 5347(a). Subchapter 14 was repealed by R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

Subchapter 15, Relief From Obligations Imposed Under the Small Employer Health Benefits Program, was adopted as R.1993 d.629, effective November 5, 1993. See: 25 N.J.R. 4577(a), 25 N.J.R. 5692(a).

Subchapter 6, Standard Employer and Employee Application and Small Employer Certification Forms, Subchapter 7, Program Compliance, Subchapter 17, Fair Meeting Standards, and Subchapter 18, Petitions for Rules, were adopted as R.1993 d.644, effective November 12, 1993. See: 25 N.J.R. 4437(a), 30 N.J.R. 5668(a).

Subchapter 3A, Non-Standard Health Benefits Plan, was adopted as R.1994 d.499, effective September 2, 1994. See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b). Subchapter 3A as was repealed and Subchapter 3A, Non-Standard Health Benefits Plans, was adopted as new rules by R.1997 d.62, effective February 3, 1997. See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Subchapter 9, Informational Rate Filing Requirements Pursuant to the Small Employer Health Benefits Program, was adopted as R.1994 d.25, effective December 9, 1993. See: 25 N.J.R. 5757(a), 26 N.J.R. 245(a).

Subchapter 16, Withdrawals of Small Employer Carriers From the Small Employer Health Benefits Plans Market, was adopted as R.1994 d.26, effective December 9, 1993. See: 25 N.J.R. 4859(a), 26 N.J.R. 247(a).

Subchapter 2, New Jersey Small Employer Health Benefits Program Plan of Operation, was adopted as R.1994 d.48, effective December 22, 1993. See: 25 N.J.R. 4563, 26 N.J.R. 391(a).

Subchapter 8, Carrier Certification of Non-Member Status, and Subchapter 10, The Market Share Report, were adopted as R1994 d.228, effective April 11, 1994. See: 26 N.J.R. 1588(a), 26 N.J.R. 1873(a).

Subchapter 11, Nonstandard Health Benefits Plan Filings With the Commissioner: Form Filings and Request to Withdraw Plan Forms, was adopted as R.1994 d.580, effective November 21, 1994. See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a). Subchapter 11 was renamed Nonstandard Health Benefits Plans (Filings With the Commissioner): Requirements for Maintaining Nonstandard Plans by R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

Subchapter 19, SEH Program Premium Comparison Survey, was adopted as R.1995 d.289, effective June 5, 1995. See: 27 N.J.R. 1127(b), 27 N.J.R. 2233(a).

Subchapter 7A, Loss Ratio Reports; Dividends and Credits, was adopted as R.1996 d.213, effective May 6, 1996. See: 28 N.J.R. 59(a), 28 N.J.R. 234(b), 28 N.J.R. 2388(a).

Subchapter 13, Nonstandard Plans: Withdrawal of Plans, was adopted as R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

Pursuant to Executive Order No. 66(1978), Subchapters 1 through 7, 8, 10, 17, 18, and Appendix Exhibits A through KK of Chapter 21, Small Employer Health Benefits Program, were readopted by the Small Employer Health Benefits Program Board as R.1998 d.512, effective September 25, 1998. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

11:21–1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.162 as amended by P.L. 1993, c.162, P.L. 1994, c.11, P.L. 1994, c.97, P.L. 1995, c.50, P.L. 1995, c.298, and P.L. 1995, c.340 (N.J.S.A. 17B:27A–17 et seq.), herein referred to as the Small Employer Health Benefits Act. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A–17 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Small Employer Health Benefits Program pursuant to N.J.S.A. 17B:27A–17 et seq.

(b) Provisions of the New Jersey Small Employer Health Benefits Act and of this chapter shall be applicable to all carriers that are members of the Small Employer Health Benefits Program, and to such other carriers as the specific provisions of the statute and this chapter may state.

(c) Provisions of the New Jersey Small Employer Health Benefits 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 November 30, 1992, except as the specific provisions of the statute and of this chapter state otherwise.

Petition for Rulemaking: Exhibit G.
See: 26 N.J.R. 2488(b), 26 N.J.R. 3089(a), 26 N.J.R. 3758(a).
Petition for Rulemaking: Exhibit G.
See: 26 N.J.R. 5120(a), 27 N.J.R. 1321(b).
Petition for Rulemaking: Exhibits A through G.
See: 26 N.J.R. 5120(c), 27 N.J.R. 946(c).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted additional P.L. references.

11:21–1.2 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 P.L. 1992, c.162, as adopted and subsequently amended (N.J.S.A. 17B:27A–17 et seq.), also referred to herein as the Small Employer Health Benefits Act.

"Affiliated carrier" means a carrier that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another carrier.

"Board" means the Board of Directors of the New Jersey Small Employer Health Benefits 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 an insurance company authorized to issue health insurance, a health maintenance organization, a hospital service corporation, medical service corporation and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. The term "carrier" shall not include a joint insurance fund established pursuant to State law. For purposes of this chapter, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

"Cash deductible" or "deductible" means the amount of covered charges that a covered person must pay before the health benefits plan pays any benefits for such 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" (29 U.S.C. § 1002(33)).

"Coinsurance" means the percentage of a covered charge that must be paid by a covered person. Coinsurance does not include cash deductibles, copayment or non-covered charges.

"Coinsurance cap" means the maximum amount a covered person is required to pay as a result of the application of the coinsurance under the standard plans, as set forth in the Appendix Exhibits to this chapter. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the coinsurance cap.

"Coinsured charge limit" means, with respect to a preferred provider organization (PPO) plan, or a point of service (POS) plan, developed based on the standard health

benefit plans set forth in the Appendix Exhibits to this chapter, the amount of covered charges a covered person must incur before no coinsurance is required with the following exception. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the coinsured charge limit.

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

"Copayment" or "copay" means a specified dollar amount a covered person must pay for specified covered charges.

"Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: a group health plan; a group or individual health benefits plan; Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.); Title XIX of the Federal Social Security Act (42 U.S.C. §§ 1396 et seq.), other than coverage consisting solely of benefits under section 1928 of Title XIX of the Federal Social Security Act (42 U.S.C. § 1396s); chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code (5 U.S.C. §§ 8901 et seq.); a public health plan as defined by Federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act" (22 U.S.C. § 2504(e)); or coverage under any other type of plan as set forth by the Commissioner by regulation. Creditable coverage shall not include coverage consisting solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage, as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of health benefits plan.

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

"Dependent" means the spouse or child of an eligible employee subject to applicable terms of the employee's health benefits plan.

"Eligible employee" means a full-time, bona fide employee who works a normal work week of 25 or more hours. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefits plan of a small employer, but does not include employees who work less than 25 hours a week, work on a temporary or substitute basis or are participating in an employee welfare arrangement pursuant to a collective bargaining agreement.

"Enrollment date" means, with respect to a person covered under a health benefits plan, the date of enrollment of the person in the health benefits plan or, if earlier, the first day of the waiting period for such enrollment.

"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. §§ 300 et seq.)

"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" (29 U.S.C. § 1002(32)) 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 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" (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.

In (b), deleted "Effective on the fiscal quarter ending on September 30, 1994," at the beginning; deleted a former (d); and recodified former (e) as (d).

11:21–7.13 Paying benefits

(a) In paying benefits for covered services under the terms of the small employer health benefits plans provided by health care providers not subject to capitated or negotiated fee arrangements, small employer carriers shall pay covered charges for medical services, on a reasonable and customary basis or actual charges, and, for hospital services, based on actual charges. Reasonable and customary 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, incorporated herein by reference published and available from the Health Insurance Association of America, 6th Floor, East Tower, Columbia Square, 555 13th Street, NW, Washington, DC 20004–1109.

1. The maximum allowable charge shall be based on the 80th percentile of the profile.

2. Carriers shall use the profile effective as of July 1993, and shall update their databases within 60 days after receipt of periodic updates released by the Prevailing Healthcare Charges Systems.

Recodified from 11:21–7.14 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–7.12.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), rewrote the introductory paragraph.

11:21–7.14 Permissible rate classification factors

(a) For health benefits plans issued or renewed on or after September 11, 1994, a carrier shall not differentiate premium rates charged to different small employers for the same health benefits plan except on the basis of age, gender, and geography in accordance with the following restrictions:

1. Age factor categories shall be limited to the following increments: 24 and under; 25–29; 30–34; 35–39; 40–44; 45–49; 50–54; 55–59; 60–64; 65–69; 70 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 small employer on the basis of the address of the small employer's principal place of business. 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 charged to different small employers for the same standard health benefits plan, whether it be A, B, C, D, E or HMO, on the basis of family structure according to only the following four rating tiers:

1. Employee only;

2. Employee and spouse;

3. Employee and child(ren); and

4. Family.

New Rule, R.1994 d.418, effective July 15, 1994 (operative September 11, 1994).
See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).
Recodified from 11:21–7.15 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–7.13.

11:21–7.15 (Reserved)

Recodified to 11:21–7.14 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

SUBCHAPTER 7A. LOSS RATIO REPORTS; DIVIDENDS AND CREDITS

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e) and 17B:27A–25g(2).

Source and Effective Date

R.1996 d.213, effective May 6, 1996.
See: 28 N.J.R. 59(a), 28 N.J.R. 234(b), 28 N.J.R. 2388(a).

Subchapter Historical Note

Subchapter 7A, Continuation and Conversion of Existing Contracts, was adopted as R.1993 d.644, effective November 12, 1993. See: 25 N.J.R. 4437(a), 25 N.J.R. 5668(a). Subchapter 7A, Continuation and Conversion of Existing Contracts, was repealed by R.1994 d.499, effective September 2, 1994. See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b). Subchapter 7A, Loss Ratio-Reports; Dividends and Credits, was adopted by R.1996 d.213, effective May 6, 1996. See: Source and Effective Date.

11:21–7A.1 Purpose

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

11:21–7A.2 Definitions

The following terms, when used in this subchapter, shall have the following meanings:

"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 Department.

"Total employee months exposed" means the sum of the number of months that each employee was covered during the preceding calendar year. For example, if 40 employees were covered for three months, five employees were covered for 10 months and 12 employees were covered for 12 months, then the total employee months exposed would be 314 ({40 × 3} + {5 × 10} + {12 × 12}).

11:21–7A.3 Filing of loss ratio reports

(a) Each carrier having the five standard health benefit plan policy forms, non-standard policy forms or HMO plans in force at any time during the preceding calendar year shall file with the Department, for each standard plan including any standard and non-standard riders thereto and for all non-standard plans combined, an annual loss ratio report on the form appearing as Exhibit GG in the Appendix to this chapter, incorporated herein by reference.

(b) The loss ratio report shall be completed and filed with the Department on or before August 1 of the reporting year for the preceding calendar year; except that loss ratio reports for calendar year 1994, including any refund plans, shall be filed no later than June 5, 1996.

(c) Loss ratio reports submitted pursuant to this subchapter shall be sent to the Department at the following address:

Attention: SEH Loss Ratio Report Filings
Office of the Life and Health Actuary
New Jersey Department of Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625–0325

11:21–7A.4 Contents of the loss ratio report

(a) A loss ratio report filed pursuant to N.J.A.C. 11:21–7A.3 shall include the following information:

1. The reporting carrier's name and address;

2. The carrier's earned premiums before refunds or credits applicable to prior years, and claims for the preceding calendar year;

3. The carrier's loss ratio determined by dividing the claims by the premiums;

4. The carrier's calculation of the dividends and credits to be issued pursuant to N.J.S.A. 17B:27A–25g(2). (A credit is a dividend paid in the form of a reduction in a current premium due, as distinguished from dividends paid in cash.);

5. An explanation of the carrier's plan to issue dividends and credits;

6. An explanation of the carrier's plan to distribute a dividend in the event of cancellation or termination by a policyholder;

7. Certification by a member of the American Academy of Actuaries that the information provided in the report is accurate and complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A–25g(2), N.J.A.C. 11:21–7A and instructions; and

8. Such other information as the Department may request.

11:21–7A.5 Refund plan

(a) If the preceding calendar year loss ratio is less than 75 percent, the carrier shall include with the loss ratio report a plan to be approved by the Department for the distribution of all dividends and credits against future premiums for all policyholders with that policy form in the preceding calendar year in an amount sufficient to assure that the claims in the preceding calendar year plus the amount of the dividends and credits shall equal 75 percent of the premiums for the policy form in the preceding calendar year.

(b) Standard plans having total employee months exposed of less than 10,000 shall be combined for refund purposes.

(c) All non-standard plans, regardless of total employee months exposed, shall be combined for refund purposes. Standard plans shall not be combined with non-standard plans.

(d) The dividends or credits shall be issued to each policyholder who was covered for any period in the preceding calendar year.

(e) The dividend or credit amount per policyholder shall be determined by multiplying the premium for each policyholder by the percentage calculated by dividing the total refund by the total premium or on the basis of a practical and equitable alternate methodology filed by the carrier in accordance with (a) above.

(f) All dividends and credits shall be distributed by December 31 of the reporting year; except that refunds based on 1994 experience shall be made no later than 60 days following the Department's approval thereof and shall be limited to the payment of dividends—no credits will be permitted for that year.

SUBCHAPTER 8. CARRIER CERTIFICATION OF NON–MEMBER STATUS

11:21–8.1 Purpose and scope

(a) The purpose of this subchapter is to establish which carriers are not members of the SEH Program and how those carriers may be certified as non-members.

(b) This subchapter applies to any carrier which files Annual Statements with the Department evidencing premium earned on group health insurance.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), deleted reference to "other entities"; and in (b), deleted reference to accident insurance.

11:21–8.2 Definitions

Words and terms used in this subchapter shall have the meanings set forth in the Act or N.J.A.C. 11:21–1.2, unless the context indicates otherwise.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended "Group health benefits plan" and "Small employer".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.

11:21–8.3 Non-member status

(a) A carrier shall be a non-member of the SEH Program for the calendar year for which it submits a completed request for non-member certification unless the non-member certification is disapproved in writing by the Board. A carrier shall use the "Carrier Request for Non-Member Certification in the New Jersey Small Employer Health Benefits Program" form provided as Exhibit KK of these rules.

(b) A request for non-member certification shall state that:

1. The carrier neither issued nor had in force a group health benefits plan covering New Jersey small employers during the calendar year for which certification is submitted;

2. Other reasons which under law permit a carrier or entity to be certified a non-member.

Amended by R.1994 d.583, effective October 27, 1994.
See: 26 N.J.R. 4308(a), 26 N.J.R. 4629(a), 27 N.J.R. 1618(c).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended section.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), substituted "shall" for "may" following "carrier" in the second sentence.

11:21–8.4 Non-member certification requests

(a) To be considered a non-member in any calendar year, a carrier or entity shall file with the Board a completed request for non-member certification no later than March 1 of the following calendar year. Such request shall be sent to the SEH Program Administrator or Executive Director as specified at N.J.A.C. 11:21–1.3.

(b) All requests for non-member certification shall contain the statements required in N.J.A.C. 11:21–8.3 and be certified by a duly authorized officer of the carrier.

(c) A copy of such request also shall be filed by the carrier or other entity with the Commissioner as follows:

Attn: SEH Annual Certification of Non-Member Status
Life/Health Actuarial Services
New Jersey Department of Banking and Insurance
PO Box 325
Trenton, NJ 08625–0325

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), deleted reference to non-members for calendar year 1993; and in (b), inserted reference to statements required by N.J.A.C. 11:21–8.3.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted a reference to the Executive Director in the second sentence.

11:21–8.5 Decisions on filings by the Board

The Board shall, if it determines that a carrier's non-member certification is incomplete, incorrect, or not in substantial compliance with this subchapter or other law, deny a request for non-member certification in writing, stating the reasons for the determination, after review of a carrier's filing. A copy of such decision shall be sent to the carrier and to the Commissioner.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended section.

11:21–8.6 Review

(a) A carrier which has been denied non-member certification may contest that determination by filing an appeal with the Board no later than 20 calendar days after receiving the written determination from the Board.

(b) The appeal shall specify the reasons why the Board's determination is inaccurate and shall include all documentation that supports or tends to support the carrier's or entity's position. The carrier or entity also shall specify whether a hearing is requested.

(c) Within 45 days of its receipt of a request for a hearing, the Board shall determine whether bona fide issues of material fact exist such that a hearing shall be conducted.

If bona fide factual issues do not exist, the Board shall review the challenge itself and may delegate this review to an appropriate Board committee to make a recommendation to the Board. If a hearing is appropriate, the Board shall determine whether to hear the matter itself or refer it to the Office of Administrative Law for a hearing in accordance 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.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (c), substituted a reference to 45 days for a reference to 30 days in the first sentence.

SUBCHAPTER 9. INFORMATIONAL RATE FILING REQUIREMENTS PURSUANT TO THE SMALL EMPLOYER HEALTH BENEFITS PROGRAM

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17B:27A–25f, and 17B:27A–46.

Source and Effective Date

R.1994 d.25, effective December 9, 1993.
See: 25 N.J.R. 5757(a), 26 N.J.R. 245(a).

11:21–9.1 Purpose and scope

(a) The purpose of this subchapter is to establish informational rate filing requirements and procedures applicable to health benefits plans, including riders or endorsements, issued, renewed, reinstated or continued pursuant to the Act.

(b) This subchapter applies to all carriers issuing, renewing, reinstating or continuing health benefits plans to small employers pursuant to the Act.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

11:21–9.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings as defined at N.J.S.A. 17B:27A–17 or N.J.A.C. 11:21–1.2 unless defined below or the context clearly indicates otherwise.

"Classification factor" means a factor used to vary rates based upon characteristics of the employee, employer or policyholder.

"Health benefits plan" means any standard health benefits plan or nonstandard health benefits plan including any rider or endorsement thereto.

"Nonstandard health benefits plan" means a health benefits plan issued prior to January 1, 1994, which was in effect on February 28, 1994, and which has been reinstated, renewed or continued at the option of a small employer pursuant to the requirements of the Act.

"Nonstandard rider" means a rider or endorsement developed by a carrier to be offered with one or more of the standard health benefits plans.

"Plan" means a policy or contract form under which policies, contracts or certificates are issued evidencing benefits for expenses incurred or coverage of services rendered when referring to a type of health benefits plan.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board subject to the review and approval of the Commissioner.

"Standard rider" means a rider or endorsement promulgated by the SEH Board to be offered with one or more of the standard health benefits plans.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

11:21–9.3 Informational rate filing requirements for health benefits plans renewed between January 1, 1994 and January 1, 1997

(a) All carriers issuing policies, contracts or certificates under standard health benefits plans, including any standard or nonstandard rider option, on or before September 11, 1994, prior to issuing any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the following data:

1. A schedule of premiums specifying the standard health benefits plans offered, indicating the delivery system for each plan, describing the benefit differentials for the in-network and out-of-network benefits for selective contracting arrangements and listing the premium rates to be charged;

2. A description of the rating methodology or plan and the numerical value of the classification factors utilized in the calculation of a group's premium rate or rates, including but not limited to: age, gender, industry, geographic location, effective date, and rating categories (for example, standard and substandard) resulting from underwriting rules (for example, medical and non-medical);

3. A detailed actuarial memorandum setting forth the assumptions and methods used in the development of the rates, which shall include:

i. Recent claim cost experience, a description of the source of the claim costs and the time period for which the claim costs were calculated;

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended "Small employer".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.

11:21–10.3 Filing of the Market Share Report

(a) Every member of the SEH Program shall file the Market Share Report set forth as Exhibit CC in the Appendix to this chapter, incorporated herein by reference, on or before March 1. Every member shall complete Parts A, B, C and D of the Market Share Report.

1. Affiliated carriers shall submit a combined Market Share Report, except as (a)2 below implies. The combined Market Share Report shall be submitted under the name of one of the affiliated carriers' members.

2. Any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in the State, and any health maintenance organization located in the State that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall submit separate Market Share Reports.

(b) Certified Market Share Reports shall be submitted by mail or facsimile to the SEH Program Administrator or Executive Director, as set forth at N.J.A.C. 11:21–2.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), deleted "April 15, 1994 and annually thereafter no later than" following "before" in the first sentence of the introductory paragraph; and in (b), inserted a reference to the Executive Director.

11:21–10.4 Net earned premium

(a) Every member's net earned premium for the preceding calendar year ending December 31 shall be set forth in Part C of the Market Share Report.

1. Net earned premium set forth in Part C of the Market Share Report shall include net earned premium resulting from health benefits plans issued, continued or renewed during the preceding calendar year for one or more small employers.

2. Net earned premium reported in Part C of the Market Share Report shall be based upon, if not the same as, the data set forth in the member's annual reports adjusted to meet the definition of group health benefits plan, as necessary.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote (a)2.

"Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its working days during the preceding calendar year quarter, employed at least two but no more than 49 eligible employees, the majority of whom are employed within the State. A State, county or municipal body, agency, board or department shall not be considered a small employer. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended "Small employer".

11:21–10.3 Filing of the Market Share Report

(a) Every member of the SEH Program shall file the Market Share Report set forth as Exhibit CC in the Appendix to this chapter, incorporated herein by reference, on or before April 15, 1994 and annually thereafter no later than March 1. Every member shall complete Parts A, B, C, and D of the Market Share Report.

1. Affiliated carriers shall submit a combined Market Share Report, except as (a)2 below implies. The combined Market Share Report shall be submitted under the name of one of the affiliated carriers' members.

2. Any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in the State, and any health maintenance organization located in the State that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall submit separate Market Share Reports.

(b) Certified Market Share Reports shall be submitted by mail or facsimile to the SEH Program Administrator, as set forth at N.J.A.C. 11:21–2.

11:21–10.4 Net earned premium

(a) Every member's net earned premium for the preceding calendar year ending December 31 shall be set forth in Part C of the Market Share Report.

1. Net earned premium set forth in Part C of the Market Share Report shall include net earned premium resulting from health benefits plans issued, continued or renewed during the preceding calendar year for one or more small employers.

2. Net earned premium reported in Part C of the report form shall be based upon, if not the same as, the data set forth in the member's annual reports, as follows, adjusted to meet the definition of group health benefits plan, as necessary:

i. The NAIC Life and Health Blank (Blue), State page 19, entitled "Accident and Health Insurance," Column 3 less Column 4, line 23 plus line 23.2 plus line 24.6;

ii. The NAIC Fire and Casualty Blank (Yellow), State page 14 entitled "Exhibit of Premiums and Losses," Column 3 less Column 4, line 13 plus line 15.1 through line 15.6;

iii. The NAIC HMDI Blank (White), page 6, entitled "Underwriting and Investment Exhibit," Part 1, line 5, Column 9 less (Column 2 minus Column 3), and less reinsurance portions of (Column 5 minus Column 8);

iv. The New Jersey State HMO Annual Statement (for 1992 and 1993, if elected), page 32 Report # 2, Current Year Lines 1 plus 2 plus 4 plus 5; or

v. The NAIC HMO Blank (for 1993, if elected, and 1994 thereafter), page 4, Report # 2, Column 2, lines 1 plus 2 plus 3 plus 4.

11:21–10.5 Certification

All reports shall be certified as accurate, complete and conforming with the requirements of this subchapter by the Chief Financial Officer or other duly authorized officer of the member.

11:21–10.6 Failure to comply

Failure to comply with the reporting provisions of this subchapter shall result in the Board determining that the premium set forth in the member's most recent Annual Statement filed with the Department is the premium based upon which that member's market share allocation of assessments shall be calculated by the Board.

SUBCHAPTER 11. NONSTANDARD HEALTH BENEFITS PLANS (FILINGS WITH THE COMMISSIONER): REQUIREMENTS FOR MAINTAINING NONSTANDARD PLANS

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17B:27A–17 et seq., P.L. 1994, c.11.

Source and Effective Date

R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

Subchapter Historical Note

Subchapter 11, Nonstandard Health Benefits Plan Filings With the Commissioner: Form Filings and Request to Withdraw Plan Forms, was renamed Nonstandard Health Benefits Plans (Filings With The Commissioner): Requirements for Maintaining Nonstandard Plans, by R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

11:21–11.1 Purpose and scope

(a) This subchapter applies to nonstandard health benefits plans which were in effect on December 31, 1993 and have been renewed, continued or reinstated and filed with the Commissioner for informational purposes in accordance with N.J.S.A. 17B:27A–19j(6)(a) on or before January 31, 1994 which may continue to be renewed, amended and moved to another carrier by a small employer or an association, out-of-State trust and multiple employer arrangement subject to the approval of the Commissioner, but which are not subject to N.J.S.A. 17B:27A–19b, and the rating of which shall be segregated from the rating of all other health benefits plans.

(b) This subchapter defines the procedures for filing and standards for approval of nonstandard health benefits plans which were in effect on December 31, 1993 and have been renewed, continued or reinstated and filed with the Commissioner for informational purposes in accordance with N.J.S.A. 17B:27A–19j(6)(a) on or before January 31, 1994 which the carrier, association, out-of-State trust or other multiple employer arrangement shall continue to issue, and renew, and may amend and which may be moved from one carrier to another by a small employer or an association, out-of-State trust and multiple employer arrangement subject to the approval of the Commissioner.

(c) This subchapter establishes the procedures for making a complete filing of nonstandard health benefits plans with the Commissioner for renewal, amendment or movement to another carrier, and the standards for review of the filings submitted.

(d) This subchapter sets forth standards for renewal of a nonstandard health benefits plan, and standards for determining what constitutes a request for renewal by a small employer.

Amended by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Substantially amended section.

11:21–11.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings as set forth at N.J.S.A. 17B:27A–17 and N.J.A.C. 11:21–1.2, unless defined below or the context indicates otherwise.

"Benefits coverage" means the services and supplies covered by a health benefits plan and certain general provisions, definitions and covered charges with special limitations (as specified in the Checklist and Certification set forth in Part 5 of Exhibit BB of the Appendix to N.J.A.C. 11:21, incorporated herein as part of this subchapter) governing the health benefits plan.

"Closed nonstandard health benefits plan" means a health benefits plan issued prior to January 1, 1994 that was in effect on February 28, 1994 and was reinstated, renewed or continued at the option of the small employer(s) pursuant to N.J.S.A. 17B:27A–19j, but under which contracts or certificates have not been issued or offered on or after January 1, 1994 to a small employer group that was not covered under the health benefits plan prior to January 1, 1994, and which the carrier has certified shall not be offered or issued to any small employer that was not covered under the health benefits plan on December 31, 1993.

The term "closed nonstandard health benefits plan" also means a health benefits plan issued prior to January 1, 1994 that was in effect on February 28, 1994 and reinstated, renewed or continued at the option of a small employer pursuant to N.J.S.A. 17B:27A–19j under which contracts or certificates have been issued subsequent to January 1, 1994 to small employers who were not covered under the health benefits plan prior to January 1, 1994, but under which no such small employers remain covered as of the effective date of this subchapter and which the carrier has certified shall not be offered or issued to any small employer that was not

covered under the health benefits plan on December 31, 1993.

"Market," when used as a verb, means to offer or advertise as available a nonstandard health benefits plan for initial purchase by small employers or to a small employer who formerly purchased the nonstandard health benefits plan but who is not currently covered under the nonstandard health benefits plan. The term does not include continuation or renewal of a contract, policy or certificate under a nonstandard health benefits plan by a carrier for a small employer currently covered under the nonstandard health benefits plan.

"Nonstandard health benefits plan" means a health benefits plan policy or contract form under which policies or contracts were issued on or before December 31, 1993 to small employers or to one or more employees of a small employer by virtue of the employment arrangement, or a policy or contract form under which policies or contracts were issued on or before December 31, 1993 to an association, out-of-State trust or multiple employer arrangement and offered to small employers or to one or more employees of a small employer.

"Open nonstandard health benefits plan" means a nonstandard health benefits plan which has been issued or offered to a small employer group that was not covered under the health benefits plan on or before December 31, 1993, or which would otherwise meet the requirements for a closed nonstandard health benefits plan except that the carrier has not certified that the nonstandard health benefits plan shall not be offered for issue to any small employer that was not covered under the health benefits plan on December 31, 1993.

Amended by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
In introductory paragraph, substituted reference to N.J.A.C. 17B:27A–17 for reference to the Act; added "Benefits coverage", "Closed nonstandard health benefits plan", and "Open nonstandard health benefits plan"; deleted "Substantial threat to a carrier's financial condition" and "Withdraw"; and amended "Market" and "Nonstandard health benefits plan".

11:21–11.3 General standards for continuing and renewing a nonstandard health benefits plan

(a) A carrier shall continue and renew a nonstandard health benefits plan in accordance with this subchapter unless the carrier has:

1. Filed a request to withdraw the nonstandard health benefits plan in accordance with the requirements of N.J.A.C. 11:21–13, and the request has been approved by the Commissioner; or

2. The carrier has filed a notice of withdrawal from the small employer market in accordance with the requirements of N.J.A.C. 11:21–16 and N.J.S.A. 17B:27A–23e.

(b) Renewal of a nonstandard health benefits plan shall be provided at the request of a small employer that is covered by the nonstandard health benefits plan issued by the carrier at the time that the request is made.

1. A request made by a small employer that was covered by the nonstandard health benefits plan issued by the carrier, but who is not so covered at the time that the request is made, shall not be deemed a request for renewal.

2. A request made of a carrier by a small employer to renew a nonstandard health benefits plan issued by and inforce under another carrier at the time the request is made shall not be deemed a request for renewal.

(c) Notwithstanding (b) above, a carrier shall not be required to renew a nonstandard health benefits plan under the following circumstances:

1. Nonpayment of the required premium by the policyholder, contractholder or employer;

2. Fraud or misrepresentation of the policyholder, contractholder or employer, or of the enrollees or their representative with respect to renewal of eligible employees and dependents;

3. The small employer fails to meet either the participation or contribution requirements; or

4. In the case of nonstandard health benefits plans issued to or through an association, trust or other multiple employer arrangement, for a small employer if the small employer ceases to be a member of the association, trust or other multiple employer arrangement.

(d) In the event that a small employer is being nonrenewed pursuant to (c)4 above, the carrier shall provide notice to the small employer that the same standard health benefits plan(s) available to the small employer through the association, trust or other multiple employer arrangement are available from the carrier directly along with the other standard health benefits plans and rider options that the carrier offers to other small employers.

Repeal and New Rule, R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Section was "Restricted withdrawal and marketing".

11:21–11.4 Certification of benefits coverage and actuarial value of nonstandard health benefits plans

(a) For nonstandard health benefits plans for which the carrier made an informational filing of a Certification of Prior Filing and Compliance with P.L. 1994, c.11, set forth as Part 3 of Exhibit BB in the Appendix to this chapter, on or before January 20, 1995 in accordance with N.J.A.C. 11:21–11.9, or made an informational filing of a Certification of Informational Filing and Compliance with P.L. 1994, c.11, as set forth as Part 4 of Exhibit BB in the Appendix to this chapter, on or before January 31, 1995 in accordance with N.J.A.C. 11:21–11.9, carriers shall file the nonstandard health benefits plan accompanied by a completed Checklist and Certification as set forth in Part 5 of Exhibit BB in the Appendix to this chapter, incorporated herein as part of this subchapter.

(b) Each such filing shall comply with N.J.A.C. 11:4–40, except that only one copy of the forms need be submitted. The forms submission shall include the nonstandard health benefits plan form, the form of all riders offered therewith, and the application for the nonstandard health benefits plan.

(c) Separate checklists and certifications and certified statements as set forth in Part 5 of Exhibit BB of the Appendix to this chapter shall be submitted for each nonstandard health benefits plan.

(d) A checklist and certification and statement certified to by an officer of the carrier submitted pursuant to this section shall not be accepted by the Commissioner until it is complete.

Repeal and New Rule, R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Section was "Request to withdraw nonstandard health benefits plans".

11:21–11.5 Closed books of business

(a) A carrier seeking approval to treat a nonstandard health benefits plan as a closed nonstandard health benefits plan shall specify that on the Checklist and Certification required to be filed for that nonstandard health benefits plan pursuant to N.J.A.C. 11:21–11.4.

(b) Notwithstanding that a nonstandard health benefits plan may meet the definition of a closed nonstandard health benefits plan, if the carrier does not specify that the nonstandard health benefits plan is closed as set forth in (a) above, the carrier shall not treat the nonstandard health benefits plan as a closed nonstandard health benefits plan at any time in the future.

Repeal and New Rule, R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Section was "Review and approval of a request to withdraw".

11:21–11.6 Obligation to market

(a) Except with respect to nonstandard health benefits plans for which the carrier has filed a statement in accordance with N.J.A.C. 11:21–11.5, the carrier shall market the nonstandard health benefits plan to all small employers, their eligible employees and their eligible employees' dependents, as appropriate, within an association, out-of-State trust or other multiple employer arrangement, with all options and riders until such time as the carrier withdraws the nonstandard health benefits plan pursuant to N.J.A.C. 11:21–13, the carrier withdraws from the small employer market pursuant to N.J.A.C. 11:21–16, or, in the case of an association, the association terminates its sponsorship or endorsement of the nonstandard health benefits plan.

1. The obligation to market a nonstandard health benefits plan exists only with respect to an association's, trust's or other multiple employer arrangement's small employers, the small employers' eligible employees and the eligible employees' dependents, as appropriate; a carrier shall not newly issue a nonstandard health benefits plan to any other association, out-of-State trust or multiple employer arrangement (that will be offered to small employer members or participants of the association, multiple employer arrangement or out-of-State trust) except as N.J.A.C. 11:21–11.8 may apply.

2. The carrier shall similarly market every nonstandard health benefits plan that the carrier agrees to add to its portfolio in accordance with N.J.A.C. 11:21–11.8 at the request of a small employer or association, out-of-State trust or multiple employer arrangement.

(b) With respect to nonstandard health benefits plans offered by or through an association, multiple employer arrangement or out-of-State trust, the small employers of the association, multiple employer arrangement or out-of-State trust shall be offered one or more standard health benefits plans through the association, multiple employer arrangement or out-of-State trust, among which shall be Plan C.

(c) No carrier shall be relieved of its obligation to market all of the standard health benefits plans by virtue of marketing at least one standard health benefits plan through an association, multiple employer arrangement or out-of-State trust.

Repeal and New Rule, R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Section was "Standards for the process of withdrawal of a nonstandard health benefits plan either by cancellation or nonrenewal".

11:21–11.7 Amendments

(a) A carrier may amend a nonstandard health benefits plan that has been approved or deemed approved by the Commissioner by submitting for approval the amendment together with a new, completed Checklist and Certification set forth in Part 5 of Exhibit BB of the Appendix to this chapter.

1. Each such filing shall comply with N.J.A.C. 11:4–40, except that only one copy of the form(s) need be submitted.

2. The carrier shall submit a separate Checklist and Certification for each nonstandard health benefits plan form being amended, clearly identifying the nonstandard health benefits plan form, and the date(s) previous certification(s) made in compliance with this subchapter were filed.

3. The carrier shall certify on the Checklist and Certification, for each plan being amended that the amendment to the nonstandard health benefits plan does not reduce the actuarial value or the benefits coverage of the nonstandard health benefits plan below the benefits coverage of Plan A and the actuarial value of the standard health benefits plan with the lowest actuarial value of the standard health benefits plans created by the Board.

4. The carrier simultaneously shall submit an explanation of the manner in which the amendment to the nonstandard health benefits plan affects the premiums for the health benefits plan, in accordance with N.J.A.C. 11:21–8.

(b) Notwithstanding (a) above, a carrier shall not amend a nonstandard health benefits plan for six months following the date that the first contract or policy under the nonstandard health benefits plan becomes effective with that carrier if the carrier agreed to add the nonstandard health benefits plan to its portfolio at the request of a small employer pursuant to N.J.S.A. 17B:27A–19j(12) and N.J.A.C. 11:21–11.8.

Repeal and New Rule, R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Section was "Other policyholder rights unaffected".

11:21–11.8 Agreement by a carrier to add a nonstandard health benefits plan to its portfolio

(a) A carrier may agree to add a nonstandard health benefits plan not currently being offered by the carrier to its portfolio of small employer health benefits plans at the request of either an association, multiple employer arrangement, trust or a single small employer if that nonstandard health benefits plan has been renewed by the current carrier in accordance with this subchapter and upon the new carrier filing the nonstandard health benefits plan with the Commissioner in accordance with N.J.A.C. 11:4–40 and submission of a completed Checklist and Certification as set forth in Part 5 of Exhibit BB of the Appendix to this chapter.

(b) The filing carrier simultaneously shall comply with N.J.A.C. 11:21–11.6, with initial date of marketing of the nonstandard health benefits plan specified in writing by the filing carrier, which date shall be no later than the effective date of the filing carrier's obligations pursuant to any contract transferred to the filing carrier under the nonstandard health benefits plan.

(c) Upon written request by the Department, the carrier currently marketing the nonstandard health benefits plan shall submit to the Department in writing for each nonstandard health benefits plan form being accepted by a filing carrier the current carrier's identification of the nonstandard health benefits plan form, and the date(s) the current carrier's checklists and certification(s) with appropriate statements made in compliance with this subchapter for the nonstandard health benefits plan form(s) were filed by the Department (including amendments thereto, if any).

(d) If the filing carrier is accepting the nonstandard health benefits plan upon the request of an association, trust or multiple employer arrangement, the filing carrier may amend the nonstandard health benefits plan form to be effective simultaneously with the effective date of the filing carrier's obligations pursuant to any contract transferred to the filing carrier under the nonstandard health benefits plan, subject to the filing carrier filing an amendment made in accordance with N.J.A.C. 11:21–11.7.

(e) If the filing carrier agrees to add a nonstandard health benefits plan to its portfolio at the request of a small employer, the filing carrier shall not amend the nonstandard health benefits plan for six months following the date that the filing carrier's obligations pursuant to the contract issued to the small employer under the nonstandard health benefits plan becomes effective.

1. Any amendment made subsequently shall be made by the filing carrier in accordance with N.J.A.C. 11:21–11.7.

(f) A filing carrier shall not make a request to withdraw a nonstandard health benefits plan that it adds to its portfolio of small employer health benefits plans for at least one 12 month period following the date that the filing carrier's obligations pursuant to contracts issued under the nonstandard health benefits plan first become effective.

New Rule, R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Former section recodified as N.J.A.C. 11:21–11.10.

11:21–11.9 Additional standards for certifications and standards for review of certifications by the Department

(a) In addition to complying with the other requirements of this subchapter, certifications submitted by carriers in accordance with this subchapter shall comply with the requirements of N.J.A.C. 11:4–40.4, 40.5 and 40.11.

(b) All rate filings shall be submitted as specified in N.J.A.C. 11:21–9.

New Rule, R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Former section recodified as N.J.A.C. 11:21–11.11.

11:21–11.10 Informational filing of nonstandard health benefits plans (made in accordance with N.J.S.A. 17B:27A–19j(6)(a) on or before January 31, 1995)

(a) A carrier shall submit a Certification of Prior Filing and Compliance with P.L. 1994, c.11, as set forth in Part 3 of Exhibit BB of the Appendix to this chapter, incorporated herein as part of this subchapter, for all nonstandard health benefits plans continued, renewed or reinstated pursuant to P.L. 1994, c.11, if the carrier has previously submitted the nonstandard health benefits plans to the Commissioner for filing and the nonstandard health benefits plans were so filed.

(b) A carrier shall submit a Certification of Informational Filing and Compliance with P.L. 1994, c.11, as set forth in Part 4 of Exhibit BB of the Appendix to this chapter, incorporated herein as part of this subchapter, for all nonstandard health benefits plans continued, renewed or reinstated pursuant to P.L. 1994, c.11, if those nonstandard health benefits plans were not previously submitted to the Commissioner for filing.

(c) A separate certification shall be submitted for each nonstandard health benefits plan no later than January 20, 1995 if any policy, contract or certificate under the nonstandard health benefits plan was renewed in 1994 prior to November 21, 1994, or no later than 30 days after the date that the first policy, contract, or certificate under the nonstandard health benefits plan shall be first renewed after the effective date of this subchapter, whichever date is earlier.

(d) A certification submitted pursuant to this section shall not be filed by the Commissioner until it is complete.

1. The Commissioner shall notify a carrier when a certification is determined by the Commissioner to be deficient, specifying the reasons therefor in writing.

2. The Commissioner shall determine a certification to be deficient if the certification in any way deviates from the forms as set forth in the Appendix, fails to provide answers to any of the questions contained therein, or the form fails to be certified by a duly authorized officer of the carrier. A certification shall continue to be considered deficient until the carrier submits information satisfactory to the Department to render the certification complete.

3. A carrier shall submit the information necessary to cure any deficiency(ies) or incompleteness specified within 30 days of the date of the notice, or shall become subject to fine.

(e) The completed certification shall include all amendments necessary to bring the nonstandard health benefits plan into compliance with N.J.S.A. 17B:27A–17 et seq. as required by P.L. 1994, c.11. The amendments shall include all necessary language changes, and shall clearly indicate (for ease of reference) all additions and deletions in language necessary for both the nonstandard health benefits plan and any riders and endorsements which may have been issued with or for the nonstandard health benefits plan.

Recodified from 11:21–11.8 and amended by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Section name changed by adding parenthetical text.

11:21–11.11 Penalty and fines

A carrier failing to comply with the requirements of this subchapter shall be subject to payment of a fine not less than $2,000 nor more than $5,000 per violation. Except for plans issued through an out-of-State trust, no fine or other penalty shall be assessed against a carrier with nonstandard health benefits plans specified at N.J.A.C. 11:21–11.4 for failure to comply specifically with this subchapter until May 16, 1997, and, with the exception of plans issued through an out-of-State trust, all carriers with nonstandard health benefits plans as specified at N.J.A.C. 11:21–11.4 shall have the opportunity to come into compliance with this subchapter without penalty by May 16, 1997. This provision shall not effect any penalty or fine made against a carrier prior to the effective date of this subchapter.

Recodified from 11:21–11.9 and amended by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Substantially amended section.

SUBCHAPTER 12. (RESERVED)

SUBCHAPTER 13. NONSTANDARD PLANS: WITHDRAWAL OF PLANS

Authority

P.L. 1995, c.340, §§ 2 and 7.

Source and Effective Date

R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

11:21–13.1 Purpose and scope

(a) This subchapter sets forth the procedures by which a carrier may make a request to withdraw a nonstandard health benefits plan.

(b) This subchapter sets forth standards for review of a request to withdraw a nonstandard health benefits plan.

11:21–13.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings as defined at N.J.S.A. 17B:27A–17 or N.J.A.C. 11:21–1.2 unless defined below or the context clearly indicates otherwise.

"Closed nonstandard health benefits plan" means a health benefits plan issued prior to January 1, 1994 that was in effect on February 28, 1994 and was reinstated, renewed or continued at the option of the small employer(s) pursuant to N.J.S.A. 17B:27A–19j, but under which contracts or certificates have not been issued or offered on or after January 1, 1994 to a small employer group that was not covered under the health benefits plan prior to January 1, 1994, and which the carrier has certified will not be offered or issued to any small employer that was not covered under the health benefits plan on December 31, 1993.

The term "closed nonstandard health benefits plan" also means a health benefits plan issued prior to January 1, 1994 that was in effect on February 28, 1994 and reinstated, renewed or continued at the option of a small employer pursuant to N.J.S.A. 17B:27A–19j under which contracts or certificates have been issued subsequent to January 1, 1994 to small employers who were not covered under the health benefits plan prior to January 1, 1994, but under which no such small employers remain covered as of the effective date of this subchapter and which the carrier has certified will

not be offered or issued to any small employer that was not covered under the health benefits plan on December 31, 1993.

"Market," when used as a verb, means to offer or advertise as available a nonstandard health benefits plan to a small employer for initial purchase or to a small employer who formerly purchased the nonstandard health benefits plan but who is not currently covered under the nonstandard health benefits plan. The term does not include continuation or renewal of a contract, policy or certificate under a nonstandard health benefits plan by a carrier for a small employer currently covered under the nonstandard health benefits plan.

"Nonstandard health benefits plan" means a health benefits plan policy or contract form under which policies or contracts were issued on or before December 31, 1993 to small employers or to one or more employees of a small employer by virtue of the employment arrangement, or a policy or contract form under which policies or contracts were issued on or before December 31, 1993 to an association, out-of-State trust or multiple employer arrangement and offered to small employers or to one or more employees of a small employer.

"Open nonstandard health benefits plan" means a nonstandard health benefits plan which has been issued or offered to a small employer group that was not covered under the health benefits plan on or before December 31, 1993, or which would otherwise meet the requirements for a closed nonstandard health benefits plan except that the carrier has not certified that the nonstandard health benefits plan will not be offered or issued to any small employer that was not covered under the health benefits plan on December 31, 1993.

"Withdraw" or "withdrawal" means a cancellation or nonrenewal initiated by a carrier, association, multiple employer arrangement or out-of-State trust of all inforce policies, contracts or certificates issued under a nonstandard health benefits plan.

11:21–13.3 Restricted withdrawal and marketing

(a) A carrier, association, multiple employer arrangement or out-of-State trust shall not withdraw a nonstandard health benefits plan without prior approval of the Commissioner if there was one or more policies or contracts inforce under that nonstandard health benefits plan on December 31, 1993, and one or more small employers continued to be covered under that nonstandard health benefits plan as of January 1, 1994, except as (b) below applies.

(b) A carrier may withdraw a nonstandard health benefits plan without obtaining prior approval pursuant to this subchapter if the carrier is effecting withdrawal from the small employer market in accordance with N.J.A.C. 11:21–16.

(c) A carrier shall market all open nonstandard health benefits plans made available through an association, trust or other multiple employer arrangement to all small employers members within that association, trust or other multiple employer arrangement, and the employees of such small employers.

(d) A carrier shall not market a closed nonstandard health benefits plan either directly or through an association, out-of-State trust or multiple employer arrangement.

(e) An association, multiple employer arrangement or out-of-State trust may market an open nonstandard health benefits plan, but if it does market an open nonstandard health benefits plan to its members' employees and dependents it shall offer coverage to all eligible employees and their dependents within the membership of the association, multiple employer arrangement or out-of-State trust, and in no instance shall actual or expected health status be used in determining membership.

1. An association, multiple employer arrangement or out-of-State trust that markets an open nonstandard health benefits plan shall also market at least one standard health benefits plan in accordance with N.J.A.C. 11:21–11.6.

2. In no instance shall a closed nonstandard health benefits plan be marketed.

3. No carrier shall be relieved of its obligation to market all of the standard health benefits plans by virtue of marketing at least one standard health benefits plan through an association, multiple employer arrangement or out-of-State trust.

11:21–13.4 Request to withdraw nonstandard health benefits plans

(a) A carrier may submit to the Commissioner a completed request to withdraw one or more closed and open nonstandard health benefits plan(s) at any time except that a carrier shall not:

1. Submit more than one request to withdraw at any one time, but may amend its request to withdraw, if necessary;

2. Submit a request to withdraw a nonstandard health benefits plan that the carrier added to its portfolio of health benefits plans in accordance with N.J.A.C. 11:21–11.8 within the first 12 month period following the effective date of the carrier's obligation pursuant to contracts issued under that nonstandard health benefits plan; or

3. Submit a request to withdraw while a request for relief pursuant to N.J.A.C. 11:20–11 or 11:21–15 is pending.

(b) A carrier may submit a single filing to request withdrawal of more than one closed and open nonstandard health benefits plans, but shall clearly specify each nonstandard health benefits plan for which a withdrawal is sought, with separate proofs of unreasonable financial burden submitted for each nonstandard health benefits plan.

(c) A carrier shall submit five copies of each request to withdraw in loose leaf form, inserted into two-ring or three-ring binders, tabbed or otherwise indexed to correspond to the exhibits set forth below.

1. A cover letter stating:

i. The name of the carrier, and the name, title, telephone number and telefax number of a contact person familiar with the filing to whom the Department may direct any additional questions;

ii. A clear specification of the nonstandard health benefits plan(s) which the carrier is seeking to withdraw, including the market name(s), form number(s), and the date(s) the form filing(s) was (were) approved by the Department; and

iii. A statement of facts relied upon as the basis under which the request is sought, including the specific factor(s) upon which the Commissioner may find that maintaining the nonstandard health benefits plan(s) represents an unreasonable financial burden to the carrier;

2. If the carrier intends to establish that renewal of an open nonstandard health benefits plan is an unreasonable financial burden for the carrier, then the carrier shall provide the following:

i. A statement certified to by an officer of the carrier that the total number of lives eligible for small employer health benefits plans covered under the open nonstandard health benefits plan during the 12 month period immediately preceding the date of submission of the request to withdraw was 1,000 or fewer, including only employees and not dependents; or a demonstration that the actual loss ratio of the open nonstandard health benefits plan is 100 percent, or greater, for the 12 month period preceding the date of submission of the request to withdraw;

ii. A detailed explanation, with supporting documentation, of the projected effect that continuation of the nonstandard health benefits plan(s) would have on the immediate and long term financial condition of the carrier;

iii. The most recent financial examination report, whether conducted by the carrier's state of domicile or other state;

iv. A statement addressing whether the carrier is planning to modify its method of doing business in any way, including, but not limited to, new acquisitions or new restructuring;

v. Three-year financial projections beginning with the calendar year of the date of the filing assuming both that the request to withdraw is granted and that it is denied;

vi. 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; and

vii. Any other information the Commissioner may specifically deem relevant to the consideration of the particular carrier's request.

(d) The request to withdraw shall be accompanied by the form of the notice of nonrenewal to be provided to policyholders, contractholders, and certificateholders, which notice shall be in compliance with N.J.A.C. 11:21–13.6(a).

(e) Carriers requesting to withdraw a nonstandard health benefits plan shall concurrently provide notice of the request to the SEH Program at the address specified at N.J.A.C. 11:21–1.3.

(f) At the time of the filing of the request to withdraw, the carrier shall specify the number of policies, contracts and certificates issued under each nonstandard health benefits plan that is the subject of the request to withdraw, the approximate number of lives covered under each such nonstandard health benefits plan, and the approximate number of small employers covered under each such nonstandard health benefits plan.

(g) Carriers submitting a request to withdraw shall submit that request to:

SEH Program
Request to Withdraw Nonstandard Plans
Division of Financial Solvency
New Jersey Department of Banking and Insurance
CN 325
Trenton, NJ 08625–0325

11:21–13.5 Review and approval of a request to withdraw

(a) The Department shall deny a request to withdraw if the request fails to substantially comply with the filing format and information requirements set forth in N.J.A.C. 11:21–13.4. The Department shall notify the carrier in writing that its request to withdraw is deficient on such grounds. If the carrier intends to pursue its request to withdraw, the carrier shall submit the additional information specified or otherwise submit a filing in accordance with the format requirements specified in N.J.A.C. 11:21–13.4 within 30 days of receipt of the Department's notice of deficiency. Failure to submit within 30 days the required information shall result in the carrier's request being denied without prejudice.

(b) When the Commissioner determines that the requirement to continue servicing the nonstandard health benefits plan(s) specified in the request to withdraw is an unreasonable financial burden for the carrier, the Commissioner shall notify the carrier in writing that it may withdraw the specified nonstandard health benefits plan(s) subject to the standards of N.J.A.C. 11:21–13.6.

(c) If the Commissioner denies a carrier's request to withdraw made pursuant to the provisions of N.J.A.C. 11:21–13.4, the carrier may request a hearing on the Commissioner's determination within seven days from the date of receipt of such determination as follows:

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

i. The name, address, and daytime telephone number 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 statement describing in detail the basis for which the carrier believes that the Commissioner's denial is erroneous.

2. The Commissioner may, after receipt of a properly completed request for a hearing, provide for an informal conference between the carrier and such personnel of the Department as the Commissioner may direct, to determine whether there are material issues of fact in dispute.

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.

i. In a matter which has been determined to be a contested case, if the Commissioner finds that there are no good-faith disputed issues of material fact and the matter may be decided on the documents filed, the Commissioner may notify the applicant in writing as to the final disposition on the matter.

ii. 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 Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

11:21–13.6 Standards for the process of withdrawal of a nonstandard health benefits plan

(a) Carriers shall effect the withdrawal of the specified nonstandard health benefits plan(s), if the request is granted by the Commissioner, through nonrenewal of the policies, contracts or certificates issued under the nonstandard health benefits plan(s) at the time of the 12–month anniversary date of each such policy, contract or certificate, provided that each policyholder, contractholder or certificateholder is given 60 days written notice prior to the date of the nonrenewal.

1. The carrier shall include in the notice the reasons for the nonrenewal (that is, that withdrawal of the health benefits plan has been approved by the Commissioner pursuant to this subchapter).

2. The carrier shall include in the notice an offer to obtain coverage under the standard health benefits plans issued by the carrier if the policyholder, contractholder, or certificateholder is a small employer (unless the carrier has been granted relief by the Commissioner pursuant to N.J.S.A. 17B:27A–26) or a statement that coverage may be available under an individual health benefits plan if the policyholder, contractholder or certificateholder is not a small employer.

3. The carrier shall include in the notice the name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information concerning the withdrawal.

4. The carrier shall provide notice of the withdrawal to the producer of record for each policy, contract or certificate within 60 days of the date that the request to withdraw is granted.

(b) The withdrawal of the nonstandard health benefits plan shall be completed within 16 months of the date that the request to withdraw is granted.

(c) The nonstandard health benefits plan that is the subject of the request to withdraw shall not be marketed by or through an association, multiple employer arrangement or out-of-State trust to any new small employer from the date that the request to withdraw is granted.

11:21–13.7 Other policyholder rights unaffected

Except with respect to a right of guaranteed renewability or noncancellation, nothing in this subchapter shall be construed to contravene any rights of policyholders, contractholders or certificateholders concerning cancellation requirements or obligations set forth in a policy or contract of a health benefits plan that is the subject of a request to withdraw.

SUBCHAPTER 14. (RESERVED)

Subchapter Historical Note

Subchapter 14, Declaration and Approval of Reinsuring or Risk-Assuming Carrier Status, was adopted as new rules by R.1993 d.551, effective October 15, 1993. See: 25 N.J.R. 4572(a), 25 N.J.R. 5347(a). Subchapter 14 was repealed by R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

SUBCHAPTER 15. RELIEF FROM OBLIGATIONS IMPOSED UNDER THE SMALL EMPLOYER HEALTH BENEFITS PROGRAM

Authority

N.J.S.A. 17:1–8, 17:1–8.1, 17:1C–6(e), 17B:27A–17 et seq. and P.L. 1993, c.162.

Source and Effective Date
R.1993 d.629, effective November 5, 1993.
See: 25 N.J.R. 4577(a), 25 N.J.R. 5692(a).

11:21–15.1 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–38 or to offer coverage or accept applications to a small employer, pursuant to N.J.S.A. 17B:27A–26.

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

11:21–15.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A–17 and N.J.A.C. 11:21–1, 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–17 et seq.

"Financially impaired" means a member which, after November 5, 1993, 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 pursuant to N.J.S.A. 17B:27A–38 or a waiver of obligations pursuant to N.J.S.A. 17B:27A–26, as applicable.

11:21–15.3 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–38 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. 11:21–15.4, 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.

11:21–14.4 Declaration to be a reinsuring or risk-assuming carrier

(a) Every small employer carrier shall file a declaration with the Board and Commissioner on or before October 4, 1993 or within 30 days of the date that the Board files its Plan of Operation with the Commissioner for review, whichever date is later, stating whether the small employer carrier elects to operate as a risk-assuming carrier or a reinsuring carrier for purposes of compliance with the Program.

1. For purposes of compliance with this declaration deadline, the 30 day period shall begin to run from the date set forth on the notice sent to carriers by the Board of the submission of the Plan of Operation to the Commissioner, rather than the actual date of the Plan of Operation's submission, if the two dates are different.

2. The notice shall be considered properly sent if the Board sends it to the mailing address of the carrier which the carrier has on file with the Board.

3. Any small employer carrier that fails to file a timely declaration shall be deemed to have submitted a declaration to be a reinsuring carrier on October 4, 1993 or the 30th day following the date that the Board submitted its Plan of Operation to the Commissioner, whichever date is later, for purposes of determining the statutory election period for that carrier.

4. Any small employer carrier that is disapproved as a risk-assuming carrier shall be deemed to have elected to operate as a reinsuring carrier on October 4, 1993 or the 30th day following the date that the Board submitted its Plan of Operation to the Commissioner, whichever date is later, for purposes of determining the statutory election period for that small employer carrier.

5. The statutory election period shall be deemed to begin on January 1, 1994.

(b) A small employer carrier may make a permissive election pursuant to this subsection, notwithstanding either an affirmative or deemed filing by that carrier pursuant to (a) above. A small employer carrier that makes a permissive election pursuant to this subsection shall file a declaration with the Board and the Commissioner on or before December 21, 1994, stating whether the small employer carrier elects to operate as a risk-assuming carrier or as a reinsuring carrier for purposes of compliance with the Program.

1. Any small employer carrier that is disapproved as a risk-assuming carrier pursuant to its permissive election shall be deemed to have elected to operate as a reinsuring carrier as of the close of the permissive election period under this subsection.

2. Any carrier that is determined by the Department to have been a small employer carrier as of the close of the permissive election period under this subsection, which was not a small employer carrier at the time that the election pursuant to (a) above was required to be made, and that has not made an election before the close of the permissive election period under this subsection, shall be deemed to have elected to operate as a reinsuring carrier as of the final date of the permissive election period under this subsection.

3. A small employer carrier that has either affirmatively filed or has been deemed to have filed pursuant to (a) above that fails to submit a separate filing during the permissive election period, pursuant to this subsection, shall continue to be considered by the Board and the Commissioner to have filed pursuant to (a) above.

4. The statutory election period for any affirmative or deemed permissive election shall be deemed to begin on January 1, 1994.

(c) Every carrier that is not currently a small employer carrier but determines to become one, shall file, at least 90 days prior to issuing any small employer health benefits plans, a declaration with the Board and the Commissioner stating whether the carrier elects to operate as a risk-assuming carrier or as a reinsuring carrier for purposes of compliance with the Program.

1. Any such carrier that fails to file a timely declaration shall be deemed to have elected to operate as a reinsuring carrier as of the date the carrier files policy forms or certification of utilization of small employer policy forms, as appropriate, with the Board and the Commissioner.

2. Any such carrier that is disapproved as a risk-assuming carrier shall be deemed to have elected to operate as a reinsuring carrier as of the date the carrier elected to operate as a risk-assuming carrier.

3. In any calendar year in which a carrier elects to operate, or is deemed to have elected to operate, as a reinsuring carrier:

i. If the date, or deemed date, of election is on or before June 30 of that year, the statutory election period shall be deemed to begin on January 1 of that calendar year.

ii. If the date, or deemed date, of election is on or after July 1 of that year, the statutory election shall be deemed to begin on January 1 of the immediately succeeding calendar year.

(d) A carrier operating as a reinsuring carrier which elects to operate as a risk-assuming carrier effective upon the expiration of the statutory election period applicable to the reinsuring carrier shall file a declaration with the Board and the Commissioner 90 days prior to the end of the applicable statutory election period stating that the reinsuring carrier elects to operate as a risk-assuming carrier for purposes of compliance with the Program.

1. The election shall not be effective until the end of the statutory election period.

2. The election shall not be effective until approved by the Commissioner as provided in this subchapter, except that all approved such risk-assuming elections shall relate back to January 1, if approval occurs subsequent to the end of the carrier's reinsuring statutory election period.

3. A reinsuring carrier that does not file such an election in a timely manner, or that is disapproved as a risk-assuming carrier, shall remain a reinsuring carrier through the end of the succeeding statutory election period, commencing upon the expiration date of the then-current statutory election period.

(e) Carriers electing to be reinsuring carriers shall complete the "Reinsuring Carrier Declaration" form set forth in Exhibit U, Part 1 of the Appendix to this chapter, incorporated herein by reference. Carriers electing to be risk-assuming carriers shall complete the "Risk–Assuming Carrier Declaration" form set forth in Exhibit U, Part 2 of the Appendix to this chapter, incorporated herein by reference. Completed declaration forms shall be certified by the chief financial officer or other duly authorized officer of the carrier.

Amended by R.1994 d.55, effective December 30, 1993.
See: 26 N.J.R. 328(b), 26 N.J.R. 809(a).
Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

11:21–14.5 Application to be a risk-assuming carrier

(a) Every carrier filing a declaration electing to operate as a risk-assuming carrier additionally shall submit to the Commissioner an application to be a risk-assuming carrier as set forth below in (b), (c), (d) and (e).

(b) Carriers shall file five copies of the declaration and application with the Commissioner at the following address:

Attention: SEH Declaration/Approval
New Jersey Department of Insurance
Division of Financial Examinations
20 West State Street
CN–325
Trenton, New Jersey 08625–0325

(c) Every carrier filing for risk-assuming carrier status shall complete in full the Risk–Assuming Application Form set forth in Exhibit U, Part 3 of the Appendix to this chapter, incorporated herein by reference.

1. Carriers shall complete section D, E, or F of the Risk–Assuming Application Form, as is appropriate for the type of carrier.

2. The completed Risk–Assuming Application Form shall be certified by the chief financial officer, or other duly authorized officer, of the carrier.

3. The Risk–Assuming Application Form shall be supported by an actuarial opinion that the carrier's portfolio is of good and sufficient value, liquidity and diversity to assure the carrier's ability to meet its outstanding obligations as they mature. As an alternative, the carrier may submit an actuarial opinion that complies with the Model Actuarial Opinion and Memorandum Regulation adopted by the National Association of Insurance Commissioners (Volume IV, Page 822–1, available by calling (816) 374–7259). A carrier need not submit the actuarial memorandum specified by the Model Actuarial Opinion and Memorandum Regulation for purposes of this subchapter.

4. The Risk–Assuming Application Form shall be accompanied by a statement setting forth the carrier's group experience in New Jersey for the past three years, if any. If a carrier or its affiliated carriers have no New Jersey group experience, then the statement shall set forth the national experience of the carrier and its affiliate(s). The experience information shall include:

i. The number of group contracts in force annually;

ii. The number of small employer group contracts in force annually;

iii. The respective lapse rates of all group contracts and of small employer group contracts annually;

iv. The respective net earned premium for group contracts and for small employer group contracts annually;

v. The respective incurred claims for group contracts and for small employer group contracts annually;

vi. Assumptions used in developing the calculations in (c)4i through v above, where estimations have been made; and

vii. Assumptions regarding similarities and dissimilarities between the marketplace upon which the foregoing data is based and the current New Jersey small employer group market.

5. In completing and certifying the Risk–Assuming Declaration Form and the Risk–Assuming Application Form, the carrier agrees that, upon approval by the Commissioner as a risk-assuming carrier:

i. It will not seek any reimbursement for any losses that will be incurred with respect to small employer health benefits plans as long as it retains its status as a risk-assuming carrier;

ii. It is financially competent to accept any obligation(s) required by the Act; and

iii. It does not intend to file an application for relief of any kind from its obligations under the Act for a period of one calendar year from the date that its application is approved or deemed approved.

(d) Carriers that have previously sought and obtained relief from their obligation(s) under the Act as a small employer carrier shall demonstrate to the satisfaction of the Commissioner that the carrier no longer has any need for relief and has been operating in full compliance with the Act, including the payment of all assessment amounts owed and issuance of small employer health benefits plans on a guaranteed issue basis, for a period of no less than 12 consecutive calendar months preceding the date of application.

(e) A declaration filed with the SEH Board to be a risk-assuming carrier shall not be effective until an application for risk-assuming carrier status has been approved as provided in this subchapter.

Amended by R.1994 d.55, effective December 30, 1993.
See: 26 N.J.R. 328(b), 26 N.J.R. 809(a).
Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

11:21–14.6 Procedures for review of applications for risk-assuming carrier status

(a) The time period for the Commissioner's review of an application for risk-assuming carrier status shall commence upon the day a complete application is received by the Commissioner.

(b) If the application is incomplete, the Department shall so advise the carrier in writing not later than 30 days after receipt of the application.

1. The application shall be deemed to be complete if the carrier is not notified in writing that the application is incomplete.

2. Notice to the carrier that the application is incomplete shall specify the missing item(s) or information. The notice shall advise the carrier that the deficiency must be cured within 30 days of receipt of notice, and that failure to cure the deficiency within 30 days of receipt of notice shall result in disapproval of the application. A deficiency shall not be considered cured until all of the missing items or information is received by the Department from the carrier.

3. Receipt of the specified missing items or information by the Department subsequent to the 30 day period specified in (b)2 above shall be deemed to be a new application and shall begin a new time period for review. Whenever a carrier submits information or missing items not specified by the Department in accordance with (b)2 above, it shall be deemed to be an amendment of the submission to which the information or missing items are to be attached, and shall begin a new time period for review.

(c) The Commissioner may approve an application for risk-assuming carrier status if the carrier meets the standards set forth in N.J.A.C. 11:21–14.7.

1. The Commissioner shall notify the carrier of the approval or any disapproval of its application in writing, and shall contemporaneously send a copy of the notice to the SEH Board.

2. Except as set forth in (b) above, an application shall be deemed approved if not disapproved within 90 days of its receipt.

3. Notice to the carrier that the application is disapproved shall be in writing and specify the reasons for disapproval.

11:21–14.7 Standards for approval

(a) The Commissioner may approve an application for risk-assuming status for a carrier that is an insurer if the carrier meets the following standards:

1. The carrier is authorized or admitted to transact the business of health insurance in this State;

2. The carrier is not in a hazardous financial condition as set forth in N.J.A.C. 11:2–27 and as may be amended hereafter;

3. The carrier has at least the capital and surplus currently required to commence business in this State, unless a carrier has made application for a waiver of such requirements pursuant to P.L. 1993, c.235 and N.J.A.C. 11:2–39 and such application has not been disapproved; and

4. The carrier is qualified based on its history of assuming and managing risk, and its experience in managing small employer group business.

(b) The Commissioner may approve an application for risk-assuming carrier status for health service corporations, hospital service corporations and medical service corporations if the carrier meets the following standards:

1. The carrier is authorized to transact business in this State;

2. The carrier is not in a hazardous financial condition as set forth in N.J.A.C. 11:2–27 and as may be amended hereafter;

3. The carrier has either:

i. The surplus amounts required to be maintained in accordance with N.J.S.A. 17:48–10 or N.J.S.A. 17:48A–14, if the carrier is a hospital service corporation or a medical service corporation, respectively; or

ii. The amount required to be maintained in its special contingent surplus account for its other activities in accordance with N.J.S.A. 17:48E–17.1a and b, if the carrier is a health service corporation; and

4. The carrier is qualified based on its history of assuming and managing risk, and its experience in managing small group business.

(c) The Commissioner may approve an application for risk-assuming carrier status for HMOs if the carrier meets the following standards:

1. The carrier is authorized to transact business as an HMO in this State;

2. The carrier is not in a hazardous financial condition as set forth in N.J.A.C. 11:2–27 and as may be amended hereafter;

3. The carrier has a statutory net worth as filed annually with the Department of at least $1 million; and

4. The carrier is qualified based on its history of assuming and managing risk, and its experience in managing small group business.

(d) The Commissioner may solicit and consider comments from the Board in determining any carrier's application to operate as a risk-assuming carrier.

11:21–14.8 Hearings

(a) If the Commissioner disapproves an application for risk-assuming carrier status made pursuant to this subchapter, the carrier may request a hearing on the Commissioner's determination, but must do so within 20 days from the date of receipt of notice of such determination.

(b) A request for a hearing shall be in writing and shall include:

1. The name, address, and telephone number of a contact person representing the carrier who is familiar with the matter;

2. A copy of the notice of disapproval;

3. A statement requesting a hearing; and

4. A concise statement describing the basis for which the carrier believes that the Commissioner's findings of fact are erroneous.

(c) Upon receipt of a properly completed request for a hearing which sets forth good-faith, disputed issues of material fact, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

SUBCHAPTER 15. RELIEF FROM OBLIGATIONS IMPOSED UNDER THE SMALL EMPLOYER HEALTH BENEFITS PROGRAM

Authority

N.J.S.A. 17:1–8, 17:1–8.1, 17:1C–6(e), 17B:27A–17 et seq. and P.L. 1993, c.162.

Source and Effective Date

R.1993 d.629, effective November 5, 1993.
See: 25 N.J.R. 4577(a), 25 N.J.R. 5692(a).

11:21–15.1 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–38 or to offer coverage or accept applications to a small employer, pursuant to N.J.S.A. 17B:27A–26.

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

11:21–15.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A–17 and N.J.A.C. 11:21–1, 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–17 et seq.

"Financially impaired" means a member which, after November 5, 1993, 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 pursuant to N.J.S.A. 17B:27A–38 or a waiver of obligations pursuant to N.J.S.A. 17B:27A–26, as applicable.

11:21–15.3 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–38 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. 11:21–15.4, 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. 11:21–15.4. 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.

(e) If a request fails to materially comply with the filing format and information requirements set forth in N.J.A.C. 11:21–15.4 and this section, the Department shall notify the member that its request for relief is deficient and is denied on such grounds. The notice shall also set forth any information or other action required to cure the deficiency(s). If the member intends to pursue its request, the member shall submit the additional information specified or otherwise submit a filing in accordance with the format requirements specified in this section within 15 days of receipt of the Department's notice of deficiency. Failure to submit within 15 days the information necessary in the proper format to cure the deficiency shall result in the member's request being denied.

(f) All requests for relief or other information required pursuant to this subchapter shall be filed with the Department at the following address:

SEH Program
Request for Relief
New Jersey Department of Insurance
Division of Financial Solvency
20 West State Street
CN–325
Trenton, NJ 08625

11:21–15.4 Informational filing requirements

(a) When requesting relief from obligations pursuant to N.J.S.A. 17B:27A–26b or 17B:27A–38, the applicant shall provide with its request the following information in a clear, concise and complete manner:

1. A cover letter stating:

i. The name of the applicant;

ii. The form of relief and, if a deferral of less than the full amount, specific amount/percentage of relief which the applicant is requesting;

iii. A statement of facts relied upon as the basis under which relief is sought, including the specific factor(s) upon which the Commissioner may find that the member is or would be placed in a financially impaired position as set forth in N.J.A.C. 11:2–27.3(a)1 to 29; and

iv. The name, title, telephone number and telefax number of a contact person familiar with the filing to whom the Department may direct any additional questions;

2. A detailed explanation, with supporting documentation, of the projected effect that fulfillment of the obligation would have on the immediate and long term financial condition of the applicant unless relief is granted as requested;

3. The most recent financial examination report, whether conducted by the applicant's state of domicile or other state;

4. A statement addressing whether the applicant is planning to modify its method of doing business in any way including, but not limited to, new acquisitions or new restructuring;

5. If the applicant is a member of a holding company system, the following shall be provided:

i. A list of all members of the holding company system;

ii. A list of all intercompany transactions for the period beginning January 1 in the year of the filing to the date of the quarterly statement immediately preceding the date of the filing, in the format set forth in the statutory annual statement filed by the applicant; and

iii. A copy of the registration statement filed pursuant to N.J.S.A. 17:27A–3 and the applicant's organizational chart;

6. An actuarial opinion attesting to the adequacy of reserves specifically for all accident and health lines of business, and for all lines of business which the applicant transacts, in the format of and satisfying all requirements for the actuarial opinion and memorandum required to be submitted as a part of the annual statement filed by the applicant.

i. If the applicant is a health maintenance organization, the applicant shall obtain and file an actuarial opinion which complies with the requirements set forth in (a)6 above;

7. A report signed by the attesting actuary referred in (a)6 above, which includes, in summary form if necessary, all data utilized, a complete explanation of methods and assumptions and sufficient additional narrative to account for any features of the data or circumstances necessary for proper interpretation;

8. A copy of the annual statement of the applicant, including all accompanying exhibits, filed with this State immediately preceding the date of the relief filing;

9. Copies of all quarterly statements for the period beginning January 1 in the year of the filing to the quarterly statement immediately preceding the date of the filing;

10. Three year financial projections beginning with the calendar year of the date of the filing assuming relief is granted and assuming relief is denied. The projections shall include, in summary form if necessary, all data utilized, and a complete explanation of methods and assumptions utilized and relied upon by the applicant in making the projections. The projections shall include results for the applicant's operations worldwide by line of business and for the applicant's operations in New Jersey only for health benefits plans issued pursuant to N.J.S.A. 17B:27A–17 et seq. The projections shall assume the same rate of assessment as in the first year for the subsequent years, 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, hospital service corporations and medical service corporations, the balance sheet and Underwriting and Investment Exhibit of the statutory annual statement filed by the 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 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. 11:21–15 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."

11:21–15.5 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., 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. 11:21–15.4(a)1i and ii—cover letter with name of applicant and describing relief sought;

2. N.J.A.C. 11:21–15.4(a)1iv—name, title, telephone number and telefax number of person familiar with the filing;

3. N.J.A.C. 11:21–15.4(a)3—most recent financial examination report;

4. N.J.A.C. 11:21–15.4(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. 11:21–15.4(a)8—annual statement filed immediately preceding date of filing;

6. N.J.A.C. 11:21–15.4(a)12—non–refundable filing fee; and

7. N.J.A.C. 11:21–15.4(a)13—additional information required by the Commissioner to evaluate a particular filing.

11:21–15.6 Disposition of request for relief

(a) When the Commissioner determines pursuant to N.J.S.A. 17B:27A–26b or 17B:27A–38 as applicable, that the member 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–38, the member shall remain liable to the SEH Program for the amount deferred and shall be prohibited from reinsuring any individuals or groups in the SEH Program if it fails to pay assessments.

(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 of 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.

11:21–15.7 Hearings

(a) If the Commissioner denies a member's request for relief made pursuant to this subchapter, or if the member objects to the terms of the relief granted, the member may request a hearing on the Commissioner's determination within seven days from the date of receipt of such determination as follows:

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

i. The name, address, and daytime telephone number 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 describing the basis for which the member believes 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 material issues of fact in dispute.

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.

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 Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

ii. In a matter which has been determined to be a contested case, if the Commissioner finds that there are no good-faith disputed issues of material 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.

11:21–15.8 Notice of the SEH Program

Members requesting relief pursuant to this subchapter shall concurrently provide notice of all such requests to the SEH Program through the Interim Administrator or Administrator, as appropriate. Members shall also provide notice to the SEH Program of all dispositions of such requests by the Commissioner, within 15 days of such disposition.

11:21–15.9 Exceptions for health maintenance organizations due to lack of capacity

(a) Any member HMO asserting that it is not required to offer coverage or accept applications pursuant to the requirements of the Act because it reasonably anticipates that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of the additional small employer groups, pursuant to N.J.S.A. 17B:27A–26a, 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 anticipates that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of the additional small employer groups, and the basis for that assertion, with supporting documentation, certified by the president or duly authorized officer of the member; and

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–26a.

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

11:21–15.10 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, medical service corporations, hospital service corporations or health maintenance organizations as may be authorized by law, including, but not limited to, placing an insurer, health service corporation, medical service corporation, hospital service corporation or health maintenance organization in rehabilitation, liquidation or conservation pursuant to N.J.S.A. 17B:32–31 et seq.

11:21–15.11 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–17 et seq. and the SEH 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 16. WITHDRAWALS OF SMALL EMPLOYER CARRIERS FROM THE SMALL EMPLOYER HEALTH BENEFITS PLANS MARKET

Authority

N.J.S.A. 17:1C–6(e) and 17B:27A–23.

Source and Effective Date

R.1994 d.26, effective December 9, 1993.
See: 25 N.J.R. 4859(a), 26 N.J.R. 247(a).

11:21–16.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers may cease doing business in the small employer market in this State. The subchapter applies to all small employer carriers issuing or renewing policies or contracts after November 30, 1992. Pursuant to the provisions of N.J.S.A. 17B:27A–17 et seq., every policy or contract issued to a small employer in this State shall be renewable with respect to all eligible employees or dependents at the option of the policy or contract holder or small employer, except under the circumstances prescribed by N.J.S.A. 17B:27A–23(a) through (g). One of the circumstances delineated therein is where a carrier ceases to do business in the small employer health benefits plans market in New Jersey pursuant to N.J.S.A. 17B:27A–23e.

(b) This subchapter applies to all small employer carriers as defined in this subchapter that seek to cease doing business in the small employer market.

11:21–16.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings set forth in the Act or at N.J.A.C. 11:21–1.3 unless defined below or unless the context clearly indicates otherwise:

"Affiliate" or "affiliated company" means a carrier that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the carrier that initiates a withdrawal.

"Cease doing business" for purposes of these rules means withdraw or withdrawal.

"Nonstandard health benefits plan" means a health benefits plan policy or contract form under which policies, contracts or certificates were issued on or before December 31, 1993 to small employers or to one or more employees of a small employer by virtue of the employment arrangement.

"State" means the State of New Jersey.

"Withdraw" or "withdrawal" means the cancellation on a date certain or the termination on the anniversary date of all in force nonstandard health benefits plans or small employer health benefits plans, or both as appropriate, issued to small employers without offering replacement with a small employer health benefits plan (or a nonstandard health benefits plan, if offered through an association, multiple employer arrangement or out-of-State trust that continues to market its nonstandard health benefits plans pursuant to P.L. 1994, c.11), except where such action is taken pursuant to N.J.S.A. 17B:27A–23a through d, f and g or is approved by the Commissioner in accordance with N.J.A.C. 11:21–11.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

11:21–16.3 General provisions

(a) No small employer carrier shall cancel, nonrenew, or terminate, except in accordance with N.J.S.A. 17B:27A–23a through d, f and g, or refuse to issue any small employer health benefits plan unless the small employer carrier withdraws from the small employer market in New Jersey in accordance with the provisions of this subchapter.

(b) No small employer carrier shall cancel, nonrenew, or terminate any nonstandard health benefits plan prior to February 28, 1997, except in accordance with N.J.S.A. 17B:27A–23a through d, f and g, or upon prior approval of the Commissioner in accordance with N.J.A.C. 11:21–11, unless the small employer carrier withdraws from the small employer market in New Jersey in accordance with the provisions of this subchapter.

(c) Any small employer carrier which seeks to withdraw from the small employer market in this State shall provide the Commissioner with written notification of its intent to withdraw not later than eight months prior to either the cancellation of all of its in force policies or contracts on a date certain or the termination on the anniversary date of each in force policy or contract. The carrier shall choose only one of these methods and shall specify in the notice which method of withdrawal it chooses.

1. Until such time as the withdrawal shall be completed, the withdrawing carrier shall continue to be governed by N.J.S.A. 17B:27A–17 et seq. and all rules promulgated thereunder.

2. A withdrawing carrier shall cease issuing new policies no more than two months after filing a notice of intent to withdraw with the Commissioner.

(d) The notice of withdrawal to the Commissioner shall be sent to the attention of: SEH Withdrawal Notice, Division of Financial Solvency, New Jersey Department of Insurance, CN 325, Trenton, NJ 08625, and shall include an original and two copies of the following information:

1. The carrier's percentage market share in the small employer market, if known, including its most recent policy or contract count and annual amount of direct premium earned and written;

2. A statement, describing with specificity, the reasons for which the carrier is withdrawing from the small employer market in this State;

3. A statement indicating whether the carrier has any affiliates writing any health lines in this State, the names of such affiliates and the lines of insurance written and a statement indicating whether any such affiliates will continue to write small employer health benefits plans;

4. 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;

5. A statement specifying the date or dates upon which the small employer health benefits plans and nonstandard health benefits plans, as applicable, shall be terminated, specifying either:

i. The specific date upon which the carrier shall cancel all in force policies or contracts; or

ii. The dates upon which all in force policies or contracts shall be terminated, which shall be the anniversary dates of the policies or contracts of each policyholder;

6. The date upon which the carrier shall cease writing any new nonstandard health benefits plans (if through an association, multiple employer arrangement or out-of-State trust) or small employer health benefits plans, as applicable, which shall be no later than two months after the date the carrier has filed its notice with the Commissioner; and

7. A copy of the form of notice required pursuant to (f) below, which is to be mailed to each affected small employer.

(e) The Commissioner shall review the notice of withdrawal to determine whether it complies with (d) above and whether sufficient notice will be provided to policyholders. The Commissioner shall notify, in writing, the small employer carrier of any deficiencies and the requirements which are necessary to bring it into compliance with N.J.S.A. 17B:27A–23 and this subchapter.

1. A carrier which submitted a notice to the Commissioner pursuant to N.J.S.A. 17B:27A–23e prior to December 9, 1993 shall file the information requested in (d) above, no later than February 7, 1994.

i. Where the carrier complies with (e)1 above, the carrier's notice to the Commissioner shall relate back to the date of the carrier's original submission to the Commissioner. Notwithstanding the date of notice to the Commissioner, a carrier shall provide at least six months written notice to a small employer that its contract or policy shall be cancelled on a date certain or terminated on the anniversary date.

ii. Where a carrier fails to file the supplemental information as required by (e)1 above, the date of notice to the Commissioner shall be deemed to be the date upon which the carrier has filed with the Department all of the items set forth in (d) above. Dates for all other notices required by this subchapter shall be calculated from this new date.

2. A carrier which has submitted its notice of intent to withdraw prior to December 9, 1993 shall comply with the notice requirements set forth at (f), (g), (h) and (i) below, to which all other carriers must similarly comply, unless the Commissioner authorizes or specifies otherwise, to prevent undue hardship to either the carrier, the policyholders, or both.

(f) Any small employer carrier which seeks to withdraw from the small employer market shall, not later than two months following the date of notification to the Commissioner, nor less than six months in advance of the effective date of the cancellation on a date certain or termination on the anniversary date of the policy or contract, mail a notice to every small employer insured by the carrier, informing the small employer that the policy or contract will be cancelled on a date certain or terminated on the anniversary date. This initial notice to each small employer shall be sent by certified mail and shall include the following information:

1. The date upon which the policy or contract shall be cancelled or terminated;

2. That the policy or contract is being cancelled or terminated under the authority of N.J.S.A. 17B:27A-23(e) and this subchapter;

3. 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;

4. A statement that the small employer may contact its broker for additional information regarding the withdrawal;

5. A notice that, on or after January 1, 1994, a list of active small employer carriers and examples of their rates may be obtained by writing to the New Jersey Department of Insurance, Division of Public Affairs, CN 325, Trenton, NJ 08625-0325, or by calling (609) 633-3955, and requesting the Small Employer Health Benefits Plans Comparison Guide; and

6. A statement that pursuant to N.J.S.A. 17B:27A-19, all carriers offering small employer health benefits plans must issue coverage to any small employer group which requests coverage under a small employer health benefits plan, meets the participation requirements of the carrier, and pays the required premium for the coverage.

(g) A withdrawing small employer carrier shall provide at least one copy of its notice of intent to cancel on a date certain or termination on the anniversary of each policy or contract, to the producer of record for each policy or contract. The notice shall be sent by certified mail, no less than six months prior to the effective date of withdrawal.

(h) Simultaneous with its notice to the Commissioner, a withdrawing small employer carrier shall submit a notice to the Board at the address specified at N.J.A.C. 11:21-1.2, which:

1. Indicates that the carrier shall withdraw from the State of New Jersey;

2. States whether the carrier shall either cancel all of its in force policies or contracts on a date certain or shall terminate its in force policies or contracts on their anniversary date; and

3. Sets forth the date or dates upon which (g)1 and 2 above shall occur.

(i) Following the initial notice to the small employer, a small employer carrier shall submit subsequent notices to the small employer of the cancellation on a date certain or the termination on the anniversary date of the contract and the date upon which the cancellation or termination shall occur. Such notice shall be included with each monthly premium bill or premium notice issued prior to the date of cancellation or termination. Where no monthly premium statement is transmitted, a small employer carrier shall provide a small employer with no fewer than three notices, which notices shall be sent at minimum on the sixth, third and last month prior to the date of cancellation or termination.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

11:21-16.4 Restrictions on writings

(a) Any small employer carrier that ceases to do business pursuant to this subchapter shall be prohibited from writing new business in the New Jersey small employer market for a period of five years from the date it provides notice to the Commissioner of its planned withdrawal.

(b) Any carrier which has withdrawn from the small employer market in this State shall be prohibited from issuing any small employer health benefits plans until it has complied with N.J.A.C. 11:21-14, and has been approved or deemed approved by the Commissioner, if appropriate, to issue such policies.

(c) Any small employer carrier which withdraws from the small employer market shall cancel on a date certain or terminate on the anniversary date of all of its in force small employer health benefits plans and nonstandard health benefits plans in accordance with N.J.A.C. 11:21-16.3.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

11:21-16.5 Penalties

Failure to comply with the requirements of this subchapter shall result in the imposition of penalties pursuant to N.J.S.A. 17B:27A-43 and any and all other penalties provided by law.

11:21-16.6 Other policyholder rights unaffected

Nothing in this subchapter shall be construed to contravene any rights of policyholders concerning cancellation requirements or obligations set forth in a policy or contract issued by a small employer carrier.

11:21–16.7 Revocation of a notice of intent to withdraw

(a) A carrier may revoke its notice of intent to withdraw, filed with the Commissioner pursuant to N.J.A.C. 11:21–16.3, prior to the date that its withdrawal is complete, by submitting a statement to the Department at the address specified at N.J.A.C. 11:21–16.3(d) and to the Board at the address specified at N.J.A.C. 11:21–1.2 revoking its notice of intent to withdraw. The revocation shall be signed by a duly authorized officer, and shall include the following:

1. A statement agreeing to reinstate any small employer that was cancelled, nonrenewed or terminated by the carrier pursuant to the provisions of N.J.S.A. 17B:27A–23e and this subchapter;

2. A statement agreeing that all policies and contracts under a nonstandard health benefits plans shall be brought into compliance with the provisions of N.J.S.A. 17B:27A–17 et seq., as required by P.L. 1994, c.11, no later than the first 12–month anniversary date of the policy or contract occurring after September 11, 1994;

3. A statement agreeing that a carrier shall not issue directly a nonstandard health benefits plan to a small employer, and a statement agreeing that any nonstandard health benefits plan which continues to be offered for issue to small employers by or through an association, multiple employer arrangement or out-of-State trust shall be offered to all small employer members of the association, multiple employer arrangement or out-of-State trust; and

4. A statement agreeing that the carrier shall comply with the requirement to offer small employer health benefits plans in accordance with the provisions of N.J.S.A. 17B:27A–17 et seq.

New Rule, R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

SUBCHAPTER 17. FAIR MARKETING STANDARDS

11:21–17.1 Plan identification and marketing materials

(a) Each small employer carrier which issues marketing and/or promotional materials in conjunction with the standard health benefits plans may attach its own name or identification to each of the plans, but shall also identify each of those standard health benefits plans by the alphabetical designation (A, B, C, D, E, HMO, HMO POS) assigned to it in N.J.A.C. 11:21–3.1. The alphabetical designation shall be clearly identified in the designation of each of the small employer carrier's standard health benefits plans.

(b) All terms, definitions, and text used in the small employer carrier's marketing and/or promotional material shall be consistent with the Act and this chapter.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), inserted "standard" preceding "health benefits plan" throughout and inserted reference to HMO POS.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Deleted former (c).

11:21–17.2 Retention of marketing and promotional materials

Small employer carriers shall maintain a complete file of all marketing and promotional material specific to the health benefits plans, which it disseminates to consumers, producers, or otherwise publicly disseminates. Small employer carriers shall retain each piece of promotional and marketing materials for a period of three calendar years from the last date the material is publicly disseminated, which shall be deemed its complete file for the purposes of this subchapter. Upon written request of the Board, a small employer carrier shall, within three business days, make available for inspection its complete file of marketing and promotional material to the Board.

11:21–17.3 Certification

(a) Each small employer carrier disseminating marketing and promotional material shall certify that its marketing and promotional material conforms with the requirements of this subchapter. The certification, set forth in Part 2 of Exhibit BB of the Appendix, incorporated herein by reference, shall be signed by a duly authorized officer of the small employer carrier. Each small employer carrier shall file its initial certification with the Board no later than the first day upon which the small employer carrier disseminates promotional or marketing materials for the health benefits plans to consumers, producers or the public in general.

(b) Small employer carriers shall continue to file a certification as required in (a) above on an annual basis, on or before March 1 of each year following the filing of its initial certification.

Amended by R.1994 d.153, effective February 28, 1994.
See: 26 N.J.R. 741(a), 26 N.J.R. 1352(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), inserted "carrier" preceding "disseminates promotional or marketing"; and in (b), inserted March 1 deadline.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), deleted ", or by February 15, 1994, whichever date is later" at the end.

11:21–17.4 "Get the Facts" brochure

Small employer carriers shall set forth in their promotional and/or marketing materials that a Small Employer Health Benefits "Get the Facts" brochure about small employer health benefits coverage is available and can be obtained upon request, free of charge, by a small employer from the small employer carrier. Small employer carriers shall provide or mail the "Get the Facts" brochure to small employers within three business days of request. A small employer

carrier may arrange for delivery or distribution of the "Get the Facts" brochure through its licensed agents or brokers.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Substituted references to a "Get the Facts" brochure for references to a Buyer's Guide throughout.

11:21–17.5 Producer contracts

(a) A small employer carrier may select those insurance producers, as defined by N.J.S.A. 17:22A–2j, with whom it chooses to contract. No small employer carrier shall terminate or refuse to renew the contract of its insurance producers because of health status-related factors of eligible employees or dependents or the occupation or geographic location of the small employer groups placed by the insurance producer with the small employer carrier.

(b) No small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an insurance producer that provides for or results in any consideration provided to an insurance producer for the issuance or renewal of a small employer health benefits plan that varies on account of health status-related factors of eligible employees or dependents, or the industry, occupation or geographic location of a small employer covered by a small employer health benefits plan.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), and (b), substituted "health status-related factors of eligible employees or dependents, or the" for "the health status, claims experience,".

SUBCHAPTER 18. PETITIONS FOR RULES

11:21–18.1 Scope

This subchapter shall apply to all petitions made by interested persons for the promulgation, amendment or repeal of any rule by the Board, pursuant to N.J.S.A. 52:14B–4(f).

11:21–18.2 Procedure for petitioner

(a) Any person who wishes to petition the Board to promulgate, amend or repeal a rule shall submit to the Board, in writing, the following information:

1. Name and address of the petitioner;

2. The substance or nature of the rulemaking which is requested;

3. The reasons for the request and the petitioner's interest in the request; and

4. References to the authority of the Board to take the requested action.

(b) 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.

(c) Any document submitted to the Board which is not in substantial compliance with (a) above shall not be deemed to be a petition for a rule requiring further Board action pursuant to N.J.S.A. 52:14B–4(f).

11:21–18.3 Procedure of the Board

(a) Upon receipt of a petition in compliance with N.J.A.C. 11:21–18.2 the Board shall, within 15 days, file 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 30 days of receiving a petition in compliance with N.J.A.C. 11:21–18.2, 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) Board's action on a petition may include:

1. Denying the petition;

2. Filing a notice of proposed rule or a notice of preproposal for a rule with the Office of Administrative Law; or

3. Referring the matter for further deliberations, the nature of which shall be specified and which shall conclude upon a specified date. The results of these further deliberations shall be mailed to petitioner and submitted to the Office of Administrative Law for publication in the New Jersey Register.

Amended by R.1998 d.512, effective September, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted ", within 15 days," following "shall" in the introductory paragraph.

SUBCHAPTER 19. SEH PROGRAM PREMIUM COMPARISON SURVEY

Authority

N.J.S.A. 17:1–8.1, 17:1C–6e and 17B:27A–33.

Source and Effective Date

R.1995 d.289, effective June 5, 1995.
See: 27 N.J.R. 1127(b), 27 N.J.R. 2233(a).

11:21–19.1 Purpose and scope

(a) This subchapter requires the annual submission of data by small employer carriers to the Department, and establishes the format for the submission of such data, regarding premiums charged for the five standard health benefits plans, the HMO plan, and any standard rider packages established by the Board, so that the Department may develop and publish an annual SEH Program Premium Comparison Survey, pursuant to N.J.S.A. 17B:27A–33g.

(b) This subchapter shall apply to all small employer carriers.

11:21–19.2 Definitions

The following words and terms, when used in this subchapter, shall have the meanings as defined at N.J.S.A. 17B:27A–17 and N.J.A.C. 11:21–1.2, unless defined below or the context clearly indicates otherwise.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board subject to review and approval by the Commissioner.

"Standard rider" means a rider promulgated by the SEH Board to be offered with one or more of the standard health benefits plans.

11:21–19.3 SEH Program premium comparison survey

(a) Every small employer carrier shall prepare and file with the Department a premium survey reflecting premiums charged for each of the five standard small employer health benefits plans, the HMO plan, and for any standard rider packages, as set forth in Exhibit FF of the Appendix to this chapter, incorporated herein by reference.

(b) Every small employer carrier shall complete the survey in the format set forth in Exhibit FF in accordance with the instructions set forth therein, and shall not vary the information solicited in Exhibit FF.

(c) Completed survey forms shall be filed no later than November 1 of each year, and shall reflect the monthly premiums to be charged for each of the five standard health benefits plans, the HMO plan, and any standard rider packages as of January 1 of the year immediately following. The initial survey shall be due November 1, 1995 reflecting premiums as of January 1, 1996.

(d) In addition to the requirements in (c) above, every small employer carrier shall complete and submit a survey in the format set forth in Exhibit FF no later than July 1, 1995, which shall reflect the monthly premiums charged as of that date for each of the five standard health benefits plans, the HMO plan, and any standard rider packages, with appropriate modification of the dates set forth in Exhibit FF.

(e) All filings shall be accompanied by the following certification signed by the person who completed the survey: "I _____ certify that the information set forth in the attached SEH Program Premium Comparison Survey is true and accurate, and hereby further certify that I am authorized to execute this certification on behalf of the carrier named in the survey."

(f) Completed survey forms and signed certification shall be filed with the Department pursuant to this subchapter at the following address:

SEH Program Premium Comparison Survey
Division of Public Affairs
New Jersey Department of Insurance
20 West State Street
PO Box 325
Trenton, New Jersey 08625–0325

11:21–19.4 Penalties

Failure to comply with the requirements of this subchapter may result in the imposition of penalties as authorized by law, including, but not limited to, penalties set forth in N.J.S.A. 17B:27A–17 et seq.

APPENDIX

EXHIBIT A

[Carrier] **PLAN A**

SMALL GROUP HEALTH BENEFITS BASIC POLICY

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER: [G-12345]

GOVERNING JURISDICTION: New Jersey

EFFECTIVE DATE OF POLICY: [January 1, 1998]

POLICY ANNIVERSARIES: [January 1st of each year beginning in 1999.]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February, 1998 .]

AFFILIATED COMPANIES: [DEF Company]

[Carrier] in consideration of the application for this Policy and of the payment of premiums as stated herein, agrees to pay benefits in accordance with and subject to the terms of this Policy. This Policy is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages constitute this Policy.

The Effective Date is specified above.

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]

[Dividends are apportioned each year.]

POLICY INDEX

EXHIBIT FF
SEH PROGRAM PREMIUM COMPARISON SURVEY

Submit this completed survey in duplicate no later than September 1 of each year to: SEH Program Premium Comparison Survey, Division of Public Affairs, New Jersey Department of Insurance, 20 West State Street, CN 325, Trenton, New Jersey 08625.

Part 1
COMPANY AND RESPONDENT INFORMATION

Company Name: _____ NAIC: _____
Respondent's Name: _____
Respondent's Title: _____
Respondent's Address: _____
Respondent's Telephone: _____
Respondent's Facsimile: _____

Part 2
TOLL-FREE INFORMATION

Company's Toll-Free Telephone number where an applicant may obtain a premium quote: _____
Please indicate if a switchboard or message recording is reached by the toll-free number and the respective period of service:
Switchboard Service Times: _____
Message Recording Service Times: _____

Part 3
DIRECTIONS FOR COMPLETING THE PREMIUM SURVEY

A. Specify the monthly premium, rounded to the nearest whole dollar, that will be charged for a standard policy issued on the next January 1 to an employer as set forth in paragraph C below, for each policy form and rider in the categories listed in the survey for each plan in accordance with paragraph D below. In showing the rider premium, list only the additional premium for a rider, not the total premium for a plan including the rider. The following abbreviations apply:

SCA	-	Selective Contracting Arrangement (that is, an arrangement for the payment of predetermined fees or reimbursement levels for covered services by the carrier to preferred providers or preferred provider organizations (see N.J.A.C. 11:4-37.2)).
NR	-	The plan is offered or purchased without any standard riders.
PC	-	The prescription card rider (Exhibit H or J, Part 2 of the Appendix to N.J.A.C. 11:21).
PM	-	The prescription mail order rider (Exhibit H or J, Part 3 of the Appendix to N.J.A.C. 11:21).
PMC	-	The prescription card and mail order rider (Exhibit H or J, Part 1 of the Appendix to N.J.A.C. 11:21).
MH	-	The mental/nervous and substance abuse rider (Exhibit I of the Appendix to N.J.A.C. 11:21).

B. Use "NA" to indicate when any rider or plan variation is not being offered.

C. For purposes of completing the survey, assume the following policyholder:

Three small employers, one of each employer being located in the following counties: Camden, Middlesex, and Bergen, and each with six employees as follows:

1. Single Female—age 27
2. Single Male—age 37
3. Female Parent—age 47, with two children
4. Male Employee and Spouse—both age 57
5. Male Employee—age 27
   Spouse—age 24
   Two children—both under age 18
6. Female Employee—age 47
   Spouse—age 50
   Two children—both under age 18

D. For purposes of completing the survey, show the premium for only one delivery system option as described on the form, and indicate by checking the appropriate space if other delivery systems for the plan are available.

Part 4
PREMIUM SURVEY

PLAN A

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—
PLAN A PREMIUM 1/1/19___

	NR
Camden	
$250	$_____
Middlesex	
$250	$_____
Bergen	
$250	$_____

Premium Rate Guarantee Period (if any): _____

Above Premiums
Based on (check one):
Traditional ____
SCA—No Gatekeeper ____
SCA—Gatekeeper ____
Other Delivery Systems Available: Yes ___ No ___
Note: Coinsurance percentages for Plan A are established by rule — no variations are permitted. See Exhibit A of Appendix to N.J.A.C. 11:21.

PLAN B

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—
PLAN B PREMIUM 1/1/19___

Camden

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Middlesex

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Bergen

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____
Above Premiums
Based on (check one):
Traditional _____
SCA—No Gatekeeper ____

Coinsurance Percentage:
In-Network ____ Copay (if any) $____
Out-of-Network ____

SCA—Gatekeeper ____

Coinsurance Percentage:
In-Network ____ Copay (if any) $____
Out-of-Network ____

Other Delivery Systems Available: Yes ____ No ____

PLAN C

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—
PLAN C PREMIUM 1/1/19___

Camden

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Middlesex

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Bergen

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

Above Premiums

Based on (check one):

Traditional _____

SCA—No Gatekeeper _____

Coinsurance Percentage:
In-Network ____ Copay (if any) $_____
Out-of-Network ____

SCA—Gatekeeper _____

Coinsurance Percentage:
In-Network ____ Copay (if any) $_____
Out-of-Network ____

Other Delivery Systems Available: Yes _____ No _____

PLAN D

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—
PLAN D PREMIUM 1/1/19___

Camden

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Middlesex

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Bergen

	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

Above Premiums

Based on (check one):

Traditional _____

SCA—No Gatekeeper _____

Coinsurance Percentage:
In-Network ____ Copay (if any) $_____
Out-of-Network ____

SCA—Gatekeeper _____

Coinsurance Percentage:
In-Network ____ Copay (if any) $_____
Out-of-Network ____

Other Delivery Systems Available: Yes _____ No _____

PLAN E

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—
PLAN E PREMIUM 1/1/19___

Camden

	NR	PC	PM	PMC	MH
$150	$_____	$_____	$_____	$_____	$_____

Middlesex

	NR	PC	PM	PMC	MH
$150	$_____	$_____	$_____	$_____	$_____

Bergen

	NR	PC	PM	PMC	MH
$150	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

Above Premiums
Based on (check one):

Traditional _____

SCA—No Gatekeeper _____

Coinsurance Percentage:
In-Network ____ Copay (if any) $_____
Out-of-Network ____

SCA—Gatekeeper _____

Coinsurance Percentage:
In-Network ____ Copay (if any) $_____
Out-of-Network ____

Other Delivery Systems Available: Yes _____ No _____

HMO PLAN

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—
HMO PLAN PREMIUM 1/1/19___

Camden

	NR	PC	PM	PMC	
$5	$_____	$_____	$_____	$_____	$_____
$10	$_____	$_____	$_____	$_____	$_____
$15	$_____	$_____	$_____	$_____	$_____
$20	$_____	$_____	$_____	$_____	$_____

Middlesex

	NR	PC	PM	PMC	
$5	$_____	$_____	$_____	$_____	$_____
$10	$_____	$_____	$_____	$_____	$_____
$15	$_____	$_____	$_____	$_____	$_____
$20	$_____	$_____	$_____	$_____	$_____

Bergen

	NR	PC	PM	PMC	
$5	$_____	$_____	$_____	$_____	$_____
$10	$_____	$_____	$_____	$_____	$_____
$15	$_____	$_____	$_____	$_____	$_____
$20	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

New Rule, R.1995 d.289, effective June 5, 1995.
See: 27 N.J.R. 1127(b), 27 N.J.R. 2233(a).

Administrative correction.
See: 30 N.J.R. 1047(a).

APPENDIX

EXHIBIT GG

Loss Ratio Report Form
New Jersey Small Employer Health Benefits Program
Reporting Year _____
For Preceding Calendar Year Ending December 31, _____

Name of Carrier: _____ NAIC # _____

Address: _____

Check one: Insurance Company _____ HMO _____ Service Plan _____

A separate Report Form shall be completed and filed for each affiliate in addition to a combined report form for affiliated insurance companies or affiliated HMOs. Definitions and instructions regarding words and terms appearing below may be found on the reverse side.

	Total	Standard Plans	Open Non-Standard Plans	Closed Non-Standard Plans
1. Premiums				
2. Claims (a. +b. – c. + d. – e) (See definitions, reverse side)				
a.				
b.				
c.				
d.				
e.				
3. Loss Ratio (2./1.)				
4. Dividends (.75 x 1. – 2.)*				
5. Dividend Percentage (4. ÷ 1.)				

*Note Instruction 4.

I certify that the above information is accurate and complete and has been prepared in accordance with N.J.A.C. 11:21-7A. If Dividends (or credits) are required, an explanation of our plan to issue them is attached.

Actuary's Signature _____ Date _____ Type or Print Actuary's Name _____

Title _____ Telephone Number _____

REPORTING FORM DEFINITIONS AND INSTRUCTIONS

1. "Premiums" are the total earned premiums, on the same earned basis as in the carrier's Annual Statement for the preceding calendar year, before dividends or credits applicable to prior years: (a) combined for all Standard Health Benefits Plans; (b) combined for open Nonstandard Health Benefits Plans; and (c) combined for Closed Nonstandard Health Benefits Plans. Include all Rider Premiums, both Standard and Nonstandard Riders, with the respective Plans which are ridered. The Closed Nonstandard Plans column is for the policies which are renewal only policies continued pursuant to N.J.S.A. 17B:27A-19j(3)(b).

2. "Claims" are equal to

a. claims paid in the preceding calendar year regardless of the year incurred;

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

c. 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 year's Loss Ratio Report);

d. plus a residual reserve equal to 3.3 percent of a. + b. – c.;

e. less the residual reserve as reported in the preceding calendar year's Loss Ratio Report.

3. "Loss Ratio" is the quotient, to the nearest .1 percent, of the Claims divided by the Premiums (2. divided by 1.).

4. "Dividends" are calculated on a combined basis for all standard health benefits plans; for all open nonstandard health benefits plans combined; and for all Closed Nonstandard health benefits plans combined. "Dividends" are equal to 75 percent of the Premiums less Claims (75% of 1. less 2.). (No dividends are required to be paid for nonstandard plans for reporting year 1995.) If the calculated amount is less than zero, then use zero. The Total column should be the sum of the calculated plan columns.

5. "Dividend Percentage" is the percentage ratio of Dividends to Premiums (4. divided by 1.).

Loss Ratio Reports are required to be completed and filed with the Department on or before August 1 of each year for the preceding calendar year, in accordance with N.J.A.C. 11:21-7A. Reports and all required accompanying statements and other information should be sent to the Department at the following address:

Attn: SEH Loss Ratio Report Filings
Life and Health Division
NJ Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

New Rule, R.1996 d.213, effective May 6, 1996.
See: 28 N.J.R. 59(a), 28 N.J.R. 234(b), 28 N.J.R. 2388(a).
Administrative correction.
See: 30 N.J.R. 1047(a).

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote the exhibit.

New Rule, R.1996 d.213, effective May 6, 1996.
See: 28 N.J.R. 59(a), 28 N.J.R. 234(b), 28 N.J.R. 2388(a).

Administrative correction.
See: 30 N.J.R. 1047(a).

EXHIBIT HH

[Carrier] **HMO - POS PLAN**

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION
POINT OF SERVICE CONTRACT

CONTRACTHOLDER: [ABC Company]

GROUP CONTRACT NUMBER **GOVERNING JURISDICTION**
[G-12345] NEW JERSEY

EFFECTIVE DATE OF CONTRACT: [January 1, 1998]

CONTRACT ANNIVERSARIES: [January 1st of each year, beginning in 1999.]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February 1998.]

AFFILIATED COMPANIES: [DEF Company]

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 and pay benefits in accordance with and subject to the terms of this Contract. This Contract is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages constitute this Contract.

The Effective Date is specified above.

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]

TABLE OF CONTENTS

SECTION PAGE

RIGHT TO RECOVERY - THIRD PARTY LIABILITY
MEDICARE AS SECONDARY PAYOR
STATEMENT OF ERISA RIGHTS
CLAIMS PROCEDURE FOR [NON-NETWORK] BENEFITS

SCHEDULE OF PREMIUM RATES AND CLASSIFICATION

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

Covered Employee Only	$]
[Covered Employee and Spouse	$
Covered Employee and Child(ren)	$
Covered Employee and Family (including Covered Employee, spouse and one or more eligible dependents)]	$

We have the right to 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.**

This Contract's classification, and the coverages and amounts which apply to each class are shown below:

CLASS
[All eligible employees]

OVERVIEW OF THE PLAN (Copayment, Deductibles, and Coinsurance)

[NETWORK]	
Copayment	$[15], unless otherwise stated
Emergency Room Copayment	$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the Schedule of Covered Services and Covered Supplies]

[NON-NETWORK]	
Calendar year Cash Deductible (All Cause)	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	[$250, $500, or $1000]
Per Covered Family	[$500, $1,000 or $2,000 NOTE: Must be individually satisfied by 2 separate [Members]] [$750, $1500, or $3000]
Emergency Room Copayment (waived if admitted within 24 hours)	$50
Coinsurance	[30%, 20%] [**except as stated below**]
Exception: For charges for Mental and Nervous Conditions and Substance Abuse treatment	25%]
Coinsured Charge Limit	$10,000

MAXIMUM LIFETIME BENEFITS

[NETWORK]	Unlimited, **except as** otherwise stated
[NON-NETWORK]	$5,000,000 per [Member], **except as** otherwise stated

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES

THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.

SERVICES	[NETWORK]	[NON-NETWORK]
Hospital		
Inpatient (unlimited days)	[$150] Copayment / day; maximum / admission [$750]; maximum / cal. year [$1500]	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment / visit	Deductible/Coinsurance
Practitioner services provided at a Hospital		
Inpatient Visit	$0 Copayment / visit	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment / visit; waived if another Copayment applies	Deductible/Coinsurance
Emergency Room	$50 Copayment / visit; credited toward Inpatient Copayment if admission occurs within 24 hours	$50 Copayment; waived if admission occurs within 24 hours; Deductible/Coinsurance
Maternity	$25 Copayment for initial visit only; $0 Copayment thereafter	Deductible/Coinsurance
Practitioner Services	[$15] Copayment / visit	Deductible/Coinsurance
Preventive Care; NOTE: [Non-Network] benefits LIMITED; Refer to the Covered Charges section	[$15] Copayment / visit	See the Covered Charges Section
Surgery		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Pre-Admission Testing	[$15] Copayment	Deductible/Coinsurance
Second Surgical Opinion	[$15] Copayment	Deductible/Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	[NETWORK]	[NON-NETWORK]
Specialist Services	[$15] Copayment	Deductible/Coinsurance
Therapy Services NOTE: Limited Benefits. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment	Deductible/Coinsurance
Diagnostic Services		
Inpatient	$0 Copayment	Deductible/Coinsurance
Outpatient Visit	[$15] Copayment	Deductible/Coinsurance
Rehabilitation Services NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	Subject to the Hospital Inpatient Copayment; waived if admission immediately preceded by inpatient hospitalization	Deductible/Coinsurance
Skilled Nursing Center NOTE: [Non-Network] benefits LIMITED. Refer to the Covered Charges section	$0 Copayment	Deductible/Coinsurance

Mental or Nervous Conditions and Substance Abuse	**Inpatient:** [$150] Copayment / day; maximum / admission [$750]; maximum / cal. year [$1500]; Maximum 30 days/ calendar year **Outpatient:** [$15] Copayment / visit; Maximum 20 visits/ calendar year. Refer to the Covered Services and Supplies section for an explanation of the rules for exchange	Deductible/Coinsurance **Inpatient:** Maximum 30 days/Calendar Year **Outpatient:** Maximum 20 visits/Calendar Year Refer to the Covered Charges with Special Limitations Applicable to [Non-Network] Benefits section for an explanation of the rules for exchange
Therapeutic Manipulation: Limited Benefit. Refer to the Covered Services and Supplies and Covered Charges sections	[$15] Copayment / visit	Deductible/Coinsurance
Prescription Drugs	at the option of the Carrier: [$15] Copayment per prescription; or the [Non-Network] Coinsurance	Deductible/Coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES (Continued)

SERVICES	**[NETWORK]**	**[NON-NETWORK]**
Home Health Care	Covered; $0 Copayment	Deductible/Coinsurance; Subject to Pre-Approval
Hospice Care	Covered; $0 Copayment	Deductible/Coinsurance; Subject to Pre-Approval
Podiatric Care	[$15] Copayment / visit	Deductible/Coinsurance

NOTE: NO [NETWORK] SERVICES OR SUPPLIES WILL BE PROVIDED IF A [MEMBER] FAILS TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN [OR HEALTH CENTER] [OR THE CARE MANAGER]. READ THE [MEMBER] PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES. [NON-NETWORK] BENEFITS MAY BE PROVIDED, SUBJECT TO THE TERMS AND CONDITIONS OF THIS CONTRACT CONCERNING [NON-NETWORK] BENEFITS. [PLEASE READ THE UTILIZATION REVIEW FEATURES SECTION CAREFULLY. THE UTILIZATION REVIEW FEATURES SECTION CONTAINS A PENALTY FOR NON-COMPLIANCE.]

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

FOR ANY SPECIFIC [NETWORK] SERVICES AND SUPPLIES WHICH ARE SUBJECT TO LIMITATION, ANY SUCH [NETWORK] SERVICES OR SUPPLIES THE [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE CORRESPONDING [NON-NETWORK] BENEFIT FOR THAT SERVICE OR SUPPLY. SIMILARLY, FOR ANY SPECIFIC [NON-NETWORK] BENEFITS WHICH ARE SUBJECT TO LIMITATION, ANY SUCH BENEFITS THE [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE CORRESPONDING [NETWORK] SERVICES AND SUPPLIES AVAILABLE FOR THAT SERVICE OR SUPPLY. THE [NETWORK] SERVICES AND SUPPLIES SECTION AND THE [NON-NETWORK] COVERED CHARGES SECTION CLEARLY IDENTIFY WHICH SERVICES AND SUPPLIES AND COVERED CHARGES ARE AFFECTED BY THIS REDUCTION RULE.

Daily Room and Board Limits ***Applicable to [Non-Network] Benefits***

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 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 [Member] is being isolated in a private room because the [Member] 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) of the covered daily room and board charge made by the hospital during the [Member's] preceding Hospital confinement, for semi-private accommodations.

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 and benefits are provided.

[**ACTIVELY AT WORK or ACTIVE WORK.** Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.]

ALCOHOL ABUSE. Abuse of or addiction to alcohol.

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 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.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Contract and each succeeding yearly date thereafter.

AFFILIATED COMPANY. A corporation or other business entity affiliated with the Contractholder through common ownership of stock or assets.

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 Board of Directors of the New Jersey Small Employer Health Program.

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

[**CARE MANAGER.** An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

CASH DEDUCTIBLE or DEDUCTIBLE. The amount of Covered Charges that a [Member] must pay before this Contract pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments, and Non-Covered Services and Supplies and Non-Covered Charges. See the **Cash Deductible** section of this Contract for details.

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 or the percentage of Covered Charges, as applicable, that must be paid by a [Member]. Coinsurance does **not** include the Cash Deductible, Copayments, or Non-Covered Services and Supplies and Non-Covered Charges.

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

CONTRACTHOLDER. Employer or organization which purchased this Contract.

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

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 CHARGES. Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of this Contract, as applicable to [Non-Network] benefits. The services and supplies must be:
a) furnished or ordered by a 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 Contract, We pay benefits for Covered Charges incurred by a [Member] while he or she is covered by this Contract. Read the entire Contract to find out what We limit or exclude.

COVERED EMPLOYEE. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of this Contract, as applicable to [Network] benefits.

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

CREDITABLE COVERAGE. With respect to an Employee [or Dependent], coverage of the Employee [or Dependent] under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

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

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

Even if a [Member] is in a Hospital or other Facility, We do not provide for care if it is mainly custodial.

[**DEPENDENT.** An Employee's:
a) legal spouse;
b) unmarried Dependent child who is under age 19; and
unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. We can require periodic proof of a Dependent child's status as a full-time student.
Under certain circumstances, an incapacitated child is also a Dependent. See the **Eligibility** section of this Contract.

An Employee's "unmarried Dependent child" includes his or her legally adopted child, his or her step-child if such step-child depends on the Employee for most of his or her support and maintenance and children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purposes of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

A Dependent is not a person who is on active duty in any armed force.

A Dependent is not a person who is covered by this Contract as an Employee.

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

[DEPENDENT'S ELIGIBILITY DATE.
The later of:
a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.]

DIAGNOSTIC SERVICES. Procedures ordered by a 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) EKGs, EEGs, and other electronic diagnostic tests.

With respect to [Non-Network] benefits, **except** as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

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

DURABLE MEDICAL EQUIPMENT. Equipment We [or the Care Manager] 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, and wheelchairs.

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.

EFFECTIVE DATE. The date on which coverage begins under this Contract for the Contractholder, or the date coverage begins under this Contract for a [Member], as the context in which the term is used suggests.

EMPLOYEE. A Full-Time paid Employee (25 hours per week) of the Employer. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Contract. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Contract's conditions of eligibility.

EMPLOYEE'S ELIGIBILITY DATE.

a) the date of employment; or
b) [the day] after any applicable waiting period ends.

EMPLOYER. [ABC Company].

ENROLLMENT DATE. With respect to a [Member], the Effective Date or, if earlier, the first day of any applicable waiting period.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We [or the Care Manager] 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 the treatment of a type of cancer 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 [or the Care Manager] 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 United States Food and Drug Administration (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:
a) The American Medical Association Drug Evaluations;
b) The American Hospital Formulary Service Drug Information; or
c) 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 non-affiliated 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 Center.

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 and are covered by this Contract.

FULL-TIME. A normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

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.

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" (29 U.S.C. δ 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 delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or plan issued to a Small Employer, 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; 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 CARE CENTER OR HEALTH CENTER.** A place operated by or on behalf of an HMO where [Network] Practitioners provide Covered Services and Supplies to [Members].]

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 under a hospice care program. 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) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

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. A sickness or disease suffered by a [Member].

[**INITIAL DEPENDENT.** Those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.]

INJURY. Damage to a [Member's] body, and all complications arising from that damage.

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

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Organizations.

LATE ENROLLEE. An eligible Employee [or Dependent] who requests enrollment under this Contract more than [30] days after first becoming eligible. However, an eligible Employee [or Dependent] will not be considered a Late Enrollee under certain circumstances. See the Employee Coverage [and Dependent Coverage] subsection[s] of the Eligibility section of this Contract.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Examples of Medical Emergencies include but are not limited to heart attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness.

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a health care Provider that We [or the Care Manager] 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 a Medical Emergency, with respect to [Network] services and supplies, and in all instances with respect to [Non-Network] benefits, 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. 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 (includes Covered Employee[and covered Dependents, if any)].

[[MEMBER] SERVICES. Carrier has the option to include a definition of such services in the 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 OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental or Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us [or Our associated medical groups] to provide Covered Services or Supplies.

[NEWLY ACQUIRED DEPENDENT. An eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.]

NICOTINE DEPENDENCE TREATMENT. "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. Charges which do not meet this Contract's definition of Covered Charges or which exceed any of the benefit limits shown in this Contract, or which are specifically identified as Non-Covered Services and Supplies and Non-Covered Charges or are otherwise not covered by this Contract.

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 and Non-Covered Charges, or which exceed any of the limitations shown in this Contract.

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

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

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

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

PER LIFETIME. During the lifetime of an individual, regardless of whether he or she was covered under this Contract or any other contract, policy or plan:
a) as an Employee or Dependent; and
b) with or without interruption of coverage.

PLAN SPONSOR.

Has 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. δ 1002(16)(B)). That is:
a) the Small Employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board or trustees, or other similar group of representatives of the parties who establish or maintain the plan.

PLAN YEAR. The year that is designated as the plan year in the plan document of a Group Health Plan, except if the plan document does not designate a plan year or if there is no plan document, the Plan Year is a Calendar Year.

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 and which are covered by this Contract.

PRE-APPROVAL or PRE-APPROVED. Our written approval for specified services and supplies prior to the date the charges are incurred. Services or supplies for which the charges have not been pre-approved are not covered.

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

See the **Non-Covered Services and Supplies and Non-Covered Charges** section of this Contract for details on how this Contract limits the services and benefits for Pre-Existing Conditions.]

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 Medical Association Drug Evaluations;
- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Drug Information; or

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

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

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

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE and CUSTOMARY. With respect to [Network] services and supplies, the negotiated arrangement. With respect to [Non-Network] benefits, an amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary for the [Non-Network] benefits under this Contract. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REFERRAL. With respect to [Network] services or supplies, specific direction or instruction from a [Member's] Primary Care Physician [or Health Center] [or the Care Manager] in conformance with Our policies and procedures that directs a [Member] to a Facility or Provider for health care.

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

b) be approved for its stated purpose by Medicare.
In some places a Rehabilitation Center is called a "rehabilitation hospital."

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, foot orthotics and supportive devices for the foot.

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

SCHEDULE. The **Schedule of Covered Services and Supplies and Covered Charges.**

SERVICE AREA. As applicable to [Network] services and supplies, the 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 (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

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

SMALL EMPLOYER. In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two Employees on the first day of the Plan Year, and the majority of the Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

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

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

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

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

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.

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

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

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 or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:
Chelation Therapy - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.
Dialysis Treatment - the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
Infusion Therapy - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.
Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.
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.
Respiration Therapy - the introduction of dry or moist gases into the lungs.
Speech Therapy - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

TOTAL DISABILITY OR TOTALLY DISABLED. Except as otherwise specified in this Contract, an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. [A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex.] The Employee [or Dependent] must be under the regular care of a Practitioner.

[**WAITING PERIOD.** With respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the Group Health Plan.]

[**WE, US, OUR.** [Carrier].

YOU, YOUR, AND YOURS. The Contractholder.]

ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees
Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Contract, all of the Contractholder's Employees [who are in an eligible class] will be eligible if the Employees are [Actively at Work] Full-Time Employees. [In certain situations, the Actively at Work requirement will not apply. If an Employee is not Actively at Work due to a Health Status Related Factor, the Employee will nevertheless be considered an Eligible Employee. In addition, refer to the Exception below.]

For purposes of this Contract, We will treat partners, proprietors and independent contractors like Employees if they meet the Contract's **Conditions of Eligibility**.

Conditions of Eligibility

Full-Time Requirement
[Except where an Employee is not Actively at Work due to a Health Status Related Factor, and except as stated below,]We will not cover an Employee unless the Employee is [an Actively at Work] [a] Full-Time Employee.

Enrollment Requirement
We will not cover the Employee until the Employee enrolls and agrees to make the required payments, if any. If the Employee does this within [30] days of the Employee's Eligibility Date, coverage will start on the Employee's Eligibility Date.

If the Employee enrolls and agrees to make the required payments, if any:
a) more than [30] days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment;
We will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Contract's Pre-Existing Conditions limitation.

When an Employee initially waives coverage under this Contract, the Plan Sponsor [or We] should notify the Employee of the requirement for the Employee to make a statement that waiver was because he or she was covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If an Employee initially waived coverage under this Contract and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll

under this Contract, We will not consider the Employee [and his or her Dependents] to be [a] Late Enrollee[s], provided the coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;;
d) divorce or legal separation;
e) death of the Employee's spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.

But, the Employee must enroll under this Contract and pay the appropriate premium within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs..

If an Employee initially waived coverage under this Contract because he or she had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage under this Contract within 30 days of the date the COBRA continuation ended, We will not consider the Employee to be a Late Enrollee. Coverage will take effect as of the date the COBRA continuation ended.

In addition, an Employee [and any Dependents] will not be considered [a] Late Enrollee[s] if the Employee is employed by an employer which offers multiple Health Benefits Plans and the Employee elects a different plan during the open enrollment period.

[Further, an Employee and his or her Dependent spouse, if any, will not be considered Late Enrollees because the Employee initially waived coverage under this Contract for himself or herself and any then existing Dependents provided the Employee enrolls to cover himself or herself and his or her existing Dependent spouse, if any, under this Contract within 30 days of the marriage, birth, adoption or placement for adoption of a Newly Acquired Dependent.]

[The Waiting Period
This Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6 months] of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Contract from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6 months] of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Contract from the day after Employees complete [6 months] of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under this Contract from the day after Employees complete [6 months] of continuous Full-Time service with the Employer.]

The Contractholder who purchased this Contract may have purchased it to replace a plan the Contractholder had with some other carrier. An Employee may have satisfied part of the eligibility waiting period under the Contractholder's old plan before it ended. If so, the time satisfied will be used to satisfy this Contract's eligibility waiting period if:
a) the Employee was employed by the Employer on the date the Contractholder's old plan ended; and
b) this Contract takes effect immediately upon termination of the prior plan.

Multiple Employment
If an Employee works for both the Contractholder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat the Employee as if only one firm employs the Employee. And such an Employee will not have multiple coverage under this Contract. But, if this Contract uses the amount of an Employee's earnings to Determine class, or for any other reason, such Employee's earnings will be figured as the sum of his or her earnings from all covered Employers.

When Employee Coverage Starts
[Except where an Employee is not Actively at Work due to a Health Status Related Factor, and except as stated below, an] [An] Employee must be [Actively at Work, and] working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. [If an Employee is not Actively at Work on the scheduled Effective Date, and does not qualify for the exception to the Actively at Work requirement, We will postpone the start of his or her coverage until he or she returns to Active Work.]

[Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.]

The Employee must elect to enroll and agree to make the required payments if any, within [30] days of the Employee's Eligibility Date. If he or she does this within [30] days of the Employee's Eligibility Date, his or her coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is scheduled Effective Date of an Employee's coverage.

If the Employee does this more than [30] days after the Employee's Eligibility Date, We will consider the Employee a Late Enrollee. Coverage is scheduled to start on the date the Employee signs the enrollment form.

[EXCEPTION to the Actively at Work Requirement
The Exception applies if the Contractholder who purchased this Contract purchased it to replace a plan the Contractholder had with some other carrier. An Employee who is not Actively at Work due to Total Disability on the date this Contract takes effect will initially be eligible for limited coverage under this Contract if:
a) the Employee was validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) this Contract takes effect immediately upon termination of the prior plan.

The coverage under this Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under this Contract will end one year from the date the person's coverage under this Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of this Contract.]

When Employee Coverage Ends
An Employee's coverage under this Contract will end on the first of the following dates:
a) [the date] an Employee ceases to be [an Actively at Work] [a] Full-Time Employee for any reason. Such reasons include, death, retirement, lay-off, leave of absence, and the end of employment.
b) [the date] an Employee stops being an eligible Employee under this Contract.
c) the date this Contract ends,[or is discontinued for a class of Employees to which the Employee belongs.]
d) the last day of the period for which required payments have been made for the Employee, subject to the **Payment of Premium - Grace Period** section.

Also, an Employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. This Contract's benefits provisions explain these situations. Read this Contract's provisions carefully.

[DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits
An Employee's eligible Dependents are:
a) the Employee's legal spouse;
b) the Employee's unmarried Dependent children who are under age 19; and
c) the Employee's unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Eligible Dependents will not include any Dependent who is:
a) covered by this Contract as an Employee or
b) on active duty in the armed forces of any country.

Adopted Children and Step-Children
An Employee's "unmarried Dependent children" include the Employee's legally adopted children, his or her step-children if they depend on the Employee for most of their support and maintenance and children under a court appointed guardianship. We will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We will treat such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children
An Employee 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 plan, such a child may stay eligible for Dependent health benefits past this Contract's age limit.

The child will stay eligible as long as the child stays 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 the Employee for most of his or her support and maintenance.

But, for the child to stay eligible, the Employee must send Us written proof that the child is incapacitated and depends on the Employee for most of his or her support and maintenance. The Employee has 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 the Employee's does.

Enrollment Requirement

An Employee must enroll his or her eligible Dependents in order for them to be covered under this Contract. We consider an eligible Dependent to be a Late Enrollee, if the Employee:
a) enrolls a Dependent [and agrees to make the required payments] more than [30] days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Contract's Pre-Existing Conditions limitations section, if any applies.

If the Employee's dependent coverage ends for any reason, including failure to make the required payments, his or her Dependents will be considered Late Enrollees when their
coverage begins again.

When an Employee initially waives coverage for a spouse and/or eligible Dependent children under this Contract, the Plan Sponsor [or We] should notify the Employee of the requirement for the Employee to make a statement that waiver was because the spouse and/or eligible Dependent children were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Contract and stated at that time that such waiver was because they were covered under another group plan, and the Employee now elects to enroll them in this Contract, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;;
d) divorce or legal separation;
e) death of the Employee's spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.

But, the Employee's spouse or eligible Dependent children must be enrolled by the Employee, and the appropriate premium must be paid, within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

And, We will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Contract, to be a Late Enrollee, if:
a) the Employee is under legal obligation to provide coverage due to a court order; and
b) the Employee's spouse or eligible Dependent children are enrolled by the Employee, and the appropriate premium must be paid, within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to the court order.

In addition, if an Employee initially waived coverage under this Contract for the Employee's spouse or eligible Dependent children because the spouse and/or Dependent children had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage for the spouse and/or Dependent children under this Contract within 30 days of the date the COBRA continuation ended, We will not consider the spouse and/or Dependent children to be Late Enrollees. Coverage will take effect as of the date the COBRA continuation ended.

When Dependent Coverage Starts
In order for an Employee's Dependent coverage to begin, the Employee must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to all of the terms of this Contract, the date an Employee's Dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents and agrees to make any required payments.

If the Employee does this within 30 days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the Dependent's Eligibility Date, or
b) the date the Employee becomes covered for Employee coverage.

If the Employee does this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:
a) the date the Employee signs the enrollment form; or
b) the date the Employee becomes covered for Employee coverage.

Once an Employee has dependent coverage for Initial Dependents, the Employee must notify Us of a Newly Acquired Dependent within the [30] days after the Dependent's Eligibility Date. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child or newly adopted child will be covered from the later of:
a) the date the Employee notifies Us [and agrees to make any additional payments], or
b) the Dependent's Eligibility Date for the Newly Acquired Dependent.

If the Contractholder who purchased this Contract purchased it to replace a plan the Contractholder had with some other carrier, a Dependent who is Totally Disabled on the date this Contract takes effect will initially be eligible for limited coverage under this Contract if:
a) the Dependent was validly covered under the Contractholder's old plan on the date the Contractholder's old plan ended; and
b) this Contract takes effect immediately upon termination of the prior plan.

The coverage under this Contract will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under this Contract will end one year from the date the person's coverage under this Contract begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Contractholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of this Contract.

Newborn Children
We will cover an Employee's newborn child for 31 days from the date of birth. Coverage may be continued beyond such 31 day period as stated below:
a) If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days[, provided the premium required for Dependent child coverage continues to be paid][.][and, in order to access [Network] services and supplies, the Employee must notify Us of the birth of the newborn child in order for coverage to continue beyond the initial 31 day period.]
b) If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
1) make written request to enroll the newborn child[; and
2) pay the premium required for Dependent child coverage within 31 days after the date of birth for coverage to continue beyond the initial 31 days.]

If the request is not made [and the premium is not paid] within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends
A Dependent's coverage under this Contract will end on the first of the following dates:
a) [the date]Employee coverage ends;
[b) the date the Employee stops being a member of a class of Employees eligible for such coverage;]
[c)]. the date this Contract ends;
[d)]. the date Dependent coverage is dropped from this Contract for all Employees eligible for such coverage;
[e). the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.]
[f)]. At 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

Read this Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have the right to replace certain group benefits with converted contracts.]

EXTENDED HEALTH BENEFITS

If this Contract ends and a [Member] is Totally Disabled and under a Practitioner's care, We will extend health benefits for that person under this Contract as explained below. This is done at no cost to the [Member].

We will only extend benefits for a [Member] due to the disabling condition. Any services and supplies must be provided before the extension ends. And what We cover is based on all the terms of this Contract.

We do not cover services, supplies, or charges due to other conditions. And, We do not cover services, supplies or charges incurred by other family members.

The extension ends on the earliest of:
a) the date the Total Disability ends;
b) one year from the date the person's coverage under this Contract ends; or
c) the date the person has reached the payment limit, if any, for his or her disabling condition.

The Employee must submit evidence to Us that he or she or his or her Dependent is Totally Disabled, if We request it.

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.
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 incorrect or incomplete information 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, including but not limited to; theft, damage to [Our] [[Network] Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
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 Contract after that date.

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

[MEMBER] PROVISIONS: APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES

THE ROLE OF A [MEMBER'S] PRIMARY CARE PHYSICIAN
A [Member's] Primary Care Physician 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 Physician [or the Care Manager] and identify himself or herself as a [Member] of this program.

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

[THE ROLE OF THE CARE MANAGER. The Care Manager will manage a [Member's] treatment for [a Mental or Nervous Disorder, Substance Abuse, or Alcohol Abuse]. A [Member] must contact the Care Manager or the [Member's] Primary Care Physician when a [Member] needs treatment for one of these conditions.]

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]
When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Physician [or Health Center].

[Members] select a Primary Care Physician [or Health Center] 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 Physician initially selected cannot accept additional patients, a [Member] will be notified and given an opportunity to make another Primary Care Physician selection. [If a [Member] fails to select a Primary Care Physician [or Health Center], We will make a selection on behalf of the [Member].]

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

[Transfer requests received within the first twenty-five (25) days of the month will be effective the first day of the following month. If We receive the request after the twenty-fifth (25th) day, then the change will be effective the first day of the second month following the request.]

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 Employee, coverage may be terminated for the Employee as well as any of the Employee's 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.

REFERRAL FORMS
A [Member] can be referred for Specialist Services by a [Member's] Primary Care Physician.

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

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 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 this Contract in accordance with the General Provisions. 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.

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, Covered Employee, for himself or herself, 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 [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 [or the Care Manager] may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and in connection with [Network] benefits, 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 Physician or a Provider referred in writing by the Primary Care Physician without notifying the [Member] that such benefit would not be covered under this Contract.

INDEPENDENT CONTRACTOR RELATIONSHIP
a) No [Network] Provider or other provider, institution, Facility or agency is our agent or employee. Neither We nor Our employees are an agent or employee of any [Network] Provider or other Provider, institution, Facility or agency.
b) Neither the Contractholder nor any [Member] is our agent, representative or employee, or an agent or representative of any [Network] Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Contract.
c) [Network] Practitioners maintain the physician-patient relationship with [Members] and are solely responsible to [Members] for all medical services which are rendered by [Network] Practitioners.
d) No Contractholder or [Member] shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

[APPEALS PROCEDURE
Variable by Carrier, as approved by the State of New Jersey.]

COVERED SERVICES AND SUPPLIES *APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES*

[Members] are entitled to receive the services and supplies in the following sections when Medically Necessary and Appropriate, subject to the payment by [Members] of applicable Copayments [or Coinsurance] as stated in the applicable Schedule.

*Please read the **COVERED SERVICES AND SUPPLIES** section carefully.*

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

1) **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2) **Home visits** by a [Member's] Primary Care Physician.
3) **Periodic health examinations** to include:
- Well child care from birth including immunizations;
- Routine physical examinations, including eye examinations;
- Routine gynecological exams and related services;
- Routine ear and hearing examination; and
- Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a [Member's] employment).

4) Diagnostic Services.
5) **Casts and dressings.**
6) **Ambulance Service** when certified in writing as Medically Necessary and Appropriate by a [Member's] Primary Care Physician and approved in advance by Us.
7) **Procedures and prescription drugs to enhance fertility,** except where specifically excluded in this Contract.
8) **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a [Member's] body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs, or dental prosthetics or devices.
9) **Durable Medical Equipment** when ordered by a [Member's] Primary Care Physician and arranged through Us.
10)**Prescription Drugs and contraceptives which require a Practitioner's prescription** and insulin needles and insulin syringes and glucose test strips and lancets; and colostomy bags, belts, and irrigators when obtained through a [Network] Provider.
[A prescription or refill will not include a prescription or refill that is more than:
a) the greater of a 30 day supply or 100 unit doses for each prescription or refill; or
b) the amount usually prescribed by the [Member's] Participating Provider.
A supply will be considered to be furnished at the time the Prescription Drug is received.]
11) **Nutritional Counseling** for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a [Member's] Primary Care Physician and approved in advance 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.

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

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a [Network] Provider upon prior Referral from a [Member's] Primary Care Physician, only at [Network] Hospitals and [Network] Facilities (or at [Non-Network]facilities upon prior written authorization by Us); however, [Network] Skilled Nursing Center 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 Participating 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 minimum of 48 hours of inpatient care in a Hospital following a vaginal delivery; and
⇒ a minimum of 96 hours of inpatient care in a Hospital following a cesarean section.

- We provide such coverage subject to the following:

⇒ the attending Practitioner must determine that inpatient care is medically necessary; or
⇒ 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 approved in advance by Us]. If a [Member] occupies a private room without such approval [Member] shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center 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 Center 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.
20. Private duty nursing only when approved in advance by Us.
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas.
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 approved in advance 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.]

(d) **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS.** The following Services are covered when rendered by a [Network] Provider at Provider's office or at a [Network] Substance Abuse Center [or Health Center] [upon prior Referral by a [Member's] Primary Care Physician] [or the Care Manager].

1. **Outpatient.** [Members] are entitled to receive up to twenty (20) outpatient visits per Calendar Year. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a [Member's] Primary Care Physician [or the Care Manager] for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. [Members] are additionally eligible, upon referral by a [Member's] Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.
2. **Inpatient Hospital Care.** [Members] are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.
3. **Chemical Dependency Admissions.** Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole Discretion it is Determined that [Members] have been cooperative with an on-going treatment plan. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate, and only to the extent of the covered benefit as defined above.

NOTE: ANY SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS BENEFITS A [MEMBER] RECEIVES AS [NON-NETWORK] BENEFITS WILL REDUCE THE BENEFITS AVAILABLE AS [NETWORK] MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE SERVICES AND SUPPLIES.

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

I. A [Member's] Primary Care Physician 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 Physician [or Health Center][or Us] [or the Care Manager] prior to seeking emergency treatment.
II. We will cover the cost of services and supplies in connection with a Medical Emergency provided within or outside our service area without a prior 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 a [Member's] Primary Care Physician 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. [Member] shall be responsible for payment for services received unless We [or the Care Manager] 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.
III. In the event [Members] are hospitalized in a [Non-Network] Facility, [Network] coverage will only be provided until [Members] are medically able to travel or to be transported to a [Network] Facility. If [Members] elect to continue treatment with [Non-Network] Providers, We shall have no responsibility to continue to provide coverage on a [Network] basis for services and supplies beyond the date [Members] are Determined to be medically able to be transported. The [Member] may be eligible for [Non-Network] benefits, subject to the terms and conditions of this Contract.

In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by [Members] of all Copayments which would have been required had similar benefits been provided upon prior Referral to a [Network] Provider.
4) Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after [Members] have been admitted to a Facility as the result of a Medical Emergency shall require prior Referral or [Members] shall be responsible for payment.
5) The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if [Members] are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager].

1. Speech Therapy, Physical Therapy, Occupational Therapy and Cognitive Therapies are covered for non-chronic conditions and acute Illnesses and Injuries upon referral to a [Network] Provider by a [Member's] Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of Illness or Injury, beginning with the first day of treatment, provided that a [Member's] Primary Care Physician certifies in writing that the treatment will result in a significant improvement of a [Member's] condition within this time period and treatment is approved in writing by Us.
2. Chelation Therapy, Chemotherapy treatment, Dialysis Treatment, Infusion Therapy, Radiation Therapy and Respiration Therapy.

NOTE: ANY THERAPY BENEFITS A [MEMBER] RECEIVES AS A [NON-NETWORK] COVERED CHARGE WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPY SERVICES AND SUPPLIES.

(g) **HOME HEALTH SERVICES.** The following services are covered when rendered by a [Network] Provider including but not limited to a [Network] Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of a [Member's] Primary Care Physician [or the Care Manager].

1. **Skilled nursing services,** provided by or under the supervision of a registered professional nurse.
2. Services of a **home health aide,** under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to [Member] is skilled in nature.
3. **Medical Social Services** by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a [Member's] medical condition.
4. **Therapy Services** as set forth above.
5. **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 Physician. 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 benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in our determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide Medically Necessary and Appropriate care.

(h) **DENTAL CARE AND TREATMENT.** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician. 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 occurs while the [Member] is covered under any health benefit plan;
2) the Injury was not caused, directly or indirectly by biting or chewing; and
3) 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.

(i) **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 Physician. We cover services and supplies for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a [Member]. However, We do not cover any services or supplies for orthodontia, crowns or bridgework.

(j)**THERAPEUTIC MANIPULATION** The following services are covered when rendered by a [Network] Practitioner upon prior Referral by a [Member's] Primary Care Physician [or the Care Manager]. 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.

NOTE: ANY THERAPEUTIC MANIPULATION BENEFITS [MEMBER] RECEIVES AS [NON-NETWORK] COVERED CHARGES WILL REDUCE THE SERVICES AND SUPPLIES AVAILABLE AS [NETWORK] THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES.

[NON-NETWORK] BENEFIT PROVISION ***APPLICABLE TO [NON-NETWORK] BENEFITS***

The Cash Deductible
Each Calendar Year, each [Member] must have Covered Charges that exceed the Cash Deductible before We pay any [Non-Network] benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Copayments, or with Non-Covered Services and Supplies and Non-Covered Charges. Only Covered Charges incurred by the [Member] while covered by this Contract 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 [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. And what We pay is based on all the terms of this Contract.

The Contractholder who purchased this Contract may have purchased it to replace a plan the Contractholder had with some other carrier.

The [Member] may have incurred charges for covered expenses under the Contractholder's old plan before it ended. If so, these charges will be used to meet this Contract's Cash Deductible if:
a) the charges were incurred and applied toward the satisfaction of the Cash Deductible under the Contractholder's old plan during the Calendar Year in which this Contract starts;
b) the charges would have been considered Covered Charges under this Contract if this Contract had been in effect:
c) the [Member] was covered by the old plan when it ended and enrolled in this Contract on its Effective Date; and
d) this Contract takes effect immediately upon termination of the prior plan.

[Family Deductible Limit
This Contract has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two [Members] in a family meet their individual Cash Deductibles 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 Contract.]

[Per Covered Family

The Per Covered Family Calendar Year Cash Deductible is shown in the Schedule. Once three or more [Members] in a family have incurred a combined total of Covered Charges toward their Per Person Cash Deductible equal to the per Covered Family Cash Deductible, each [Member] in that family will be considered to have met his or her Per Person Cash Deductible for the rest of that Calendar Year. The Charges that each [Member] in a family may use toward the Per Covered Family Cash Deductible may not exceed the amount of the Per Person Cash Deductible.]

Coinsured Charge Limit
The Coinsured Charge Limit is the amount of Covered Charges a [Member] must incur each Calendar Year before no Coinsurance is required, except as stated below.

Exception: Charges for Mental or Nervous Conditions, and Substance Abuse Treatment are not subject to or eligible for the Coinsured Charge Limit.

COVERED CHARGES ***APPLICABLE TO [NON-NETWORK] BENEFITS***

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

Note: Our payments will be reduced or eliminated if a [Member] does not comply with the Utilization Review and Pre-Approval requirements contained in this Contract.

Hospital Charges
We cover charges for Hospital room and board and Routine Nursing Care when it is provided to [Member] 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 [Member] during the Inpatient confinement.

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 Participating 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) a minimum of 48 hours of in-patient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of in-patient Hospital care following a cesarean section.

We provide such coverage subject to the following:
a) the attending Practitioner must determine that in-patient 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 [Member] 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 Contract's **Emergency Room Copayment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are not covered. This Contract's utilization review features have penalties for non-compliance that may reduce what We pay for Hospital charges.

We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this Contract.

Emergency Room Copayment Requirement
Each time a [Member] uses the services of a Hospital emergency room, he or she must pay a [$50.00] Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

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 [Member'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 [Member] on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are not covered.

And We cover all other Medically Necessary and Appropriate services and supplies provided to a [Member] 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.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are not covered.

But We limit what We will pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Contract.

Extended Care or Rehabilitation charges which We do not Pre-Approve are not covered.

ANY EXTENDED CARE OR REHABILITATION SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE EXTENDED CARE OR REHABILITATION BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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 [Member] 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; 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 Contract if performed as Inpatient Hospital services. But, payment is subject to all of the terms of this Contract and to the following conditions:

I. The [Member's] Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. The services and supplies must be:
A. ordered by the [Member's] Practitioner;
B. included in the home health care plan: and
C. furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.
II. 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 basis.
III. 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.
IV. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.
V. We do not pay for:
A. services furnished to family members, other than the patient; or
B. services and supplies not included in the home health care plan.

Home Health Care charges which We do not Pre-Approve are not covered.

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. But We limit what We will pay for the treatment of Mental or Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Contract.

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

[Carrier] does 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.

[Carrier] covers 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.

Second Opinion Charges
We cover Practitioner's charges for a second opinion and charges for related x-rays and tests when a [Member] 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 [Member] under a Hospice care program.

a) "Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the [Member's] terminal Illness or terminal Injury.
b) "Terminally ill" or "terminally injured" means that the [Member's] Practitioner has certified in writing that the [Member'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 [Member]. It must be set up and reviewed periodically by the [Member's] Practitioner.

Under a Hospice care program, subject to all the terms of this Contract, We cover any services and supplies including Prescription Drugs, to the extent they are otherwise covered by this Contract. 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 [Member'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; or
d) treatment not included in the Hospice care plan.

Hospice Care charges which We do not Pre-Approve are not covered.

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

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

Pregnancy
This Contract pays for pregnancies the same way We would cover an Illness. The charges We cover for a newborn child are explained [on the next page.]

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 [Member'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 [Member] by a Birthing Center. But charges above the daily room and board limit are not covered.

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

Benefits for a Covered Newborn Child
a) 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:
b) nursery charges;
c) charges for routine Practitioner's examinations and tests; and
d) charges for routine procedures, like circumcision.

Subject to all of the terms of this Contract, 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.

ANY NEWBORN CHILD SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE NEWBORN CHILD BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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. But We do not pay for replacements or repairs.

Blood
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 [Member].

Ambulance Charges
We cover Medically Necessary and Appropriate charges for transporting a [Member] 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 [Member] 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) any purchases without Our advance written approval;
b) replacements or repairs; or
c) 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.

Charges for Durable Medical Equipment which We do not Pre-Approve are not covered.

Treatment of Wilm's Tumor
We pay benefits for Covered Charges incurred for the treatment of Wilm's tumor in a [Member]. 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 Contract.

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.

Charges for Nutritional Counseling which We do not Pre-Approve are not covered.

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

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 Contract's Preventive Care section, We do not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs
We cover drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. And We exclude drugs that can be bought without a prescription, even if a Practitioner orders them.

We do not cover drugs to treat Mental or Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental or Nervous Conditions and Substance Abuse section of this Contract.

COVERED CHARGES WITH SPECIAL LIMITATIONS *APPLICABLE TO [NON-NETWORK] BENEFITS*

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

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury occurs while the [Member] is covered under any health benefit plan;
b) the Injury was not caused, directly or indirectly by biting or chewing; and
c) 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.

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

Prosthetic Devices
We limit what We pay for prosthetic devices. Subject to Our Pre-Approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a [Member's] body, or be needed due to a functional birth defect in a covered Dependent child. We do not pay for replacements, unless they are Medically Necessary and Appropriate. We do not pay for repairs, wigs, or dental prosthetics or devices.

Charges for Prosthetic Devices which We do not Pre-Approve are not covered.

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

We will cover charges for:
a) one baseline mammogram for a female [Member], ages 35 - 39
b) one mammogram, every 2 years, for a female [Member], ages 40 - 49, or more frequently, if recommended by a Practitioner, and
c) one mammogram, every year, for a female [Member] ages 50 and older.

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 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 not covered.

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

We cover the following Therapy Services:
Chelation Therapy, Chemotherapy, Dialysis Treatment, Radiation Therapy, Respiration Therapy

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

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

Coverage for Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per Calendar Year.

Subject to Our Pre-Approval, infusion therapy. **Charges in connection with Infusion Therapy which We do not Pre-Approve are not covered.**

NOTE: ANY THERAPY SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] THERAPY SERVICES AND SUPPLIES WILL REDUCE THE THERAPY BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Fertility Services
Subject to Our Pre-Approval We cover charges for procedures and Prescription Drugs to enhance fertility.

Charges in connection with Fertility Services which We do not Pre-Approve or which are specifically excluded, are not covered.

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 and Nicotine Dependence Treatment. But We limit what We pay each Calendar Year to:
a) per [Member] for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1, and
b) per [Member] for all other [Member]s.

These charges are not subject to the Cash Deductible or Coinsurance.

ANY PREVENTIVE CARE SERVICES OR SUPPLIES A [MEMBER] RECEIVES AS A [NETWORK] SERVICE OR SUPPLY WILL REDUCE THE PREVENTIVE CARE BENEFIT AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

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.

Vision Screening
We cover eye examination for Dependent children, through age 17, to determine the need for vision correction.

Therapeutic Manipulation
We limit what We cover for therapeutic manipulation to 30 visits per Calendar Year. And We cover no more than two modalities per visit. Charges for such treatment above these limits are not covered.

NOTE: ANY THERAPEUTIC MANIPULATION SERVICES AND SUPPLIES A MEMBER RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Mental or Nervous Conditions and Substance Abuse
We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include a condition under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

A [Member] may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker. Covered Charges for the treatment of Mental or Nervous Conditions and Substance Abuse include charges incurred for Prescription Drugs.

The [Member] must pay the Coinsurance shown on the Schedule for Covered Charges for such treatment. We limit coverage for all treatment of Mental or Nervous Conditions and Substance Abuse per Calendar Year to:
a) thirty (30) days of Inpatient confinement; and
b) twenty (20) Outpatient visits.
One or more of any unused Inpatient days may be exchanged on a two-for-one-basis for additional Outpatient visits.

We do not pay for Custodial Care, education, or training.

NOTE: ANY SUBSTANCE ABUSE AND MENTAL OR NERVOUS CONDITIONS SERVICES AND SUPPLIES A [MEMBER] RECEIVES AS [NETWORK] SERVICES AND SUPPLIES WILL REDUCE THE BENEFITS AVAILABLE AS A [NON-NETWORK] COVERED CHARGE.

Transplant Benefits
We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:
a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas
g) Allogeneic Bone Marrow
h) [Autologous Bone Marrow and Associated High Dose Chemotherapy only for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
- SCID
- WISCOT Aldrich

• Subject to Our Pre-Approval, breast cancer, if the [Member] is participating in a National Cancer Institute sponsored clinical trial. **Charges in connection with such treatment of breast cancer which We do not Pre-Approve are not covered.]**

[h) 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;
i) 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.]

NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES

THE FOLLOWING ARE NOT COVERED SERVICES AND SUPPLIES WITH RESPECT TO [NETWORK] SERVICES AND SUPPLIES, AND ARE NOT COVERED CHARGES WITH RESPECT TO [NON-NETWORK] BENEFITS UNDER THIS CONTRACT.

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless [Member] is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

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

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, 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 learning disabilities.

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.

Services or supplies for or in connection with:

a. except as otherwise stated in this Contract, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, 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 the Employee's **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: in vitro fertilization; embryo transfer; embryo freezing; and Gamete intra-fallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT); and b) drugs and drug therapy: non-FDA approved indications; and non-standard dosages, length of treatment, or cycles of therapy.

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.

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.

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.**

Supplies related to **Methadone** maintenance.

With respect to [Non-Network] benefits, **Nicotine Dependence Treatment,** except as otherwise stated in the Preventive Care section of this Contract.

Any **Non-Covered Service or Supply and Non-Covered Charge** 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 licensed **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.

[Pre-Existing Condition Limitations:

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Contracts issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Contracts issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in this Contract. See this Contract's EMPLOYEE COVERAGE [and DEPENDENT COVERAGE] subsection[s] of the ELIGIBILITY section to determine if a [Member] is a Late Enrollee. [The "Pre-Existing Conditions" provision does not apply to a Dependent who is an adopted child or-who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.]

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a [Member's] Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

We do not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the [Member] was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a [Member]. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions [or] pregnancy [, or birth defects in a covered Dependent child]. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And We waive this limitation for a [Member's] Pre-Existing Condition if the condition was payable under Creditable Coverage which covered the [Member] right before the [Member's] coverage under this Contract started. The next section shows other exceptions.

Continuity of Coverage
[NOTE: COVERAGE UNDER THIS CONTRACT IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]
If a new [Member] was covered under Creditable Coverage prior to enrollment under this Contract and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under this Contract, We will provide credit as follows. [Standard method] [We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] [Alternative method] [We give credit for the time the [Member] was covered under the Creditable Coverage based on coverage for the following [category] [categories] of benefits: [mental health;] [substance abuse treatment;] [prescription drugs;] [dental care;] [or] [vision care]. We will count a period of Creditable Coverage with respect to a category of benefits if any level of benefits is covered within that category. For all other benefits, We give credit for the time the [Member] was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.] We count the days the [Member] was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. We apply these days to reduce the duration of the Pre-Existing Condition limitation under this Contract. The person must sign and complete his or her enrollment form within 30 days of the date the

Employee's [active] Full-Time service begins. Any condition arising between the date his or her coverage under the Creditable Coverage ends and the Enrollment Date is Pre-Existing. We do not cover any charges actually incurred before the person's coverage under this Contract starts. If the Employer has included an eligibility waiting period in this Contract, an Employee must still meet it, before becoming covered.

With respect to [Network] services and supplies, any service provided without prior Referral by the [Member's] **Primary Care Physician** except as specified in this Contract.

With respect to [Non-Network] benefits, services related to **Private Duty Nursing** care, except as provided in the Home Health Care section of this Contract.

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

The amount of any charge which is greater than a **Reasonable and Customary Charge** with respect to [Network] services and supplies provided in the event of a Medical Emergency, and with respect to all [Non-Network] benefits.

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.

With respect to [Non-Network] benefits, except as stated in the Preventive Care section of this Contract, **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; or pre-marital 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 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) provided by or in a Government Hospital unless the services are for treatment:
- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

e) provided outside the United States unless the [Member] is outside the United States for one of the following reasons:
- travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;
- business assignment, provided the [Member] is temporarily outside the United States for a period of 6 months or less; and
- Subject to Our Pre-Approval, full-time student status, provided the [Member] 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 a which the student matriculates in the United States, grants academic credit. **Charges in connection with full-time students in a foreign country which are not Pre-Approved by Us are Non-Covered Services and Supplies and Non-Covered Charges.**

Services provided by a **Social Worker,** except as otherwise stated in this Contract.

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.

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,** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

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

[IMPORTANT NOTICE ***APPLICABLE ONLY TO [NON-NETWORK] BENEFITS***

[This Contract has utilization review features which are applicable to **[Non-Network]** benefits. 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 [Member]:
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 [Member] does not comply with these utilization review features, he or she will not be eligible for full benefits under this Contract. See the **Utilization Review Features** section for details.]

[This Contract has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a [Member's] medical needs in clinical situations with the potential for catastrophic claims to Determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[This Contract has centers of excellence features. Under these features, a [Member] 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 Contract. Read this Contract carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Contract he or she should [call The Group Claim Office at the number shown on his or her Identification Card.]

We are not responsible for medical or other results arising directly or indirectly from the [Member's] participation in these Utilization Review Features.]

[[NON-NETWORK] UTILIZATION REVIEW FEATURES

Important Notice: If a [Member] does not comply with this Contract's utilization review features, he or she will not be eligible for full benefits under this Contract.

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

a) the charges for the Covered Charges actually incurred;
b) the [Member] being eligible for coverage under this Contract at the time such charges are incurred; and
c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of this Contract.

Definitions

"Hospital admission" means admission of a [Member] to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

We call a Hospital admission or Surgery "emergency" if, after an evaluation of the [Member's] condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the [Member's] life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" We mean charges for 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 Contract is not payable under this Contract.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure
[If a [Member] is not satisfied with a utilization review decision, the [Member] or the [Member's] Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review Practitioner. This Practitioner will discuss the case with the Practitioner reviewer who made the initial decision. The second medical

review Practitioner will then discuss the case with the [Member's] Practitioner. The [Member's] Practitioner is then notified of the appeal's recommendation and referred to Us for any further appeals.]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a [Member] does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Contract.

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 [Member] 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 [Member] or the [Member'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 [Member] 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 [Member'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 [Member'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 admission by phone. This must be done by the [Member] or the [Member's] Practitioner no later than the end of the next regular working days or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:
a) the [Member's] name, social security number and date of birth;
b) the [Member's] 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 [Member's] Practitioner.

Continued Stay Review
The [Member] 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 [Member], 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 [Member'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 [Member's] Practitioner [by phone, of the outcome of the review. And [ABC] confirms the out come 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 [Member] does not request a pre-hospital review; or
b) the [Member] 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 [Member] 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 [Member] does not request a continued stay review; or
c) the [Member] 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 [Member] 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 Contract's:
a) Cash Deductible; or
b) Coinsured Charge Limit.

[REQUIRED PRE-SURGICAL REVIEW

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

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

The [Member] 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 [Member's] Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion
If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the [Member] must obtain a second surgical opinion in order to get full benefits under this Contract. If the second opinion does not confirm that the Surgery is Medically Necessary and Appropriate, the [Member] may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the [Member] a list of Practitioners in his or her area who will give a second opinion. The [Member] 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 [Member's] Practitioner; and
c) does not perform the Surgery if it is needed.

[ABC] gives second opinion forms to the [Member]. 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 Contract, 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 [Member] 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 [Member] 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 Contract's:
a) Cash Deductible; or
b) Coinsured Charge Limit.

[ALTERNATE TREATMENT FEATURES

Important Notice: No [Member] is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions
"Alternate Treatment" means those services and supplies which meet both of the following tests:
a) They are Determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a [Member] in connection with a Catastrophic Illness or Injury.
b) Benefits for charges incurred for the services and supplies would not otherwise be payable under this Contract.

"Catastrophic Illness or Injury" means one of the following:

a) head injury requiring an Inpatient stay
b) spinal cord Injury
c) severe burn 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.

Alternate Treatment Plan
[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a [Member] 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 [Member], [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a) the [Member], or his or her legal guardian, if necessary;
b) the [Member's] attending Practitioner; and
c) Us.

The Alternate Treatment 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; [Member]; [Member's] family, if any; and
d) estimated cost and savings.

If We, [DEF], the attending Practitioner, and the [Member] agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of this Contract.

The agreed upon alternate treatment must be ordered by the [Member's] Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion
Alternate Treatment does not include services and supplies that We [or the Care Manager] Determine to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No [Member] 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 [Member] 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 considered as 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 [Member].

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Contract. However, the Utilization Review Features will not apply.]]

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A [Member] may be covered for health benefits or services by more than one plan. For instance, he or she may be covered by this Contract as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange or provide with what another plan pays or provides. We do this so the [Member] does not collect more than he or she incurs in charges.

DEFINITIONS
"Plan" means any of the following that provide health expense benefits or services:

a) group or blanket insurance plans;
b) group hospital or surgical plans, or other service or prepayment plans on a group basis;
c) union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d) programs or coverages required by law;
e) Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:

a) Medicaid or any other government program or coverage which We are not allowed to coordinate with by law;
b) school accident type coverages written on either a blanket, group, or franchise basis;
c) group or group-type hospital indemnity benefits to the extent benefits do not exceed $150 per day;
d) group or group-type coverage where the cost of coverage is paid solely by the member;
e) Supplemental Limited Benefits Insurance coverages; nor
f) any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Subscriber", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits or services.

"Dependent" means a person who is covered by a plan for health benefits or services, but not as a subscriber.

"Allowable expense" means any necessary, reasonable, and usual item of expense or service for health care incurred by a subscriber or Dependent under either this plan or any other plan. For a Member or Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a subscriber's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the subscriber or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a subscriber or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works
We apply this provision when a subscriber or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays or provides services first, ignoring all other plans. The secondary plans than pay the remaining unpaid allowable expenses, but no plan pays or provides services more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays or provides services first are as follows:

a) A plan that covers a person as a subscriber pays first; the plan that covers a person as a Dependent pays second.
b) A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second. But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.
c) Except for Dependent children of separated or divorce parents, the following governs which plan pay first when the person is a Dependent of a subscriber:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a subscriber whose birthday falls later in the Calendar Year pays second. The subscriber's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits or services.

d) For a Dependent child of separated or divorced parents, the following governs which plan pays or provides services first when the person is a Dependent of a subscriber.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays or provides services first.
- If there is no such court order, then the plan of the natural parent with custody pays or provides services before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays or provides services before the plan of the natural parent without custody.
- If rules a, b, c and d do not determine which plan pays first, the plan that has covered the member for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information
In order to coordinate benefits and services, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan or services that should have been provided by this plan have been made by or provided another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount or equivalent value of services. And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver
We do not coordinate claims or equivalent services of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

SERVICES OR BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's coverage under this Contract when services are provided or expenses are incurred as a result of an automobile related Injury.

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

caused by an automobile or by an object propelled by or from an automobile.

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

"Eligible Services or Expenses" means that of service or expense 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 and Benefits this Contract will provide if it is primary to PIP or OSAIC.
If this Contract is primary to PIP or OSAIC it will provide services and benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of this Contract will apply if:
a) the [Member] is insured or covered for services or benefits under more than one insurance plan; and
b) such insurance plans or HMO Contracts are primary to automobile insurance coverage.

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.

Medicare
If the [Non-Network] benefits under this Contract supplement coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

GENERAL PROVISIONS

AFFILIATED COMPANIES
If the Contractholder asks Us in writing to include an Affiliated Company under this Contract, and We give written approval for the inclusion, We will treat Employees of that company like the Contractholder's Employees. Our written approval will include the starting date of the company's coverage under this Contract. But each eligible Employee of that company must still meet all the terms and conditions of this Contract before becoming covered.

An Employee of the Contractholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Contract. That Employee's service with multiple Employers will be treated as service with that one.

The Contractholder must notify Us in writing when a company stops being an Affiliated Company. As of this date, this Contract will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Contractholder or another Affiliated Company as eligible Employees.

AMENDMENT
The Contract may be amended, at any time, without a [Member's] consent or that of anyone else with a beneficial interest in it. The Contractholder may change the type of coverage under this Contract at any time by notifying Us in writing.

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 or [Member] of any of the Contractholder's or [Member's] interest, as appropriate, under this Contract is valid unless We consent thereto.

CLERICAL ERROR - MISSTATEMENTS
No clerical 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 the age of an Employee, 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, [or the amount of coverage], 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, [and in what amounts].

CONFORMITY WITH LAW
Any provision of this Contract which, on its Effective Date, is in conflict with the laws of the State of New Jersey, or with Federal law, is hereby amended to conform to 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.

CONTRACT INTERPRETATION
We shall administer Contract in accordance with its terms and shall have the sole power to Determine all questions arising in connection with its administration, interpretation and application.

EMPLOYEE'S EVIDENCE OF COVERAGE
We will give the Contractholder an individual evidence of coverage to give each covered Employee. It will describe the Employee's coverage under this Contract. It will include:
a) to whom We provide services and supplies or pay benefits;
b) any protection and rights when the coverage ends; and
c) claim rights and requirements.

In the event this Contract is amended, and such amendment affects the material contained in the evidence of coverage, a rider or revised evidence of coverage reflecting such amendment will be issued to the Contractholder for delivery to affected Employees.

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 [Non-Network] benefits to a [Member], to use the amount of payment due to offset a [Non-Network] claims payment previously made 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.

[Network] 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, affiliates, or appropriate employees or companies in administering this Contract.

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

Information in a [Member's] application may not be used by Us to void his or her coverage under this Contract or in any legal action unless the application or a duplicate of it is attached to the Evidence of Coverage issued to a [Member], or has been mailed to a [Member] for attachment to his or her Evidence of Coverage.

PARTICIPATION REQUIREMENTS
At least [75%] of the Employees eligible for insurance must be enrolled for coverage. If an eligible Employee is not covered by this Contract because:
a) the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage; or
b) the Employee is covered under any Health Benefits Plan offered by the Contractholder,

We will count this person as being covered by this Contract for the purposes of satisfying participation requirements.

PREMIUM AMOUNTS
The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage provided under this Contract. Those charges are Determined from the Premium rates then in effect and the Employees and Dependents then covered.

Premium payments may be Determined in another way. But it must produce the same amounts and be agreed to by the Contractholder and Us.

The following will apply if one or more Premiums paid include Premium charges for a [Member] whose coverage has ended before the due date of that Premium. We will not have to refund more than [the amount of (a) minus (b):

a) the amounts of the Premium charges for the [Member] that were included in the Premiums paid for the two-month period immediately before the date We receive written notice from the Contractholder that the [Member's] coverage has ended.
b) the amount of any claims paid or the value of any services provided to [Members] after their coverage has ended.]

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Contractholder to Us. They are due on each Premium Due Date stated on the first page of the Contract. The Contractholder may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. The Contractholder is liable to pay Premiums to Us from the first day the Contract is in force. 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.

PREMIUM RATE CHANGES
The Premium rates in effect on the Effective Date are shown in the **Schedule of Premium Rates and Classification** section of the Contract. We have the right to change Premium rates as of any of these dates:
a) any Premium Due Date;
b) any date that an Employer becomes, or ceases to be, an Affiliated Company.
c) 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;

d) at the discovery of a clerical error or misstatement as described below.

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

RECORDS - INFORMATION TO BE FURNISHED

We will keep a record of the [Members]. It will contain key facts about their coverage.

At the times set by Us, the Contractholder will send the data required by Us to perform its duties under this Contract, and to Determine the premium rates and certify status as a Small Employer. All records of the Contractholder and of the Employer which bear on this Contract must be open to Us for Our inspection at any reasonable time.

We will not have to perform any duty that depends on such data before it is received in a form that satisfies Us. The Contractholder may correct incorrect data given to Us, if We have not been harmed by acting on it. A person's coverage under this Contract will not be made invalid by failure of the Contractholder or the Employer, due to clerical error, to record or report the Employee for coverage.

The Contractholder will furnish Us the Employee [and Dependents] eligibility requirements of this Contract that apply on the Effective Date. Subject to Our approval, those requirements will apply to the Employee [and Dependent] coverage under this Contract. The Contractholder will notify Us of any change in the eligibility requirements of this Contract, but no such change will apply to the Employee [or Dependent] coverage under this Contract unless approved in advance by Us.

The Contractholder will notify Us of any event, including a change in eligibility, that causes termination of a [Member's] coverage immediately, or in no event later than the last day of the month in which the event occurs. Our liability to arrange or provide benefits for a person ceases when the person's coverage ends under this Contract. [If the Contractholder fails to notify Us as provided above, We will be entitled to reimbursement from the Contractholder of any benefits paid to any person after the person's coverage should have ended.]

TERMINATION OF THE CONTRACT - RENEWAL PRIVILEGE

We have the right to non-renew this Contract on any premium due date subject to 60 days advance written notice to the Contractholder for the following reasons:

a) the Contractholder moves its principal place of business outside the State of New Jersey;
b) subject to the statutory notification requirements, We cease to do business in the small group market;
c) subject to the statutory notification requirements, [Carrier] ceases offering and non-renews a particular type of Health Benefits Plan in the small group market;
d) less than [75%] of the eligible Employees are covered by this Contract. If an eligible Employee is not covered by this Contract because:
- the Employee is covered as a Dependent under a spouse's coverage; or
- the Employee is covered under an alternate Health Benefits Plan offered by the Contractholder, We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements.); or

e) the Contractholder does not contribute at least 10% of the annual cost of the Contract; [or]
f) the Contractholder ceases membership in an association or multiple employer trust, but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any [Member][;][.]
g) [there is no eligible Employee who resides, lives, or works in Our approved Service Area, but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any [Member.]; or
h) the Small Employer no longer has any enrollee in connection with this Contract who lives, resides, or works in Our Service Area and We would deny enrollment with respect to such Contract, as permitted by law.]

We have the right to non-renew this Contract on any premium due date subject to 30 days advance written notice to the Contractholder for the following reason:

During or at End of Grace Period- Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Contract will automatically end when that period ends. But the Contractholder may write to Us, in advance, to ask that this Contract be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then this Contract will end on the date requested.

Immediate cancellation will occur if the Contractholder has performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact under the terms of this Contract. This Contract is issued for a term of one (1) year from the Effective Date shown on the first page of this Contract. All Contract Years and Contract Months will be calculated from the Effective Date. Plan Years will be measured as stated in the definition of Plan Year. All periods of coverage hereunder will begin and end at 12:01 a.m. Eastern Standard Time at the Contractholder's place of business.

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

However, We have the right to non-renew this Contract on the Contract Anniversary following the date the Contractholder no longer meets the requirements of a Small Employer as defined in this Contract.

The Contractholder must certify to Us the it's status as a Small Employer every year. Certification must be given to Us within 10 days of the date We request it. If Contractholder fails to do this, We retain the right to take the actions described above as of the Contractholder's Contract Anniversary.

THE CONTRACT

The entire Contract consists of:
[a) the forms shown in the Table of Contents as of the Effective Date;

b)] the Contractholder's application, a copy of which is attached to the Contract;
[c)] any riders, [endorsements] or amendments to the Contract; and
[d)] the individual applications, if any, of all [Members].

Information in a Contractholder's 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 the Contractholder for attachment to this Contract.

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] or to the [Member's] beneficiary.

All statements will be deemed representations and not warranties.

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

CLAIMS PROVISIONS APPLICABLE TO [NON-NETWORK] BENEFITS

A claimant's right to make a claim for any benefits provided by this Contract 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 Contractholder.

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 day 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 [Member'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 an Employee files 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 [Member] or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under this Contract to such provider.

PHYSICAL EXAMS
We, at Our expense have the right to examine the [Member]. 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.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A [Member] may be eligible to continue his or her group health benefits under this Contract's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of this Contract at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR):** If a [Member] is eligible to continue his or her group health benefits under both this Contract's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Contract:

If a [Member] elects to continue his or her group health benefits under both this Contract's CCR and any other continuation sections, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the [Member]:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. The Employee must contact his or her Employer to find out if:

the Employer is subject to the COBRA CONTINUATION RIGHTS section, in which case;
the section applies to the Employee.

Important Notice
Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or
c) the Dependent child of an active, covered Employee. Except as stated below, any person who becomes covered under this Contract during a continuation provided by this section is not a qualified continuee.
Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a qualified continuee.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:
a) he or she was not terminated due to gross misconduct; and
b) he or she is not entitled to Medicare.

The continuation:
a) may cover the Employee and any other qualified continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any qualified continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Employee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Covered
If an Employee dies while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends
If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Contract, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the "special rule" applies to Dependents of an Employee who becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee's subsequent termination of employment or reduction in work hours will be the longer of the following:
a) months from the date of the Employee's termination of employment or reduction in work hours; or
b) months from the date of the Employee's earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Contract, of a covered Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities
The Employer must notify the qualified continuee, in writing, of:
a) his right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:
a) the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or
b) the date a qualified continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of a covered Dependent child.

The Employer's Liability
The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, Us, if:

a) the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end;
b) the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed covered under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends
A qualified continuee's continued group health benefits end on the first of the following:

I. with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
II. with respect to a qualified continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
A. the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
B. the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
III. with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
IV. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
the date this Contract ends;
V. the end of the period for which the last premium payment is made;
VI. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion VII. with respect to any Pre-Existing Condition of the qualified continuee;
VIII. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual contract. Read this Contract's **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

Important Notice

If An Employee's Group Benefits End
If an Employee's health coverage end due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then covered Dependents whose coverage would otherwise end at this time. If an Employee acquires one or more Dependents after the continued health coverage begins, he or she may elect to add such Newly Acquired Dependents to the continued coverage for the remaining period of continued health coverage. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

What the Employer Must Do
At the time of termination of employment or reduction of work hours, the Employer must notify the Employee, in writing, of:

a) his or her right to continue this Contract's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

What The Employee Must Do
To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed covered under this Contract on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

The Employee's continued coverage will be identical to the coverage he or she had when covered under this Contract on a regular basis. Any modifications made under this Contract will apply to similarly situated continuees. We do not ask for proof of insurability in order for an Employee to continue.

When Continuation Ends
A [Member's] continued health coverage end on the first of the following;

a) the date which is 12 months from the date the small group benefits would otherwise end;
b) the date the [Member] becomes eligible for Medicare;
c) the end of the period for which the last premium payment is made;
d) the date the [Member] becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the [Member];
e) with respect to a [Member] who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the [Member], the date such limitation or exclusion ends;
f) the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g) with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Contract.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by this Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then covered Dependents.

How And When To Continue Coverage
To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, covered under this Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay Us on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, Us.

When This Continuation Ends
These continued group health benefits end on the first of the following:
a) the end of the period for which the last payment is made, if the Employee stops paying.
b) the date the [Member] becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date this Contract ends or is amended to end for the class of Employees to which the Employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Contract.

EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:
a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If An Employee's Group Health Coverage Ends
Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care coverage will be continued. Dependents' coverage may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Coverage may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total period of 12 weeks in any 12 month period,
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

[A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were covered under this Contract may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of this Contract.]

[CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If an Employee's marriage ends by legal divorce or annulment, the group health coverage for his or her 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 the group health 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 group health 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 group health coverage under this Contract ends.

After group health coverage under this Contract ends, the former spouse and any children covered under the individual contract may still receive benefits under this Contract. If so, benefits to be paid under the individual contract, if any, will be reduced by the amount paid or the reasonable cash value of services provided under this Contract.]

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

As used in this section:
"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, covered by this Contract.
"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.
"Third Party" means anyone other than Us, the Employer or the Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us for benefits under this Contract prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:
a) a third party settlement;
b) a satisfied judgment; or
c) other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We have paid benefits or arranged [or provided] services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:
a) the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b) the third party, or its insurer, has admitted liability for the payment.

We will not provide benefits under this Contract or arrange [or provide] services and supplies to or on behalf of a Covered Person, to the extent such benefits, services or supplies would duplicate whole or partial payments, services or supplies such Covered person received from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Contract. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Contract will be the secondary health plan for [Members] who are eligible for Medicare.

The following provisions explain how this Contract's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A [Member] may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a) "Medicare" when used above, means Part 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.
b) A [Member] is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the [Member] is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health plan pays benefits for a [Member's] Covered Service or Supply or Covered Charge first, ignoring what the [Member's] "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits and Services** section for a definition of "allowable expense".

MEDICARE AS SECONDARY PAYOR (Continued)
MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability
This section applies to an Employee or his or her covered spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or covered spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a [Member], other than an Employee or covered spouse
b) an Employee or covered spouse who is under age 65, or
c) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Covered Spouse Becomes Eligible For Medicare
When an Employee or covered spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose this Contract as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Contract is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Contract will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, We will provide services and supplies and pay benefits as if he or she had' chosen Option (A).

When this Contract is primary
When a Medicare eligible chooses this Contract as his or her primary health plan, if he or she incurs a Covered Service and Supply or Covered Charge for which benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Contract. Coverage under this Contact will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Contract as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability
This section applies to a [Member] who is:
a) under age 65; and
b) eligible for Medicare by reason of disability.

Under this section, such [Member] is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a [Member] who is eligible for Medicare by reason of age; or
b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A [Member] Becomes Eligible For Medicare
When a [Member] becomes eligible for Medicare by reason of disability, this Contract is the primary plan. Medicare is the secondary plan.

If a [Member] is eligible for Medicare be reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits and Services** section of this Contract.

MEDICARE AS SECONDARY PAYOR (Continued)
MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability
This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a "ESRD Medicare eligible".

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD
When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both this Contract and Medicare, this Contract is considered primary. This Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both this Contract and Medicare, Medicare is the primary plan. This Contract is the secondary plan. If a [Member] is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of Benefits and Services** section of this Contract.

[STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:
a) Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the plan administrator's office and at other specified locations such as worksites and union halls.
b) Obtain copies of all plan documents and other plan information upon written request to the plan administrator, who may make a reasonable charge for the copies.
c) Receive a summary of the plan's annual financial report from the plan administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and

beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee's claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the plan administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the plan administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.].

CLAIMS PROCEDURE FOR [NON-NETWORK] BENEFITS

Claim forms and instructions for filing claims may be obtained from the plan administrator. Completed claim forms and any other required material should be returned to the plan administrator for submission to Us.

We are the Claims Fiduciary with discretionary authority to Determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, We will also observe the procedures listed below. All notifications from Us will be in writing.

a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after We received the claim.
b) If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which We expect to render the final decision.
c) If a claim is denied, We will provide the plan administrator, for delivery to the claimant, a notice that will set forth:
- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid. and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d) We will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, We will render a decision as soon as possible. but no later than 120 days after receiving the request. We will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.]

New Rule, R.1996 d.200, effective April 15, 1996.
See: 28 N.J.R. 27(a), 28 N.J.R. 2042(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.299, effective September 1, 1998.
See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

EXHIBIT II

[INTRODUCTION]

What is a Point of Service Plan?
A Point of Service Plan, often referred to as a POS plan, provides coverage for the services of ***in-network providers*** as well as the services of ***out-of-network providers.*** Whenever a person covered under a POS plan needs to access health care, he or she has the option to use the services of either an ***in-network provider*** (subject to any necessary authorization from his or her Primary Care Physician) or those of an ***out-of-network provider.***

What is the difference between an in-network provider and an out-of-network provider?
An ***in-network provider*** is a doctor, other practitioner or facility that has an agreement with [Carrier] to provide or arrange for covered services and supplies for the benefit of persons covered under the POS plan. An ***out-of-network provider*** is any licensed or certified provider that does not have a specific agreement with [Carrier].

Generally, the out-of-pocket cost to a person covered under a POS plan will be less if the person uses the services of an ***in-network provider*** rather than the services of an ***out-of network provider.***

How does the POS plan describe in-network and out-of-network coverage?
The POS plan contains a section which describes in-network coverage and sections which describe out-of-network coverage. The POS plan also contains many sections which apply to both the use of the services of ***in-network providers*** or the services of ***out-of-network providers.***

- **SCHEDULE.** Located in the beginning of the POS plan, the SCHEDULE identifies many of the covered services and supplies and specifies the applicable copayment for use of an ***in-network provider*** as well as the deductible and coinsurance requirement for the use of an ***out-of-network provider.*** The **SCHEDULE** also identifies some limitations to coverage.

- **COVERED SERVICES AND SUPPLIES.** This section contains a general description of the coverage a person would be entitled to if he or she were to use the services of an ***in-network provider.***

- **COVERED CHARGES** and **COVERED CHARGES WITH SPECIAL LIMITATIONS.** These sections contain descriptions of the coverage a person would be entitled to if her or she were to use the services of an ***out-of-network provider.***

How does a person access in-network providers?
[Carrier] will provide a [directory] listing all the Primary Care Physicians and facilities that have an agreement with [Carrier]. Each person must select a physician from that [directory] to be his or her Primary Care Physician, also called a PCP. The PCP supervises, coordinates, arranges or provides care, and refers a person for specialist services, as appropriate. The person may name a new PCP by notifying [Carrier].

Except in case of a medical emergency, in-network services and supplies can **only** be provided by an ***in-network provider*** (subject to any necessary authorization from his or her Primary Care Physician). [While certain routine OB/GYN care may be secured without going through the PCP, all other in-network services and supplies require the authorization of the PCP.]

How much will it cost for services and supplies if a person uses in-network providers?
[The Identification Card will specify the amount of the copayment the ***in-network provider*** will collect for most services and supplies.] For many services, after a person pays a copayment for the PCP visit, further services and supplies require no additional payment. Home Health Care and Durable Medical Equipment are examples of such services and supplies. [Carrier elected to cover prescription drugs subject to the same coinsurance requirement as applies to out-of-network covered charges.][Carrier elected to cover prescription drugs subject to a $[15] copayment.]

For example, if the POS plan required a $15 physician visit copayment, this amount would be collected from the patient, regardless of the reason for the visit and the actual cost of the services provided during the visit.

Are there restrictions on the use of an out-of-network provider?
Persons covered under a POS plan may use the services of an out-of-network provider as often as they like, subject to applicable benefit limitations. Referral from a PCP is not required, but certain services and supplies do require Pre-Approval from [Carrier], as outlined in the Contract and Evidence of Coverage.

How much will it cost for services and supplies if a person uses out-of-network providers?
After the payment of the applicable calendar year cash deductible, the person would be responsible for payment of the plan's coinsurance.

For example, assume a POS plan with out-of network benefits subject to a $250 deductible and 20% coinsurance. A person may go to a physician for a sick visit with total charges equal to $350. If the physician visit is the first out-of network charge for the year, the person would first be required to pay $250 to satisfy the deductible. Then, [Carrier] would pay 80% of the remaining $100 charges, or $80. The person's coinsurance share would be 20% of $100, or $20. Thus, the total cost to the person would be $270. After the deductible has been satisfied during a calendar year, further charges are only subject to the applicable coinsurance. **Note:** [Carrier] pays the applicable coinsurance with respect to the lesser of: a) the amount charged; or b) the Reasonable and Customary Charge, as defined in the Contract and the Evidence of coverage.